Report on an inspection visit to court custody facilities in

Cleveland, Durham and Northumbria

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by HM Chief Inspector of Prisons

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1. Introduction

This is the first report in a new programme of inspections of court custody carried out by HM Inspectorate of Prisons. These inspections contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, individual rights, and treatment and conditions, including health care. My inspectors appreciated the assistance given by staff in Her Majesty's Courts and Tribunals Service (HMCTS) and in the court custody suites, in an inspection process unfamiliar to them.

At the time of inspection, there were four Crown Court and 12 Magistrates' Court buildings with active custody suites in the region. Some courts had been recently closed and new HMCTS management structures were still being embedded after a change programme. Custody operations were contracted out, and although there were good working relationships locally between the staff of HMCTS and the contractor, HMCTS managers were insufficiently engaged with the custody function. Partnership arrangements were sound, but communication with stakeholders was patchy.

Detainees were sometimes held for relatively long periods before their case was heard because courts gave priority to other cases, or afterwards because it took time for prisons to confirm there was no other bar to release. It was welcome, however, that courts did not have cut-off times. In most places, detainees were not given clear information about their rights or how to make a complaint, and the telephone interpreting service had almost never been used.

The range of buildings was wide, from historic city-centre courthouses to modern purpose-built facilities. The physical condition of the cells area was deplorable at Newcastle Magistrates' Court, and poor at four other sites. In several places, detainees were not kept out of public view when handcuffed, especially when disembarking from vans and, for those with disabilities in particular, when being taken to or from court. Staff were generally helpful and polite to detainees, although many treated frequently-seen faces as needing little individual attention.

The information coming in with detainees was generally good. While considerable care was taken with some vulnerable detainees, a thorough initial risk assessment was lacking. Women and children were not always kept appropriately separate from the main detainee population, in vans or in the cell areas, and there was limited provision for those with disabilities or faith-related needs. Searching and handcuffing procedures were a matter of routine rather than related to risk, and were not always consistent; some of the handcuffing raised safety issues. There was little use of force.

There was a contracted medical assistance service, not frequently used. First-aid kits and training were in place but not appropriate for the needs of custody suites. Mental health services to the custody suites were good, including post-custody follow-up in the south of the area, and a scheme being piloted in the north where staff accompanied detainees to court.

This first full inspection of custody suites in a court area revealed custody staff who did their best to take care of detainees, in conditions which were in many cases poor, and with underdeveloped approaches to assessing and managing risk and to meeting legitimate needs. Improvements to buildings will require capital spends, but there is much that can be done to

improve matters in the short term, especially if HMCTS managers focus on the custody suites as an integral part of their role in running the courts.

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October 2012

2. Background and key findings

2.1 This report is the first in a series relating to 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. These Expectations have been drawn up in consultation with stakeholders, and were revised in the light of two pilot inspections before this first full inspection.

2.3 This inspection covered an area served by the police forces of Cleveland, Durham and Northumbria, within the North-East region of Her Majesty's Courts and Tribunals Service (HMCTS). Following a national programme of court closures in 2011, the court custody facilities in this area comprised:

Crown Court	Number of cells	Crown Court	Number of cells
Durham	8	Newcastle-upon-Tyne Moot Hall	5
Newcastle-upon-Tyne (Quayside)	17	Teesside	17

Magistrates' Court	Number of cells	Magistrates' Court	Number of cells
Bedlington (Mid and South Northumberland)	10	Newton Aycliffe	14
Berwick upon Tweed	6	North Tyneside	7
Consett	5	Peterlee	8
Gateshead	5	South Tyneside	11
Hartlepool	10	Sunderland	7
Newcastle-upon-Tyne	14	Teesside	17

[1] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

Leadership, strategy and planning

2.4 Structures and management within HMCTS had changed considerably over the two years preceding this inspection, and there was still a sense of flux. A number of courts had been closed as part of a national programme of closure of 93 Magistrates' Courts, and the process of assimilating the Courts and Tribunals Services into a single organisation was still being embedded. The reduction in the number of courts had not had a significant operational impact on the court custody function.

2.5 Court custody and escort operations were run by GEOAmey under contract to HMCTS. There were constructive relationships between GEOAmey and court staff at the local level, and between the various criminal justice agencies at cluster level (courts were managed in geographical clusters). However, HMCTS managers were not engaged, and in general, rarely visited the custody suites. This may have contributed to the sense that, while minor issues could be dealt with quickly through local contacts, other issues, including deep cleaning, went unattended for long periods. GEOAmey staff were managed effectively in many aspects of contract compliance, but in some particular areas relating to the care and welfare of detainees there was inconsistency between different court custody sites.

2.6 Partnership arrangements through the local criminal justice boards (LCJBs) had been reasonably effective, and were under review at the time of the inspection; the impact of police and crime commissioners was awaited with a measure of uncertainty. LCJBs had given effective attention to specific performance issues in the criminal justice process but court custody had not been part of their deliberations. The number and frequency of court user-groups in the area had diminished, partly because members did not find frequent meetings useful; it remained important to keep stakeholders engaged.

Individual rights

2.7 Several senior custody officers (SCOs) checked warrants accurately. They liaised with the court so that remanded detainees could be dealt with as soon as possible, but remanded detainees were not prioritised in some courts. Video-link hearings were sometimes prioritised over those held in custody.

2.8 There were no cut-off times (i.e. stated times after which the court would not accept cases) at any courts. However, many people were detained for several hours after they could legally be released because staff were waiting for the prison to confirm that there were no other grounds to detain the prisoner.

2.9 Custody officers made telephone calls on behalf of detainees, checking with the solicitor when necessary. Legal advisers we spoke to were content with the access and support that staff gave them. Staff checked that each detainee had legal representation. In two courts, interviews with legal advisers took place in a closed visits room, preventing legal documents from being passed between solicitor and client.

2.10 Time and space were always made available for Youth Offending Team (YOT) staff to complete post-court reports about young people, and for other consultations, after court. YOT staff were described as proactive and helpful at all courts.

2.11 Staff gave detainees only cursory information about their rights. At all courts except Berwick, they merely waved towards an A4 sheet of rights on a wall, and some detainees were brought in with no reference to their rights at all. Staff did not check whether the detainee could read.

2.12 With detainees who could not speak English, staff relied on the interpreter arranged for the court appearance, although these were likely to be unavailable at some key times. Almost no staff knew how to contact the telephone interpreting service, and many said that there was no requirement for interpretation in the court custody context, or, wrongly, that it was not provided. In some cell areas there was a multi-language poster about asking for a copy of the rights. During the inspection, GEOAmey managers issued further guidance so that custody staff had information about the telephone interpreting service.

2.13 There was a GEOAmey complaints process but it was little used, partly because staff did not generally offer detainees the opportunity to make a complaint but tried to resolve issues on the spot. There were some notices about making a complaint, but not in places where detainees would have time to read them, so they were generally not aware of how to make a complaint.

Treatment and conditions

2.14 Vehicles were in fairly good condition and properly equipped, with only a small amount of graffiti. There was widespread confusion about the separation of men, women and juveniles. Medical information needed by staff was appropriately recorded in the PER in most suites, but some confidential information had been inappropriately recorded by police in the main part of the PER.

