Report on an inspection visit to court custody facilities in

Kent

by HM Chief Inspector of Prisons

14–23 July 2014

Glossary of terms

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

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

Contents

Section 1. Introduction

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

In Kent, there were 10 courts in use that had custody facilities, including two Crown Courts. The National Offender Management Service (NOMS) had contracted GEOAmey to provide court custody and escort facilities in the county on behalf of HM Courts and Tribunals Service (HMCTS).

The management of custody was fragmented and ineffectual. Responsibility for custody was split between several organisations whose staff rarely met together. None had overall responsibility for the whole operation or for driving forward improvements.

Custody staff were allowed little discretion, this resulted in disproportionate and unreasonable treatment, such as the handcuffing of compliant detainees, including women and children. At some courts, there were too few custody staff to ensure detainees were safe. While many staff were considerate to detainees, their attempts to provide good care was undermined by the combined effects of the poor physical environment and the lack of attention given to assessing detainees needs. The care of detainees, including those who were vulnerable due to considerations such as ill health and age; or because they had attempted to harm themselves, was given very little importance. The low morale of custody staff distracted many of them from trying to improve the poor conditions in which detainees were held.

The condition of the court custody suites in Kent was among the worst we have seen. In many cells there was scarcely an inch of wall or door that was not covered in graffiti. Much of it was obscene or racist, and some contained allegations against named individuals. While some custody staff expressed shame at the state of the cells, many appeared inured to it. HMCTS managers had little awareness of the situation and were shocked when we showed them photographs we had taken. To make matters worse, cleaning was wholly inadequate at most courts. The cleaning and maintenance contractor was not fulfilling the terms of their contract and although HMCTS was aware of this, any action that had been taken had not brought about improvements. The filthy cells and the bleak corridors and interview rooms conveyed a profound disregard for those detained there.

Nevertheless, there had been some positive developments in Kent. Virtual courts, where detainees appear in court via a video link from the police station, were being piloted. They had the potential to reduce long journeys and waiting times in court cells. But HMCTS were unaware of how, in some instances, operational difficulties with virtual courts had meant some detainees remained in custody far longer than was reasonable or necessary.

This report contains recommendations that we hope will encourage the various agencies involved in the provision of court custody to work together more effectively to eliminate the serious problems we found. Those detained at Kent courts should be held in a safer and more decent environment than is currently in place.

Nick Hardwick February 2015
HM Chief Inspector of Prisons

Section 2. Background and key findings

2.1 This report is part of the programme of inspections of court custody carried out by HM Inspectorate of Prisons. These inspections contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

2.2 The inspections of court custody look at strategy, individual rights, and treatment and conditions, including health care. They are informed by a set of *Expectations for Court Custody*[1] about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.

2.3 Kent court custody suites comprised:

Custody suites	Number of cells
Sevenoaks Magistrates' Court	8
Margate Magistrates' Court	10
Maidstone Magistrates' Court	4
Dartford Magistrates' Court	5
Medway Magistrates' Court	5
Canterbury Magistrates' Court	6
Dover Magistrates' Court	9
Folkestone Magistrates' Court	8
Maidstone Crown Court	12
Canterbury Crown Court	11

Leadership, strategy and planning

2.4 Management of custody facilities in the Kent courts was fragmented and ineffectual. Court user groups met only in some courts; and physical conditions and detainee care were not discussed. The focus of inter-agency meetings was on the timely delivery of detainees to court, and we saw many examples of how a failure to address other concerns had contributed to unsatisfactory outcomes for detainees.

2.5 GEOAmey held the contract for staffing Kent's court custody suites and escorting detainees between police stations, courts and prisons on behalf of HM Courts and Tribunal Service (HMCTS). HMCTS were responsible for the court houses, including maintenance of the cells, but HMCTS managers acknowledged that they rarely visited the cells. Local relationships between HMCTS and GEOAmey were positive, but they had not led to any significant improvements in conditions in court custody.

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

2.6 Quality assurance processes barely addressed the conditions in which detainees were held: many court cells were dirty and covered in graffiti, and there were sometimes too few staff available to ensure adequate detainee care. Many custody staff lacked motivation, and in some courts, they were inadequately supervised. Contract monitoring had not been effective in improving outcomes for detainees: the processes in place had not led to improvements in physical conditions and had not brought about better care of vulnerable detainees.

2.7 The virtual court system pilot, which allows a detainee to appear at a magistrates' court via a video link in the police station, was reducing the number of journeys detainees made to court and was a promising development. However, HMCTS managers were not aware of some avoidable negative consequences such as longer stays in police custody.

Individual rights

2.8 Custody staff did not check warrants for detainees brought in by court enforcement officers so they had no way of knowing if they were detaining the right person.

2.9 Liaison with the local youth offending service (YOS) was good and we saw YOS staff attending court cells when young people were in custody. Placement orders were received from the Youth Justice Board promptly. Nevertheless, many detainees waited for unnecessarily long periods in court cells. Most were brought to court early in the morning but only had their cases heard in the afternoon. The majority who were dealt with early in the day had to remain in the cells until the evening as there was often no cellular vehicle available to transfer them to prison earlier. There were excessive delays in receiving the authority to release prisoners from the local remand prison HMP Elmley, and in one instance HMP Elmley unreasonably insisted on the return of a detainee for release the next day.

