Thematic report by HM Inspectorate of Prisons

Court custody: urgent improvement required

A thematic review of court custody in England and Wales

by HM Inspectorate of Prisons

October 2015

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

ISBN: 978-1-84099-714-9

Printed and published by:
Her Majesty's Inspectorate of Prisons
Victory House
6th floor
30–34 Kingsway
London
WC2B 6EX
England

Contents

Acknowledgements

This thematic review was conducted by:

Gary Boughen
Inspector

Peter Dunn
Inspector

Majella Pearce
Deputy Head of Health Services Inspection

Vinnett Pearcy
Inspector

Fiona Shearlaw
Inspector

Introduction

Since we drafted this report there has been the first death of a detainee in court custody for many years and the apparent homicide of DCO Lorraine Barwell at Blackfriars Crown Court in July 2015. The investigations into these matters have not yet concluded, so we cannot make any link between the concerns we identify in this report and those terrible events. However, the concerns we identify have been repeatedly made known to HM Courts and Tribunals Service through the publication of the individual reports on which this thematic is based, and we are not satisfied they have been adequately addressed. Whether or not the tragedies that have occurred so far are related to these concerns, we are clear in our view that there is a real risk of further serious incidents in future.

Anyone can end up in court custody: the guilty and the innocent; those who are a threat to the safety of others and those who are a danger to themselves; healthy adults, children and those with the range of mental health and substance misuse problems familiar from police and prison custody.

This thematic review of my inspectorate's first eight inspections of court custody in England draws together findings from our inspections of 97 courthouses with custody facilities between August 2012 and August 2014. In short, we found some of the worst custody conditions we have inspected. The treatment of detainees and the conditions in custody suites were very low priorities for the different organisations involved, which failed to adequately coordinate their custody roles. We could find almost no one at local or national level who accepted overall accountability for this state of affairs or saw it as their responsibility to address our recommendations. The treatment and conditions we found were the consequence. We found filthy, squalid cells covered in old graffiti. The needs of women, children or other detainees with particular needs were often not understood or addressed. Routine security measures were often disproportionate or inconsistent. Complaint processes in most courts, in practice, were non-existent. Health care was inadequate. Of most concern and despite, in many cases, the best efforts of custody staff, we found a dangerous disregard for the risks detainees might pose to themselves or others. Court custody is an accident waiting to happen.

The pockets of good practice inspectors found, and the fact that most court custody staff tried hard to treat people in court custody decently, shows it is not inevitable that poor conditions and degrading, unsafe practices will prevail. This report identifies some examples of good practice and draws together the key recommendations necessary to make the urgent improvement required.

Our inspections of courts custody are part of the UK's obligations arising from its status as a party to the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), which requires state parties to establish a system of independent, preventive inspection of all places of detention. We began our inspections of court custody in 2012 and developed expectations (inspection criteria) and an inspection methodology that reflect the inspection methods we use in other places of detention.

Our expectations of court custody are modest. We expect there to be a clear strategy for and leadership of the custody function; that detainees are held for the shortest time possible; and that their rights are respected. While they are in custody we expect them to be safe and treated decently according to their individual needs. We expect any health needs they have to be dealt with effectively.

We found that no single organisation exercised any effective leadership for court custody provision at local or national level. Management of court custody operations is spread between several organisations which do not always communicate effectively with each other. No organisation has a good overall picture of the situation and in my view this explains why, in many clusters, physical conditions were poor, with deep cleaning and decorating clearly neglected for years. The valuable

insights of Lay Observers – whose independent scrutiny of court custody is of pivotal importance – are often overlooked.

The contract management process, while in many ways robust, has rarely led to significant improvements in outcomes for detainees because contract monitoring is focused largely on timeliness and security. These are imperative, but detainee care needs equivalent attention. Timely delivery of detainees to court is important, but it is concerning that so little priority is given to ensuring detainees do not spend inordinately long periods in court cells after their appearance is over. Meanwhile deficits in aspects of detainee care, such as risk assessment, where poor care could result in serious harm, are allowed to remain almost entirely unaddressed.

Established practices that are applied unquestioningly tend to cause the greatest disadvantage to the most vulnerable detainees. These include the longer journeys experienced by young people, the practice of transferring women on the same vehicles as men, and the handcuffing of disabled detainees in public.

Little importance is placed on detainees being given information about their rights in court custody. In practice there are no workable complaint processes.

Of most concern is the lack of any meaningful risk assessment when detainees arrive in court custody or are released. Custody staff often received very vague information about risks in person escort record forms, and were often reluctant to talk with detainees to help clarify concerns. A few custody staff did attempt to ask detainees how they were feeling, or about what had happened when they had harmed themselves before, but it was often clear that they lacked training in risk assessment. This meant that serious risks – including risks that detainees might harm themselves or others, lapse from sleep into coma, or become ill while in custody – were not managed. Cell sharing risk assessments, necessary at busy times when detainees had to share cells, were rarely properly conducted. Some senior custody officers were 'too busy' to do them and did not consider delegating the task to another custody officer. Important changes, such as the introduction of new cell sharing risk assessments, were often communicated to custody staff without a thorough briefing that would help to ensure their purpose was understood. The implementation of such changes was poorly monitored.

On release, pre-release risk planning was unusual with, on most occasions, only a travel warrant given to vulnerable detainees. Most did not benefit from custody staff exercising any ongoing duty of care. This is in sharp contrast to our findings in police custody inspections, despite there being similar issues on release. Unlike courts, most police services recognise they have a duty of care that extends beyond the confines of the custody suite.

Often, HM Courts and Tribunals Service (HMCTS) managers were unaware of how bad conditions in the cells were, or claimed that detainees only spent a couple of hours in them. In reality, we found that many detainees spent eight or 10 hours in a tiny cell with no natural light, and sometimes no heating, that might be filthy or covered in graffiti, on a hard wooden or plastic bench with nothing to do. We found some conditions that were a threat to the health of people working in or detained at the suite.

Provision for people who were pregnant, elderly or disabled was almost always inadequate. Custody staff had little awareness of the needs of children: it was rare for any allowance to be made for their age and concerns and children were sometimes detained for long periods without adequate supervision and reassurance.

Physical health care was poor, with treatment and medication often delayed in the belief it would be provided later in prison or police custody. The first aid equipment was often insufficient for the type of emergencies likely to occur. Mental health, often linked to what was available in the court itself, was better.

These finding are not acceptable.

In each section of this report we set out key recommendations from each of the eight individual court inspections we have undertaken and we continue to expect these to be addressed.

Overall, I recommend that Ministers insist that HMCTS develops and publishes a strategy with clear performance measures for the rapid improvement of detainee treatment and custody conditions. This should include:

- the identification of named individuals at local and national level responsible for court custody conditions and treatment
- the establishment of effective and regular structures at local and national level to coordinate the work of all the organisations with a role in court custody, including the Lay Observers
- measures, including the further use of virtual courts, clear protocols with prisons and revised escort contracts, to reduce the amount of time detainees spend in court custody
- the establishment of an effective complaints procedure for all detainees in court custody and under escort that is procedurally fair, is quality controlled and in which trends are collected and monitored at national and local level
- a national programme to identify where deep cleaning and basic maintenance is required and arrangements to carry this out where necessary
- a review of arrangements for carrying out risk assessments and a requirement on managers to check the quality and timeliness of such assessments
- arrangements with the Youth Justice Board and other relevant bodies to ensure that children and vulnerable adults in court custody have their needs monitored by an appropriate adult
- the inclusion of health care in court custody in England in NHS England offender health commissioning arrangements.

Nick Hardwick August 2015
HM Chief Inspector of Prisons

Section 1. Summary

Leadership, strategy and planning

1.1 The safety and decent treatment of detainees in court custody was often neglected. A range of difficulties had contributed to a lack of inter-agency action to safeguard outcomes for detainees. Each organisation involved in court custody operations worked to different imperatives. For example, HM Courts and Tribunals Service (HMCTS) was concerned primarily with efficient case management, while the custody contractors were focused on security and timely delivery of detainees to court. While these were important, they were given much greater priority than the basic conditions in which detainees were held. There was little collective attention given by the various organisations to detainee care and safety.

1.2 In many courts there was a lack of contact between HMCTS court managers and court custody staff, and many inter-agency forums that could have devised solutions to difficulties in court custody had stopped meeting. Where the agencies did meet, not all with a role were represented.

Individual rights

1.3 Many, but not all, courts had good arrangements in place for prioritising hearings for vulnerable detainees in custody, such as children. But even when their cases were heard promptly, many spent long periods in court custody awaiting transfer. Custody and escort contractors depended on vehicle crews to help staff the court docks during the day, so there were none available to enable transfers at lunchtime. Too often, detainees who were acquitted, bailed or sentenced to community penalties could not be released immediately because the prison in which they had been held took a long time to authorise release. In some courts, fine defaulters were taken into custody, even for very minor matters, whereas in others they were allowed to wait in the court for their case to be heard. There was no good rationale for such variations, which resulted in the disproportionate and unnecessary use of custody. On some occasions, difficulties with the HMCTS-managed court interpreter contract meant the court was unable to consider bail for detainees who could not speak English. When this happened, the lack of telephone interpreter services meant that custody staff, despite their best efforts, could not explain to detainees what had happened or where they were being taken.

1.4 Few detainees were informed of the complaints process and custody staff were not proactive at recording complaints, even when detainees expressed dissatisfaction. Analysis and learning from complaints was almost non-existent.

Treatment and conditions

1.5 Women, men and children were often transferred together in cellular vehicles, which provided opportunities for male detainees to harass women. Sometimes, a woman was carried in a vehicle crewed solely by men. Most custody staff were friendly and courteous to detainees on their arrival in court custody, but many interacted with them very little thereafter, even when it was clear they would have benefited from some support. Many custody staff knew little about the specific needs of members of minority groups and there were a few examples of very disrespectful treatment.

1.6 There were no systematic risk assessments undertaken with each detainee and we found examples of important information, such as the need for an interpreter, or details of illnesses, being overlooked as a result. At the busier courts, cell sharing risk assessments (CSRA) were often completed after detainees had left the court, or not done at all. Decisions about how vulnerable detainees would be cared for were usually made on the basis of information in person escort record (PER)[1] forms from the police or from prisons, where content was often inaccurate or incomplete.