2.15 At most courts, prisoners disembarked in a closed van dock, but at some it took place in a yard open to public view. Detainees were sometimes taken handcuffed through public areas. Personal information was recorded on large whiteboards that were plainly visible to anyone standing in the booking-in desk area.

2.16 Staff were generally amiable and polite, with some particularly well attuned to the needs of some vulnerable detainees. However, at some courts, there was an assumption by staff that all detainees were regulars who required little consideration.

2.17 Female detainees were usually located separately and were dealt with by a female custody officer. In some places, pregnant women had to sit on hard benches, possibly for several hours. Juveniles were often held in the same area as adults, even though there were separate detention rooms available.

2.18 In several places, a hearing loop could be borrowed from court. There was minimal provision for those with mobility difficulties and little support for religious observance. Some staff were unclear about the correct way to search transgender detainees. Reading material was mostly limited to old newspapers that staff had brought in, and was not always offered.

2.19 Sandwiches were routinely offered at regular mealtimes, with microwave meals as a back-up, although at some courts these were rarely given. Hot drinks were offered regularly. Two courts had tracksuit bottoms available but there were no blankets or warm clothing, even though staff said that some of the cells were cold in winter. Only Berwick had an adequate supply of clothing.

2.20 There was no thorough or systematic initial risk assessment and risk management was not always good. PER forms and GEOtrack were mostly kept up to date with risk information. Observations were undertaken at the required intervals, in some cases taking considerable care with vulnerable prisoners.

2.21 Anti-ligature knives were available but not always easily accessible. All detainees were searched on arrival, even if they had already been searched by police or prison staff. The standard of searching was not consistent. In many suites, rub-down searches were carried out every time a detainee went to the toilet.

2.22 All staff received annual training in control and restraint techniques, and there was evidence of good use of de-escalation in volatile situations. There appeared to be little use of force, and all uses were recorded on a form. However, there was no systematic monitoring and analysis of use of force.

2.23 There was routine handcuffing, even in secure areas. Handcuffs were applied while climbing the stairs to the courtrooms in almost every suite, even those with continuous alarm strips on the staircases. This was especially dangerous on the steep and narrow staircases at Newcastle Moot Hall and Sunderland. At some courts, detainees were double-cuffed on the stairs (both wrists handcuffed together, and handcuffed to an officer).

2.24 Staff had a leaflet for use when a detainee had been sentenced, which explained the terminology used in court. At all suites, bus fares or travel warrants were given to those being released who needed such help.

2.25 Staff told us that escort arrangements for taking young people to secure accommodation worked well. CareUK transported young people to local authority secure accommodation. Juveniles were not supported by a specific member of staff, other than the officer allocated to a group of cells.

2.26 Most cells in the estate had no natural light. The physical condition of the cell areas differed widely, from excellent conditions at Berwick and good conditions at Consett and Peterlee, to poor conditions at Newton Aycliffe, Teesside Magistrates, Newcastle Crown Court and Sunderland, and deplorable conditions (exacerbated by recent flooding) at Newcastle Magistrates' Court, where the cells were not fit for use. At some sites, staff had cleaned and redecorated cells themselves.

2.27 Fire evacuation procedures were understood by staff. In general, cell call bells worked and were responded to promptly by staff. At most sites, toilet paper was available only on request. At Newcastle Magistrates' Court, the toilets were in an unacceptable condition.

Health care

2.28 All the suites had contact details for the contracted medical assistance service (Armatus) but few had used it. Some staff expressed concern about the service provided, which was limited to the provision of advice over the telephone.

2.29 First-aid kits were basic and probably not appropriate for the types of injury and incidents that were likely to occur in suites. Staff had only been trained in 'first aid at work', which was not tailored to meet the needs of detainees. Procedures for the administration of medication were generally sound.

2.30 There were good mental health services across the area, provided by Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) and Northumberland, Tyne and Wear NHS Foundation Trust. (NTW). TEWV referred detainees to a variety of support teams but also followed them up directly, after their time in custody. NTW provided a variety of services, including a new scheme under which staff visited detainees in the police cells and accompanied them to court.

These projects were progressing well and due to be rolled out to five more courts in the coming months, although there was limited awareness of them among court custody staff.

Main recommendations

2.31 HMCTS should establish agreed standards for treatment and conditions in court custody.

2.32 HMCTS local managers should visit court custody suites regularly, to monitor standards and to resolve or escalate any issues as appropriate.

2.33 Comprehensive risk assessments should be consistently carried out by appropriately trained staff on all detainees.

2.34 Detainees should not routinely be taken in handcuffs through areas of the court to which the public have access.

2.35 A programme of regular deep cleaning should be implemented, and standards of daily cleaning should be improved.

2.36 A survey should be undertaken of all the court cells and a programme of remedial works, to include decoration, heating, ventilation, provision of natural light, enlargement of the smallest cells, provision of interview rooms and improvements to health and hygiene, should be put in place as soon as possible.

2.37 The cells at Newcastle Magistrates' Court should be completely refurbished, with interview rooms created, or they should be closed.

National issues

2.38 Detainees should have an avenue of appeal if they are dissatisfied with the outcome of their complaint about court custody.

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 HMCTS was in the later stages of restructuring after its recent formation, and management arrangements were still emerging. Operational pressures were under control but HMCTS managers had insufficient awareness of and involvement in resolving issues in the custody suites. GEOAmey ran the suites and were consistent in meeting contract requirements, but less so in several areas of treatment and conditions. LCJBs were going through some change and uncertainty, but had given some helpful practical attention to issues of coordinated working. Custody had not featured in their discussions. Many court user-groups met relatively infrequently.

Strategic management

3.2 Structures and management within HMCTS had changed considerably over the two years preceding the inspection, and there was still a sense of flux. A number of courts had been closed as part of a national programme of closure of 93 Magistrates' Courts, and the process of assimilating the Courts and Tribunals Services into a single organisation was still being concluded. The reduction in the number of courts had not had a significant operational impact on the court custody function.

3.3 The overall strategic structures of HMCTS were still taking their final form after the major reorganisation in which the Tribunals Service had been brought within HMCTS. In consequence, managers told us that it was not yet fully clear at which level (as between local, regional and national levels of decision making) various types of issues of policy and practice would be resolved. A regional delivery director was responsible for a wide area east of the Pennines, from North Lincolnshire to the Scottish border. Cluster managers reported to him, each responsible for a number of courts within a geographical area. Each court had a delivery manager responsible for day-to-day matters.

3.4 GEOAmey had been contracted to run the custody and escort operations for HMCTS in this region in 2011. Their systems had bedded in well after initial difficulties, helped by a detailed set of operating standards and by the fact that most staff at local level had been fulfilling their present roles under different contractual arrangements for a number of years. GEOAmey staff related to HMCTS chiefly at the level of the individual courts, where the SCO in charge of the team generally had a good working relationship with the court delivery manager.

