

Report on an inspection visit to court custody facilities in

West Midlands and Warwickshire

by HM Chief Inspector of Prisons

2 – 15 December 2016

Glossary of terms

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Victory House
6th floor
30–34 Kingsway
London
WC2B 6EX
England

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Section 1. Introduction

This is a report in a series of inspections of court custody facilities carried out by HM Inspectorate of Prisons. These inspections contribute to the United Kingdom's response to its international obligation to ensure regular independent inspection of all places of detention. The inspections focus on outcomes for detainees in three areas: strategy, individual rights and treatment and conditions, including health care.

In West Midlands and Warwickshire, there were 13 courts currently in use that had custody facilities, including four Crown courts, seven magistrates' courts and a youth court. GEOAmev had been contracted by the Prisoner Escort and Custody Services (PECS) arm of Her Majesty's Prison and Probation Service (HMPPS) on behalf of HM Courts & Tribunals Service (HMCTS) to provide court custody and escort facilities in the region. The area also included an Immigration Asylum Chamber (IAC) (tribunal centre).

Working relationships between the three key agencies responsible for delivering the court custody provision were good. It was positive that the key stakeholders, in particular HMCTS, accepted responsibility for the overall care and welfare of detainees. As with other recent inspections, the provision was hampered by ineffective delivery of the cleaning and maintenance contract, for which none of the involved agencies was directly responsible.

Staffing levels were adequate. Notwithstanding some weaknesses in training, custody staff dealt with detainees professionally and on the whole paid reasonable attention to their welfare needs during their stay in court custody. However, we were concerned that the frequency of observations in a small number of cases, particularly for vulnerable detainees, was not adhered to as required. Release arrangements were generally good and staff made sure that detainees left court custody safely.

There were a number of areas that required remedial attention. Court custody cases were generally prioritised but, despite this, a number of factors contributed to some detainees spending unduly long periods in court custody. These included delays in the attendance of duty solicitors, arrival at court early for afternoon listings, and delays in authority to release from prison. Investment in many parts of the estate was required in order to address some of the unacceptable conditions we found for detainees. The application of handcuffs in the physically secure court custody facilities was often unnecessary and in the absence of individual risk assessments could be disproportionate.

Overall, this was a reasonably positive inspection. While we had significant concerns about some unnecessarily long stays, handcuffing practice and the physical environment in court custody facilities across West Midlands and Warwickshire, we found much good attention to detainee care. We have made a number of recommendations to improve the safety and care of people detained in court custody.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

January 2017

Section 2. Background and key findings

- 2.1** This report is part of the programme of inspections of court custody carried out by HM Inspectorate of Prisons. These 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) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.
- 2.2** The inspections of court custody look at strategy, individual rights, and treatment and conditions, including health care. They are informed by a set of *Expectations for Court Custody*¹ about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.
- 2.3** The inspection, completed over two weeks, consisted of observations, talking to staff and detainees, and looking at policies and case records. We visited 12 court custody suites and one immigration and asylum chamber. Visits were also conducted over a weekend.
- 2.4** The table below outlines the courts and immigration and asylum chamber, number of cells and the throughput of each custody suite:

Custody suites	Number of cells	Throughput 1 January – 31 October 2016
West Midlands courts		
Birmingham Crown Court	26	2,310
Birmingham Crown Court Annexe	8	550
Birmingham Immigration and Asylum Chamber	1 holding room	50 (June – October 2016)
Birmingham Magistrates' Court	22	4,381
Birmingham Youth Court	3	105
Dudley Magistrates' Court	7	732
Walsall Magistrates' Court	10	839
Wolverhampton Combined Court	11	1,387
Wolverhampton Magistrates' Court	10	1,769
Warwickshire courts		
Coventry Combined Court	8	84
Coventry Magistrates' Court	9	1,054
Nuneaton Magistrates' Court	8	88
Warwick Justice Centre: Leamington Spa Magistrates' Court	22	956
Warwick Combined Court		845

¹ <http://www.justiceinspectorates.gov.uk/hmiprison/about-our-inspections/inspection-criteria/>

Leadership, strategy and planning

- 2.5** HM Courts & Tribunals Service (HMCTS) in West Midlands and Warwickshire operated as a single 'cluster'. Three agencies worked together to deliver court custody services: HMCTS had overall responsibility, along with Prisoner Escort and Custody Services (PECS; part of Her Majesty's Prison and Probation Service (HMPPS)) and GEOAmeY. An HMCTS cluster manager was responsible for courts across this region and delegated responsibility to three operations managers. Nine HMCTS court delivery managers supported them and were responsible for the Crown and magistrates' courts we inspected. An HMCTS court delivery manager was also responsible for the Immigration Asylum Chamber (IAC). PECS commissioned GEOAmeY to manage court custody and provide escort services on behalf of HMCTS in West Midlands and Warwickshire.
- 2.6** Management structures in HMCTS, PECS and GEOAmeY were appropriate. Relationships between these agencies were well developed and appeared reasonably effective. Formal meeting structures between key stakeholders were in place and there was a good emphasis on the overall treatment of detainees in court custody. HMCTS accepted responsibility for court custody facilities and attempted to resolve issues that arose. HMCTS court delivery managers and accommodation liaison staff visited court custody suites relatively frequently. It was evident from meeting minutes that accommodation problems, including the poor environments in most court custody suites, had been recurring for some time. HMCTS was not directly responsible for the contract for cleaning and maintenance and, despite reporting issues and escalating to the contractor (G4S) and the Ministry of Justice Estates department when necessary, defects and shortfalls were not always addressed. HMCTS, PECS and GEOAmeY were equally frustrated by the ineffective contract.
- 2.7** Levels of staffing for court custody facilities were generally adequate. The GEOAmeY staff group was professional and courteous. However, the lack of effective ongoing and refresher training was a weakness.
- 2.8** Recruitment problems had resulted in insufficient lay observers,² which meant that they visited court custody facilities relatively infrequently. The reports they produced were thorough and highlighted some relevant issues in the court custody suites, although some HMCTS and GEOAmeY staff were not aware of their concerns as reports were not disseminated widely enough.
- 2.9** The use of prison video-link to hear eligible cases without the need for transporting prisoners to court was very good in magistrates' courts but not as well utilised in Crown courts, for a variety of reasons. The overall infrastructure in prisons, police custody and courts did not always support the wider use of video-link.
- 2.10** There was no HMCTS safeguarding policy or protocol. GEOAmeY had its own standard operating procedure but it was not well embedded and court custody staff did not always know how to report a safeguarding concern if one arose.
- 2.11** Arrangements for detainees held at the IAC, including, most notably, the provision of food, shared accommodation for detainees of different genders, and release arrangements, were inadequate.

² Independent volunteers who check that prisoners escorted by private escort companies in England and Wales are treated decently.

