Report on an inspection visit to court custody facilities in

Merseyside and Cheshire

15–19 October 2012

by HM Chief Inspector of Prisons

Glossary of terms

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1. Introduction

This is the second 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.

In Cheshire and Merseyside there were three Crown Courts and nine Magistrates' Courts, and also a Community Justice Centre and a Youth Court in Liverpool. Her Majesty's Courts and Tribunals Service (HMCTS) management structure was newly established, and it was apparent that there had not yet been much opportunity to focus on custody issues, although working relationships between the agencies and contractors involved were good. In the first year of the current custody and escort contract, most attention had been given to timely collection and delivery of detainees.

Staff ensured that people were legally detained, and courts were flexible in the times when they would hear cases, but there were still some excessive waits in cells, both before and after the court hearing. Detainees had ready access to legal advice, but not always in the right conditions, nor were their rights always clearly explained.

Staff treated detainees with courtesy, although not always engaging readily with them. Detainees were not always accorded reasonable privacy, and provision for the needs of vulnerable people and minority groups was not consistent, although the needs of those with mobility difficulties were adequately met. Although staff did not use undue force, there was a risk-averse approach to searching and to handcuffing while escorting detainees within the building.

Almost all suites were in a shabby condition: almost no deep cleaning had been done for a number of years. Graffiti was ubiquitous, including abusive and racist content in a few cases. Toilet and shower areas were kept clean, but were not all adequately screened.

A new health services provider was delivering an acceptable service. First-aid equipment needed to be upgraded, and attention was needed to the storage of medicines and to controls on the sharing of medical information on individuals. Although staff had not received training on mental health or substance misuse issues, they were supported by good services in the community, including a very effective Merseycare scheme for diverting mentally ill detainees from the offender pathway.

In summary, detainees were treated with reasonable care and respect, but without the consistent management control and scrutiny which would drive up standards. The physical condition of the custody suites was seriously marred by graffiti and by ingrained dirt. HMCTS and its partner agencies and contractors have made a start on streamlining the court custody and escort process; they now need to attend closely to the treatment and conditions for detainees.

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December 2012

2. Background and key findings

2.1 This report is the second 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.

2.3 This inspection covered an area served by the police forces of Merseyside and Cheshire within the north-west 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
Warrington	7	Chester	7
Liverpool	20		

Magistrates' Court	Number of cells	Magistrates' Court	Number of cells
Liverpool	11	Halton	5
Sefton	12	Warrington	7
Wirral	11	Macclesfield	3
Chester	9	St Helens	8
South Cheshire (Crewe)	8	Liverpool Youth Court	4
North Liverpool Community Justice Centre	2		

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

Leadership, strategy and planning

2.4 There were good working relationships between the National Offender Management Service (NOMS) commissioners and the commercial provider. Liaison with the courts service was less developed; the HMCTS management structure was still bedding in, and there were some signs of the beginnings of improvement. There was better liaison at local court level.

2.5 The range of agencies involved in criminal justice work had recently focused more practically on improving outcomes, including work to ensure the timely return of detainees from court to prison, and the introduction of flexible court sittings at weekends. Court user groups were in place and included custody issues in their discussions, but in several places had not been meeting regularly in recent months. The introduction of video-enabled courts had had some impact.

2.6 Formal procedures for the safeguarding of children and of vulnerable adults, including the making of referrals to relevant agencies, were not in place, even though there was a practical focus on keeping vulnerable people safe. Although there had recently been useful clarification of the cleaning contract, there was not sufficient management grip on the condition, décor and cleanliness of the cell areas. This was partly because in the early stages of the custody contract, attention had been more on the timely transporting of detainees than on conditions in the custody suites.

2.7 The Lay Observers[2] scheme was operating, but at a low level pending the appointment of new members of the panel.

Individual rights

2.8 Detention was appropriately authorised, although in Merseyside those brought in by court enforcement officers were routinely placed in a cell. Long waits in cells were frequent, often of up to four hours waiting for transfer to prison after a hearing. Delays had often occurred because of the wait for prisons to confirm, after a person has been released by the court, that the release could proceed – this problem was confined to HMP Liverpool. Although managers were striving to have custody cases given priority in courts, this was said by staff not to be happening at some sites. Courts were not operating cut-off times, so there was flexibility in dealing with late arrivals; this was beneficial, but there were still cases of long waits before a detainee was called up to the court. There was, on the whole, good input from youth offending teams (YOTs), although with some delays.

2.9 There were inconsistent arrangements for informing someone of a detainee's whereabouts: in some suites staff were prepared to contact family, at others not. Solicitors had good and prompt access to clients in the cells, and all detainees were asked who their solicitor was or called the duty solicitor. Interview facilities were adequate in some places, but elsewhere were not soundproof or were closed visits rooms, and there were no such rooms at all at Warrington Magistrates' Court.

2.10 Detainees' rights were displayed and available in paper copies, but staff took varying levels of care to ensure that detainees were aware of their rights. Most custody staff had never used the telephone interpretation service whose number was displayed, relying on interpreters from the

[2] Lay Observers, established under the Criminal Justice Act 1991, are independent volunteers who check that prisoners escorted by private escort companies in England and Wales are treated decently.

court, or those supplied by the police in the case of those coming from police custody. There were sometimes considerable delays in getting interpreters.

2.11 Complaints information was displayed and complaint forms were available on request. Some senior custody officers (SCOs) explained routinely to newly arrived detainees how they could make a complaint. Very few complaints were in fact submitted, and staff said that they had not received feedback from complaints.

Treatment and conditions

2.12 Vans for court transport were in reasonable condition. There was no unanimity among staff about the purpose of the partition fitted in the escort vans, and there was not consistent separation on vans of women from men. There were not long waits in vans. Vehicle docks were suitably private except at Halton, Macclesfield, where it was in public view and overlooked by adjoining businesses, and Chester, where vans could not enter the building and arrival was completely open to public view. Lists of detainees' names were in some places visible to all those passing the staff office on the way to and from cells.

2.13 There were procedures to identify any individual needs of new detainees. There was some staff training on diversity but staff were not well aware of how to manage young people, children and women in custody. Women were kept on the same cell corridor as men in some suites. People with mobility difficulties were diverted to courts which had suitable facilities. Provision for faith needs was largely lacking; for example, only two suites had proper prayer mats, and sacred books were available only from the courts themselves. There were inconsistent approaches to the treatment of transgender detainees.