3.5 HMCTS managers were, with few exceptions, not engaged with or in close touch with the day-to-day operations of the custody function, and did not monitor treatment and conditions in custody against any agreed standards (see main recommendation 2.31). Many of them visited the cells rarely, their time being taken up with the running of the courts themselves, for which they had the more direct responsibility (see main recommendation 2.32). Most GEOAmey staff said that they did not know the HMCTS local staff or manager, and that they could not remember them visiting the cells area. At the level of the cluster, there was good liaison between GEOAmey area managers and their counterparts in HMCTS, but their cooperation focused more on the escort function than on any issues relating to court custody. One practical outcome was that while staff in many custody suites said that small-scale repairs were carried

out promptly through liaison with the HMCTS local staff, anything more (from deep cleaning and cell painting upward) was hard to arrange.

3.6 The internal management of the GEOAmey operation was in many respects proactive and there was a practical emphasis on contract compliance, which ensured a good measure of consistency in those aspects of performance that were explicitly specified in the contract. For example, some handcuffing practices described in this report were universal and staff did not feel that they had any discretion in individual cases; while in many suites staff would not permit family visits for juveniles, even if circumstances justified it or the judge recommended it. In some other areas, relating in particular to the care and welfare of detainees, there was inconsistency between sites.

Partnerships

3.7 The regional delivery director and other senior managers were engaged with LCJBs, attending meetings regularly and leading on some practical projects to improve coordinated working between the criminal justice agencies. LCJBs had provided useful opportunities to tackle specific performance issues across the criminal justice system, enabling HMCTS to work jointly with the Crown Prosecution Service, police and the National Offender Management Service (NOMS); however, court custody had not featured in the minutes of these meetings. The role of the LCJBs was currently being re-examined, in order to move the dominant perspective from strategic overview and high-level planning to a focus on performance. Further developments were waiting on more clarity about the likely impact of the police and crime commissioners, when elected. Quarterly meetings organised by NOMS for all those involved in prisoner escort and custody functions were an effective operational forum, bringing together court managers, police, prisons and GEOAmey (with the Youth Justice Board also invited).

3.8 Court user-groups had previously been a useful forum to enable a variety of stakeholders to have an input into the running of court custody in the area. They had become less frequent in general, largely because stakeholders had felt that frequent meetings were not necessary in an age when much could be achieved through email. At the time of the inspection, three courts had regular six-monthly meetings, one had a three-monthly meeting, while seven had had no meeting in the previous six months. Berwick was in the latter group, but had instituted a clear process whereby a user-group member could raise an issue for discussion by requesting that it be placed on the agenda of the monthly senior management meeting, in which case the other user-group members would be invited to attend. This seemed a reasonable compromise, although meetings twice yearly would help to maintain contact between the relevant individuals in the user-group member bodies.

Recommendation

3.9 Court user-groups should meet at regular intervals to support communication and good working relationships between key stakeholders.

4. Individual rights

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

Detention

4.1 Custody officers at all courts checked warrants, production orders and court lists to ensure that they had the necessary authority to detain. We were told that, on the rare occasions that court enforcement officers (CEOs) brought a detainee to the cells, the SCO examined the warrant. We observed SCOs contacting court staff appropriately to progress cases and reduce the length of time that detainees spent in the cells. However, in several courts, remands were not prioritised, and video-link hearings at Hartlepool were prioritised over those held in custody, leading to long stays that could have been avoided. Staff at Hartlepool also gave an example of a detainee from HMP Holme House who had been produced each Thursday over several months for an appearance on domestic violence charges. His case had been repeatedly adjourned because of priority given to those on bail; he had eventually been given a restraining order.

4.2 At Sunderland, an SCO appropriately refused to detain a woman because arrangements were being made to admit her to hospital under a Mental Health Act section. However, elsewhere there were instances, whether in police or court custody, where detention was lawful but of questionable necessity. For example, a case at Teesside Magistrates' Court involved a woman who had voluntarily gone to the police station because she had heard that there was a warrant outstanding for her failure to appear at court to answer a charge of neglecting to ensure that her children attended school. The police could have instructed her to go straight to court but instead she had been arrested, taken into police custody for several hours, then brought before the court and bailed.

4.3 We were told that arrangements with YOTs worked well, with local YOT staff attending each court daily and no undue delays in arranging placements in secure accommodation or young offender institutions (YOIs).

4.4 At Newcastle 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, 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.

4.5 Unusually, the magistrates' courts had no set court cut-off times (see paragraph 2.8) and we observed detainees being brought from police custody at various times during the day, including in the afternoons. At Durham Crown Court, custody staff declined to admit legal representatives during the staff lunch break.

4.6 Most of the detainees we saw arriving in custody did not want anyone informed of their whereabouts. Except at Durham Crown Court, most custody staff assured us that they would make a telephone call on behalf of the detainee if required, but only after checking with the

legal representative that the detainee was not barred from contacting the person. At Newcastle Moot Hall, a detainee told us that he had had no opportunity to inform his partner that the location of his trial had been changed at the last minute.

Recommendations

4.7 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.

4.8 Courts should liaise with HMP Durham to resolve the delays experienced in confirming that detainees can be released.

Housekeeping points

4.9 Person escort record forms should not routinely be stamped 'not for release'.

4.10 Staff should ensure that detainees can inform someone of their whereabouts, and check with court staff or legal advisers that it is appropriate for this person to be contacted.

Legal rights

4.11 On arrival, detainees were given little information about their rights and entitlements. At most suites, staff simply gestured towards a notice of rights and entitlements displayed on the wall, stating, '*you know your rights*'. At some courts there was an additional multi-language poster displayed, informing detainees in a range of languages that they could request a copy of their 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. At Newcastle Crown Court, we saw detainees taken to their cell before they had time to look at the notice of rights and entitlements. No attempts were made at any courts to ascertain if detainees could read, and only at Berwick, where laminated copies of rights and entitlements information were available, could detainees have a copy to read in the cell. Rights and entitlements were available in a range of languages, and at Teesside Crown Court we saw them issued to a Spanish-speaking detainee in his language.

4.12 Custody staff ensured that detainees had time to meet their legal representatives before and after their court appearance. Staff contacted legal representatives when necessary. Legal representatives we spoke to confirmed that custody staff facilitated detainees' access to legal advice.

4.13 We were assured that time and space were always made available for YOT staff to complete post-court reports about young people, and for other consultations, after court. YOT staff were described as proactive and helpful at all courts, notifying custody staff if a young person was expected to come into custody. Nevertheless, 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. At Durham Crown Court, the interview rooms were off the main corridor, and consultations taking place in them could clearly be overheard from the corridor. At Newton Aycliffe and North Tyneside, legal consultations had to take place in closed visits booths that were cramped and unsuitable because the screens prevented legal advisers from handing documents to their clients.

4.14 The contracted telephone interpreting service was not in use at any of the courts. At Newcastle Crown Court, we were told, wrongly, that no interpreting service was available. Few SCOs at any courts knew the PIN required to access the service. We were often told that it was not required because court interpreters normally attended the cells, with the legal representative, to interpret the post-court consultation. However, interpreters might leave the court building before detainees are transferred, leaving detainees who might be in distress, at risk of self-harm or in need of information about where they are being taken without the necessary help. This was compounded by telephones only being available in staff offices in many courts. During the inspection, GEOAmey managers issued further guidance to custody staff about how to use the telephone interpreting service.