1.7 Use of force to restrain non-compliant detainees was rare, and most custody staff had good interpersonal skills that enabled them to calm potential conflicts. However, use of handcuffing was excessive, with all detainees handcuffed even within the secure area of the custody suite. Many detainees were handcuffed in public, including when entering and leaving cellular vehicles in the street. We were told of instances in which disabled detainees were taken in handcuffs through public areas of the courthouse because there was no secure, private, step-free route to the courtroom. Custody staff claimed that handcuffing was based on risk assessment but we could find no written risk assessments to justify it and at many courts decisions about handcuffing were based on custom and practice.

1.8 Custody staff usually checked on detainees in cells at the required intervals, but at some courts there were sometimes too few staff to be able to so sufficiently frequently to meet safety and security requirements.

1.9 At many courts, basic cleaning and maintenance had been neglected. At some, there was scarcely an inch of cell wall that was not covered in graffiti, some of it racist, offensive to women, or containing abuse and threats against named individuals. Much of it had been there for many years. Problems with the cleaning contractor's performance at some courts meant that detainees were held in unhygienic conditions. At more than one, detainees told us they were reluctant to use the communal toilet because it offered little privacy and was dirty.

1.10 Custody staff at some courts had made impressive efforts to improve conditions, even by repainting cells themselves, but at others they seemed to have become inured to the degradations of the physical environment.

Health care

1.11 Each court custody suite had access to health care advice from a contractor, which could also provide a paramedic if needed, but we found the service was used very little even when there was a clear need for advice. Detainees who might be unwell could therefore face long journeys without having had any medical attention. No courthouses had automated external defibrillators (AEDs) and first aid kits were usually inadequate.

1.12 We saw many instances in which detainees who had been prescribed medication in police custody were supplied with insufficient medication to last them through a long day at court, even when it should have been taken at predetermined intervals to be effective. Person escort records (PERS) sent from police stations and prisons were not handled confidentially and lacked important information.

[1] A PER must be completed for every escorted external movement of a prisoner, whether responsibility transfers to another agency or not and to whatever destination. It is designed to convey information about the assessed risks to others who may need to know about them.

1.13 Access to mental health services in court custody was variable: it was excellent in some courts, yet difficult to obtain in neighbouring areas. Most custody staff told us they would like to acquire better skills in working with detainees who had mental health problems.

Section 2. Aims of this report

2.1 In 2012, as a result of The Public Bodies (Abolition of Courts Boards, Her Majesty's Inspectorate of Courts Administration and Public Guardian Board) Order 2012, HM Inspectorate of Courts Administration was disbanded and responsibility for the inspection of court custody transferred to HM Inspectorate of Prisons.

2.2 Since our first inspection of court custody in Cleveland, Durham and Northumbria in August 2012, we have carried out eight further inspections of court custody and published eight reports. The aim of this short thematic report is to bring together and summarise the findings from those first inspections. These inspections and this report are purely concerned about the treatment and conditions of detainees in court custody. They do not address any matter which happens in the court itself.

2.3 There were wide variations in the characteristics of the areas inspected, which included inner city courts such as in Liverpool, as well as rural areas with dispersed populations like Suffolk. Two separate companies, Geo Amey and Serco Wincanton provided court custody and most of the escort services.

2.4 The principle findings from the inspections, especially the findings about which we had most concern, were, to some extent, common to all the areas we inspected. Court custody operations are particularly complicated because they are largely subject to national contracts but they depend on good local inter-agency cooperation for the quality of care provided to people detained in court custody. Our inspection reports address issues that need to be tackled nationally through HMCTS structures and the contract management process. The reports are also concerned with the way in which local arrangements can either enhance or hamper efforts made by the providers and those who manage the contracts to improve detainee care, and reduce the length of time detainees spend in what are usually unsatisfactory conditions in court cells. Our intention is that this short thematic report will be used to address the larger national considerations that determine the way in which detainees are treated and which are less open to being shaped by local management arrangements than the day to day practice 'on the ground'.

2.5 This report, and our experience of inspecting court custody (an area of custodial provision in which we have not previously been involved), will be used to revise and update our *Expectations: Criteria for assessing the treatment and conditions for detainees in court custody*, originally published in 2012. The revised version of court custody *Expectations* will be published in 2015, following consultation. The new *Expectations* will also draw on the findings from transfers and escorts within the criminal justice system, and will link to our *Expectations for police custody* which are also currently under review.

2.6 HM Inspectorate of Prisons' remit only extends to the treatment and conditions of detainees held in court custody. The important matters of the overall efficiency of the courts system are outside our remit and while there is obviously some link between the efficiency of the system and the treatment of detainees, this report does not address the former.

2.7 However, in his report on efficiency in criminal proceedings, the Rt Hon Sir Brian Leveson observed that: 'the criminal justice system is not, in reality, a single system: the police, the CPS, the defence community, HMCTS, the judiciary, the probation service and NOMS (to say nothing of the Ministry of Justice and the Home Office) all have different priorities and different financial imperatives with performance indicators (where they exist) that are not aligned. The only way of improving the end to end operation is to bring the different participants in these systems together to debate and agree on initiatives to improve the

whole'[2]. Our findings in just one aspect of the system, court custody, echo those wider conclusions.

[2] Leveson, Sir Brian (2015) *Review of efficiency in criminal proceedings Judiciary of England and Wales* (https://www.judiciary.gov.uk/wp-content/uploads/2015/01/review-of-efficiency-in-criminal-proceedings-20151.pdf)

Section 3. Background to this report

3.1 Court custody inspections contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – to prevent the ill-treatment of detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

3.2 Inspections focus on outcomes for detainees in three areas: strategy, individual rights, and treatment and conditions, including health care. Each area is underpinned by a set of standards known as *Expectations* which set out the outcomes for detainees we expect to find. These *Expectations* are referenced against international human rights standards and norms, have been drawn up in consultation with stakeholders, and were revised in the light of two pilot inspections in 2011.

3.3 This thematic reviews findings from our first eight court custody inspection reports published between October 2012 and February 2015. During those inspections, 27 Crown courts and 70 magistrates' courts were inspected, including juvenile courts. It also draws on our 2014 thematic report *Transfers and escorts within the criminal justice system*[3]. That thematic report collated findings across the places of detention that we inspect, providing a comprehensive overview of detainees' treatment and experiences during escorts and transfers.

3.4 A consistent theme of our court custody inspections is that no single organisation has an overview of the whole picture, and as a consequence, problems often remain unresolved.

3.5 HMCTS is an executive agency of the Ministry of Justice (MOJ) and was created on 1 April 2011 through the merger of HM Courts Service and HM Tribunals Service. It operates on the basis of a partnership between the Lord Chancellor and the Lord Chief Justice. The Lord Chancellor is the minister responsible to Parliament for courts, tribunals and the justice system. He has a statutory duty to uphold the continued independence of the judiciary. His statutory responsibilities include ensuring that there is an efficient and effective system to support the business of the courts and tribunals, resourcing the system adequately, and ensuring the judiciary is supported in undertaking its function to deliver justice independently[4].

3.6 HMCTS has overall responsibility for the administration of the criminal, civil and family courts and tribunals in England and Wales and non-devolved tribunals in Scotland and Northern Ireland, and this includes court custody. HMCTS works with the independent judiciary to provide a fair, efficient and effective justice system.

3.7 The process of creating HMCTS in 2011 involved restructuring and the closure of many local court houses. HMCTS has a regional structure and courts in each region are arranged in 'clusters' that encompass all the criminal courts in one or more of the counties in the region. Each cluster has a cluster manager, supported by a team of delivery managers who are responsible for operations in one or more court houses. In 2014 there were approximately

---

[3] HMI Prisons (2014) *Transfers and escorts within the criminal justice system: a thematic review by HM Inspectorate of Prisons*

[4] Section 1 Courts Act 2003, section 39 of the Tribunals Courts and Enforcement Act 2007.

240 magistrates' courts and 76 Crown court locations in England and Wales[5], arranged in clusters that usually correspond to one or more counties or major cities.

3.8 Since 2011, two court custody and escort companies have been commissioned by the National Offender Management Service Prisoner Escort and Custody Services (NOMS PECS) to staff court custody and provide escort services, on behalf of HMCTS. The two companies are Serco Wincanton, which provides services in London and the Eastern Region, and GEOAmey, the contractor for all the other regions in England, and Wales. Contractual arrangements between NOMS PECS and the two main court custody and escort contractors are supervised by a network of PECS contract delivery managers based regionally. The MOJ announced at the time that 'these contracts will save the government over £250M, a saving of 20 per cent over the seven year contract. The National Offender Management Service is committed to making its contribution to reduce public borrowing and achieving best value for money for the taxpayer'[6]. A third company, Serco, is contracted by the Youth Justice Board (YJB) to provide the secure escort service for children going to or from secure training centres (STCs).

3.9 There were 818,168 PECS escort journeys between October 2013 and September 2014 – including 23,585 escorts of children – and the total cost of the contracts was £128.2 million. This included inter-prison transfers. In 2014, NOMS PECS escorted 139,157 detainees to the Crown court and 263,384 to the magistrates' courts, from police stations and prisons. In addition, PECS contractors received 18,226 detainees into custody who had previously been on bail at the Crown court, and 11,128 in the magistrates' courts.

3.10 GEOAmey and Serco Wincanton employ prisoner escort and custody officers (PCOs) who are based either at a particular court if they primarily staff court custody, or at one of the regional vehicle bases if their role is mainly to collect and deliver detainees in cellular vehicles from police stations to court and to prison. To ensure that vehicle 'crews' are fully deployed when the courts are sitting, they help with staffing the court custody operation when not out on the vehicles, and that includes cell checks and supervising detainees in the dock while their cases are being heard. PCOs are supervised by a senior custody officer (SCO) at the vehicle base or at the court. Usually, each courthouse has one SCO, though a small number of SCOs are responsible for custody operations at more than one court.