2.14 Very little reading material was available to detainees, limited to what staff brought in. Property was stored securely. Some limited information for detainees, such as a leaflet, 'What happens to me next', was available at most courts, although a leaflet designed for young people was given to adults in some cases; staff at the Crown Courts were careful to explain to newly detained people what would happen next.

2.15 Staff treated detainees in a respectful and appropriately friendly manner, although their interactions with them were largely restricted to the required observations. In almost all courts there were sufficient permanent staff. There was adequate food and drink at most sites, issued with appropriate flexibility. For those on long trials at a Crown Court, the range was very narrow. Microwave meals were given at most courts, but hardly ever at Liverpool Crown Court.

2.16 No formal risk assessment was used to assess detainees, including for their suitability to share a cell; staff often asked common-sense questions relating to self-harm and mental health, and referred to the person escort record (PER). Again, there was inconsistency between suites. No staff carried anti-ligature knives; they were present in the suites but not always immediately accessible. Only the Crown Courts ever facilitated a domestic visit, on the direction of a judge.

2.17 There were formal morning briefings at some courts and, even where this was not possible, SCOs ensured that staff were aware of individual detainee risks and needs. Transfers to the courtroom were prompt, and nearly all through secure areas. Staff rarely used force – they were aware of reporting procedures – but the amount of searching was inconsistent, and in some contexts was disproportionate. At some courts there was excessive handcuffing within relatively secure areas, and there was a lack of clarity on the scope for local risk assessment to determine whether handcuffs should be used.

2.18 Bus tickets and travel warrants were given to those needing help to get home, and small amounts of cash at two courts only. There were instances of good care for those being released, and other examples of lack of help for vulnerable people with genuine needs.

2.19 At all courts, basic health and safety checks were done regularly, but not in depth. There was no natural light in almost all suites, and walls were dirty in all suites. Almost all suites were in need of a deep clean, and, in many, staff said that it had been a number of years since a deep clean had been carried out. All suites had graffiti on the walls, on the inside of cell doors and elsewhere – some sites were worse than others, and some were very seriously defaced by graffiti, including, in a minority of suites, abusive and racist words and swastikas. Toilets and washing facilities were inadequately screened in a small number of suites but most were reasonably clean. Staff were familiar with fire evacuation procedures. At almost all courts, cell call bells were working fully and were responded to quickly.

2.20 All staff were aware of how to access assistance in case of detainee health problems; two courts had used the service and found it satisfactory. Aggregated contract performance data were not collected by GeoAmey. The ambulance service was said to be quick to respond when called. All staff were first-aid trained; a switch to annual training was in hand. They had access to first-aid boxes, although the content was not all wholly appropriate and some of it was out of date; checks took place but were not documented at all suites. There were no defibrillators in the courts or custody suites. Some custody suites were malodorous but there were no infestations.

2.21 Health interactions and interventions were recorded in the PERs. Health information received by custody staff was said to be incomplete at times, but we observed some confidential information being inappropriately supplied. Medicines were handled carefully but storage was in some respects unsatisfactory. Custody staff were prepared to help detainees to continue with their prescribed medicines.

2.22 Custody staff had access to mental health and substance misuse professionals, who offered advice and saw detainees as appropriate. The liaison and diversion from custody scheme in Liverpool was exemplary.

Main recommendations

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

2.24 A standard risk assessment proforma should be completed for each detainee, and staff should be trained in completing it.

2.25 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, provision of interview rooms and improvements to health and hygiene, should be put in place as soon as possible.

2.26 There should be a clear policy on the use of the partition in cellular vehicles and escort staff should implement it.

National issues

2.27 There should be a national body to which detainees who have complained about court custody can appeal if they are dissatisfied with the outcome of their complaint.

2.28 HMCTS should establish agreed standards for treatment and conditions in court custody, and include these in the measurement of performance.

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.

Strategic management

3.1 There were good working relationships between NOMS commissioners and the provider, GeoAmey. Liaison between GeoAmey and the courts service was less developed, but had started to improve considerably as new management structures had begun to take effect in HMCTS, with cluster managers each taking responsibility for a group of courts across an area. Local HMCTS operations and delivery managers were also fairly newly in place, each with responsibility for a larger court or more than one smaller court. In several cases, GeoAmey senior custody officers (SCOs) were not yet in touch with these delivery managers. However, SCOs said that the local court administrative staff were cooperative and helpful in addressing everyday issues about the accommodation (see main recommendation 2.23).

3.2 Although routine involvement of custody staff in local operational communication was undeveloped, following a successful regional pilot at Bury Magistrates' Court there were plans to involve SCOs in weekly operational court meetings, and also the daily 'team information board' meetings each working day. While there were logistical difficulties in regular attendance at such meetings, there was encouraging progress towards effective operational liaison between SCOs and court staff.

3.3 Video-enabled courts were used in three Cheshire courts, although the low availability of video-link slots at HMP Altcourse was said to limit the scope for their use for people in prison; however, there was frequent use of video-link to HMP Liverpool. The number of opportunities for video-link at Magistrates' Courts in Merseyside had reduced because Merseyside had been an early adopter of the abolition of committal hearings in Magistrates' Courts.

3.4 Cleaning contracts were held by G4S, under facilities management arrangements for court buildings as a whole. Recent clarification of the contract had led to improvements, such as a regular programme of deep cleaning, and the confirmation that cleaning requirements included cell walls, although in several suites staff said that cleaning was still largely confined to the floors.

3.5 The GeoAmey contract, which had been in place for a year, was still bedding in, in terms of operational delivery, and the focus had been on reaching performance targets on the promptness of collection and delivery of prisoners to and from courts, police custody and prisons. There was good management information on these issues, shared openly between providers and commissioners. The focus of contract monitoring had begun to broaden to include the prioritising of custody cases, and the prompt collection of prisoners after the conclusion of their court hearing, although both of these issues clearly remained problematic.

3.6 Few complaints were received; they were tracked through the GeoAmey national compliance department and communicated to the appropriate parties. Prison Escort and Custody Services (PECS) managers had access to the complaints database and carried out some quality assurance of the timeliness and quality of responses.