4.15 A complaints process had been put in place by GEOAmey but we heard no detainees being told about it, except at Berwick. At some courts, a small poster was displayed, informing detainees that they could complain, but not in places where they would have time to read them, so they were not generally aware of how to make a complaint. Staff said that they would normally try to resolve complaints immediately and informally. Few complaints were received, despite many detainees telling us that they were dissatisfied with various matters, such as the physical conditions in the cells – for example, that they were too cold. 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 (see recommendation 2.38).

Recommendations

4.16 Detainees should be told on their arrival about their rights and entitlements. They should be given written information about these, and staff should offer to read them to detainees.

4.17 Sufficient comfortable, private and sound-proofed interview rooms should be made available at all courts for legal consultations and the provision of welfare advice.

4.18 Staff should be told how to use the telephone interpreting service, and telephones should be provided in suitable locations.

4.19 Detainees should be told how to make a complaint and not be discouraged from doing so.

Good practice

4.20 *At Berwick upon Tweed, detainees were given a laminated copy of their rights and entitlements to take into the cell with them.*

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 We inspected cellular vehicles at each court and most were in a reasonably clean condition, with only a small amount of graffiti. At Sunderland, a vehicle smelt of tobacco smoke and we found two cigarette ends in one of the compartments. All vans had first-aid kits, anti-ligature knives and bottled water.

5.2 Staff were generally uncertain about the circumstances in which they should close the vehicle's partition, which is intended to aid the separation of men and women, or of adults and juveniles. Some thought that it was used to separate men and women, while others said that it was to be used only when transporting juveniles. One staff member told us that the contractor's policy was not to use the partition at all.

5.3 Most journeys to court were short, except for those between HMP Durham and Berwick, which covered a long distance. Detainees who had made this journey told us, and it was recorded in the PERs, that they had been given a comfort stop after the appropriate interval. Detainees were not kept waiting for unduly long periods to be taken from vehicles into the court buildings.

5.4 Escort staff ensured that all necessary information about detainees accompanied them with the PER, although the quality of police information about self-harm was often inadequate, with vague phrases, such as '*attempted self-harm in 2011*', being commonplace. In one instance, a detainee's hepatitis C status had been written on the PER instead of being sealed in a confidential health care envelope. Court custody staff checked incoming PERs carefully, to ensure that all the necessary documents, and detainees' property, had been received.

5.5 At most courts, prisoners disembarked in a closed van dock, but at some there was insufficient protection from public attention. At Berwick, the vehicle dock area was overlooked by flats, and at Sunderland by an office block. At Newcastle Moot Hall, vans stopped in an area that was open to public view on three sides. At all courts, defendants were sometimes remanded or given custodial sentences in courts that had no direct access to the cells; this meant that detainees were escorted to the cells in handcuffs, in full public view (see main recommendation 2.34). This situation was particularly problematic at Newcastle Magistrates' Court, where the route went past the Witness Service office. At Sunderland and Teesside Magistrates' Court, only one court was located on the same level as the cells, so this was used for hearings involving detainees with disabilities; this required such detainees to be taken in handcuffs through a public corridor.

5.6 In most courts, information about detainees displayed on whiteboards could be seen by other detainees and legal advisers. This was a particular problem at Bedlington, where the window of an interview room was opposite the whiteboard, and it also overlooked a desk on which PERs and other documents were placed.

Recommendations

5.7 The policy on the use of the partition in cellular vehicles should be clarified and escort staff should implement it.

5.8 Adequate provision should be made for detainees to be transferred from cellular vehicles to the cells in privacy.

5.9 Confidential information on whiteboards and in documents should be placed out of general view.

Housekeeping points

5.10 Detainees should not be permitted to smoke in cellular vehicles.

5.11 Confidential medical information accompanying detainees should be contained in a sealed confidential envelope.

Treatment

5.12 At all courts, a basic needs assessment was available with the PER for all detainees arriving from police stations or from custody. For detainees previously on bail who were remanded or sentenced to custody, staff completed an HM Prison Service basic assessment form and a PER, usually in private in an interview room, although there was no interview room at Newcastle Magistrates' Court. At some courts, staff allowed detainees to write down telephone numbers from their mobile telephones in case they were not allowed to do this in the prison reception area.

5.13 Many staff told us that they tried to '*treat everyone the same*'. Most staff treated detainees courteously, yet many failed to be proactive in offering basic amenities. Consett and Peterlee were exceptions, with staff well attuned to the needs of some vulnerable detainees, and sensitive in their dealings with them. Detainees we spoke to there confirmed this, describing staff as very friendly. One detainee had learning difficulties, requiring an appropriate adult, and staff spent a considerable amount of time with him, keeping him updated about what was happening. The SCO liaised with the court clerk to ensure that an appropriate adult would be available for his court hearing. At all courts, detainees told us that they felt fairly well looked-after, within the constraints imposed by the bleak physical environment in most courts. However, at some courts, there was an assumption by staff that all detainees were regulars who required little consideration, and we saw a few staff being reluctant to go out of their way to give help, even when not busy, preferring instead to work 'by the book'.

5.14 Although diversity training was now included in induction training, many staff had not received it and some did not understand either the meaning of the term or the importance of diversity. Little consideration was given to meeting the diverse needs of detainees. For example, in some places pregnant women had to sit on hard benches, possibly for several hours, although staff told us that they would try to get their cases heard early. At most courts, staff were vague about the provision that could be made for women with babies, although at Bedlington we were told that they might be allowed to wait in an interview room instead of being put in a cell. At some courts, there were notices advising women that hygiene packs were available. There was no clear focus on the needs of black and minority ethnic detainees, older detainees, foreign nationals or young people. At all courts, YOT staff telephoned each day to find out if

there were any young people in custody, and attended the court to see them if there were. Young people were generally held on the same cell corridors as adults, even at Newton Aycliffe, where separate detention rooms were available. Male and female detainees were mainly held in separate corridors (see also paragraph 5.40).

5.15 No cell areas had had hearing loops fitted, although at most we were told that a portable hearing loop could be borrowed from the court. There was an amplifying headset in the interview room at South Tyneside but, because of poor acoustics, anyone with a hearing impairment would have found it difficult to participate in an interview in that room. Some staff were unsure about which courts in the region had provision for detainees with disabilities. The only court with this provision was Newcastle Crown Court, which had a lift from the cell area, and a dock which was accessible from the cells without going through public areas. At Durham Crown Court, we were told that detainees with disabilities would be referred to Preston Crown Court, which would be an excessive distance for them and their families to travel. We were also told that detainees in a wheelchair would be sent to Teesside Magistrates' Court, but the lift for those with disabilities at this court had been out of order for many months, and the only access to the courts from the custody cells for those using a wheelchair took them through a public area.

5.16 Many staff were unsure about the procedure for searching transgender detainees. Some told us, correctly, that they would try to offer the detainee a choice about the gender of the officer searching them, or would always ask a female officer to undertake the search. Others quoted the contractor's policy, which was to have the search undertaken by an officer of the same biological sex.

5.17 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. At all suites except Berwick, the prayer mat was an unsatisfactory carpet sample square or a rubber doormat, and holy books were available only from the court. At Berwick, there was a proper Muslim prayer mat, Qur'an and other holy books, respectfully stored. Only at Newcastle Crown Court and Berwick was there a means of determining the direction of Mecca.