3.11 Other contractors are also involved. Cleaning of cells is the responsibility of a different contractor, and some courts are owned by a separate company which has their own system for maintenance. Other organisations, in particular police services, the local prisons, and health service providers, also have a role to play in court custody and escorts. Among this complex interplay of multiple contractors, commissioning, and performance targets, the needs of detainees in court custody and while under escort can be overlooked.

3.12 A detainee may come into court custody in a number of ways. In simple terms, most people who are charged with an offence are bailed by the police to appear at the local magistrates' court. People are bailed if the offence is not very serious, if the police believe it is unlikely they will fail to attend court, or if there are no strong objections to them being on bail while they wait to attend court. Some people who are charged with an offence are not bailed by the police. That is likely to be when the offence is very serious, if the detainee has a history of failing to attend court in the past, or if it is believed there are strong risks associated with being on bail, such as a risk of further offending or interfering with witnesses. These detainees are kept in police custody until they can be taken to the next available court, usually the local magistrates' court the next day. Sometimes the detainee might be taken to an 'occasional' court, which is a magistrates' court that is convened to sit on a Saturday or

[5] Ministry of Justice (2014) Court Statistics Quarterly April to June 2014: Ministry of Justice Statistics Bulletin

[6] Ministry of Justice (2011) New prison escort contact to save £250M; News story. Gov.UK web site.

bank holiday; but this is not possible in every area and some detainees charged on a Friday afternoon stay in police custody until the next working day, usually a Monday.

3.13 During the night, police custody staff send a list of detainees in police custody who need to go to court the next day to the escort and court custody contractor, which makes arrangements for them to be collected by one of its cellular vehicles the next morning. The escort contractor then collects detainees from the police custody suite on the morning of the court appearance. Detainees will be taken in handcuffs from the police cells to the cellular vehicle, then on arrival at the court will be taken from the vehicle and placed in a court cell. They may have a consultation with a legal adviser, but otherwise will wait in the cell until it is time to go into the dock. At busy times, several detainees might share a court cell. In some courts, police and court cells are located in the same building and the same cells are sometimes used by both services. In these instances vehicles are not needed, but arrangements must be in place to hand over responsibility for the people in custody from police to court custody staff. Sometimes defendants on bail are remanded in custody by the court, or given a custodial sentence. They are then brought into court custody as 'off-bailers' directly from the dock.

3.14 If the court acquits a detainee or gives them bail or a non-custodial penalty, they are released by court custody staff. If a detainee is sentenced to custody or remanded in custody, they will stay in the court cells until a cellular vehicle arrives for the transfer to prison. Usually, several detainees will be carried on one cellular vehicle, which might have to stop at several prisons to deliver detainees. For that reason, journeys to prisons only a short distance from the court can sometimes take several hours because multiple stops, possibly involving waiting to get access to the prison, might be made.

3.15 When a detainee is remanded in custody and returns to court at a later date, the escort contractor will send a cellular vehicle to the prison to collect him or her for the court appearance.

3.16 Sometimes people subject to warrants for failing to appear previously, or failing to pay a fine, are brought to court by police officers, or in some areas, by civilian court enforcement officers (CEOs) who are contracted by the court. Arrangements for dealing with people subject to warrants vary from one area to another: sometimes they can be allowed to wait at the back of the court until called forward; in some areas the CEO or police will bring them into court custody and they wait in a cell; and in some circumstances they are arrested and taken into police custody from where they will be detained and taken to court by the process described above. This often applies to people for whom a warrant has been issued for relatively minor matters that would not normally result in custody.

3.17 Most detainees appearing in the Crown court will have had their first appearance for the case in the magistrates' court. They will have been committed to Crown court for trial or sentence if the matter is so serious that the magistrates do not have the power to deal with it in the event of a conviction, or if the defendant elects to be tried in the Crown court. Detainees are brought to Crown court in the same way as they are brought from prison custody to the magistrates' courts.

Section 4. Methodology

4.1 The findings in this report are drawn from a review of the reports of eight custody cluster inspections. The clusters inspected were as follows:

Dates	Cluster	Custody and escort provider	Number of courts with custody facilities	Total number of cells
6–15 August 2012	Cleveland, Durham and Northumbria	GEOAmey	16	158
15–19 October 2012	Merseyside and Cheshire	GEOAmey	14	114
18–26 February 2013	Lancashire and Cumbria	GEOAmey	16	126
8–11 July 2013	Nottinghamshire and Derbyshire	GEOAmey	6	120
30 September to 4 October 2013	Norfolk and Suffolk	Serco Wincanton	8	64
6–14 January 2014	Cambridgeshire and Essex	Serco Wincanton	11	129
14–23 July 2014	Kent	GEOAmey	10	78
11–20 August 2014	Surrey and Sussex	GEOAmey	13	102

4.2 Information in this report is presented in an order that mirrors our *Expectations* for court custody, so the chapter headings are 'leadership, strategy and planning', 'individual rights', and 'treatment and conditions', but with health care presented in a separate chapter. Each chapter starts with the overall expected outcomes and a summary of the individual expectations that inspectors use when inspecting that particular area of provision. The chapters conclude with the key recommendations we have made and examples of any good practice we have identified.

Section 5. Leadership, strategy and planning

Expected outcomes
There is a strategic focus on the care and treatment of all those detained, during escort and at the court, to ensure that they are safe, secure and able to participate fully in court proceedings.

Expectation
Within each court area there is a strategic and inter-agency focus on custody issues, which promotes the safe, secure and decent delivery of escort, custody and court requirements.

> 'There were good relationships between HMCTS and Serco Wincanton but, as in other regions we have inspected, they had not resulted in effective action being taken to improve outcomes for detainees. There was uncertainty about HMCTS's role in relation to the provision of court custody, and few formal channels through which problems concerning the care of detainees could be resolved. Arrangements for inter-agency collaboration differed between the two counties and overall, leadership was somewhat fragmented.' **(Cambridgeshire and Essex)**

5.1 In all eight inspections, we found a range of difficulties had contributed to a lack of inter-agency action being taken to safeguard outcomes for detainees. Each organisation involved in court custody operations worked to different imperatives. The custody and escort contractors were primarily concerned with preventing escapes and ensuring that detainees were delivered to the dock on time as these were the subject of stringent contractual requirements. HMCTS had recently restructured and at the time of the first four inspections, new posts and processes were bedding in. The focus of these posts and processes was on efficient and effective administration of justice and the achievement of cost savings.

5.2 The failures of one organisation impacted on others. For example, failures in the national cleaning contract meant that court custody staff placed detainees in dirty cells (see paragraphs 7.39–7.41). In some regions, the geographical areas for which agencies were responsible did not correspond with each other. The custody contractor's regions did not reflect the court cluster boundaries and the clusters dealt with more than one health trust. Primary health care in court custody is now the only part of offender health care that is not commissioned by NHS England, which contributes to a variation in services and a gap in provision between police and prison custody. This increased the complexity of the management arrangements and meant that services available at court in one part of the cluster, for example mental health outreach, were not accessible in another. In Nottinghamshire and Derbyshire for example, HMCTS had little contact with GEOAmey, except in Derby where HMCTS had taken the initiative to arrange a special meeting to improve operational difficulties, which had been productive.

5.3 Some HMCTS managers acknowledged that they rarely visited the cells.

> 'There was little evidence that HMCTS staff monitored the treatment and conditions of detainees to any agreed standards. They were not involved in the implementation of new policies and practices by the contractor, even though some of these (for example, the assessment of vulnerability) were instrumental in detainees' capacity to participate in criminal justice processes.' **(Lancashire and Cumbria)**

5.4 In Surrey and Sussex, court managers acknowledged that, until recently, they seldom visited the cells, but facilities managers were now expected to make a monthly visit to the custody suites for which they were responsible, which was a positive development.

5.5 In all clusters we inspected, court user groups (CUGS) had been used as a forum to resolve operational problems among the various organisations involved in the local courts, including statutory agencies and local solicitors. However, we found that CUGs had frequently lapsed, or took place only occasionally. Sometimes we were told there had not been a meeting lately as there had been no items put forward for the agenda. At some CUGs, court custody contractors were not represented, or if they did attend, custody was rarely discussed. This was despite the existence in all clusters of a range of difficulties involving the interaction of custody operations with other parts of the criminal justice system, including poor physical conditions in the cells, inadequate consultation rooms in the cell areas for legal advisers and prison 'lock-outs'[7].

5.6 In Norfolk and Suffolk, contact between HMCTS and the custody contractor Serco Wincanton was managed by local HMCTS delivery managers, but not all visited courts regularly and the cordial 'just pick up the phone' approach that they described had not achieved improvements. HMCTS staff had been concerned about low staffing levels in custody but they told us they were unsure how to address it. Serco Wincanton managers met monthly with their PECS contract delivery manager, but we found that:

> '… the meetings were concerned more with security and timely delivery of detainees to court than about detainee care, and participants could recall few instances where detainee care had been discussed.' **(Norfolk and Suffolk)**

5.7 In Cambridgeshire and Essex too, HMCTS had concerns about low staffing levels in custody, which they told us had caused problems getting detainees to court. They were not convinced the contract monitoring picked up all the difficulties they experienced. In September 2013 the MOJ made Serco Wincanton subject to administrative supervision following allegations of fraud and concerns about staffing levels. We found that:

> '… the slow response to such concerns (about staffing in the court custody suites) risked causing unsatisfactory practices in custody to become embedded, particularly those relating to detainee care and safety.' **(Cambridgeshire and Essex)**

5.8 The lack of effective inter-agency forums meant that meetings between the various organisations sometimes had to be convened on an ad hoc basis to discuss a particular difficulty. A meeting arranged by an HMCTS delivery manager in Derby to clarify the roles and responsibilities of the various agencies had led to a reduction in the unacceptably long journeys young people experienced to and from court. Others had not been so productive because not every relevant organisation had been invited, or had not attended.

5.9 Lay Observers[8] were often not invited to inter-agency forums and in some areas, HMCTS managers did not meet them at all. We often noted that concerns reported by Lay Observers remained unaddressed, often for months or years.