Individual rights

- 2.12** There was a listings protocol, and we saw a number of cases in which children and vulnerable detainees were prioritised. However, several factors contributed to too many detainees being held in court custody for unnecessarily long periods. These included: delays in the attendance of duty solicitors and court interpreters; long delays before courts received the authority to release detainees who had been held in prison; and detainees being brought from prison early in the morning to Crown courts, when their cases were not listed until the afternoon. Data and our observations also suggested that delays in producing warrants were also an issue. Evidence suggested that when vehicles were available, moves to prison took place throughout the day.
- 2.13** We encountered numerous occasions where court enforcement officers (CEOs),³ who executed court warrants, brought detainees into court custody, which in most cases was unnecessary.
- 2.14** Leaflets containing details of detainees' rights in custody and the local complaints process were placed in cells before a detainee's arrival. However, custody staff did not always check that the detainee could read or understand the information. Information about detainees' rights was readily available in a number of languages but staff were not always proactive in giving this to detainees. Access to legal representatives and arrangements for legal visits were generally good.
- 2.15** Engagement by youth offending service (YOS) teams with children detained in court custody was reasonable.
- 2.16** Professional telephone interpreting facilities were available in all the courts but staff were not always confident to use them, and did so infrequently. Telephone interpreting was not well used to assist in checking on the detainee's welfare or in effectively assessing and managing risk. Arrangements for dealing with detainees' complaints were adequate.

Treatment and conditions

- 2.17** The cellular vehicles we inspected were reasonably clean and graffiti was less prevalent than we normally encounter. However, children and women were sometimes transported on the same vehicles as adult men. Anti-ligature knives and other equipment, such as first-aid kits, were readily accessible on vehicles. Most vehicle docks were secure and protected detainees from media or public attention. When this was not the case, there were good arrangements to maintain detainees' privacy and dignity.
- 2.18** Morale among custody officers was good and they worked well together as a team. Most staff treated detainees with courtesy and respect. When vulnerable detainees were dealt with, staff showed interest and concern about their welfare. Despite sometimes being exposed to demanding behaviour, staff engaged patiently and professionally with detainees and we saw no evidence of punitive attitudes.
- 2.19** Most officers treated detainees as individuals and generally responded flexibly to each case, depending on the circumstances. Although all staff completed an element of diversity and equality awareness as part of their induction, there was insufficient ongoing or refresher training in this area. This meant that staff were generally reliant on their existing knowledge

³ This also included bailiffs employed by local authorities to execute warrants in relation to the non-payment of council tax.

and experience. This lack of formal training in diversity was highlighted when we found limited understanding about how to deal with transgender detainees at most sites.

- 2.20** Feminine hygiene products were available in all of the custody suites but female detainees were not usually notified about this.
- 2.21** Care was taken to ensure that children were kept apart from adult detainees, and separate cell locations were usually used. Staff often showed a greater degree of patience and tolerance with children than they would towards adult detainees, and used age-appropriate language with them. There were suitable procedures to ensure that children remanded or sentenced to secure accommodation or prison were transferred appropriately. We saw most children being escorted between secure training centres and the court efficiently.
- 2.22** Adequate stocks of religious materials were held in each of the suites and were stored respectfully. Reading material was not offered routinely and there was nothing available in languages other than English or for children.
- 2.23** Facilities for detainees with a disability were limited and only two of the courts we inspected were compliant with the Disability Discrimination Act (DDA). There were no adapted cells with lowered call bells and no hearing loops, and there was no literature available in Braille or an easy-read format. As access to specialist facilities was so limited, such detainees often had to travel further to court than those without a disability. Many detainees with mobility issues were dealt with in non-DDA-compliant facilities, which was sometimes difficult for them. Staff told us that they would make efforts to meet detainees' individual needs in these situations but we did not always see this happen; for example, a walking stick was removed from a detainee with acute mobility issues.
- 2.24** All courts had stocks of ambient microwave meals, which were prepared in reasonably clean facilities. Most courts also had a good supply of freshly prepared sandwiches, biscuits and crisps. Meals were always offered at lunchtime, but detainees were also given food at other times, on request or when staff thought this was necessary. Detainees were normally offered a drink on arrival. However, in line with public health guidelines, we were not assured that water was always drawn from a source that we were confident was suitable for drinking water.
- 2.25** Staff briefings were inconsistent. Not all staff were present and they often took place before detainees arrived and before risks were known.
- 2.26** Not all staff who visited cells carried an anti-ligature knife, which posed a potential risk to the safety of detainees. On occasion, we found that no staff were carrying anti-ligature knives. There was no standardised reception risk assessment process. In some custody suites, the informal dynamic risk assessment process was reasonable but it was inconsistent and reliant on the confidence and experience of officers.
- 2.27** The programme for observing detainees was generally acceptable. However, we found evidence that the frequency of monitoring, particularly for those identified as the most vulnerable, was not always carried out in line with the agreed protocol.
- 2.28** Although staff made referrals to support agencies when they had concerns about vulnerable detainees, too few were aware of any formal safeguarding protocol or referral mechanisms.
- 2.29** Detainees were searched sensitively, although there was too much routine searching in the absence of a robust and individualised risk assessment.
- 2.30** Cell call bells were not always answered promptly. Cell sharing risk assessments (CSRAs) were not always completed before detainees were required to share a cell, and sometimes

did not reflect some of the important information available, which posed significant potential risks to detainees.