5.18 Staff had attempted to provide reading materials for detainees by bringing in old newspapers and, in the urban courts, copies of the free *Metro* newspaper. However, 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 crossword and word search puzzles.

5.19 Arrangements for securing detainees' property were satisfactory, although during the inspection at Consett, three detainees were brought in by the police and taken relatively quickly up to the court, with their property left on the floor of the office instead of being placed in the available lockers.

5.20 Detainees who were newly remanded or sentenced to custody were told what to expect. At all courts, there were some information leaflets about local custodial establishments, although these were shown to detainees rather than being given to them to read. The contractor's standard leaflet for young people contained some inaccurate information about YOIs.

5.21 All courts held stocks of sandwiches, which were within date, and microwave meals. At North Tyneside, the use-by date of some meals had expired. Sandwiches were routinely offered at

regular mealtimes. At some courts, staff told us that detainees could have a microwave meal at lunchtime if they did not like the sandwiches but in others, microwave meals were not offered for lunch. Food preparation areas were normally shared with the staff kitchen. Most were reasonably clean but at some courts the microwave oven was dirty. At all courts, detainees were given a hot drink on arrival and at intervals thereafter. At Consett, Peterlee and Gateshead, they were offered biscuits as well. All courts provided a hot microwave meal to detainees who were likely to be still in custody, or on a vehicle, after 5pm, in case they could not get a meal on arrival at the establishment to which they were being sent, although at Teesside Crown Court detainees involved in a long trial told us that they had subsisted only on sandwiches for several days. In more than one instance, we considered that staff should have offered a hot meal. For example, at Newcastle Crown Court a young woman had been brought in on a warrant for failing to attend. She was dressed in light summer clothing and had complained that she was cold and hungry, yet staff had not offered her a microwave meal.

5.22 At Newcastle Crown Court, a female detainee wearing shorts complained consistently of being cold but there was no clothing or blankets available. At Hartlepool, custody staff allowed a detainee in a paper suit to put on his own clothing because he was cold. Hartlepool had only tracksuit bottoms in stock. Newton Aycliffe had some tracksuit bottoms but staff did not offer them. Only Berwick had an adequate supply of clothing, which was provided by the police. There were no blankets or warm over-clothing at any court, even though some of the cells were cold in the winter (see section on physical conditions).

Recommendations

5.23 Every court cell area should have a copy of each 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.

5.24 A reasonable range of amenities, including hot meals when necessary and reading materials, should be offered in response to detainees' needs.

5.25 There should be suitable provision in the region to enable detainees with disabilities to appear at court within a reasonable distance of their home.

Housekeeping points

5.26 Staff should tell female detainees about the availability of hygiene packs.

5.27 GEOAmey should revise its policy on caring for transgender detainees and ensure that staff implement it.

5.28 Detainees' property should be stored securely at every court.

5.29 Out-of-date food should be disposed of and food preparation equipment should be kept clean.

Safety

5.30 At Gateshead, there was a formal staff briefing at which the SCO told all staff about the detainees who were in custody and drew attention to any self-harm warning markers. We were told that the staff briefing took place at every court, but we did not see it taking place at shift

changeover times at other courts. Some informal sharing of information about vulnerable detainees took place among staff at Consett, led by the SCO.

5.31 At Gateshead, we observed the SCO contacting the police station to clarify the context in which a detainee had attempted to escape some years ago, so that they could make a better risk assessment. All courts had access to GEOtrack, the database for information about those detained in court cells, which included warning markers and information about vulnerability. SCOs told us that when they were not confident that all the data they needed was provided on the PER, they could look at the database for further information.

5.32 The lack of a thorough or systematic initial risk assessment was a common feature across the courts, and there were examples of poor care (see main recommendation 2.33). 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 staff visiting his cell. The approach of a few custody staff was, as one put it, '*All I'm bothered about is that no one dies and no one escapes*'. At Newcastle Crown Court, we saw staff going to a cell to speak to a detainee who had self-harm warning markers on the PER. The risk assessment was basic, consisting of two questions: '*are you all right today*' and '*you're not going to hurt yourself are you?*' There was no attempt to explore with the detainee how she might react to the outcome of the hearing or what had triggered the previous self-harm. The SCO told us that the detainee had already been asked about self-harm on the cellular vehicle, and the PER confirmed this, but a discussion on a vehicle would not have offered sufficient privacy or time to explore such issues properly. There was a widespread sense that detainees were mostly regular offenders, well known to staff, and that there was therefore little need to discuss matters such as self-harm in detail with them.

5.33 Observations were undertaken at the required intervals and recorded on the PER or the GEOtrack system. Six observations per hour were undertaken for detainees for whom there were self-harm markers. Records confirmed that constant observation was occasionally used for detainees at very high risk of self-harming.

5.34 In some suites, detainees were regularly placed together in group cells. Risk was informally assessed using PNC markers on the PER and information from the GEOtrack system before allowing detainees to share a cell. At Newcastle Crown Court, a recent use of force appeared to have arisen from disruption after three men had been placed in one cell, even though other cells had been vacant.

5.35 All staff received annual training in control and restraint techniques. All uses of force were recorded on a form, which was sent to relevant managers but in most cases was not retained at the court. There was generally little use of force, and there was evidence of good use of de-escalation in volatile situations. There was no systematic monitoring of use of force, so trends could not be analysed, although the GEOAmey manager and PECS manager were aware of patterns from incident reports.

5.36 Anti-ligature knives were kept in first-aid boxes, which could have delayed access to them when an urgent intervention was required. At Berwick, the blade of the anti-ligature knife was damaged.

5.37 Post-court visits by probation and YOT staff were encouraged but at most courts, visits by family members and friends for vulnerable detainees were available in exceptional circumstances only, usually when ordered by the court. A direction on this matter from the Recorder of Newcastle was in place at Newcastle Crown Court. However, at Sunderland, we

were told that social visits could never be allowed, even when requested by the court, because of GEOAmey policy.

5.38 At most courts, staff told us that if they had concerns about the safety of a detainee going to custody, they briefed escort staff and in some circumstances telephoned prison reception staff. When there were concerns about a vulnerable detainee being released, they informed the detainee's legal representative or contacted the YOT, local probation service or, when available, the mental health diversion team accordingly.

5.39 All detainees were searched on arrival, even if they had been searched by police or other staff previously and had remained under supervision thereafter. Searching methods were inconsistent; for example, at one court a detainee was not asked to remove a thick jacket for a rub-down search, whereas detainees in other suites were asked to do this. Strip-searching was carried out infrequently, on the basis of intelligence and with authorisation from an area manager; however, data about the use of strip-searching were not recorded. Rub-down searches were carried out frequently in many suites – for example, every time a detainee went to the toilet, which seemed disproportionate.

5.40 Staff tried to keep men, women and children separate but at most courts the extent to which such separation could be achieved was limited by the layout of the cell corridors. At Berwick, the designated cells for young people and women were close to the staff desk, and at Consett young people were located in the cells nearest to the desk. At Newcastle Crown Court, if a male detainee had to be restrained during arrival from court, he was placed in the nearest cell to the lift entrance, which was in the female cell area.

5.41 There were no significant delays in transferring detainees from the cells to the courtrooms. Routes to courtrooms were secure, with all courts equipped with affray alarms in the corridors and on the stairs to the docks. At Newcastle Magistrates' Court, one section of the affray alarm strip had been damaged for at least a year.