5.10 Communications within the custody contractor's own organisations were sometimes problematic. There were few opportunities for SCOs to meet together to share good practice or resolve problems. GEOAmey and Serco Wincanton managers told us they regularly visited the courts cells for which they were responsible, but nevertheless there was often an over-reliance on emails to communicate changes in policy and practice that affected detainee care.

---

[7] The term 'lock-outs' refers to prisons refusing to accept detainees from court after a particular time, usually because they can only staff their reception for a limited period each day, or because the prison is full.

[8] Lay Observers are groups of volunteers who visit court custody regularly to provide independent oversight of conditions. They are part of the National Preventive Mechanism.

> 'On the first day of the inspection, a new cell sharing risk assessment form was introduced and emailed to SCOs, with no briefing; SCOs were then expected to brief their staff, which was a poor method of introducing such an important document. Although staff we spoke to were aware of the new form, none knew why it had been introduced and they had varying views about how, when and by whom it should be completed.' **(Lancashire and Cumbria)**

5.11 Unsurprisingly, this type of communication was indicative of a general failure to exercise good leadership and that contributed to lack of clarity among custody staff in every cluster inspected about how they should care for detainees.

> 'Care of detainees should have been much better. [Custody staff] had received little training in looking after and safeguarding young people; and they had not been briefed about the particular needs of detainees who were members of minority groups. Staff did not inform detainees of their rights in court custody and they sometimes failed to follow basic procedures to safeguard those who were potentially vulnerable.' **(Cambridgeshire and Essex)**

5.12 Recommendations that we made about leadership strategy and planning in the first eight court custody inspection reports included:

- HMCTS local managers should visit court custody suites regularly, to monitor standards and to resolve or escalate any issues as appropriate. (Cleveland, Durham and Northumbria)
- Court user-groups should meet at regular intervals to support communication and good working relationships between key stakeholders. (Cleveland, Durham and Northumbria, Merseyside and Cheshire, Lancashire and Cumbria)
- There should be regular liaison between HMCTS and custody managers so that court custody operations are reviewed and problems resolved. (Lancashire and Cumbria)
- HMCTS and the PECS contractor should work together to establish clear joint arrangements to ensure that Lay Observers' concerns are understood and addressed effectively. (Norfolk and Suffolk)
- There should be clear procedures for safeguarding vulnerable detainees, including those released from court, and custody staff should be briefed about how and when to use them. (Nottinghamshire and Derbyshire, Norfolk and Suffolk, Cambridgeshire and Essex)
- HMCTS should make more use of video link, 'virtual court' facilities and other provisions to reduce the need for detainees to be transported long distances to courts. (Cambridgeshire and Essex)

Section 6. Individual rights

Expected outcomes
Detainees are able to obtain legal advice and representation. They can communicate with legal representatives without difficulty.

Expectations
- Detention in court is appropriate, authorised and lasts for no longer than is reasonable.
- Detainees are given sufficient time before and after a court appearance to obtain legal or welfare advice.
- Detainees know how to make a complaint and are able to do so.

> 'People who attended Liverpool Magistrates' Court voluntarily to surrender for failure-to-appear warrants were directed across the city to the police station, where they would be arrested, detained in a cell and then brought back to court custody in a GEOAmey vehicle. It was not clear why (they) needed to be held in cells and be subjected to the associated handcuffing.' **(Merseyside and Cheshire)**

Expectation: Detention in court is appropriate, authorised and lasts for no longer than is reasonable.

6.1 In many of the eight clusters, practice varied in dealing with people arrested for fine default or for non-appearance at court. Practice varied widely not just between clusters, but between courts in a cluster as well. It was positive that at some courts, people could hand themselves in and wait to be called forward for their hearing. However, at others, people who voluntarily surrendered were told to go to the police station where they would be arrested by the police, detained, and taken to court. At Blackpool Magistrates' Court we saw a court enforcement officer unnecessarily arresting a young person who had surrendered to a warrant, and bringing him into court custody. He was later bailed. The reason for such variations, and the arrests that often resulted, seemed more related to custom and practice than any rational imperative. At Teesside Magistrates' Court, a woman surrendered to the court because she heard there was a warrant outstanding for not attending court in connection with failing to ensure her children attended school. The court directed her to go to the police station, where she was arrested and taken back to the court in custody. As is the practice in some other courts, she could have been told to wait at the court until her case could be heard.

6.2 Often, custody staff tried to minimise the time that potentially vulnerable detainees (such as children or those who had previously tried to harm themselves) spent in custody by liaising with the HMCTS court listing staff. Sometimes, this led to their cases being heard early in the day. There was a good system at most of the Surrey and Sussex courts for ensuring that the court clerk was notified when children were in the court custody suite, where HMCTS prioritised their hearings whenever possible. At Guildford Magistrates' Court, we saw four children brought into custody in the morning dealt with and released by noon, but this was not the case at all the courts in the cluster.

6.3 Many detainees spent long periods in court cells.

> 'Records at Liverpool Youth Court showed that on one day… three young people had arrived in the cells at 8.30am but had not appeared until after 3.30pm, despite the SCO attempting to expedite matters. A YOT manager told us that, while YOT and custody

> staff raised such issues at meetings of the court user group, they had little influence on court listings.' **(Merseyside and Cheshire)**

6.4 In most clusters, we found considerable variations in practice within the cluster as well as between them, and it was unclear why such variations were allowed to persist. In Merseyside and Cheshire, we found that at most courts, relationships between custody and court staff were good and SCOs could often get custody cases heard early. But this was not always the case. At Chesterfield Magistrates Court (Nottinghamshire and Derbyshire) relationships were not so effective. Custody staff told us that court staff were sometimes unwilling to answer questions about the listing of custody cases. In Merseyside and Cheshire, court cut off times were very flexible and often detainees could be brought from police stations mid-afternoon instead of the court closing its list soon after lunch, as often happened elsewhere. This was not the case in most clusters, with many courts refusing to accept detainees from the police after about 2.30pm. This often resulted in detainees spending a further night in police custody when their cases might have been dealt with the same day.

6.5 Long periods in court custody were also caused by other factors, some of which were attributable to administrative conventions rather than legitimate judicial considerations. It was common for detainees who had been bailed or acquitted, but previously been remanded in custody, to have to wait long periods for the prison they had come from to authorise their release.

> 'Crown Court, custody staff marked all person escort record forms (PERs) accompanying detainees from prisons and YOIs as 'NFR' (not for release), regardless of whether or not they knew that they were not for release. In the event of the detainee being bailed or acquitted, [custody] staff contacted the establishment to check if release could take place. Detainees from HMP Durham, in particular, could be held for an average of about two hours, and sometimes up to five hours, because the prison took some time to respond to requests to authorise release. At Teesside Crown Court, barristers had complained about their clients not being released within a reasonable time.' **(Cleveland, Durham and Northumbria)**

6.6 There were delays in obtaining placement orders from the Youth Justice Board, which sometimes caused waits for up to five hours before cellular vehicles could be booked to take children to young offender institutions. In Lancashire and Cumbria we found delays of up to five hours in receiving the placement order. We saw a report of a 2011 Lay Observer's visit to Carlisle Magistrates' Court that had drawn attention to the matter. Sometimes, delays in receiving the warrant from the court also held up the process of transferring detainees from court cells to prison. In many areas, Serco Wincanton and GEOAmey managers had commendably negotiated with the local prisons to accept interim warrants so that detainees could be moved before HMCTS staff issued the legal documents.

6.7 Our *Transfers and escorts within the criminal justice system* thematic (2014) found that in inspections of YOIs, young people often had long waits in court custody. Many waited up to seven hours in court custody and arrived at the YOI after 7pm. The report noted that 'these late arrival times can have a detrimental effect on the way that the establishment can assess and support the young person on arrival'.

Expectation: Detainees are given sufficient time before and after a court appearance to obtain legal or welfare advice.

6.8 In most court custody suites we found detainees were given little information about their rights in court custody.

> '[Custody staff] simply gestured towards a notice of rights and entitlements displayed on the wall, stating, "you know your rights"… We heard one custody officer telling a detainee, "the only right you've got, dear, is the right to breathe", and we heard this phrase repeated on another occasion.' **(Cleveland, Durham and Northumbria)**

6.9 Despite recommendations in our inspection reports, and inspectors drawing this deficiency to the attention of custody staff during every inspection, Serco Wincanton, GEOAmey and the PECS contract delivery managers made little progress in ensuring detainees were provided with proper information about their rights. Almost two years after inspecting courts in Cleveland, Durham and Northumbria, the situation was largely the same in Cambridgeshire and Essex, where we noted that detainees were told 'you know your rights' and there were different versions of the rights leaflet in use. Occasionally at some courts, custody staff started briefing detainees about their rights during the inspection and paper copies of the rights information were placed in cells. However, these good efforts had rarely been sustained when we returned to the court a day or two later. It was unusual for custody staff to ask detainees if they could read and if they needed their rights explained to them.

6.10 GEOAmey, but not Serco Wincanton, had a contract with a telephone interpretation service that theoretically was available to custody staff for explaining rights or interviewing detainees about matters such as health and self-harm concerns. However we found that the interpretation services were almost never used, partly because the only telephone in the custody suite was situated in the staff office that detainees were not allowed to enter.

6.11 At most courts, custody staff proactively contacted detainees' legal advisers and ensured detainees had prompt access to them when they arrived at court. However, provision of consultation rooms was sometimes unsatisfactory.

> 'At Newcastle Magistrates' Court, the absence of interview rooms meant that legal and welfare consultations had to take place in the corridor, in cells and even in a redundant shower, affording little privacy, dignity or comfort. At Consett, there was only one interview room, so interviews often took place in cells.' **(Cleveland, Durham and Northumbria)**

6.12 In Lancashire and Cumbria, consultation rooms were closed visits rooms where a glass screen separated the detainee from the legal adviser, and paperwork could not be passed. Legal advisers there preferred to see their clients in cells, with the doors open, which compromised privacy.

6.13 We found evidence at some courts of serious consequences for detainees arising from the lack of suitable interpretation services, especially where the HMCTS-commissioned court interpreter service had failed to send an interpreter to court, a situation which could mean the court was unable to consider bail.