Partnerships

3.7 The range of agencies involved in criminal justice work – police, prisons, the escort contractor and HMCTS – had routinely attended local and area criminal justice boards, but they had also recently sharpened their practical focus on improving outcomes through joint working. For example, a forum had been held at HMP Styal to improve performance on such issues as the timely collection of prisoners from court cells for return to prison. The introduction of flexible courts pilots had also brought the agencies together to solve the challenges involved – they were already running at Liverpool Magistrates' Court, and Sunday use of video-enabled courts in Cheshire was shortly to begin.

3.8 Formal procedures for safeguarding children and vulnerable adults, including making referrals to relevant agencies, were not part of the strategic management of court custody; such matters were generally seen as the concern of partner agencies such as the Youth Justice Board, Probation Service or Social Services. (This issue was separate from the operational processes for keeping vulnerable people safe in custody, which are covered in the section on treatment and conditions.)

3.9 Court user groups were in place – theoretically meeting each quarter at larger courts and twice a year at smaller courts, although staff in several courts said that there had not been any meetings in recent months. When they took place, the meetings were well attended, with GeoAmey representation in most cases, and custody issues were included in the discussions.

3.10 The Lay Observers scheme operated in the area, although numbers were low (many staff said that their visits were rare) and recruitment was currently under way. The Lay Observers had good access to suites and good relationships with the custody staff. They had raised several issues about the conditions for detainees, of which GeoAmey had taken note, although they did not appear often to have highlighted physical conditions as a significant problem. Lay Observers met managers twice a year.

Recommendation

3.11 Court user groups should meet at regular intervals to support communication and good working relationships between key stakeholders in the custody function.

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 carefully checked charge sheets, production orders and warrants to ensure that they had the necessary authority to detain. However, in some courts, predominantly in the Merseyside area, court enforcement officers (CEOs) sometimes brought detainees to the cells without a copy of the warrant. Custody staff said that warrants were held somewhere in the court building and could be checked. The SCOs told us that they would accept detention if the court listings team was aware of the case.

4.2 A detainee at Liverpool Magistrates' Court told us that he had attended the court voluntarily by appointment as he had been informed by the CEO that there was an outstanding warrant for him for a non-payment of a fine. He had been told by the CEO that he could sit in court and would be dealt with quickly. He was therefore surprised and concerned that he had been arrested and taken directly to the cell area, where he had been placed in a cell and later handcuffed to go to the court. Staff told us that this was a common occurrence for CEO-enforced warrants, such as those relating to the non-payment of a fine or a television licence, or occasionally for parents failing to ensure that their children attended school. CEOs in the Cheshire area told us that this scenario would be rare in their region, where such detainees would be invited to sit in the court until their case was called. Similarly, we were told that people who attended Liverpool Magistrates' Court voluntarily to surrender for failure-to-appear warrants were directed across the city to the police station, where they would be arrested, detained in a cell and then brought back to court custody in a GeoAmey vehicle. It was not clear why any such detainees needed to be held in cells and be subjected to the associated handcuffing.

4.3 We observed SCOs contacting court staff to progress cases, to reduce the time that detainees spent in the cells. However, in several courts, remands were not prioritised effectively; for example, in Halton we observed that video-link hearings were prioritised over those held in custody, leading to long stays that could have been avoided.

4.4 Records at Liverpool Youth Court showed that on one day shortly before the inspection, three young people had arrived in the cells at 8.30am but had not appeared until after 3.30pm, despite the SCO attempting to expedite matters. A YOT manager told us that, while YOT and custody staff raised such issues at meetings of the court user group, they had little influence on court listings. At North Liverpool Community Justice Centre, detainees bailed, acquitted or given non-custodial sentences had to be returned to Liverpool Magistrates' Court before they could be released, thus prolonging their stay in custody. At Warrington Magistrates' Court, which heard cases on Wednesday (Breach Court) and Friday (Sentencing), detainees who were produced from prison all arrived in the morning, even if their case was not listed until the afternoon; this meant that detainees could spend over four hours in court cells.

4.5 We heard many complaints from custody staff about the length of time taken by HMP Liverpool to authorise the release of bailed or acquitted detainees who had previously been in custody there. While most establishments approved release within an hour or less, custody staff told us

that it often took three hours for HMP Liverpool to do so, prolonging the period in custody and prompting complaints from detainees and their legal advisers.

4.6 Warrants of detention were brought down from court in a timely manner, usually within 30 minutes of remand or sentence, enabling them to be checked before ongoing transport to prison being arranged. There was no cut-off time at any court.

4.7 Some staff told us that they would make a telephone call to inform someone of a detainee's whereabouts, but that this was rarely necessary as legal representatives would normally do this and they would encourage them to do so. At some suites in Merseyside, staff said that they would not make such a call.

4.8 Custody staff described good working relationships with the local YOT, although during the inspection there were sometimes difficulties in contacting the YOT, and occasionally there were delays in YOT staff attending the cells when needed. Although it was not routine practice for YOT staff to visit the cells each morning to see every young person in custody, the team was proactive in finding out from local police stations each morning if there were young people coming to the youth court, and informing custody staff of any specific needs. There was some inconsistency in who was responsible for the care of children brought to court from secure training centres – in some places the custody staff believed that they were responsible for looking after them, and elsewhere they said that escort staff from the specialist local authority contractor stayed with the young person while in custody.

Recommendations

4.9 Defendants brought to court by court enforcement officers, or who attend voluntarily, and who can be dealt with at court on the same day should not be placed in a cell unless there is a good reason to detain them.

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

Housekeeping point

4.11 Instances when detainees are brought to court in the morning but not listed until the afternoon should be monitored and the source of such delays resolved.

Legal rights

4.12 Staff ensured that detainees obtained access to their legal advisers or a duty solicitor promptly. Most legal advisers indicated that they were generally satisfied with the arrangements for themselves and their clients.

4.13 The consultation rooms at Sefton Magistrates' Court and Chester Magistrates' Court were unsatisfactory because they were closed visits rooms with a glass partition, so advisers, probation officers and YOT officers depended on custody staff to pass any documents to detainees. In one of the rooms at Sefton, the legal adviser had to keep one finger on the intercom button to be heard on the other side of the partition. At Halton Magistrates' Court, the two interview rooms were extremely small. Probation staff refused to see clients in these rooms and had gone to the expense of installing a telephone line so that they could stand outside the room to speak to their clients; this was inappropriate and compromised privacy.