5.42 Detainees were routinely handcuffed when embarking onto and disembarking from cellular vehicles, in the cell area corridors and on the route from the cells to the courtrooms, even though in most courts these locations were all within the secure envelope of the custody suite. The GEOAmey policy allowed no local variation in relation to specific buildings. In most courts, all detainees were handcuffed when moving the short distance between their cell and an interview room to see their legal adviser. At Newcastle Crown Court, some detainees were briefly left handcuffed but unsupervised in the holding area outside the dock entrance to the court before an officer came to escort them to the courtroom. Handcuffs were always applied while climbing the stairs to the courtrooms in every suite, even those with continuous alarm strips on the staircases; this was particularly dangerous on the steep and narrow staircases at Newcastle Moot Hall and Sunderland. At Newcastle Crown Court, detainees were double-cuffed on the stairs (both wrists handcuffed together, and handcuffed to an officer), which would have made it difficult for them to grab the handrail in the event of falling. At Durham Crown Court, detainees being taken to Number 2 Court had to pass through Number 1 Court, in handcuffs, even if there was a hearing in progress, through a consultation room that could be in use, and then through a public area. At all courts, on occasion, detainees were brought through public areas in handcuffs from the courtrooms that did not have direct access to the cells, even though the courts tried not to use these courtrooms for cases that might result in custody. Detainees with disabilities would be particularly vulnerable to this potentially humiliating treatment because the courtrooms that were accessible to detainees with mobility problems tended to be those that had no direct access to the cells.

5.43 At all suites, suitable sums of money or travel warrants were given as fares to those being released, when necessary. Those needing help with fares to get home from Moot Hall had to be taken back to Newcastle Crown Court before release. At many of the courts, we saw staff offering detainees explanations of the consequences of failure to attend the next hearing, and bail conditions.

5.44 Except at Bedlington, there were no information leaflets about local support organisations for potentially vulnerable detainees being released, although at Sunderland custody staff told us that they could obtain a leaflet from the court ushers. At all courts, there was written information available on local prisons and YOIs, although at most there was only one copy of each and none was translated into other languages. Some such information was out of date; at Sunderland, the information leaflet about HMP Low Newton was dated 2007. The standard GEOAmey leaflet for young people going into custody contained some inaccurate information. At all courts, detainees were told about where they were going and staff were able to explain to those going to custody for the first time what would happen on arrival.

5.45 There was no opportunity to observe young people being collected for escort to secure accommodation but staff told us that the escort service was prompt and appropriate. While in the custody suite, juveniles were not supported by a named member of staff, other than under the same system as for adults, where each custody officer was allocated to a group of cells.

Recommendations

5.46 At each court, the senior custody officer should hold a staff briefing each morning, where information about all detainees, particularly regarding self-harm, vulnerability and needs, is shared.

5.47 All uses of force and adverse incidents should be documented and the data analysed for trends.

5.48 Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits.

5.49 GEOAmey should direct senior custody officers to allow social visits for vulnerable detainees if the circumstances are exceptional or if a visit is ordered by the court.

5.50 Staff should be briefed about how to make referrals under the local authority's safeguarding procedures if they have concerns about a vulnerable detainee who is being released.

5.51 Standards of searching should be made consistent and rub-down searches within secure areas should not be routine.

5.52 Handcuffing policy should be defined for each court in accordance with local conditions, and should take into account the needs of those with mobility problems. Detainees should not be double-cuffed on narrow staircases.

5.53 Each court should have information leaflets about local support organisations and an adequate supply of up-to-date and accurate leaflets about prisons.

5.54 Young people in court custody should be supported by a named staff member who is trained to work with young people.

Housekeeping point

5.55 Bus fares and travel warrants should be available at Newcastle Moot Hall.

Physical conditions

5.56 All courts carried out daily cell checks, including the testing of call bells, and we were told that, with some exceptions, major faults were attended to promptly. At one court, the cell check recording sheet that we were shown was undated.

5.57 Most court cells had no natural light. There were contract cleaners but at some suites the service did not seem to be effective, and several suites had not been deep cleaned for a long time (see main recommendations 2.35 and 2.36). However, Berwick was spotless, and Consett and Peterlee were also clean and well decorated. At these courts, staff cleaned the cells themselves, often after each cell occupancy, and erased or covered all graffiti.

5.58 At Newton Aycliffe, the cell doors, wooden benches, toilet doors and ceilings contained graffiti, some of it dating back a number of years, including a swastika in one cell. Walls had not been recently painted and there were traces of food and other stains on them. Flooding had affected the cells and had permeated the grilles under the plinths, although court managers had attempted to resolve these problems. The two juvenile detention cells were rarely used; one was a store room.

5.59 At South Tyneside, the cells were in a poor condition, with doors and ceilings covered in graffiti and floors and some paintwork in poor condition. At Teesside Magistrates' Court, with the exception of the cells for female detainees, the cells were in poor condition, with widespread graffiti and names burnt into the ceilings. There was also a lot of litter and dirt in the van dock. At Bedlington, standards of decoration were better but the cells were dirty and contained graffiti, and one had toilet paper stuck to the ceiling.

5.60 At Newcastle Crown Court, the cell area was comparatively modern but it had much ingrained dirt, and toilet paper stuck to the ceiling had been painted over. There was widespread graffiti, some dating back to 2009. In one cell, there were brown smears on a wall. The holes in ventilation grilles had been blocked by paint.

5.61 The cells at Durham Crown Court were tiny, one of the cells for female detainees measuring a little over four feet square. It was claustrophobic, with no natural light. Staff told us that they tried not to use it but sometimes had to use it to accommodate 'off-bailers' (detainees previously on bail who have just been remanded in custody or sentenced to custody) or young people. Three further cells in the male area were only slightly larger. Staff told us that the cells were cold in the winter and that they had requested that the heating be improved.

5.62 At South Shields, some cells were grubby. The Lay Observers had been asking for a deep clean since 2009, according to their report. At both North Shields and Teesside Crown Court, the cells were in a reasonable condition, and custody staff had repainted them themselves. At Hartlepool, the cells were bright and reasonably clean but there was widespread graffiti, with a large swastika in a juvenile cell. The Gateshead cells were in reasonable condition but showed signs of wear and tear. Staff there had a good relationship with the court manager and told us that repairs were carried out within 48 hours. Climate control in the cells helped to ensure reasonable comfort.

5.63 The cells at Newcastle Crown Court Moot Hall were ancient and dungeon-like, with stone arches. There were shackles in the cell corridors, to which detainees being transported to Australia in the 18th century had been chained. The cells were used sporadically but sometimes held up to six detainees at a time. They were dirty and contained a small amount of graffiti. Staff told us that there was no effective heating.

5.64 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 staff had to wash. A former police 'drunk cell', with its plinth too low to sit on comfortably, was used for normal occupation. 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 (see main recommendation 2.37).

5.65 The cells at Sunderland were dark, covered in graffiti and dirty. In one cell, there were lumps of a brown substance stuck to the ceiling. One detainee there told us that he was cold, in spite of the warm August weather at the time of the inspection. Staff told us that there was a problem with condensation, which was likely to be caused by inadequate ventilation. This made it necessary regularly to move detainees from one cell to another, to allow each cell to dry out.