> 'We noted on several occasions interpreters had not attended court and detainees had been remanded in custody. This had been noted by Lay Observers… These difficulties were compounded because the custody staff had no access to a telephone interpreting service in the custody suites. Consequently, detainees refused bail could be taken to prison without understanding what had happened in court or where they were going.' **(Norfolk and Suffolk)**

Expectation: Detainees know how to make a complaint and are enabled to do so.

6.14 Approaches to the handling of complaints by detainees varied greatly in the eight clusters inspected.

> 'At one court, we heard detainees on release being told, "sign here for your property and to say you have no complaints". At the time of the inspection, there was no provision for appealing against the outcome of a complaint about court custody.' **(Cleveland, Durham and Northumbria)**

6.15 Many custody staff did not understand the importance of detainees being able to complain, or the potential complaints have for helpfully drawing attention to problems. At one court, custody staff told us they had advised a detainee not to make a complaint about a particularly long wait he had experienced in a cellular vehicle, because little could be done about it. In contrast, at Derby Crown Court, custody staff described having helped detainees make complaints about the cells being cold.

> 'During the inspection, [custody] staff at one court were unable to find a Serco Wincanton complaint form, although they found some that had been issued by a previous contractor. At some courts, Prison Service complaints forms were available but were not applicable in court custody. Information about making a complaint was displayed in some courts but the notices contained incorrect information. We were told that few complaints were recorded, so there was no provision for monitoring them and analysing trends.' **(Cambridgeshire and Essex)**

> 'At Medway Magistrates' Court, a detainee was not asked if he wished to complain when his property, which escort staff had signed for, had been left behind at the police station… Custody staff did not inform detainees of their right to make a complaint, even when they expressed dissatisfaction during their detention.' **(Kent)**

6.16 Complaints in Merseyside and Cheshire were managed better. All detainees were told of the complaints process on arrival and custody staff believed cell deep cleans had resulted from a detainee complaint, though complaints were rarely made and there was no feedback to custody staff about the outcomes of investigations. In Lancashire and Cumbria complaints information was displayed at some courts and at Blackpool the SCO asked each detainee on release if they wanted to make a complaint. GEOAmey was, however, unable to provide complaint statistics for Lancashire and Cumbria because the data were not collated by region.

6.17 Since the first court custody inspection NOMS PECS have established a system for dealing with appeals by detainees in court custody about the outcomes of complaints investigations.

6.18 Recommendations that we made about individual rights in the first eight court custody inspection reports included:

- Detainees who have attended voluntarily and who can be dealt with at court on the same day should not be arrested unless there is a good reason to detain them. (Cleveland, Durham and Northumbria)
- Courts should liaise with HMP Durham to resolve the delays experienced in confirming that detainees can be released. (Cleveland, Durham and Northumbria)
- Detainees should be told about their rights and entitlements on arrival at all courts, including the process for making a complaint, and [custody] staff should offer to read or explain the information if necessary. (Norfolk and Suffolk)
- Complaints should be logged and there should be a process for monitoring and analysing any trends. (Norfolk and Suffolk)

6.19 Good practice that we cited about individual rights included:

Court custody staff had reduced the time that detainees waited for transport to prison by arranging for them to be accepted into custody through an interim warrant notification pending the warrant of detention. (Norfolk and Suffolk)

Section 7. Treatment and conditions – safety and respect

Overview

Expected outcomes
Escort staff are made aware of detainees' individual needs and these needs are met during escort and on arrival. Detainees are treated with respect and their safety is protected by supportive staff who are able to meet their multiple and diverse needs. Detainees are held in a clean and appropriate environment. Detainees are given adequate notice of their transfer, and this is managed safely and humanely.

Expectations
- Detainees are transported in vehicles that are safe, secure, clean, comfortable and suitable for their needs.
- Detainees are treated with respect and their diverse needs are addressed during their time in court custody.
- Detainees are offered sufficient food and drink.
- Custody staff assess and manage the risks presented by detainees to themselves and/or others.
- Detainees are transferred from court custody to the courtroom in a timely and secure manner, with privacy.
- Force is used only as a last resort and is proportionate and lawful.
- Detainees are transferred or released safely.
- All custody staff recognise and understand the distinct needs of children and young people being transferred to places of custody.
- All areas of court custody used by detainees are clean, safe and in a good state of repair.

Expectation: Detainees are transported in vehicles that are safe, secure, clean, comfortable and suitable for their needs.

> '[Custody staff] told us that they regularly carried women, young people and adult men in the same vehicle. At Peterborough Crown Court, we saw a six-cell vehicle carrying a woman alongside five male detainees, one of whom was on self-harm monitoring measures, without the screening partition being used. Most escort staff told us that they rarely used the partition, which one described as a 'hassle', or they used it only when conveying young people.' **(Cambridgeshire and Essex)**

7.1 Partitions in escort vehicles are sliding doors that separate the front half of a cellular vehicle from the cells in the rear. Partitions were introduced to enable escort contractors to transfer women, children and men in the same vehicle while avoiding any risk to women or children from predatory or abusive detainees. In every cluster we inspected, practice in the use of partitions varied, with some custody staff telling us it was almost impossible to open and close the partitions when the vehicle was in motion. Some vehicle crews told us it was the contractor's policy not to use the partitions. Separation is important: inspection reports of women's prisons and of YOIs include accounts of young people being verbally abused and of women being harassed by adult men on cellular vehicles. Our 2014 escorts thematic[9] found that women and children tended to have longer journeys in cellular vehicles than adult

[9] HMI Prisons (2014) Transfers and escorts within the criminal justice system: a thematic review by HM Inspectorate of Prisons

men. This may be due to the contractors' practice of delivering adult men to prison first – as male prisons tend to close their receptions earlier – and the imperative to ensure the cost of journeys is minimised by having every available cell in a vehicle occupied.

7.2 As part of the escort thematic, an HM Inspectorate of Prisons researcher undertook a 1.5 hour journey in a cellular vehicle, and her account of the journey gives an insight into how detainees might experience them.

> 'Even with my driver under strict instruction to "keep me safe" and brake as carefully as possible… the journey was not a smooth one. Every time the van slowed down or stopped, I felt myself slide forward on the plastic seat, a few times banging my head back on the hard plastic headrest… I was told that many detainees choose to take off their jumper, if they are wearing one, to use as a headrest. I was in the van for 1.5 hours. The seat, although initially satisfactory, became uncomfortable after about an hour – in our prisoner survey 37% said they had spent more than two hours in the van… Add to this the fact that I could not comfortably lean back and that I had to right myself and prepare to brace frequently, and the last half hour of my journey became very uncomfortable.'

7.3 In Nottinghamshire and Derbyshire, we had concerns about some five hour journeys that had been experienced by children held at HMYOI Hindley. PECS managers told us that when appearing in court children were now held in establishments that were nearer, but we were not convinced this problem had been permanently resolved. Some long journeys were out of proportion to the nature of the alleged offence. In Norfolk and Suffolk, we came across a detainee who had been arrested in London for non-payment of a fine for a motoring offence. He was transported for a three-hour journey to Norwich magistrates' court for a five minute hearing and then released to make his way back to London. We were told it was common for people to be brought long distances after arrest on warrants. While there will be legitimate reasons for this, it is unclear why such cases cannot be dealt with through video link or at a court nearer to the defendant's home area.

7.4 We found that cellular vehicles were often dirty and that there were sometimes no arrangements for regular deep cleans. At Nottingham Crown Court:

> '… there was a foul stench in a cellular vehicle, which detainees complained about as they disembarked, and the van was covered in graffiti.' **(Nottinghamshire and Derbyshire)**

In Cambridgeshire and Essex, we found that:

> '… at one court, the cool box carried by the van, which was used to carry sandwiches on longer journeys, was filthy and smelt foul, and contained cups of water and dirty tissues.' **(Cambridgeshire and Essex)**

7.5 Most but not all courts we inspected had private secure vehicle docks, though in Cleveland, Durham and Northumbria several of the courts had no private vehicle dock. In those that did not, detainees embarked and disembarked from vehicles in public view, where they were sometimes vulnerable to public attention and press photography. In one court in Norfolk and Suffolk, detainees entered and left cellular vehicles in the street next to a busy café. All cellular vehicles must carry an anti-ligature knife, but we found that the first aid box in which the knife in a vehicle in Sussex was kept had been incorrectly sealed, and it took staff five minutes to get access to it.

7.6 Written information about detainees almost always travelled with them, but PERs often contained inaccurate or vague information about health and risk. Sometimes, confidential medical information that should have been in a sealed envelope was instead written on the PER. We saw some PERs with detainees' HIV or hepatitis C status written unnecessarily on

them. In many courts, confidential information about detainees was displayed where other detainees could see it.

> 'At Carlisle and Preston Combined Courts, information about detainees was displayed on a whiteboard… This included the detainee's name, cell number, court number, legal representative's name and numeric codes relating to risk indicators. [Custody staff]… told us that detainees regularly studied the board to identify who was lodged in the custody suite… At Preston Magistrates' Court, a detainee's hepatitis C status was written prominently on the whiteboard (out of detainee view) and on the PER, and told to the escort staff; this was unnecessary and a breach of confidentiality.' **(Lancashire and Cumbria)**

7.7 In Cambridgeshire and Essex, we found that the information on some of the whiteboards was inaccurate, with detainees held in a different cell to the one specified. It was unclear why the whiteboards were needed as more accurate information was available on the computer custody system.

Expectation: Detainees are treated with respect and their diverse needs are addressed during their time in court custody.

7.8 On arrival in court custody, most detainees were taken in handcuffs from the cellular vehicle into the booking-in area where their property was checked against their PER. They were then subject to a pat-down search and placed in a cell, where their handcuffs would be removed. Escort contractors did not accept detainees from the police in paper suits, which was good.

7.9 We found that almost all detainees were offered a cup of tea or coffee on arrival in court custody, and some were given something to read. In all courts, most custody staff were friendly and polite to detainees. But they interacted with them very little thereafter, other than checking on them by looking through the window or hatch in the cell door at the required intervals. In many courts, custody staff brought in newspapers and magazines from home to give to detainees, but sometimes there was nothing available to help pass the time.