- 2.31** Most detainees were transferred from court custody to the courtroom in a timely manner. However, in some courts there were not sufficient affray alarms.
- 2.32** Person escort records (PERs) received from the police and some prisons (most notably HMP Birmingham) were not always completed with sufficient detail to identify any presenting risks, including specific health issues. Verbal handovers between escort and custody staff were generally cursory and focused on the demeanour of detainees during transit.
- 2.33** Release arrangements were mostly adequate. Petty cash, bus tickets and travel warrants for trains were generally available for detainees leaving custody, but they were not offered routinely in all suites. However, we found evidence that care was taken to make sure that vulnerable people were released safely. Despite being readily available, too few detainees were given information about links to support services on release, or information about the prison they were being transferred to. Most placement orders for children were accessed promptly but we found some evidence of unnecessary delays in accessing these and transferring children to secure accommodation.
- 2.34** Force was used sparingly and such incidents were recorded routinely. Action was taken to address any concerns during a routine staff debrief which took place after each incident in which force had been used. We were confident that force was used only as a last resort, following efforts to de-escalate. However, some documentation lacked detail about the circumstances leading up to the deployment of force.
- 2.35** Routine handcuffing in the absence of individualised risk assessments was disproportionate in the secure and controlled custody areas.
- 2.36** Checks we conducted across the estate revealed a large number of potential ligature points in every suite. While staff were already aware that some of these existed, they did little or nothing to eradicate or mitigate the potential risks.
- 2.37** Conditions in the custody suites varied considerably. The two modern suites at Nuneaton and Warwick Justice Centre were well equipped and clean. Conditions in the cells at Dudley were also reasonable. However, elsewhere, conditions were much poorer, including significant amounts of graffiti, some of which was offensive, and many cells were cold.
- 2.38** Cleaning was carried out in all custody suites daily, but the regime was inadequate and sometimes involved simply clearing rubbish. As a result, many of the cells that detainees occupied remained unacceptably dirty. The toilet and hand-washing facilities for detainees were mostly adequate, although some lacked privacy.
- 2.39** United Safe Care provided health advice, which staff could access over the telephone. Health care professionals could also be sent to court custody suites if necessary. Staff were not always fully aware of the full range of services that United Safe Care provided and told us that they were mostly dissatisfied with the service, as they felt it was often unresponsive.
- 2.40** Some custody staff were out of date with their first-aid training, which had an impact on the duties to which they could be allocated. The triennial updates for first-aid training were too infrequent to maintain competency. Automated external defibrillators were not available in the court custody suites, with the exception of Warwick Combined Court, where this was available in the neighbouring police custody suite. Some items in first-aid boxes were out of date. Some boxes were over- or understocked and we were not confident that they were checked regularly. Medication was stored securely and staff were confident in issuing medication in an appropriate manner.

- 2.41** PERs did not always include all relevant health information, and some health practitioners inappropriately opened 'medical-in-confidence' envelopes, which should only be opened in the case of a clinical emergency.
- 2.42** Throughout the inspection, court custody staff told us that detainees often arrived from police custody suites with no or insufficient medication to see them through the day. This was problematic as some detainees remained in court custody for long periods.
- 2.43** Most staff told us that they had not received any training to assist them in identifying and supporting detainees with mental health or substance use problems. Access to mental health and substance use practitioners varied considerably across the court cluster, with some courts having no service at all.

Main recommendations

- 2.44** **HM Courts & Tribunals Service (HMCTS), Prisoner Escort and Custody Services (PECS), and the escort and custody contractor should investigate the reasons for the prolonged periods that some detainees spend in court custody cells. Measures should be put in place to ensure that detainees have their cases prioritised, where possible, and are transferred or released without delay.**
- 2.45** **Handcuffs should be used only if necessary, justified and proportionate.**
- 2.46** **The conditions in most custody suites should be improved. The cleaning regime should be significantly improved to ensure that all cells are cleaned and kept clean and tidy every day, to an acceptable standard. All offensive graffiti should be removed immediately.**
- 2.47** **All court custody cells should be examined to identify potential ligature points and action should be taken to eliminate or mitigate potential risks.**

Section 3. Leadership, strategy and planning

Expected outcomes:

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

- 3.1 HM Courts & Tribunals Service (HMCTS) in West Midlands and Warwickshire operated as a single 'cluster'. Three agencies worked together to deliver court custody services: HMCTS, which had overall responsibility, along with Prisoner Escort and Custody Services (PECS) (part of Her Majesty's Prison and Probation Service (HMPPS)) and GEOAmeY. An HMCTS cluster manager, supported by three operations managers, was responsible for managing court custody services across West Midlands and Warwickshire. Nine HMCTS court delivery managers were directly responsible for the day-to-day provision of court custody in the Crown and magistrates' courts we inspected. An HMCTS court delivery manager was also responsible for the Immigration Asylum Chamber (IAC). Court managers had regular contact with GEOAmeY staff, particularly concerning any problems affecting court custody operations. HMCTS had a clear line management structure for the cluster.
- 3.2 PECS commissioned GEOAmeY to manage court custody and provide escort services on behalf of HMCTS in West Midlands and Warwickshire. A general manager for GEOAmeY had oversight and responsibility for court custody and was supported by two GEOAmeY area business managers (ABMs), who held responsibility for the day-to-day management of services in courts. A further ABM was responsible for escort and transport services. Eleven court custody managers reported to the ABMs and were responsible for the daily running of court custody facilities. The contractual arrangement between PECS and GEOAmeY was supervised by two PECS contract delivery managers.
- 3.3 Strategic meetings between GEOAmeY, HMCTS and PECS took place regularly. Minutes and strategic interviews reflected that the respective agencies paid good attention to the care and welfare of detainees. They were all were sighted on some recurring issues, including the poor environments in most court custody suites (see below and section on physical conditions).
- 3.4 Working relationships between HMCTS and GEOAmeY were relatively well developed and embedded. HMCTS accommodation liaison staff and court delivery managers visited court custody suites reasonably regularly. HMCTS operations managers were aware of and sighted on issues affecting the care and welfare of detainees. HMCTS was bound by, but not directly responsible for, a Ministry of Justice Estates contract with G4S to provide cleaning and maintenance services for the whole courthouse, including court custody facilities, and escalated problems they were made aware of appropriately. GEOAmeY staff generally attended HMCTS daily team information briefings and told us that they found this to be a useful conduit for raising any issues.
- 3.5 GEOAmeY staff understood how and to whom any cleaning or maintenance issues should be reported. They generally escalated appropriate issues to HMCTS, if required. While there was generally good liaison between GEOAmeY and HMCTS, some staff had become desensitised to the dirt and graffiti they saw every day and we repeatedly found conditions that were unacceptable and which we considered to be disrespectful (see also section on physical conditions and main recommendation 2.46). HMCTS, GEOAmeY and PECS told us that they were frustrated that the contract was not delivered effectively and that, despite their best efforts, some faults and defects remained unaddressed for long periods. While we acknowledged that HMCTS did not own the contract, this did not detract from the often unacceptable and disrespectful conditions that we found in most court custody facilities.