5.66 At most courts, we were told that HMCTS staff rarely visited the cells. Although, with some exceptions (see below), urgent faults were mostly rectified quickly, less urgent works were often not attended to. At Newcastle Moot Hall, the faults log contained no record of when faults had been rectified.

5.67 Staff responded promptly to cell call bells, although the sounder at North Tyneside had not worked for years and at Bedlington maintenance records showed that the call bell sounders had been out of action for a two-month period earlier in 2012.

5.68 There were no mattresses at any of the courts, even though they were available from the police at Berwick. Some courts contained wooden benches but the more modern cells had hard plastic benches that would have been particularly uncomfortable for detainees who were older, unwell, pregnant or had disabilities, who might have had to sit in a cell for up to 10 hours.

5.69 All court custody suites had toilets that were reasonably well screened. Toilet paper was available on request. Most had hand-washing facilities, soap and towels, with the exception of Newcastle Magistrates' Court (see paragraph 5.64) and Sunderland, where there was only a tiny trickle of water and no soap.

5.70 All courts had clear fire evacuation procedures, with which staff were familiar. At most courts, HMCTS had organised emergency exercises, although these had not required the evacuation of the court cells. The fire evacuation procedure for Newcastle Moot Hall gave detailed, separate instructions about evacuating judges, jurors, other court users and staff but it made no mention of detainees.

Recommendations

5.71 Defects in cell call bell systems should be rectified promptly.

5.72 Mattresses, and blankets or warm clothing should be made available at all courts.

Housekeeping points

5.73 A small supply of toilet paper should be placed in each toilet.

5.74 Court emergency evacuation procedures should specify the means by which the cells can be evacuated and there should be regular practice evacuations.

Health care

5.75 GEOAmey had a contract with Armatus to provide telephone advice in the first instance or the services of a paramedic or GP if required. There were notices in each custody area about how staff should access the service. However, some staff told us that they were not confident with the advice they were given by Armatus so they preferred to call an ambulance if a detainee became unwell. Data provided by GEOAmey showed that in the first six months of 2012, the service had only been used three times.

5.76 First-aid kits were available in the court custody areas but they did not contain the necessary equipment to enable staff to deal with a serious self-harm incident. Staff had only been trained in 'first aid at work', which was not tailored to meet the needs of detainees. All staff we spoke to were up to date with their training, which had to be renewed every three years. No defibrillators, oxygen or suction were available in any of the court buildings.

5.77 Detainees sent to court from prisons usually had their medications sent in individualised blister packs, attached to the PER forms. Staff administered them at the relevant times and recorded the details on the PER form. This was not the case for those sent from police custody, who rarely came with any medication, even if it had been prescribed and administered while the detainee had been in custody.

5.78 The North-East had well-established mental health services, which were being enhanced as part of the Big Diversion Project, run by North East Offender Health. Tees, Esk and Wear Valley NHS Foundation Trust provided adult mental health services to all the court custody suites in the local area. They had a team of 4.4 whole-time-equivalent nurses and an approved mental health social worker, and they worked from Monday to Friday. They took referrals from police, probation staff, solicitors and court custody staff. They tried to see clients as early in their custody as possible; court custody staff told us that the team often knew about a detainee before he or she arrived in court custody. The team said that it was not always possible to see clients in court custody in a therapeutic environment; for example, in Newton Aycliffe, they had to see clients through a glass screen and they had to sit sideways because the space was so cramped. In Consett, they saw clients in the court cells. The team had instant access to their Trust's clinical information system via laptops and took a pragmatic approach to sharing information about their clients with relevant staff in the criminal justice system, after obtaining written consent. The team could refer clients to the crisis or early intervention teams in their Trust, and also to services such as substance misuse, counselling or the client's GP. They were also able to follow up clients directly, after their period in custody. In Teesside, there was also a Youth Justice Liaison and Diversion team.

5.79 Mental health teams from Northumberland, Tyne and Wear NHS Foundation Trust covered the courts in the north of the court area. The service comprised an amalgamation of several different schemes, as a result of the merger of various NHS organisations, so there were some inconsistencies. For example, in Bedlington they were able to see detainees in the police cells and then personally accompany them to the court; in Newcastle Magistrate' Court and North Tyneside, the scheme was only available in the courts in the mornings. There were plans to streamline the service with the aim of promoting the schemes and ensuring that they were able to identify those with learning disabilities. The teams did not all have remote access to their Trust's clinical information system, so they relied on administration staff at the Trust. The teams liaised with crisis and early intervention teams, local safeguarding teams and substance misuse services after obtaining written consent from their clients.

Recommendations

5.80 The first-aid kits in court custody should be customised to ensure that they contain the necessary equipment to deal with incidents that are likely to occur in the environment, such as serious self-harm.

5.81 There should be equipment to maintain an airway and an automated external defibrillator available in each of the court custody suites, and staff should be trained to use them.

5.82 All detainees who have the need for prescribed medications should have access to them while in court custody.

5.83 Mental health liaison and diversion schemes should be available to detainees at all times that the courts are open.

6. Summary of recommendations

Main recommendations

6.1 HMCTS should establish agreed standards for treatment and conditions in court custody. (2.31)

6.2 HMCTS local managers should visit court custody suites regularly, to monitor standards and to resolve or escalate any issues as appropriate. (2.32)

6.3 Comprehensive risk assessments should be consistently carried out by appropriately trained staff on all detainees. (2.33)

6.4 Detainees should not routinely be taken in handcuffs through areas of the court to which the public have access. (2.34)

6.5 A programme of regular deep cleaning should be implemented, and standards of daily cleaning should be improved. (2.35)

6.6 A survey should be undertaken of all the court cells and a programme of remedial works, to include decoration, heating, ventilation, provision of natural light, enlargement of the smallest cells, provision of interview rooms and improvements to health and hygiene, should be put in place as soon as possible. (2.36)

6.7 The cells at Newcastle Magistrates' Court should be completely refurbished, with interview rooms created, or they should be closed. (2.37)

National issues

6.8 Detainees should have an avenue of appeal if they are dissatisfied with the outcome of their complaint about court custody. (2.38)

Recommendations

Leadership, strategy and planning

6.9 Court user-groups should meet at regular intervals to support communication and good working relationships between key stakeholders. (3.9)

Individual rights

6.10 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. (4.7)

6.11 Courts should liaise with HMP Durham to resolve the delays experienced in confirming that detainees can be released. (4.8)

6.12 Detainees should be told on their arrival about their rights and entitlements. They should be given written information about these, and staff should offer to read them to detainees. (4.16)

6.13 Sufficient comfortable, private and sound-proofed interview rooms should be made available at all courts for legal consultations and the provision of welfare advice. (4.17)

6.14 Staff should be told how to use the telephone interpreting service, and telephones should be provided in suitable locations. (4.18)

6.15 Detainees should be told how to make a complaint and not be discouraged from doing so. (4.19)

Treatment and conditions

6.16 The policy on the use of the partition in cellular vehicles should be clarified and escort staff should implement it. (5.7)

6.17 Adequate provision should be made for detainees to be transferred from cellular vehicles to the cells in privacy. (5.8)