There were no interview rooms at Warrington Magistrates' Court, so legal representatives had to meet detainees in the cell, with the door open. These cells were in a poor condition and not appropriate for this purpose (see section on physical conditions). At Chester Magistrates' Court, conversations from closed interview rooms could be clearly heard in the custody area.

4.14 At each court there was a written information sheet about rights and entitlements; this was sometimes given to detainees on arrival, or a copy was placed in each cell, or it was taped to a wall and detainees' attention was drawn to it, but checks were not always made to determine whether the detainee could read it. At Sefton, staff took care over this, while at Wirral and Liverpool Magistrates' Court they were more perfunctory. At Chester Crown Court, we saw detainees being placed in cells without any reference to their rights. Because North Liverpool Community Justice Centre was a 'satellite' court, detainees appearing there were given their rights at Liverpool Magistrates' Court, unless they were brought in by a CEO.

4.15 In most courts, rights and entitlements leaflets were all in English but we were told that they could be obtained in other languages from the computer programme 'SharePoint', although this often proved to be difficult to do. However, at several courts, including Warrington Crown Court, Liverpool Crown Court, Chester Crown Court and Wirral Magistrates' Court, staff had previously printed out a small selection of the rights and entitlements leaflets in various foreign languages in preparation for any non-English-speaking detainees being brought into the suite. All suites had a multi-language poster on the wall, giving basic information about legal rights, but this was not always easily visible to detainees on arrival.

4.16 Telephone interpreting services were rarely used at any court custody suite and no two-way telephones were available to facilitate telephone interpretation. In some suites, a poster for a professional interpreting service was displayed but many staff appeared to be unaware of the service. Staff told us that they would use court interpreters, but custody staff could not satisfactorily explain how they would communicate with a detainee after the interpreter had left the court building – for example, if a detainee became ill or distressed while waiting for a cellular vehicle. At Halton, staff said that interpreters often attended only after a long wait, or not at all.

4.17 In all courts, staff told detainees on arrival that there was a complaints process. Information about the right to make a complaint was included in the rights and entitlements leaflets. Official complaints were infrequent, and staff said that they rarely got any feedback from them, although at Chester Magistrates' Court they believed that the introduction of deep cleaning in cells had been instigated by official complaints by detainees. At the time of the inspection there was no national body to which detainees unsatisfied with the outcome of a complaint could appeal.

Recommendations

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

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

4.20 At every court, detainees should be told on their arrival about their rights and entitlements, and staff should offer to read or explain 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 Most of the cellular vehicles we inspected at each court were reasonably clean, with only a small amount of graffiti. All vans had first-aid kits, anti-ligature knives and bottled water. At Liverpool Youth Court, we inspected a car that was being used to transport a child; it was clean and equipped with tinted windows, for privacy. The police vehicle that was used to transport detainees from Liverpool Magistrates' Court to the North Liverpool Community Justice Centre was grubby inside, bore graffiti and did not carry an anti-ligature knife.

5.2 There was some uncertainty among staff concerning the circumstances in which they should close the vehicle's partition. Some thought that the partition should be used to separate men and women, while others thought that it should not be used at all. We saw men and women being transported in the same vehicle with no partition being used, but also saw the partition being closed in a vehicle containing adults and juveniles.

5.3 Most journeys to court were short, rarely much more than an hour. However, we saw a woman who had been collected at Chester at 6.40am arrive at Wirral Magistrates' Court at 9.05am. Detainees were not kept waiting for unduly long periods to be taken from vehicles into the court buildings.

5.4 At most courts, prisoners disembarked in a closed or screened van dock, but at some there was insufficient protection from public attention. For example, at Chester Crown Court, the vehicle dock area could not accommodate the larger escort vans, so detainees were brought off the van into an area which was directly overlooked by a public space. At Wirral, the van dock was overlooked by flats and public buildings. At Macclesfield, the area was overlooked by adjoining businesses and the public. At Halton, the vehicle dock was in the police vehicle park and the gates were often opened, leaving the area open to public scrutiny.

5.5 Few courts had any replacement clothing available, although we saw no detainees arriving at court in police-issue paper suits.

5.6 All courts afforded private routes to courts from the cells, so no detainee had to be brought into public view. The only exception to this was at Macclesfield, where one court had no direct access to the cells, so detainees had to be brought through the public area – normally in handcuffs. However, we were assured that this particular court was infrequently used for potential custody cases.

5.7 In most courts, information about detainees was displayed on whiteboards which could be seen by other detainees and, occasionally, by legal advisers. We saw several detainees studying these boards. However, very limited information was displayed: the surname, together with numeric codes which related to risk indicators.

Recommendation

5.8 Detainees should be transferred from cellular vehicles to the cells in privacy.

Housekeeping point

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

Treatment

5.10 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. This was usually done in a discrete room, and was done with particular care at Sefton, although at Liverpool Crown Court this interview took place in a room which doubled as a property store. A prisoner reception form had recently been introduced but not all staff were aware of when it was to be completed or its purpose thereafter (see main recommendation 2.24).

5.11 The custody staff were polite, friendly and courteous with detainees, and detainees told us that they felt well cared for. There were sufficient permanent staff in all suites except Liverpool Youth Court, where there was a temporary shortfall at the time of the inspection. However, many staff made little effort to interact with detainees, except when undertaking observations and escort duties. Exceptions to this included staff at Warrington Crown Court, who showed a great deal of care and sensitivity to a detainee who was very agitated about his court appearance. Staff spoke to him at regular intervals to reassure him and kept him regularly updated about what was happening.

5.12 A limited amount of information was available to detainees who were newly remanded or sentenced to custody. At all courts, there was basic written information, entitled, 'What will happen next?'. A leaflet about young offender institutions was in use at Liverpool Youth Court, while at Sefton the same leaflet was all that was available for adults going to prison for the first time. A few courts had information leaflets, in English only, on HMYOI Hindley and HMP Liverpool. At the Crown Courts, staff took care over explaining privately to those committed to custody what would happen to them.