- 3.6** An HMCTS listings protocol specified that court custody cases, particularly for women and children, should be prioritised. GEOAmeY staff alerted court staff when vulnerable detainees were in custody, and we were told, and saw evidence, that cases were prioritised where possible.
- 3.7** We were told that court user groups took place only every six months at the Crown courts. Attendance was often poor and meeting minutes did not reflect a focus on the care and welfare of detainees.
- 3.8** Staffing levels for court custody facilities were generally adequate. GEOAmeY delivered a good initial training package but this was not supported by ongoing refresher training or development activities. Although staff were generally professional and courteous (see section on respect), there was insufficient investment in their development. The triennial first-aid refresher training being delivered was not sufficient to maintain good awareness.
- 3.9** GEOAmeY issued a range of standard operating procedures (SOPs) but were concerned that these were not always communicated effectively to operational staff or monitored for ongoing understanding and compliance. For example, the SOP concerning 'special groups' (Number 20) detailed the treatment of transgender detainees. This SOP was confusing and not reflective of the written briefings we had seen, and most staff were not confident about how they would treat a transgender detainee in custody (see also paragraph 5.6).
- 3.10** Recruitment problems had resulted in insufficient lay observers, which meant that they visited court custody suites relatively infrequently. Their visits resulted in thorough reports, which were appropriately focused on detainees' conditions. Not all HMCTS and GEOAmeY court custody managers were aware of lay observers' reports as they were not disseminated widely enough. Managers who had seen them told us that they found them helpful.
- 3.11** The PECS contract delivery managers convened monthly performance/contract compliance meetings with GEOAmeY. Issues concerning detainee care and about the physical conditions in most courts were raised frequently there (see also section on physical conditions and main recommendation 2.46). The PECS contract delivery managers conducted 'safe, secure, decent and compliant' (SSDC) audits in each court custody facility. Reports from these audits were sent only to GEOAmeY. Only court custody managers were aware of the action plans that had been created following the audits.
- 3.12** PECS was advised of all reports of use of force in court custody, and dip-sampled a selection of them (see section on use of force).
- 3.13** The use of virtual courts (intended to remove the requirement for prisoners physically to attend court) for eligible cases was very good in magistrates' courts but not as well utilised in Crown courts, for a variety of reasons. Some judges often insisted that detainees attend court rather than be dealt with remotely, which sometimes made the system less effective and efficient than intended. The infrastructure in prisons, police custody and courts to support the wider use of video-link hearings was described as inadequate by HMCTS.
- 3.14** There was no HMCTS safeguarding policy or protocol that set out how detainees at risk, including children, would be protected from harm, abuse or maltreatment. GEOAmeY had its own guidance document concerning safeguarding but staff were not always aware of their responsibilities and did not always know how to report a safeguarding concern if one arose (see also paragraph 5.23).
- 3.15** Arrangements for detainees held in the IAC were inadequate. Tascor, a privately contracted company, was responsible for transporting detainees there and supervising them during their stay. The holding room was austere and often shared by male and female detainees whose cases were not linked, which was inappropriate. However, the HMCTS delivery manager

responsible for the IAC told us that, as a result of our concerns, she had taken action with her listings team to ensure that men and women would not be listed for hearings on the same day in the future. Other than a limited range of books, there was little else to keep detainees occupied during their time in the holding room. Tascor staff told us that they were routinely given only a croissant and a packet of crisps to provide for lunch to detainees, which was insufficient. There were no formal arrangements to ensure that detainees were released safely. HMCTS and Tascor staff told us that they had no responsibility for detainees who were released. There was no provision of money or travel warrants to ensure that detainees could get home safely. There were no support leaflets for detainees released.

Recommendations

- 3.16 There should be an HMCTS safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable adults at risk.**
- 3.17 The treatment of detainees held in the Immigration Asylum Chamber, including the provision of suitable meals, activities to occupy them and support for their release, should be improved.**

Section 4. Individual rights

Expected outcomes:

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

- 4.1** At most courts, custody officers checked the documentation that accompanied each detainee, to ensure that they had the correct authority to detain; however, this was usually done once the detainee had already been placed in their cell. HM Courts & Tribunals Service (HMCTS) confirmed that there was no arrangement for court enforcement officers (CEOs), who executed warrants on behalf of courts, to deliver compliant individuals directly to the court room and avoid unnecessary detention in cells or excessive handcuffing and searching procedures (see paragraph 5.44). In the records we reviewed for the previous month, it was apparent that detainees apprehended by CEOs were lodged in the court cells at most of the magistrates' courts across the cluster. We saw numerous compliant detainees being brought into court cells by CEOs, which resulted in unnecessarily intrusive procedures such as searching and handcuffing, and created an additional burden for the already busy court custody staff.
- 4.2** HMCTS had a listings protocol. This outlined that custody cases, particularly those which involved children and vulnerable detainees, should be prioritised, where possible, to take into account the fact that detainees had spent a night in police custody or travelled from prison, and we saw this taking place. However, we identified some long delays which contributed to detainees being held in court custody for longer than necessary. We saw and were told of delays in the attendance of duty solicitors, which we were told was sometimes due to the availability of the relevant paperwork. At Walsall Magistrates' Court, we saw a Vietnamese detainee who was further remanded and returned to prison owing to the non-attendance of a court-appointed interpreter. At Birmingham Magistrates' Court, we saw a Polish detainee who was remanded in custody over the weekend as the police had failed to book a court-appointed interpreter to assist her (see main recommendation 2.44).
- 4.3** It was common for detainees who had been bailed or acquitted, but previously remanded in custody, to have to wait for long periods before the prison they had come from authorised their release. We were also told of long delays when the individuals were subject to licence conditions, and that this was a particular problem at HMP Birmingham. In the records we reviewed at a number of courts, we found delays of over two hours in the relevant authority to release being received. This included one case at Birmingham Crown Court Annexe, where a detainee was released by the court at 11.55am and returned to his cell; court custody staff sent off the necessary paperwork to HMP Birmingham promptly but the licence was not received from the prison until 3.50pm, at which point the detainee was finally released (see main recommendation 2.44).
- 4.4** Long periods in court custody were also caused by other factors. At the Crown courts, we were told that it was common practice for detainees to be brought from prison early in the day, even though their cases were not listed until the afternoon, and we found evidence of this in the records we reviewed. We also found delays of between three hours and six hours 15 minutes (the latter at Wolverhampton Combined Court) for remanded or sentenced detainees to be transported to prison, having been dealt with by the court in the morning. These delays were relatively infrequent at busier courts but more common at others (see main recommendation 2.44). Evidence suggested that when vehicles were available, moves to prison would take place throughout the day (see also paragraph 5.31). We found few excessive delays at the end of the day as courts were cleared quickly after business had terminated.