> 'At Bedlington this provision amounted to a cardboard box containing odd mixed-up pages from old newspapers, some dating back four months. At several courts, we spoke to detainees who wanted something to read but had not been offered anything. At Peterlee, staff offered detainees crosswords and word search puzzles.' **(Cleveland, Durham and Northumbria)**

7.10 There were examples of custody staff providing good care for detainees and treating them with respect, and across all of the clusters, many of the detainees we spoke to told us they thought they were well treated. At Carlisle Magistrates' Court, custody staff showed us a letter recently received from a detainee, thanking custody staff for the care and consideration they had shown her. In Cleveland, Durham and Northumbria we observed some exceptionally good care of vulnerable detainees, with staff spending a lot of time supporting a detainee who had learning difficulties.

7.11 Few detainees knew about their entitlements: we spoke with many who were unaware, for example, that they could ask for a magazine or for facilities for religious observance. Many staff assumed, and told us, that detainees knew exactly what was available and what they were entitled to, even though this was often not the case.

7.12 When asked about provisions for equality and diversity, most court custody staff told us they tried to 'treat everyone the same', but this meant that some detainees were subject to disadvantage or disrespectful treatment.

> 'Custody staff were mostly friendly towards detainees. However, with some notable exceptions they interacted little with them, and we saw several very vulnerable detainees left alone in cells for long periods who would have benefited from an assessment of their needs and some support. Staff lacked knowledge about how to deal with people from different communities and had received little training about diversity. At some courts, there were no female custody staff on duty to care for women and girls in custody. Some vehicle crews were all male, even when transferring female detainees. Provisions for religious observance were inadequate. We were disturbed to hear a custody officer describe a transgender detainee as 'it' and 'the thing.' **(Surrey and Sussex)**

7.13 At no courts was there any provision for the comfort of elderly or pregnant detainees who might struggle to sit on hard wooden or plastic benches for hours. Few courts had any blankets or warm clothing, despite many cells having problems with heating (see paragraph 7.44). Custody staff at Basildon Magistrates' Court could obtain blankets through an informal arrangement with staff at the nearby police station, but that was exceptional. There was little specific provision for women. While all courts had stocks of feminine hygiene products, it was rare for these to be proactively offered – custody staff assumed women would ask for them if they needed them – and women were not routinely asked if they might be pregnant. We saw notable examples of poor care of female detainees.

> 'At Wirral, a woman who was repeatedly vomiting was not offered any medical help, although she was provided with paper bags to be sick into. She was sharing a cell with a woman with whom she had no connection.' **(Merseyside and Cheshire)**

7.14 Most courts had some provision for religious observance, but it was very limited. Some had a carpet sample that they offered to detainees who needed a prayer mat, some had a bible, but few had copies of holy books of the other main religions, claiming these were available from the court if needed.

> 'No detainees were asked about religious observance, dietary requirements or any other needs on arrival at the court. At Newcastle Crown Court, a Muslim detainee told us that staff had not asked him if he had any religious commitments, and he was delighted when we told him that he could request privacy in which to pray, and a prayer mat.' **(Cleveland, Durham and Northumbria)**

7.15 However, at Berwick, unusually, there was a good range of items kept for religious observance, including a proper prayer mat and a compass to determine the direction of Mecca.

7.16 Provision for detainees with disabilities was limited and often inadequate. In each cluster, one or two courts had been designated as being compliant with the Disability Discrimination Act. For example:

> 'At Mansfield Magistrates' Court we were told that cases involving disabled detainees were sometimes heard there, but that none of the cells had any adaptations and the toilet that was said to have been adapted for disabled detainees had no hand rails.' **(Nottinghamshire and Derbyshire)**

7.17 We found it was common for disabled detainees who could not climb stairs to courts, or whose wheelchairs would not fit in lifts, to be taken to and from courts via public areas in handcuffs. The contractors' handcuffing policies allowed custody staff little discretion. Many SCOs would ask security staff to try to clear public areas before bringing through a detainee in handcuffs, or would liaise with HMCTS staff to have the case heard in a court that had direct access to the cells, but at most courts it was not always possible to accommodate the needs of disabled detainees properly.

7.18 At almost all courts we inspected, there was confusion about how to care for transgender detainees. Many custody staff said they would have to ensure transgender people were searched by a member of staff of their birth gender, regardless of their current status. The contractors' policies on this were unclear and contained outdated advice. Our recommendations that policy should be brought into line with that of the police and prisons had not been implemented.

Expectation: Detainees are offered sufficient food and drink.

7.19 In most clusters, food was provided at lunchtime in the form of sandwiches or, sometimes, ambient microwave meals. Tea and coffee was offered on arrival and at intervals during the day. Some custody staff recognised that detainees coming from prison may have eaten their breakfast several hours earlier and would offer a packet of biscuits, but that was not universal. At most courts, custody staff would offer a microwave meal to detainees waiting to be transferred to prison if they were still in court custody late in the afternoon, as they might miss an evening meal at the prison. However, this did not always ensure that detainees who attended court on more than one consecutive day were provided with an adequate diet.

> 'Detainees were given a choice of microwave meals at standard mealtimes, although some meals were slightly out of date. Some had a low calorific content that would not sustain detainees coming to court each day for a trial, particularly if in doing so they missed the evening meal at the prison. While some PCOs said that they were not permitted to give more than one meal to a detainee per session, others stated that they had flexibility. Most detainees we spoke to, and many [custody] staff, had concerns about the size of the meals available and their quality.' **(Norfolk and Suffolk)**

7.20 At most courts, food preparation areas were basic but clean, though at some, there was accumulated dirt and unsuitable equipment. Many microwave ovens were dirty inside.

Expectation: Custody staff assess and manage the risks presented by detainees to themselves and/or others.

7.21 Basic risk assessment was unsatisfactory and almost non-existent at most courts. There was no systematic assessment undertaken on arrival.

> 'The lack of a thorough or systematic initial risk assessment was a common feature across the courts, and there were examples of poor care… A young person's PER recorded that he had cut himself in 2011 but he was not asked about it during booking in. When we questioned this, we were told that staff would speak to him shortly in his cell, but we did not subsequently see any [custody] staff visiting his cell.' **(Cleveland, Durham and Northumbria)**

7.22 When we asked staff how they assessed risk when there was no systematic risk assessment, some told us that concerns would have been discussed with the detainee on the cellular vehicle. No detainees with whom we spoke could recall such discussions, and the vehicles lacked the privacy needed in which to explore sensitive issues. Information about risk that accompanied detainees was often incomplete or vague.

> 'The PER form for another detainee who had made a serious attempt at suicide on the night before was annotated with "attempted to hang himself last night", with no further details.' **(Merseyside and Cheshire)**

With no systematic process, it was contingent on the skills and commitment of individual members of custody staff as to whether effective attempts were made to correct the lack of information by asking detainees about their circumstances.

7.23 At many but not all courts, SCOs conducted a morning briefing with custody staff. Sometimes, information was provided about detainees' risk but at others, the briefing was concerned with telling staff what duties were being assigned to them. Some custody staff made commendable efforts to engage with detainees in assessing and managing risk, but many lacked the skills and facilities to follow this through properly.

> 'At Preston Magistrates' Court, we saw the SCO give a good briefing to custody officers about a young man who had self-harmed, whose father had recently killed himself, and for whom an assessment, care in custody and teamwork (ACCT) self-harm monitoring document had been opened in prison. However, although [custody] staff were diligent in conducting observations every 10 minutes, they made little effort to interact with him and did not tell him that he was being moved to a different prison. He became tearful and frightened when he discovered this. [Custody staff] told us that they would have informed him of the move shortly before putting him on the cellular vehicle, which would have given them little opportunity to explore his fears or offer reassurance.' **(Lancashire and Cumbria)**

7.24 Cell sharing risk assessments (CSRAs) should be completed whenever detainees have to share cells, but we found wide variations in their use. Most custody staff told us they avoided placing more than one detainee in each cell. However, sometimes they would put someone who had a history of self-harm in with another detainee to provide some additional support and supervision. At some busier courts, cell sharing happened regularly if there were too few cells to enable single-occupancy and some of the largest cells were designated as capable of holding up to about six detainees.

> 'At Mansfield Magistrates' Court, a cell-sharing risk assessment form was completed for each detainee, whereas at other courts only young people or detainees with self-harm warning markers received the assessment. At Nottingham Magistrates' Court, custody staff used a new cell-sharing form specifically for young people… Generally, however, cells were allocated before the detainees arrived, rarely changing, so we questioned the extent to which the cell-sharing risk assessment was meaningful.' **(Nottinghamshire and Derbyshire)**

7.25 At a busy Saturday court in Essex, custody staff admitted they were 'too busy' to complete CSRAs for the detainees who shared cells. At another court in the cluster, a CSRA was completed for one detainee sharing, but not the other person. During one inspection, a change to the method by which CSRAs were completed was conveyed to staff via email with no attempt made to brief the SCO in person about the change and its purpose (see paragraph 5.10).

7.26 Effective risk management depends on there being sufficient staff available and at some clusters, we had concerns about staffing levels in court custody:

> 'One day at Peterborough Crown Court there was no SCO or deputy SCO on duty… When problems arose, no effective leadership was exercised, putting detainees at potential risk. Although there appeared to be sufficient [PCOs] to care for detainees during the inspection, at most courts custody staff relied on assistance from vehicle crews, some of whom did not know the custody suites or their facilities sufficiently well… [custody] staff at one court were not able to operate the closed-circuit television (CCTV) system, rendering it ineffective in monitoring a vulnerable detainee.' **(Cambridgeshire and Essex)**

7.27 While in all clusters, custody staff were generally diligent in performing the required number of regular observations of detainees, at some, the computer recording system created demands, on SCOs in particular, that they struggled to meet. For example, in Norfolk and Suffolk, the Serco escort recording system (SERS) alerted custody staff to when checks were due, but staff struggled to keep up with the system's demands to make and record checks. At busy times, staff constantly entered details of checks, legal visits and court attendance, but we saw the pressure placed on the SCO to constantly update it result in errors: at one court we saw that the officer recording cell checks on the computer had been not been told a detainee had gone up to court, which meant he mistakenly recorded the detainee as being in his cell. In Kent, a magistrates' court custody suite was overcrowded on one occasion during the inspection, which resulted in detainees being held in a cellular vehicle for two hours while other detainees had to sit on cell floors. The SCO told us that he had been too busy to record any cell checks that day.