5.13 Diversity training was included in induction training, and many staff said that they had received some form of it, either at induction or in later updates. However, in general, little consideration was given to meeting the diverse needs of detainees. For example, it was only at Sefton that we saw staff routinely ask women if they were pregnant; all detainees at this court were asked if there was anything about their welfare of which staff should be aware. Staff did not routinely ask about any dependents. At Liverpool Magistrates' Court and Chester Crown Court we were told that there were cushions or old jumpers available for pregnant women to sit on; elsewhere, they had to sit on hard benches, possibly for several hours. All courts had feminine hygiene packs available but only two courts (Halton and Warrington Magistrates' Court) had notices advertising this; in the others, detainees had to request one. At Wirral, a woman who was repeatedly vomiting was not offered any medical help, although she was provided with paper bags to be sick into. She was sharing a cell with a woman with whom she had no connection. Where possible, male and female detainees, and juveniles and adults, were held in separate corridors. However, in some court cells this was not practicable because of their design.

5.14 There was little provision for the needs of minority groups or vulnerable people. Prayer mats were rarely available and holy books had to be sourced from the court. A Qibla sign (showing the direction of Mecca) was affixed in the corridors of most court custody suites, although the direction indicated was not always accurate. No detainees were asked about religious observance, dietary requirements or any other needs on arrival at the court. There was poor provision for detainees who could not speak English and most staff said that they would resort to 'sign language' on most occasions (see also paragraph 4.16 and recommendation 4.19).

5.15 No cell areas had hearing loops and there was no information in Braille. Liverpool Magistrates' Court, Liverpool Crown Court, Sefton, Chester Magistrates' Court and the North Liverpool Community Justice Centre were compliant with the Disability Discrimination Act and therefore received detainees with disabilities from surrounding courts; however, the stairlift at Sefton was not able to accommodate all who needed such assistance, and cell call bells were too high.

5.16 Many staff were unsure about the procedure for searching transgender detainees. Some told us, correctly, that they would either 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 birth gender.

5.17 Some staff had provided reading materials for detainees by bringing in old newspapers and magazines, all in English, but we rarely saw them being handed out without a request being made. At several courts, we spoke to detainees who wanted something to read but had not been offered anything. At Liverpool Youth Court, we were told that there had previously been a budget for magazines and comics, which had been effective in helping to keep young people occupied. Since the budget had been withdrawn, staff had resorted to bringing in their own magazines for detainees, but they were mainly of appeal only to adults.

5.18 Arrangements for securing detainees' property were usually satisfactory, although at Liverpool Crown Court the property was kept in a room also used for reception interviews with those coming from court.

5.19 All courts held stocks of sandwiches and microwave meals, and food preparation areas were reasonably clean. Sandwiches were routinely offered at regular mealtimes, and hot drinks were given on reception and on request throughout the day. 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 rarely offered. Some detainees we spoke to at Crown Courts said that they had been at the court daily for several weeks and had received the same limited choice of sandwiches every day. Some staff said that they might provide a hot microwave meal to detainees who were likely to be still in custody, or on a vehicle, after 4.30pm, in case they could not get a meal on arrival at the establishment to which they were being sent.

Recommendations

5.20 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.

5.21 Hearing loops, and Braille versions of key information for detainees, should be available.

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

Housekeeping points

5.23 Accurate information about local establishments should be made available at all courts, in a range of languages, or detainees should be advised of their content via a suitable interpreting service.

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

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

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

Safety

5.27 At some courts (for example, Liverpool Magistrates' Court) there was a formal staff briefing, but this was understandably short as it took place before detainees arrived, when information about them was still scant. However, some vulnerability markers were available on the GEOtrack system and we saw staff consulting this and using the information in the briefings. Once detainees arrived it was difficult to call a staff briefing, so issues surrounding previously unknown risk factors involving detainees' welfare were communicated individually.

5.28 Escort staff ensured that the PER accompanied the detainee. These generally contained sufficient information, although custody staff said that police information about self-harm was sometimes lacking in detail. Court custody staff checked incoming PERs before detainees were taken off the vans, enabling them to make some assessment of risks, including, where necessary, for cell sharing, and to ensure that detainees' property was correctly recorded.

5.29 There was no thorough or systematic initial risk assessment on arrival in the custody suite (see main recommendation 2.24), but SCOs usually referred to the PER and GEOtrack (a computerised case management system), and asked straightforward questions about the detainee's state of mind. For example, at Chester Magistrates' Court a detainee requesting that he be placed in a cell with someone else was refused as there was information about previous attacks by this individual on cell mates. The PER form for another detainee who had made a serious attempt at suicide on the night before was annotated with 'attempted to hang himself last night', with no further details. Court staff made efforts to ascertain additional information as the detainee had been at the same court two days earlier and had been on an open assessment, care in custody and teamwork (ACCT) self-monitoring document at that time. Staff at Liverpool Crown Court were less thorough in exploring such issues. Adequate care was normally given to newly arrived detainees, although a woman withdrawing from heroin who complained of bad stomach pains on arrival in the custody suite was asked how long she had been in pain but was not asked if she wanted to see a health care worker.

5.30 Observations were undertaken at the required intervals and recorded on the PER or the GEOtrack system. There was widespread inconsistency as to whether information about risks, for example, should be recorded on the paper PER or on GEOtrack. Accordingly, it was not certain that information captured in one recording system would be passed on as necessary. During the inspection, the suites were in transition to a new version of GEOtrack which was more able to record information properly.

5.31 We were told that constant observations would be facilitated if a detainee had been risk assessed as requiring them. GeoAmey's operating standards stated that observations of detainees who were considered particularly vulnerable should be at a minimum of six times an hour, and all staff we spoke to were aware of this.

5.32 All detainees were searched on arrival, even if they had been searched by police or prison staff and had remained under supervision thereafter. Searching methods were inconsistent; for example, at one court, shoes were removed and searched, whereas at another shoes were not removed. Rub-down searches were carried out frequently in many suites – for example, every time a detainee went to the toilet or saw a legal representative or drug worker; we were not assured this was necessary. 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.

5.33 Anti-ligature knives were kept in first-aid boxes, which could have delayed access to them if an urgent intervention was required. Staff were not clear if these knives were single- or multi-use.

5.34 There were no significant delays in transferring detainees from the cells to the courtrooms. Routes to courtrooms were secure, all courts being equipped with affray alarms in the corridors and on the stairs to the docks.