- 4.5** The national guidance stating that a detention warrant should be produced within 30 minutes of a court hearing or appearance was achieved at most of the Crown courts we inspected. However, at some courts we found routine waits in excess of an hour, which delayed the organisation of transport for detainees and lengthened their stay in court custody cells. In the records we reviewed, we found many long delays, of up to and over two hours, in the production of warrants. In one case, we found a delay of over five hours. Court custody and HMCTS staff told us that warrants were not always picked up if there were no vehicles to move detainees to prison; however, regardless of the reasons, such delays were poor (see main recommendation 2.44).
- 4.6** Custody staff told us that they could accept detainees before lunchtime, but after that the decision as to whether to accept a detainee was made by the clerk of the court. We were told that detainees would be accepted throughout the day, and as late as 3pm. The records we reviewed showed that detainees had been accepted as late as 4.30pm at Leamington Spa Magistrates' Court, which meant that they did not have to be held in police custody overnight.
- 4.7** Court custody staff told us that if a detainee wanted someone informed of their whereabouts, they would attempt to assist them, provided that this did not involve contacting a possible victim in a case. We were told of a number of cases where staff had contacted relatives on behalf of detainees, and we saw staff at Birmingham Magistrates' Court contact a relative of a female being released, so that they knew she was on her way home.
- 4.8** Leaflets outlining detainees' rights and the local complaints process were placed in cells before a detainee's arrival, although these were sometimes in a poor condition and barely legible. However, custody staff did not always explain that the information was in the cell and failed to check if detainees could read or understand it. At one court, we saw a detainee tell the cells officer that he could not read or write but no effort was made to read the rights documentation to him. The information about detainees' rights was available in a number of languages, but staff were not always proactive in issuing these to detainees.
- 4.9** Custody staff at all the courts liaised well with court ushers, security staff or directly with legal representatives' firms, to ensure that all detainees had legal representation when they arrived at the court custody suite. We saw legal representatives allowed access to detainees in suitable interview rooms; however, at Walsall Magistrates' Court we were told that there were often queues to these rooms as only two of the rooms were used, despite the availability of another two interview rooms elsewhere in the suite. Detainees at all courts were allowed to retain legal documents that were relevant to their case.
- 4.10** Custody staff at all courts we visited said that they had a reasonable relationship with representatives from their local youth offending service (YOS) but it was sometimes difficult for custody staff to identify which particular YOS had responsibility for a child, as this was often linked to where they were resident. In most cases, the YOS was notified by either the police or the court when a child was held in court custody; on Saturdays, there was a clear procedure for the YOS to telephone the courts to confirm if any children were held. This allowed children to receive visits from the YOS so that the child's needs, risks and circumstances could be presented to the court. During the inspection, we saw custody staff notifying either the court clerk or usher when a child was in the court custody suite, so that their case could be prioritised, where possible, to minimise their detention time.
- 4.11** Details of how to access the professional telephone interpreting service were available in all of the court custody suites. Custody staff knew about the service but were not confident to use it because in some cases they were concerned about detainees gaining access to custody offices where the telephone was located. Data supplied by GEOAmey showed that this service had not been used by any court in the cluster since 1 January 2016. Custody staff at

all the courts told us that they used the court-appointed interpreter to check how non-English-speaking detainees were feeling, but this service was not routinely available when such detainees were initially admitted into custody, when their welfare should have been checked to assess and manage risk. However, we saw the telephone interpreting service being used on two occasions to good effect when court-appointed interpreters either failed to attend or were not booked for court (see paragraph 4.2).

- 4.12** On the whole, complaints were dealt with adequately. Data provided by GEOAmev showed that there had been 16 complaints in the previous 10 months across all the court custody suites. Most detainees were told on arrival that there was a complaints procedure. Notices detailing the procedure were placed in cells (see above) and displayed in all the custody suites but these contained out-of-date information. Staff were aware of the complaints process but some were unclear about who was responsible for investigating them.

Recommendations

- 4.13 HMCTS should ensure that compliant defendants apprehended by court enforcement officers are not taken into court custody unless there are good reasons to do so.**
- 4.14 Professional telephone interpreting services should be readily accessible in each custody suite and used as necessary.**
- 4.15 Rights documentation should be issued to detainees in their own language.**
- 4.16 Up-to-date complaints documentation should be available and all detainees should be informed of the complaints process.**

Section 5. Treatment and conditions

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 sensitively and humanely.

Respect

- 5.1 The cellular vehicles we inspected were reasonably clean. We found some graffiti in cellular compartments, but this was less extensive than we normally see. Well-equipped, modified domestic vehicles were used to transport children to and from secure training centres (STCs) but, as two members of escort staff were required to sit alongside the child, space inside was cramped. Despite this, they were still much more suitable for transporting children than the vans.
- 5.2 Some journeys to the court were relatively long; for example, prisoners travelling from HMP Peterborough were sometimes on vehicles for over two hours. Escort staff told us that they regularly transported male and female detainees on the same vehicle, and also that older children were sometimes transported with adults, as the contract permitted this. In addition, partitions were not always used to create a degree of separation.
- 5.3 All of the vehicles we examined were suitably equipped with anti-ligature knives and first-aid kits, and these were readily accessible to staff. They also contained bottled drinking water; where necessary, preparations were made in advance to make sure that food was carried on vehicles.
- 5.4 Most detainees arrived at court from local police custody suites and prisons, and were disembarked promptly from vehicles. Most vehicle docks were secure and protected detainees from media or public attention. When this was not the case, entrances to court custody areas were located discreetly; staff told us that they did not have any difficulty in ensuring that detainees' privacy and dignity were maintained on arrival at court.
- 5.5 Morale among custody officers appeared to be good, in spite of the day-to-day pressures and frustrations they commonly experienced as part of their job. Officers treated each other considerately and worked well together as a team. During the inspection, we consistently observed staff interacting with detainees in a courteous and respectful manner, and we came across some staff who demonstrated outstanding attention to meeting the needs of detainees. When vulnerable detainees were dealt with, we often saw staff showing an interest and concern about their welfare. Despite sometimes being exposed to aggressive or threatening behaviour by detainees, staff seemed prepared to adopt a firm but patient approach and we saw no evidence of punitive attitudes.
- 5.6 Most officers treated detainees as individuals and we found evidence to show that they responded flexibly, depending on the circumstances of each case. Although all staff had completed some training on diversity and equality as part of their induction, they had few opportunities to update this. This meant that staff were mostly reliant on their existing knowledge and experience in relation to how they dealt with diversity. This lack of formal training was exemplified when, apart from at one site, we found a lack of understanding about how to deal with transgender detainees (see also paragraph 3.9).