7.28 We also saw some examples of good care of vulnerable detainees. At Colchester Magistrates' Court, custody staff placed a detainee in a glass fronted observation cell as he was unwell and at risk of having a seizure, and they talked with him during their cell visits. In Lancashire and Cumbria, custody staff placed a very vulnerable young woman in a small cell next to a staff work area and looked after her well, engaging her in conversation and interacting with her throughout.

7.29 In compliance with the contractors' policies, staff did not carry anti-ligature knives. They were kept in the first aid kit, or in a filing cabinet instead, which could delay access to them in an emergency. At Chesterfield Magistrates' Court, an additional anti-ligature knife was kept in a prominent position in the staff office, which was better but not ideal. All cellular vehicles, except the one kept at North Liverpool Community Justice Centre, carried an anti-ligature knife.

Expectation: Detainees are transferred from court custody to the courtroom in a timely and secure manner, with privacy.

7.30 At all courts, detainees were transferred from the cells to the court rooms promptly and this was actively monitored through the contract compliance process. But we found examples of disadvantage for disabled detainees (see paragraphs 7.16 and 7.17) that arose from the combined effects of court buildings that were not designed with disabled people's needs in mind and the contractor's handcuffing policies.

Expectation: Force is used only as a last resort and is proportionate and lawful.

7.31 Detainees arrived at court custody suites in handcuffs in accordance with the contractors' policy that detainees would be handcuffed when moving around the suites, including having handcuffs applied when entering and leaving cellular vehicles (but not while travelling). Custody staff were allowed little discretion about handcuffing. All detainees were handcuffed everywhere, even from cells to legal visits in the consultation room, and at some courts, to the toilet. In Cleveland, Durham and Northumbria we were concerned about safety as detainees were double-cuffed on the steep stairs to the docks at Newcastle Crown Court and Sunderland Magistrates' Court. In Merseyside and Cheshire, custody staff told us that anyone refusing to be handcuffed would be reported as 'refusing to attend court', even though this might not have been the detainee's intent. In several clusters there were courtrooms which were only accessible via public areas, through which detainees would be handcuffed.

> 'Almost all detainees were handcuffed irrespective of gender, age, previous history, compliance or nature of the offence. This routine use of handcuffing was frequently unnecessary and disproportionate. However, we saw [custody] staff at Bury St Edmunds

> use their discretion for handcuffing detainees to the courtroom, where the narrow staircase into the dock could have been dangerous. We also saw a detainee with walking difficulties taken to another court without handcuffs. These examples show that in reality, staff did occasionally exercise some discretion about handcuffing, and it would be better if it was recognised.' **(Norfolk and Suffolk)**

7.32 Custody staff in all clusters generally made good use of the training they had received in employing interpersonal skills to gain the cooperation of non-compliant detainees, and use of force other than routine handcuffing was infrequent. In Lancashire and Cumbria: '… use of force was recorded on a form but only at one court were copies kept that we could inspect'.

7.33 In most courts, all detainees were searched on arrival, even if they had been searched by police or prison staff and had remained under supervision thereafter. Searching methods were often inconsistent: sometimes, shoes were removed and searched, whereas at other courts shoes were not removed. Rub-down searches were carried out frequently, for example, every time a detainee went to the toilet or saw a legal representative.

Expectation: Detainees are transferred or released safely.

> 'At Chester Magistrates' Court staff showed us leaflets about accommodation options for homeless or otherwise vulnerable people. There were instances of good care for those being released, but at Wirral Magistrates' Court we saw a person of no fixed abode who appeared to show signs of mental illness. She had five large bags of belongings and 95 pence, but was released with no support other than the court advising her to attempt to seek accommodation at a nearby hostel. A woman at Sefton Magistrates' Court who had been withdrawing from heroin was released, in pain, without being asked if she could get home. No advice was offered about where she might go for treatment.' **(Merseyside and Cheshire)**

7.34 Most police forces carry out pre-release risk assessments with detainees who are bailed or released with no further action, and most offer detainees leaflets about support organisations in the community. However, we found that when detainees went to court they were unlikely to be given any help or support on release, other than being offered bus fares or a travel warrant – even when, as in the example above, they were clearly vulnerable. In a Surrey magistrates' court we observed a detainee with a diagnosis of tuberculosis being released without any attempt made to ascertain if he was in touch with health services in his home area. Custody staff did not consult with their health provider before releasing him.

7.35 In Cleveland, Durham and Northumbria there were some information leaflets that could be given to detainees going to prison, but they were out of date. A leaflet about young offender institutions was old and contained incorrect information. In Merseyside and Cheshire there were no leaflets about local prisons so court custody staff gave all detainees, including adults, the standard leaflet on YOIs instead. In Nottinghamshire and Derbyshire there was no leaflet about HMP Nottingham except at Nottingham Crown Court, where we found the leaflet in a cupboard: staff did not know about it. In Norfolk and Suffolk, some courts had copies of a booklet detailing what happened in the first 24 hours of arriving at HMP Peterborough, which was available in several languages, but this was exceptional. In Cambridgeshire and Essex:

> '… we saw [custody] staff at one court completing an HM Prison Service personal record form for a detainee entering prison for the first time, without providing any information about what would happen on arrival at prison.' **(Cambridgeshire and Essex)**

Expectation: All custody staff recognise and understand the distinct needs of children and young people being transferred to places of custody.

> 'Young people (aged 10–17) were not provided with a named person to care for them during their time in custody. Staff had little awareness of local safeguarding procedures for vulnerable detainees and had not received any child protection training… Court staff relied on the YOTs if they had any concerns about young people in their custody. However, we saw a 15-year-old boy detained at Workington, having been detained at the police station overnight. He was clearly afraid and unsure as to what was happening. Although a YOT worker telephoned the custody suite, no visit was made. We were told that the court often tried to expedite the cases of young people in custody; however, this youth was one of the last to be brought before the court that day and was not released until 1.40pm.' **(Lancashire and Cumbria)**

7.36 We found a range of problems in the care of children and young people across all eight clusters. Custody staff had little awareness of the particular needs of children in custody and few had received training on dealing with children. This was particularly concerning given that a national change in the escorting arrangements for children from secure children's homes in 2012 meant that court custody staff were now responsible for caring for these children in court custody, instead of the previous arrangement whereby specialist escort staff would remain in the court cells to look after them. Such children could be as young as 10. In none of the clusters we inspected were children treated any differently to adults, other than sometimes being located in a separate cell corridor. We saw children spending long periods in small cells, provided with little or nothing to occupy their time, often in receipt of no supportive attention from custody staff (see paragraphs 6.3, 6.6 and 6.7).

7.37 During the inspection of Surrey and Sussex, it became apparent that Serco, the specialist contractor for transferring children to secure training centres (STCs), was not always performing adequately, which meant that children sometimes experienced long delays waiting for transfer. One child who Serco could not collect promptly was moved from court to the local police station when the court closed for the day. He had been compliant, but he was unwilling to go back to the police station and was removed from the court cell by force. He was kept in police custody until 2am when Serco collected him. A 16-year-old girl was not collected until 11.15pm, despite being sentenced at 3.15pm. The Youth Justice Board told us it was aware of such delays and had required improvements in the contractor's performance.

7.38 Generally, custody staff made good use of the expertise of the local YOT when they were concerned about a child in court custody, but we found occasions when YOT staff were not available to attend. While custody staff sensibly told us they would contact their manager for advice in such circumstances, we were not assured that the contractors' area business managers would have the necessary time, knowledge and expertise to be able to effectively safeguard vulnerable children.

Expectation: All areas of court custody used by detainees are clean, safe and in a good state of repair.

> 'The condition of the cells at Newcastle Magistrates Court was deplorable. Water ingress during recent heavy rain had caused rot, damp, heavy staining and damage to tiles, and one cell was so badly damaged that it had been taken out of use. The backs of doors were covered in graffiti. Some of the toilets did not flush properly. The contract for replenishing the paper towels had been cancelled, so detainees had to share one grubby cotton towel, which [custody] staff had to wash. A former police 'drunk cell', with its plinth too low to sit on comfortably, was used for normal occupation. [Custody staff] told us that the cells were very cold in the winter. They had made numerous requests

> for improvements but little had been done because of difficulties in establishing which authority would be responsible for the works required. Remedial work was due to start during the inspection but it was limited in scope, with only the prevention of further water penetration and the repair of toilets planned at the time.' **(Cleveland, Durham and Northumbria)**

7.39 Physical conditions at Newcastle were particularly bad, but in most clusters there were court houses with the cells in poor condition. Often, maintenance had been neglected and many court cells had not been painted for years. Graffiti was widespread. We were concerned to find racist graffiti at several courts, including swastikas, and graffiti that accused named individuals of being paedophiles.

> 'The physical conditions of the custody facilities were very poor; there was ingrained dirt in the cells and toilets. Cleaning standards were inadequate and deep cleaning rarely took place or was poorly conducted. Most cells were covered in graffiti, much of it pornographic, racist, or misogynist. Many custody staff seemed to have become inured to the poor condition of the cells. Lay observers had reported the conditions for many months, but no effective action had been taken.' **(Kent)**

7.40 At Burnley Magistrates' Court, we found graffiti dated 2003 and custody staff told us they could get nobody to take responsibility for removing it. At some court houses, staff had resorted to painting the cells themselves in a commendable attempt to improve conditions. But at one court, the SCO's request for a pot of paint so that he could obscure the graffiti had been refused.

> 'At Sefton, the cells were dirty, with deeply ingrained dirt on the floor, deposits of brown matter on the ceilings and brown smears on the walls adjacent to the toilets. There was much graffiti, including obscene words. Staff could not recall a deep clean ever having been carried out; one had been arranged just before the inspection, but it had not taken place.' **(Merseyside and Cheshire)**

7.41 Maintenance was often neglected, even when its neglect led to insanitary conditions. At Nottingham Crown Court there were defects that staff said had persisted for years, including missing skirting in the detainees' toilets that made thorough cleaning impossible. At Ipswich Magistrates' Court, the toilets were dirty and the toilet seats appeared to be stained with excrement. The staff kitchen, where detainees' meals were prepared, was grubby and in need of refurbishment.