5.35 All staff had received annual training in control and restraint techniques. All uses of force were recorded on a form, which was sent to relevant managers. 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 generally allowed staff no discretion in this. In most courts, all detainees were handcuffed when moving the short distance between their cell and an interview room to see their legal adviser or even to visit the toilet. Handcuffs were always applied while climbing the stairs to the courtrooms in every suite, since staff were not clear whether handcuffing practice could be varied according to local conditions. Staff told us that anyone refusing to be handcuffed would be reported as 'refusing to attend court', even though this might not have been the intent of the detainee.

5.36 Although some courts had closed visit facilities, social visits were rarely permitted and usually only when directed by a judge; we were told that this had occurred at both Chester Crown Court and Liverpool Crown Court. Staff at Chester Crown Court said that a small number of visits had also been facilitated on an individual basis, depending on the circumstances of the case.

5.37 At most suites, bus tickets or travel warrants were given as fares to those being released, when necessary. At two courts only, small amounts of cash were given if appropriate.

5.38 Most suites had no information leaflets about local support organisations for potentially vulnerable detainees being released, although at Chester Magistrates' Court staff showed us leaflets about accommodation options for homeless or otherwise vulnerable people. There were instances of good care for those being released, but at Wirral Magistrates' Court we saw a person of no fixed abode who appeared to show signs of mental illness. She had five large bags of belongings and 95 pence, but was released with no support other than the court advising her to attempt to seek accommodation at a nearby hostel. A woman at Sefton Magistrates' Court who had been withdrawing from heroin was released, in pain, without being asked if she could get home. No advice was offered about where she might go for treatment (see also paragraph 5.29).

5.39 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. Staff had not received any training in safeguarding children and vulnerable adults. They indicated that, when necessary, they would informally approach staff from the Probation Service or YOTs to seek additional support for detainees.

Recommendations

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

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

5.42 Handcuffs should only be used if it is necessary, justified and proportionate.

5.43 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.

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

Housekeeping points

5.45 Cash, bus tickets or travel warrants should be available at all courts to assist those detainees released with difficulties in getting home.

5.46 Each court should have information leaflets about local support organisations.

Physical conditions

5.47 The condition of the court cell estate varied. In Wirral Magistrates' Court and Liverpool Magistrates' Court, some cells had been built in the 19th century. The older custody suites not unexpectedly appeared more shabby.

5.48 All courts carried out basic daily cell checks, including the testing of call bells, and we were told that major faults were attended to promptly. Some cells had manageable ligature points, mainly associated with the peeling of sealant around the benches. Most cells had no natural light. All cells were cleaned daily but several suites had not been deep cleaned for a long time.

5.49 At Chester Crown Court, there were many stains on the walls and a substantial amount of paper was stuck to the ceiling of several cells. This paper had been in-situ for several months and, in spite of requests for the cells to be deep cleaned, this had not happened. There was much graffiti on the back of doors, on walls and on floors, and in several cells graffiti was burnt onto the ceilings. Staff had painted some cells in their own time to try to improve the situation. Although cell call bells were audibly working, the lights outside the cells to indicate this were extremely dim.

5.50 At Liverpool Magistrates' Court, the cell doors, wooden benches and ceilings bore graffiti, some of it dating back a number of years, including a swastika (which was removed during the inspection). Walls had not been recently painted and there were traces of food and other stains on them.

5.51 The cells at Liverpool Crown Court were clean, as they had been deep cleaned in the week before the inspection – according to staff, for the first time in several years. However, graffiti had not been removed; this was widespread, mostly on the back of the doors and on benches, and some of it was offensive. Detainees at this suite could not use the toilets in private as they were situated adjacent to the booking-in desk. The area was mostly open plan, with a flimsy screen erected between the toilets, the urinal area and the desk. We witnessed staff inappropriately discussing a detainee's medication, unaware that another detainee was in the toilet area and able to hear their conversation. One detainee told us that he had found it difficult to use the toilet facilities because of their location and the number of staff grouped in the vicinity. This was degrading for detainees and staff alike. Several detainees at Liverpool Crown Court told us that the cells were cold.

5.52 Warrington Crown Court, Chester Magistrates' Court, Macclesfield Magistrates' Court and St Helens Magistrates' Court cells were clean, with minimal graffiti, but at Halton Magistrates' Court and Crewe Magistrates' Court most of the cell doors, wooden benches, walls and ceilings contained graffiti; some of this dated back a number of years, and included a swastika in one cell at Crewe Magistrates' Court and some offensive racist graffiti in a cell at Halton. Walls had not been recently painted or cleaned and there were stains on many of them. The men's toilets at Macclesfield and Halton were inadequately screened.

5.53 At Sefton, the cells were dirty, with deeply ingrained dirt on the floor, deposits of brown matter on the ceilings and brown smears on the walls adjacent to the toilets. There was much graffiti (see Appendix II), including obscene words. Staff could not recall a deep clean ever having been carried out; one had been arranged just before the inspection but it had not taken place. In the booking-in area, detainees were told to sit on a chair with torn and dirty upholstery. In-cell toilets were not sufficiently clean.

5.54 The cells at North Liverpool Community Justice Court were reasonably clean, although there was some graffiti. The toilet there was clean, well equipped, and private.

5.55 At Warrington Magistrates' Court, the cells were dirty and in a poor state of decoration. There was graffiti on the walls, doors, ceiling, wooden plinths and around the cell call bells in most of the cells. There was ingrained dirt on the floors and brown matter on some of the walls. We were told that there had not been a deep clean at the custody suite for a long time. The temperature in the cell block was 26 degrees Celsius in the morning and cells were often too hot (see main recommendation 2.25).

5.56 At more than one court, staff told us that they had little support from prisons in dealing with detainees who caused graffiti. They had often reported it but only one custody officer could recall having been called to prison to give evidence at an adjudication.

5.57 Staff responded promptly to cell call bells, all of which were in working order. On many occasions we saw staff explaining their use to a detainee when they were placed in a cell.

5.58 There were no blankets, mattresses or warm over-clothing at any court, even though some of the cells were said to be cold in the winter. With the exception of the courts mentioned above, court custody suites had toilets that were reasonably well screened, and toilet paper was readily available. Most had hand-washing facilities, soap and towels.

5.59 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.