- 5.7** Female detainees were usually allocated a female member of staff to look after them. Feminine hygiene products were available at all of the custody suites but female detainees were not always notified about this in advance or offered them routinely.
- 5.8** Children were dealt with sensitively and with an appropriate degree of tolerance. Staff often instinctively treated them in a parental way, showing a greater degree of patience and tolerance than they would towards adult detainees. They explained about the facilities and how routines worked, used age-appropriate language and asked questions to make sure that the child understood. At one of the magistrates' courts, we witnessed a senior custody officer (SCO) spending a great deal of time talking to a child who was very agitated, in order to help calm him down. Although this was a time-consuming exercise, it worked, and we were told that this approach was not unusual. In contrast to this good work, at one of the youth courts we observed staff failing to pay sufficient attention to a rather nervous child who had been charged with a serious offence.
- 5.9** Care was taken to ensure that children were kept apart from adult detainees, and separate cell locations were usually used. At Birmingham Crown Court, we saw staff going to considerable lengths to make sure that children did not come into direct contact with adults.
- 5.10** We saw several examples of children being escorted between STCs and the courts, and these transfers were carried out efficiently. During a weekend visit, we observed a child being remanded into custody for the first time. A suitable placement in a young offender institution was identified quickly and transportation was arranged promptly. However, we found some data which suggested that there had been delays in securing placement orders in a minority of cases, which meant that some children had not left court custody until late in the evening (see also paragraph 5.31).
- 5.11** Adequate stocks of religious materials were held in each of the suites and these were stored respectfully, in designated areas.
- 5.12** There was limited reading material available for detainees, consisting of collections of books, magazines and free newspapers, all brought in by staff. These items were not offered routinely and there was nothing available in languages other than English. There was no reading material that was suitable specifically for children; at one of the youth courts, we saw a child remaining in custody for over three hours without being offered anything to read.
- 5.13** Facilities for detainees with a disability were limited and only two of the courts we inspected were DDA compliant. Many of the courts had steep flights of stairs, which all detainees appearing in court had to negotiate. Although there were some good facilities for detainees with disabilities at Nuneaton Magistrates' Court, these were not serviceable. There were no adapted cells with lowered call bells and no hearing loops, and there was no literature available in Braille or an easy-read format. As access to specialist facilities was so limited, such detainees often had to travel further to court than those without a disability. Many detainees with restricted mobility were held in non-DDA-compliant facilities, which caused varying degrees of discomfort. Staff told us that when these types of issue arose, they tried to make reasonable efforts to meet these detainees' particular needs, but we did not always see this being carried out in practice. For example, we observed one case where a walking stick was removed from a detainee with highly restricted mobility.
- 5.14** There were suitable arrangements at each of the suites to allow detainees to have their property stored under lock and key, with appropriately limited access to it.
- 5.15** All courts maintained stocks of ambient microwave meals, which were prepared in reasonably clean facilities. Although not appetising, there was a suitably wide range of these products available. In one court, we found a batch of meals which had passed their shelf life. Most courts also had a good supply of freshly prepared sandwiches, which were more

popular with detainees. Where possible, in order to meet demand, staff tried to order sufficient sandwiches in advance, and spare sandwiches were sometimes offered to detainees on release. Supplies of biscuits and crisps were also held at each site. Meals were always offered at lunchtime, but detainees were also given food at other times, on request or when staff thought this was necessary. Detainees were normally offered a hot or cold drink on arrival. There was a water fountain at Nuneaton Magistrates' Court but in most of the other locations, water was taken from taps in various locations in the custody suites, some of which were not clearly identified and from a public health perspective we were not confident that they were all suitable for drinking water.

Recommendations

- 5.16 Men, women and children should always be transported in separate escort vehicles.**
- 5.17 All court custody staff should receive regular training in equality and diversity.**
- 5.18 Detainees with disabilities should have access to custody suites and cells that meet their needs.**
- 5.19 All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers, which should be routinely offered to detainees.**

Safety

- 5.20** Daily staff briefings were not carried out consistently across the court custody suites. The briefings often began without the whole staff team present and took place before detainees arrived and their presenting risks had been identified. In addition, there was no consistent reception risk assessment process across the courts. Custody staff relied too much on PERs to identify risk, but these did not always contain sufficient detail (see below). A checklist was available to help to assess the risk of arriving detainees, but some staff struggled to complete this in a timely manner, and not all courts used it; in several suites, the SCO or a member of staff just checked on the detainee's well-being that day. We saw inconsistent approaches and were not satisfied that all staff had the confidence or experience to use an informal and otherwise reasonable approach when assessing detainees' risk while in court custody.
- 5.21** The designated 'cells' officer, plus one other in some of the bigger suites, was nominated to carry an anti-ligature knife, and another one was stored in the staff office. Cell visits were not always carried out by the cells officer, and in some courts the anti-ligature knife was not carried or handed over to the person conducting the checks, which posed a potential risk to the safety of detainees. During the inspection, when inspectors checked, no staff were carrying anti-ligature knives at Wolverhampton Magistrates' and Warwick Combined Courts.
- 5.22** Levels of observation were set appropriately for most detainees but we found some inconsistencies. At Birmingham Crown and Magistrates' Courts, staff carried out 30-minute observations for detainees without an identified vulnerability, while in all other courts 60-minute observations were in place. For the most vulnerable detainees, observations took place six times per hour. In some courts, there was no systematic approach to ensuring that checks were completed at the specified time. In the busier courts, including Birmingham Magistrates' and Crown Courts, a nominated court custody officer was required to complete a cell visits check sheet every time they visited a cell, and this was used to update

detainees' records. Across the whole cluster, we saw some vulnerable detainees not being visited at the required frequency.

- 5.23** Some custody staff were knowledgeable about making referrals to appropriate support agencies in the community if they had concerns about detainees. Staff in several courts provided examples of having helped vulnerable detainees and contacting support agencies. HM Courts & Tribunals Service (HMCTS) had no formal safeguarding protocol. GEOAmev had a safeguarding lead and a standard operating procedure, but the latter did not include referral mechanisms. Most court custody staff were unaware of the formal safeguarding arrangements (see also paragraph 3.14 and recommendation 3.16).
- 5.24** Most detainees were searched appropriately and sensitively by staff. However, there was too much unnecessary routine searching in secure areas, in the absence of a robust and individualised risk assessment. In most cases, detainees were searched on arrival, and then each time they left their cell, even when moving from one part of the court cell block to another, and when returning from visits with legal representatives or to the toilet.
- 5.25** Although most cell bells were answered quickly, during the inspection we observed some response times that were too long. There were few systems for monitoring cell call bells. With no member of staff taking specific responsibility for answering the call bells in one court, we saw detainees waiting for up to 20 minutes.
- 5.26** In the busier magistrates' courts, detainees were regularly required to share cells. CSRAs were not completed for all occupants before they were co-located. At one court, we saw three CSRAs completed before the arrival of detainees, when their risks were unknown. A further three CSRAs were not completed in full until several hours after cell sharing had started. One of these detainees was a sex offender who should not have been sharing a cell. Staff did not understand the annotation on this detainee's PER which indicated his offence and level of risk. Another detainee, who had been released by the court but was awaiting a governor's authority to release, was inappropriately placed back into a cell with a detainee who had still not appeared in court.
- 5.27** There were no significant delays in presenting detainees at court. There were generally sufficient affray alarms in the courts to summon help, but in some courts there were insufficient alarms on the routes to most courtrooms. At Leamington Spa Magistrates' Court and Warwick Combined Court, where the facility is shared with the police, we saw court staff responding to affray alarms in the police custody suite, and police responding to alarms in court custody. There should be a process to ensure that the procedures followed by both court staff and police are legally and operationally sound.
- 5.28** Most of the PERs completed by police, prisons (most notably HMP Birmingham) and court enforcement officers (CEOs) contained insufficient information about potential risks, and very limited medical information. Escort staff generally gave verbal handovers to court custody staff but these were sometimes limited to how the detainee had reported feeling that day.
- 5.29** Arrangements for releasing detainees safely were mostly adequate but there was no systematic pre-release risk assessment across the courts. All courts had stocks of petty cash and travel warrants for trains, but some had no day-saver bus tickets. Detainees were not routinely asked how they were getting home or if they had the means. Staff did not always offer travel warrants or day-saver bus tickets, or provide money to meet transport costs. However, we saw some good attention to helping detainees, particularly the most vulnerable, get home safely.
- 5.30** Leaflets about support services for detainees being released, and information about local prisons for those being transferred were available in every suite but were not provided

routinely. Few staff understood that they had a duty to refer detainees if they had concerns about them leaving court custody. Some said that they would contact their line manager, the youth offending service (YOS) or probation service in such cases but most were unfamiliar with internal avenues, such as the GEOAmev safeguarding lead.