6.18 Confidential information on whiteboards and in documents should be placed out of general view. (5.9)

6.19 Every court cell area should have a copy of each 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. (5.23)

6.20 A reasonable range of amenities, including hot meals when necessary and reading materials, should be offered in response to detainees' needs. (5.24)

6.21 There should be suitable provision in the region to enable detainees with disabilities to appear at court within a reasonable distance of their home. (5.25)

6.22 At each court, the senior custody officer should hold a staff briefing each morning, where information about all detainees, particularly regarding self-harm, vulnerability and needs, is shared. (5.46)

6.23 All uses of force and adverse incidents should be documented and the data analysed for trends. (5.47)

6.24 Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits. (5.48)

6.25 GEOAmey should direct senior custody officers to allow social visits for vulnerable detainees if the circumstances are exceptional or if a visit is ordered by the court. (5.49)

6.26 Staff should be briefed about how to make referrals under the local authority's safeguarding procedures if they have concerns about a vulnerable detainee who is being released. (5.50)

6.27 Standards of searching should be made consistent and rub-down searches within secure areas should not be routine. (5.51)

6.28 Handcuffing policy should be defined for each court in accordance with local conditions, and should take into account the needs of those with mobility problems. Detainees should not be double-cuffed on narrow staircases. (5.52)

6.29 Each court should have information leaflets about local support organisations and an adequate supply of up-to-date and accurate leaflets about prisons. (5.53)

6.30 Young people in court custody should be supported by a named staff member who is trained to work with young people. (5.54)

6.31 Defects in cell call bell systems should be rectified promptly. (5.71)

6.32 Mattresses, and blankets or warm clothing should be made available at all courts. (5.72)

6.33 The first-aid kits in court custody should be customised to ensure that they contain the necessary equipment to deal with incidents that are likely to occur in the environment, such as serious self-harm. (5.80)

6.34 There should be equipment to maintain an airway and an automated external defibrillator available in each of the court custody suites, and staff should be trained to use them. (5.81)

6.35 All detainees who have the need for prescribed medications should have access to them while in court custody. (5.82)

6.36 Mental health liaison and diversion schemes should be available to detainees at all times that the courts are open. (5.83)

Housekeeping points

Individual rights

6.37 Person escort record forms should not routinely be stamped 'not for release'. (4.9)

6.38 Staff should ensure that detainees can inform someone of their whereabouts, and check with court staff or legal advisers that it is appropriate for this person to be contacted. (4.10)

Treatment and conditions

6.39 Detainees should not be permitted to smoke in cellular vehicles. (5.10)

6.40 Confidential medical information accompanying detainees should be contained in a sealed confidential envelope. (5.11)

6.41 Staff should tell female detainees about the availability of hygiene packs. (5.26)

6.42 GEOAmey should revise its policy on caring for transgender detainees and ensure that staff implement it. (5.27)

6.43 Detainees' property should be stored securely at every court. (5.28)

6.44 Out-of-date food should be disposed of and food preparation equipment should be kept clean. (5.29)

6.45 Bus fares and travel warrants should be available at Newcastle Moot Hall. (5.55)

6.46 A small supply of toilet paper should be placed in each toilet. (5.73)

6.47 Court emergency evacuation procedures should specify the means by which the cells can be evacuated and there should be regular practice evacuations. (5.74)

Good practice

Individual rights

6.48 At Berwick upon Tweed, detainees were given a laminated copy of their rights and entitlements to take into the cell with them. (4.20)

Appendix I: Inspection team

Martin Kettle	Team leader
Gary Boughen	Inspector
Michael Calvert	Inspector
Peter Dunn	Inspector
Vinnett Pearcy	Inspector
Elizabeth Tysoe	Health care inspector

Appendix II: Photographs

Figure 1: Cell corridor at Newcastle Crown Court Moot Hall

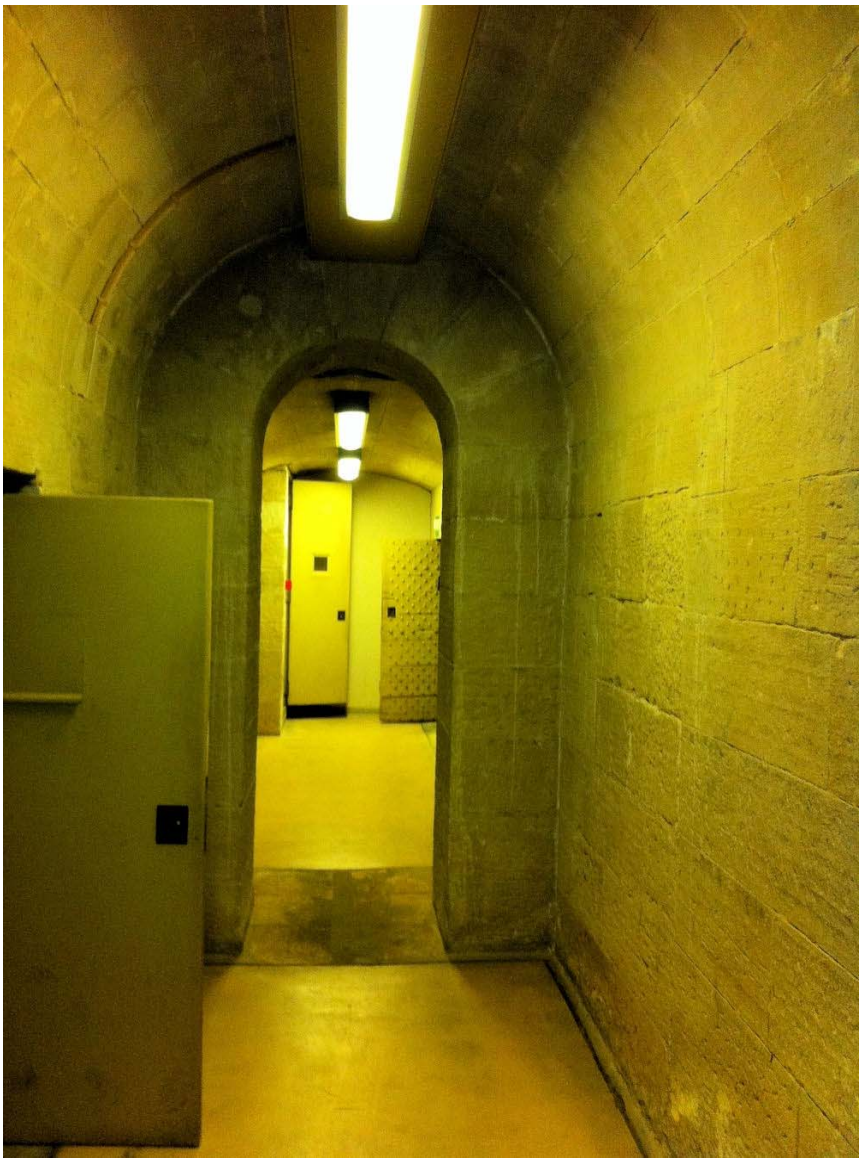

Figure 2: Ingrained dirt in a cell at Newcastle Crown Court Moot Hall

Figure 3: Cell at Sunderland Magistrates' Court

Figure 4: Ceiling of cell at Sunderland Magistrates' Court