Recommendations

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

5.61 The toilets adjacent to the staff working area in Liverpool Crown Court should be moved.

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

Housekeeping point

5.63 Defects in the lighting of the cell call bell system at Chester Crown Court should be rectified promptly.

Health care

5.64 The health services provider, Taylor-Made, provided telephone advice in the first instance or the services of a visiting health care professional if required, and there were notices in each custody area notifying staff about how they could access the service. Staff could also contact the ambulance service in more urgent situations. Since August 2012, when the contract began, the health services provider had been called on four occasions, by three courts. Staff had found the advice received to be helpful. Some SCOs had local audit systems for the use of the health services provider but GeoAmey did not collect aggregated data.

5.65 GeoAmey staff had access to first-aid kits in the court custody areas but in some suites some of the content – for example, plasters and airway aids – was out of date, and some were over-stocked. The kits were checked regularly but not all checks were documented. Staff were trained in 'first aid at work' and were up to date with their training. Annual first-aid training, which would be more suitable for this environment, was being introduced. There were no defibrillators, and there was no oxygen or suction available in any of the court buildings.

5.66 Some custody staff expressed concern that medical information supplied by the police was incomplete. The PER forms we saw contained relevant medical information and we saw some detainees arriving with Medacs (the Merseyside police health care provider) medical reports; it was unclear if consent had been obtained to share such detailed confidential information. Medications for detainees arriving from prisons were usually sent in individualised blister packs, attached to the PER forms. Staff then administered them at the relevant times and recorded this on the PER form. However, this was not the case for those sent from police custody, who rarely came to court with any medications, even if it had been prescribed and administered while the detainee had been in custody. Subject to risk assessment, detainees were permitted to retain possession of inhalers and sublingual sprays. In some suites, detainees' medicines were stored on the floor or on shelves, along with general property, and in others were locked in designated cabinets. At each suite, heat-sensitive medicines were stored in a refrigerator, but temperature checks did not take place regularly in all suites.

5.67 While most court custody staff believed that a large number of detainees had mental health problems, they said that numbers had reduced because of successful mental health diversion from police custody. They all said that good working relationships with detainees were critical for ensuring safe custody and de-escalating tense situations but none had received training in mental health awareness. There were three NHS mental health trusts – 5 Boroughs, Cheshire, and Wirral Partnership and Merseycare – providing criminal justice liaison teams to police and court custody suites in their respective catchment areas. Court custody officers telephoned for assistance as required and responses were said to be prompt. In busier courts, mental health professionals visited daily. Custody staff expressed satisfaction with mental health provision and commented that the mental health staff usually knew about a detainee before s/he arrived in court custody. Mental health professionals provided advice to the courts and access to further mental health assessment and treatments as appropriate. In Liverpool, Merseycare was carrying out a diversion-from-custody pilot scheme. This involved providing in-reach services to detainees in police and court custody; in the four months since the pilot had started (June 2012), 30 detainees had been diverted into hospital care, compared with 24 in the previous full year.

5.68 Custody staff at Magistrates' Courts commented that most detainees had substance use needs – particularly alcohol-related. None had received training in substance use awareness. All court custody suites had access to drug intervention programme (DIP) workers, provided by a variety of agencies, including Addaction, Arch and the Crime Reduction Initiative. Custody staff from Magistrates' Courts occasionally contacted the services, but those from Crown Courts rarely did so. Responses from these agencies were said to be swift. DIP workers were based in some courts and visited the custody area daily. Court custody staff expressed satisfaction with these services and told us that the DIP workers usually already knew about the detainee when they were contacted. Detainees with drug problems were offered support in community programmes and those with alcohol problems were referred to dedicated programmes. Clean needles and harm minimisation advice and supplies were available from local drug services. Juvenile detainees were signposted to specialist services and to YOT workers.

Recommendations

5.69 First-aid kits should contain the necessary equipment to deal with incidents that are likely to occur in the environment, such as serious self-harm; they should all be in-date and subject to documented checks.

5.70 Each court custody suite should hold an automated external defibrillator and equipment to maintain an airway, and staff should be trained to use them.

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

5.72 Court custody staff should be trained to identify and appropriately refer detainees who may be experiencing mental health or substance use-related problems.

Housekeeping points

5.73 GeoAmey staff should assure themselves that consent has been obtained to access confidential medical information received from the police.

5.74 Detainees' medication should be stored securely in all custody suites.

5.75 Maximum and minimum temperatures should be recorded daily for refrigerators used to store detainees' medication to ensure that heat-sensitive items are stored within the 2–8°C range. Corrective action should be taken where necessary and should be monitored by senior staff.

Good practice

5.76 *The Merseycare diversion-from-custody scheme enabled the early withdrawal of mentally ill detainees from the offender pathway.*

6. Summary of recommendations

Main recommendations

6.1 HMCTS managers should visit court custody suites regularly, to monitor standards and to resolve or escalate any issues as appropriate. (2.23)

6.2 A standard risk assessment proforma should be completed for each detainee, and staff should be trained in completing it. (2.24)

6.3 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, provision of interview rooms and improvements to health and hygiene, should be put in place as soon as possible. (2.25)

6.4 There should be a clear policy on the use of the partition in cellular vehicles and escort staff should implement it. (2.26)

National issues

6.5 There should be a national body to which detainees who have complained about court custody can appeal if they are dissatisfied with the outcome of their complaint. (2.27)

6.6 HMCTS should establish agreed standards for treatment and conditions in court custody, and include these in the measurement of performance. (2.28)

Recommendations

Leadership, strategy and planning

6.7 Court user groups should meet at regular intervals to support communication and good working relationships between key stakeholders in the custody function. (3.11)

Individual rights

6.8 Defendants brought to court by court enforcement officers, or who attend voluntarily, and who can be dealt with at court on the same day should not be placed in a cell unless there is a good reason to detain them. (4.9)

6.9 Courts should liaise with HMP Liverpool to resolve the delays experienced in confirming that detainees can be released. (4.10)

6.10 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)

6.11 Staff should be told how to use the telephone interpreting service, and telephones should be provided in suitable locations. (4.19)

6.12 At every court, detainees should be told on their arrival about their rights and entitlements, and staff should offer to read or explain them. (4.20)

Treatment and conditions

6.13 Detainees should be transferred from cellular vehicles to the cells in privacy. (5.8)

6.14 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. (5.20)

6.15 Hearing loops, and Braille versions of key information for detainees, should be available. (5.21)

6.16 A reasonable range of amenities, including hot meals, when necessary, and reading materials, should be offered in response to detainees' needs. (5.22)