- 5.31** Data supplied, and our observations, suggested that efforts were made to return detainees to prison quickly after completion of their court appearance. However, we saw too many detainees waiting for long periods for a transfer back to prison on completion of their cases, many in excess of five hours, when escort vehicles were not available (see main recommendation 2.44).

Recommendations

- 5.32 All staff undertaking observations and cell visits should carry anti-ligature knives at all times.**
- 5.33 A standardised reception risk assessment process should be introduced.**
- 5.34 Set levels of observation should always be adhered to.**
- 5.35 The searching of detainees in secure areas should be based on a robust and individual risk assessment.**
- 5.36 Cell call bells should be answered promptly and always within five minutes.**
- 5.37 Cell sharing risk assessments should take account of all available information and should always be completed before any detainees are required to share cells.**
- 5.38 Staff should receive further training and guidance on the importance of completing cell sharing risk assessments correctly and for all detainees before they are required to share cells.**
- 5.39 Person escort records should contain detailed and dated risk and health information, to ensure detainees' safety.**
- 5.40 Pre-release risk arrangements should be improved. Custody staff should check if detainees have any immediate needs or concerns that should be addressed before they leave custody.**
- 5.41 Staff should provide detainees with information about local support organisations on release from court custody, and with information about prisons when they are to be transferred to prison.**
- 5.42 Children remanded or sentenced to local authority secure accommodation should be transferred promptly on completion of their cases.**

Use of force

- 5.43** Across the 13 courts inspected, there had been 46 incidents involving the use of force between 1 January and 31 October 2016, which was relatively low. We were confident that force was used only as a last resort, following efforts to de-escalate, and that such incidents were recorded routinely. Staff statements were written promptly but some included cursory descriptions about the circumstances leading up to the deployment of force, and lacked

rigour. Staff debriefs took place shortly after each incident and attempts were always made to debrief with detainees. During the staff debrief, SCOs discussed the techniques used and any areas of concern. All custody staff were trained to use control and restraint techniques and had attended their annual refresher training course.

- 5.44** All detainees, including children, were handcuffed routinely, even when being moved within secure, controlled custody areas and in the absence of individual and robust risk assessments (see main recommendation 2.45). We were told that discretion was used in applying handcuffs to detainees with mobility problems.

Physical conditions

- 5.45** During the inspection, we carried out a review of the cells we had access to, at each of the courts. Although this investigation was not complete or comprehensive, we were able to establish the presence of a large number of potential ligature points in every suite we visited (see main recommendation 2.46). In many, but not all, instances, staff were already aware of these problems but did little or nothing to eradicate or mitigate the potential risks.
- 5.46** Conditions in the custody suites varied considerably across the estate. The two modern suites at Nuneaton and Warwick Combined Court were well equipped and clean. Although the Dudley suite was older, the cells there were also in a reasonable condition. However, elsewhere, the conditions were much poorer (see main recommendation 2.46). This was particularly the case at Birmingham Magistrates' Court (see Appendix II), where the turnover was extremely high, and at Wolverhampton Magistrates' Court, where part of the fabric of the building dated back to the 18th century. At several suites, and particularly at Coventry Magistrates' Court, we received complaints about the cells being very cold. No blankets were available but we saw custody staff moving detainees to alternative cells, where possible.
- 5.47** Cleaning was carried out in all custody suites daily, but the regime was inadequate and at some of the busier suites this sometimes involved simply clearing rubbish. As a result, many of the cells in these locations, such as at Walsall Magistrates' Court, remained unacceptably dirty (see main recommendation 2.46 and Appendix II). The toilets and hand-washing facilities for detainees were generally adequate but some toilet facilities lacked privacy.
- 5.48** Graffiti was not widespread across the estate but in the older suites, such as at Birmingham and Wolverhampton Magistrates' Courts and Birmingham Crown Court, graffiti was prevalent, some of which was offensive (see Appendix II).
- 5.49** Use of the cell call bell was not always explained to detainees on admission.
- 5.50** Each suite had a designated fire marshal. Instructions for staff about what to do in the event of a fire were displayed in all the suites, and staff we spoke to were familiar with them. Fire alarms were tested weekly but we were not provided with evidence of evacuations being carried out.

Health

- 5.51** United Safe Care had become GEOAmey's medical service provider in July 2015. They provided health advice over the telephone, and a visiting health care professional could attend if required. Staff also contacted the ambulance service in emergency situations. Contact details for United Safe Care were displayed clearly in each suite, but contained the old contractor name. Staff we spoke to were not always aware of the full range of services provided under the contract, and some told us that they were mostly dissatisfied with the

service, as they felt it was often unresponsive. In some cases, SCOs told us that they no longer relied on the telephone service and just called the ambulance service, which was not appropriate as some cases were not described as medical emergencies. Data supplied by the company showed that they had been contacted by the courts 15 times in the previous six months. Most of these calls had been for advice or to verify the issue of medication to detainees; however, in four cases a health care professional had been requested to attend, mostly to administer pain relief.