> 'Detainees (at Liverpool Crown Court) could not use the toilets in private as they were situated adjacent to the booking-in desk. The area was mostly open plan, with a flimsy screen erected between the toilets, the urinal area and the desk. We witnessed custody staff inappropriately discussing a detainee's medication, unaware that another detainee was in the toilet area and able to hear their conversation. One detainee told us that he had found it difficult to use the toilet facilities because of their location and the number of staff grouped in the vicinity. This was degrading for detainees and staff alike.' **(Merseyside and Cheshire)**

7.42 Some defects had implications for detainee care. We were concerned about potential ligature points in some cells at Ipswich, and custody staff acknowledged this was not something they covered during their daily checks.

7.43 Some courthouses had cells that were too small to accommodate detainees for long periods. At Blackpool, custody staff told us the smallest cells were never used, but a few days later we found a vulnerable young woman had been placed in them so she would be near the staff office. At Norwich Crown Court, a detainee was kept in a cell approximately nine feet by

four feet for eight hours. The bench was too short to lie on, and at busy times up to three detainees would share small cells such as this. Very few cells anywhere had any natural light.

> 'Cells were not always checked between occupancies. For example, at Chelmsford Magistrates' Court we saw a detainee being placed in a cell which contained confidential documents relating to the previous detainee's court case, including their name and address, charge details and drug testing results; these documents were only removed from the cell at our suggestion.' **(Cambridgeshire and Essex)**

7.44 At many courts there were problems with the heating and ventilation system. We found many cells that were too cold to sit in comfortably. At the vast majority of these courts, there were no blankets or warm clothing. Some did keep a small stock of old coats to lend detainees, but there were no facilities for laundering them. We found that at some courts, lay observers had drawn attention to the cold for months.

7.45 All cells had call bell buttons that detainees could press to get attention, and mostly they were responded to promptly. Custody staff tended to assume that all detainees were regular attendees who knew what the call bells were for, but this was not always the case.

> 'Most detainees we spoke with knew what they were for, but one young person told us he did not know he could press the cell call bell if he needed anything.' **(Nottinghamshire and Derbyshire)**

7.46 Recommendations that we made about treatment and conditions in the first eight court custody inspection reports included:

- HMCTS should make more use of video link and 'virtual court' facilities to reduce the need for detainees to be transported long distances to courts. (Norfolk and Suffolk, main recommendation)
- GEOAmey should revise its policy on caring for transgender detainees and ensure that staff implement it. (Cleveland, Durham and Northumbria)
- Every court cell area should have a copy of the holy books of the main religions, a suitable prayer mat, which is respectfully stored, and a reliable means of determining the direction of Mecca. (Norfolk and Suffolk)
- Serco Wincanton should liaise with local prisons, Cambridgeshire Constabulary and Essex Police to discuss the transfer of information and completion of person escort records (PERs) for detainees. PERs should clearly identify the health risks for each detainee, while ensuring that confidentiality is appropriately maintained. (Cambridgeshire and Essex)
- All [custody] staff should receive diversity and equality training that includes how to care for young people. (Cambridgeshire and Essex)
- Comprehensive risk assessments should be consistently carried out by appropriately trained [custody] staff on all detainees. (Cleveland, Durham and Northumbria)
- Cell sharing risk assessments should be completed for all detainees subject to sharing, before this takes place. (Cambridgeshire and Essex)
- Handcuffs should only be used if justified and proportionate. (Nottinghamshire and Derbyshire)

- The cells at Newcastle Magistrates' Court should be completely refurbished, with interview rooms created, or they should be closed. (Cleveland, Durham and Northumbria)

- A programme of regular deep cleaning should be implemented, and standards of daily cleaning should be improved. (Merseyside and Cheshire).

7.47 Good practice that we cited about treatment and conditions included:

Some courts had copies of a very informative booklet detailing what happens in the first 24 hours of arriving at HMP Peterborough, which was available in several languages. (Norfolk and Suffolk)

Section 8. Treatment and conditions – health care

Expected outcomes
Escort staff are made aware of detainees' individual needs and these needs are met during escort and on arrival. Detainees are treated with respect and their safety is protected by supportive staff who are able to meet their multiple and diverse needs. Detainees are held in a clean and appropriate environment. Detainees are given adequate notice of their transfer, and this is managed safely and humanely.

Expectations
The health needs of detainees are addressed during their time in custody.

Expectation: The health needs of detainees are addressed during their time in custody.

8.1 Both custody contractors maintained a contract with an independent medical services provider which was able to give advice on the telephone and, if necessary, send a paramedic to any courthouse.

> 'While [custody] staff knew how to access the medical services provider (MSP) not all knew who the provider was. We could not locate accumulated contract monitoring data. [The MSP] told us there had been one callout in 2013, and custody staff told us they occasionally telephoned for advice, mostly about detainees' medication. While the response was said to be helpful, staff generally seemed reluctant to make use of the service.' **(Nottinghamshire and Derbyshire)**

> '[Custody staff] we spoke to were aware of and positive about the [health care] service, although most believed it offered telephone advice only – we spoke to one detainee who had been incorrectly advised by custody staff that it was not possible to treat his reported migraine at the suite.' **(Norfolk and Suffolk)**

8.2 In Cleveland, Durham and Northumbria, the MSP had been used only three times in the past six months as custody staff preferred to call an ambulance if they had concerns. At Nottingham Crown Court, we observed some very poor practice when a detainee did not receive his prescribed medication at the designated time. Staff preferred the prison to administer it, even though this meant the detainee would not receive the medication until several hours after it was due.

> 'All [custody] staff were qualified in first aid and received updates every three years; however, with the low level of reported incidents, the training was too infrequent to maintain adequate skill levels.' **(Cambridgeshire and Essex)**

8.3 In Norfolk and Suffolk, a first aid kit in each suite contained basic supplies, but the equipment was inadequate for the type of emergency that may happen in custody, such as heart attacks and self-harm. Most kits had some out-of-date stock, despite weekly documented checks.

> 'There was no AED, oxygen or suction in any of the court buildings. We heard of several occasions during the previous two years when detainees and other individuals had collapsed in the courts; it was unclear how these situations had been reported and aggregated data used for learning purposes.' (**Lancashire and Cumbria)**

8.4 Many PERs from police and prisons contained confidential health information that should have been in a sealed envelope, yet failed to specify how custody staff should care for detainees with health problems.

> 'One PER recorded that a detainee was on a substance misuse programme and received unnamed medication, but his risk of alcohol withdrawal fits was not specified and the medication prescribed by the prison to prevent these was not supplied, although it was due while he was at court. These issues were only identified when the detainee raised concerns about his lack of medication with the inspection team, and custody staff took appropriate action when we informed them.' **(Norfolk and Suffolk)**

8.5 Detainees from police custody rarely came with any medication, even if it had been prescribed and they needed to take it while in court custody. When detainees' medication did accompany them into court custody, usually from prison, it was not always stored securely, often being left on the office desk with the PER instead of being locked away.

> 'Medication arriving from prison was in sealed bags, which delayed its administration… The Serco Wincanton medical policy was out of date and required review. Medication in some suites was stored unsecured with the PERs.' **(Cambridgeshire and Essex)**

8.6 Mental health services were excellent in a few courts, for example in Norfolk and Suffolk, where good support was readily available from the local mental health trust which provided advice to the courts and access to further mental health assessment and treatment.

> '[Custody staff] at all suites reported very good access to telephone advice and staff visits for mental health issues, plus effective active communication from the mental health team about its patients attending court. However, this support was only available on weekdays and staff were unsure what to do at the weekend.' **(Norfolk and Suffolk)**

8.7 Similar good provision was available in Merseyside and Cheshire, where effective court liaison and diversion schemes were in place. Elsewhere services were less good, often varying within a cluster if more than one provider covered the area.

> 'In Essex courts, there was good daily access to mental health professionals, and custody staff were positive about the service. However, mental health practitioners told us that the lack of an agreed process for Mental Health Act 1983 assessments had resulted in some detainees being inappropriately remanded to prison. In Cambridgeshire courts, mental health professionals were available only in Peterborough Magistrates' Court, as part of a pilot project.' **(Essex and Cambridgeshire)**

8.8 Surrey Partnership Trust mental health workers regularly visited the Surrey courts, but in Sussex, mental health workers were unable to visit their local courts every day due to staff shortages, and we observed one detainee who needed an assessment not being seen for that reason. In Lancashire and Cumbria, there was no liaison or diversion scheme at all in Carlisle, and at other courts, probation staff acted as gatekeepers to community mental health services.

8.9 Many court custody staff told us they felt they needed more training in how to recognise and deal with detainees' mental health problems and to tell those with substance misuse problems about services. Mostly, however, we found access to such services was good. In Lancashire and Cumbria, and in Merseyside and Cheshire, community drug project workers attended the court when needed. In Nottinghamshire and Derbyshire they attended most, but not all, magistrates' courts each day to see detainees who wanted help with substance misuse problems. In Norfolk and Suffolk, most detainees were seen by substance misuse services in police custody, but in Cambridgeshire, substance misuse staff did not visit the

court custody suites and we were told that court custody staff had never needed to refer any detainees.

8.10 Recommendations that we made about health care in the first eight court custody inspection reports included:

- Court custody staff should be trained to identify and appropriately refer detainees who may be experiencing mental health or substance use-related problems. (Merseyside and Cheshire)
- There should be access to mental health services for detainees appearing to have mental health problems. (Lancashire and Cumbria)
- All detainees who require prescribed medications while in court custody should have access to it. (Norfolk and Suffolk)
- All detainees should have access to mental health support at all times that the courts are open. There should be clear process agreed with the courts and mental health trusts for the provision of Mental Health Act assessments. (Cambridgeshire and Essex).

8.11 Good practice that we cited about health care included:

The Merseycare diversion-from-custody scheme enabled the early withdrawal of mentally ill detainees from the offender pathway. (Merseyside and Cheshire)