6.17 Standards of searching should be made consistent and rub-down searches within secure areas should not be routine. (5.40)

6.18 Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits. (5.41)

6.19 Handcuffs should only be used if it is necessary, justified and proportionate. (5.42)

6.20 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. (5.43)

6.21 Young people in court custody should be supported by a named staff member who is trained to work with young people. (5.44)

6.22 A programme of regular deep cleaning should be implemented, and standards of daily cleaning should be improved. (5.60)

6.23 The toilets adjacent to the staff working area in Liverpool Crown Court should be moved. (5.61)

6.24 Mattresses, and blankets or warm clothing should be made available at all courts. (5.62)

6.25 First-aid kits should contain the necessary equipment to deal with incidents that are likely to occur in the environment, such as serious self-harm; they should all be in-date and subject to documented checks. (5.69)

6.26 Each court custody suite should hold an automated external defibrillator and equipment to maintain an airway, and staff should be trained to use them. (5.70)

6.27 All detainees who have the need for prescribed medications should have access to it while in court custody. (5.71)

6.28 Court custody staff should be trained to identify and appropriately refer detainees who may be experiencing mental health or substance use-related problems. (5.72)

Housekeeping points

Individual rights

6.29 Instances when detainees are brought to court in the morning but not listed until the afternoon should be monitored and the source of such delays resolved. (4.11)

Treatment and conditions

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

6.31 Accurate information about local establishments should be made available at all courts, in a range of languages, or detainees should be advised of their content via a suitable interpreting service. (5.23)

6.32 Staff should tell female detainees about the availability of hygiene packs. (5.24)

6.33 GeoAmey should revise its policy on caring for transgender detainees and ensure that staff implement it. (5.25)

6.34 Detainees' property should be stored securely at every court. (5.26)

6.35 Cash, bus tickets or travel warrants should be available at all courts to assist those detainees released with difficulties in getting home. (5.45)

6.36 Each court should have information leaflets about local support organisations. (5.46)

6.37 Defects in the lighting of the cell call bell system at Chester Crown Court should be rectified promptly. (5.63)

6.38 GeoAmey staff should assure themselves that consent has been obtained to access confidential medical information received from the police. (5.73)

6.39 Detainees' medication should be stored securely in all custody suites. (5.74)

6.40 Maximum and minimum temperatures should be recorded daily for refrigerators used to store detainees' medication to ensure that heat-sensitive items are stored within the 2–8°C range. Corrective action should be taken where necessary and should be monitored by senior staff. (5.75)

Good practice

Treatment and conditions

6.41 The Merseycare diversion-from-custody scheme enabled the early withdrawal of mentally ill detainees from the offender pathway. (5.76)

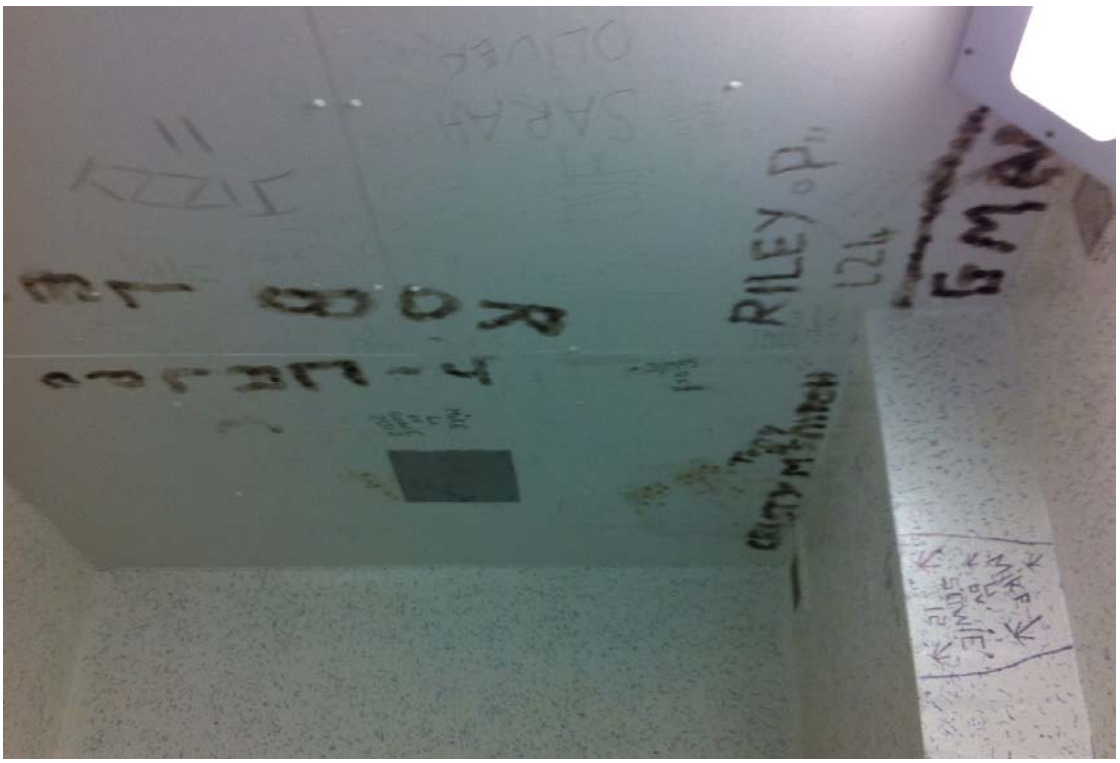
Appendix I: Inspection team

Nick Hardwick	Chief Inspector
Martin Kettle	Team leader
Gary Boughen	Inspector
Fiona Shearlaw	Inspector
Peter Dunn	Inspector
Vinnett Pearcy	Inspector
Karen Dillon	Inspector
Paul Tarbuck	Health care inspector

Appendix II: Photographs

Cell at Halton Magistrates' Court with graffiti and stains from food and bodily fluids

Cell at Sefton Magistrates' Court showing graffiti and stains on walls and ceiling



In-cell toilets at Sefton Magistrates' Court with soiled walls and floor

Racist graffiti in cell at Halton Magistrates' Court

Offensive graffiti in cell at Halton Magistrates' Court naming a person as a 'grass', which staff had attempted to erase