- 5.52** All staff were required to complete a 'first aid at work' qualification, although several had not received refresher training, and this had an impact on the duties to which they could be allocated. Updates for first-aid training were normally conducted every three years, but annual training specific to the environment was required to maintain an adequate skill level. Many staff had not used or practised these skills and there was no on-site resuscitation equipment, suction, oxygen or automated external defibrillators, other than at Warwick Combined Court, where this was available in the neighbouring police custody suite. The basic first-aid kits we found in most suites varied in their contents, as most of these were either over- or understocked, and in some cases contained out-of-date stock. We were not confident that these kits were checked regularly.
- 5.53** For many of the detainees received from police custody, the police supplied copies of their notes of medical examinations, including details of diagnosis and medication administered, within the PER; this breached medical confidentiality requirements as they were not sealed in an envelope, to be opened in the case of a medical emergency. We saw a health care practitioner at Wolverhampton Combined Court opening 'medical-in-confidence' envelopes which had travelled with detainees from prison, when there was no emergency; this, again, compromised medical confidentiality. Health information was not consistently written in the PER in a way that clarified the risk without giving a diagnosis – for example, PERs for some detainees from HMP Birmingham simply stated 'physical health' without clarifying the actual risks.
- 5.54** Throughout the inspection, court custody staff told us that detainees often arrived from police custody suites with no or insufficient medication to see them through the day, even if it had been prescribed and administered while the detainee had been in police custody. This was a particular concern for detainees arriving with ongoing alcohol withdrawal symptoms as there was a risk of severe health complications if they remained in court custody for long periods (see section on individual rights). However, some detainees arrived from police custody or prison with their own prescribed medication, along with clear instructions, which staff handed to detainees for self-administration at the relevant times, recording this on the PER. Court custody staff were aware of the appropriate requirements for safe drug administration, and medicines were stored securely.
- 5.55** Detainees were allowed to keep their asthma inhalers (to relieve difficulty in breathing) and angina sprays (to relieve heart pain or tightness) with them in their cells. They were not allowed to keep insulin pens, blood sugar testing equipment or EpiPens, but we were told that these were usually stored in the custody suite offices and were accessible if required.
- 5.56** Detainees with mental health issues and substance use problems were usually identified and assessed before arriving from prison or police custody. Access to mental health and substance use practitioners varied considerably across the court cluster, with some courts having no dedicated service at all, although contact numbers were available when this was the case. During the inspection, we found community psychiatric nurses at some magistrates' courts, including Birmingham, Coventry and Dudley, who were actively involved in assessing the needs of vulnerable detainees and providing custody staff with helpful guidance and advice. Across all courts, most custody staff told us that they had not received any training to assist them in identifying and supporting detainees with mental health or substance use problems. Some court custody staff demonstrated a reasonable understanding of drugs and

alcohol issues and most were aware of the particular risks associated with alcohol withdrawal; however, they were less knowledgeable of the effects of opiate withdrawal.

Recommendations

- 5.57** Custody staff should be appropriately trained and annually updated in emergency response skills, including basic life support and the use of automated external defibrillators, and should also have regular training to enhance their mental health and drugs and alcohol awareness.
- 5.58** First-aid equipment should include sufficient up-to-date kit, including basic equipment to maintain an airway and automated external defibrillators, in custody areas.
- 5.59** 'Medical-in-confidence' envelopes should be opened only in a medical emergency.
- 5.60** All detainees who require prescribed medications while in court custody should have access to it.
- 5.61** Mental health liaison and diversion schemes should be available at all courts.

Section 6. Summary of recommendations and good practice

Main recommendations

- 6.1** HM Courts & Tribunals Service (HMCTS), Prisoner Escort and Custody Services (PECS), and the escort and custody contractor should investigate the reasons for the prolonged periods that some detainees spend in court custody cells. Measures should be put in place to ensure that detainees have their cases prioritised, where possible, and are transferred or released without delay. (2.44)
- 6.2** Handcuffs should be used only if necessary, justified and proportionate. (2.45)
- 6.3** The conditions in most custody suites should be improved. The cleaning regime should be significantly improved to ensure that all cells are cleaned and kept clean and tidy every day, to an acceptable standard. All offensive graffiti should be removed immediately. (2.46)
- 6.4** All court custody cells should be examined to identify potential ligature points and action should be taken to eliminate or mitigate potential risks. (2.47)

Recommendations

Leadership, strategy and planning

- 6.5** There should be an HMCTS safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable adults at risk. (3.16)
- 6.6** The treatment of detainees held in the Immigration Asylum Chamber, including the provision of suitable meals, activities to occupy them and support for their release, should be improved. (3.17)

Individual rights

- 6.7** HMCTS should ensure that compliant defendants apprehended by court enforcement officers are not taken into court custody unless there are good reasons to do so. (4.13)
- 6.8** Professional telephone interpreting services should be readily accessible in each custody suite and used as necessary. (4.14)
- 6.9** Rights documentation should be issued to detainees in their own language. (4.15)
- 6.10** Up-to-date complaints documentation should be available and all detainees should be informed of the complaints process. (4.16)

Treatment and conditions

- 6.11** Men, women and children should always be transported in separate escort vehicles. (5.16)
- 6.12** All court custody staff should receive regular training in equality and diversity. (5.17)
- 6.13** Detainees with disabilities should have access to custody suites and cells that meet their needs. (5.18)
- 6.14** All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers, which should be routinely offered to detainees. (5.19)
- 6.15** All staff undertaking observations and cell visits should carry anti-ligature knives at all times. (5.32)
- 6.16** A standardised reception risk assessment process should be introduced. (5.33)
- 6.17** Set levels of observation should always be adhered to. (5.34)
- 6.18** The searching of detainees in secure areas should be based on a robust and individual risk assessment. (5.35)
- 6.19** Cell call bells should be answered promptly and always within five minutes. (5.36)
- 6.20** Cell sharing risk assessments should take account of all available information and should always be completed before any detainees are required to share cells. (5.37)
- 6.21** Staff should receive further training and guidance on the importance of completing cell sharing risk assessments correctly and for all detainees before they are required to share cells. (5.38)
- 6.22** Person escort records should contain detailed and dated risk and health information, to ensure detainees' safety. (5.39)
- 6.23** Pre-release risk arrangements should be improved. Custody staff should check if detainees have any immediate needs or concerns that should be addressed before they leave custody. (5.40)
- 6.24** Staff should provide detainees with information about local support organisations on release from court custody, and with information about prisons when they are to be transferred to prison. (5.41)
- 6.25** Children remanded or sentenced to local authority secure accommodation should be transferred promptly on completion of their cases. (5.42)
- 6.26** Custody staff should be appropriately trained and annually updated in emergency response skills, including basic life support and the use of automated external defibrillators, and should also have regular training to enhance their mental health and drugs and alcohol awareness. (5.57)
- 6.27** First-aid equipment should include sufficient up-to-date kit, including basic equipment to maintain an airway and automated external defibrillators, in custody areas. (5.58)
- 6.28** 'Medical-in-confidence' envelopes should be opened only in a medical emergency. (5.59)

- 6.29** All detainees who require prescribed medications while in court custody should have access to it. (5.60)
- 6.30** Mental health liaison and diversion schemes should be available at all courts. (5.61)

Section 7. Appendices

Appendix I: Inspection team

Kellie Reeve
Fionnuala Gordon
Ian Macfadyen
Fiona Shearlaw

Lead Inspector
Inspector
Inspector
Inspector

Appendix II: Photographs

A cell in Birmingham Magistrates' Court



Graffiti in a cell in Birmingham Crown Court Annexe



Graffiti in a cell in Walsall Magistrates' Court



A cell in Walsall Magistrates' Court