2.10 At most courts, we observed detainees being received without having their rights explained to them. However, it was good that during the inspection, some custody staff started briefing detainees more fully about their rights after we pointed out the importance of them offering this information.

2.11 A telephone interpretation service was available for custody staff, but could not be used at most courts because they did not have a room with a telephone in which detainees could be interviewed. We were told that sometimes court-appointed interpreters did not attend the court when they had been booked, which on some occasions meant the court had to remand the detainee in custody.

2.12 Detainees were not offered any information about how to complain. When escort staff failed to bring a detainee's property with him from the police station, he had to apply to the court for his bail conditions to be varied so he could return to the police station to collect it. He was not told he could make a complaint.

Treatment and conditions

2.13 Many cellular vehicles that we inspected were dirty. We were not convinced that the partitions, designed to separate male and female detainees and young people, were always used when they should have been. At some courts members of the public could watch detainees entering and leaving vehicles.

2.14 Custody staff were mostly friendly towards detainees. However, they lacked an awareness of the vulnerabilities and needs of specific groups and had received little training on these issues. We were very concerned when we heard a custody officer describe a transgender detainee as 'it' and another refer to a mentally ill detainee as a 'nutter'. Several complaints about cold cells had been resolved by custody staff who had purchased blankets, but they were withdrawn the next day by a GEOAmey manager who, we were told, considered blankets to be an unacceptable risk because detainees might use them to harm themselves.

2.15 Risk management was haphazard. Cell-sharing risk assessments (CSRAs) were either not completed at all, or only used information from person escort records (PERs). Some CSRAs were completed after the detainees had left court custody. Staff were unclear about how often they should attend cells to check detainees. We found that staffing levels were sometimes inadequate, with too few custody officers on duty to ensure detainees, staff and visitors were safe. For example, GEOAmey policy required two prisoner custody officers (PCOs) to be present in the cell corridor before a cell door was opened, but on occasions there were not two officers present, meaning that a PCO would be reluctant to open a cell door in an emergency. Some of the contractor's staffing arrangements undermined detainee care. Use of force was rare and recording it was unnecessarily onerous due to the large number of forms that GEOAmey required their staff to complete. Handcuffing was widespread and although we were told it was based on a risk assessment, we found no written risk assessments to justify it.

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

2.17 Staff had access to a telephone medical advice service but rarely used it, and some did not know the service could also despatch a paramedic if necessary. All custody staff were trained in first aid and knew what to do in an emergency, although the refresher course once every three years was not frequent enough to maintain staff's skills. There were no automated external defibrillators, oxygen or suction. Each custody suite had a first aid kit but they were not always suitable for custody or properly maintained. PERs from prisons did not contain enough detail to inform staff of a detainee's health-related risks, but custody staff recorded health interventions well. A mental health diversion scheme had led to the establishment of four specialist mental health courts in Kent, which was positive.

Main recommendations

2.18 Adult men, women and young people should not be carried in the same escort vehicle and detainees should be transferred from cellular vehicles to the court cells in private.

2.19 Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite.

2.20 Court custody staff should be trained to identify child protection or adult safeguarding concerns and when necessary refer vulnerable detainees to suitable agencies for support and protection.

2.21 A standard risk assessment pro-forma should be completed for each detainee, and staff should be trained in completing it.

2.22 Handcuffs should only be used if necessary, justified and proportionate.

2.23 There should be sufficient staff on duty at all times to ensure the safety of detainees, staff and visitors.

2.24 An immediate programme of redecoration should be put in place, with a regular programme of deep cleaning; and all graffiti should be removed.

National issues

2.25 HMCTS and Prison Escort and Custody Services should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody. Standards should address detainee care and risk assessment, clarify the responsibilities of each organisation for resolving problems, and enable complaints in court custody to be monitored. Complaints should be included in the measurement of performance.

2.26 HMCTS should ensure that the virtual court facilities are properly monitored and evaluated so that any adverse consequences for detainees are identified and reduced.

Section 3. Leadership, strategy and planning

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

3.1 In Kent, three organisations had responsibility for the planning and management of court custody and escort services: HM Courts and Tribunals Service (HMCTS), Prisoner Escort and Custody Services (PECS) - as contracted by the National Offender Management Service (NOMS), and the custody and escort contractor GEOAmey. Other organisations, including the local youth offending service (YOS), prisons, police and, the cleaning and maintenance contractor Mitie also had key roles. An active local lay observer group visited the court cells regularly and provided independent scrutiny of the conditions.

3.2 The main focus was on the prompt delivery of detainees to court. This took precedence over detainee care and risk management. Collective leadership was diffused and fragmentary, with nobody taking overall responsibility for conditions in the custody suites. A lay observer told us that getting problems resolved was difficult because 'they all seem to work in their separate bubbles.' Many of the concerns that lay observers noted in the records of their visits remained unresolved months and sometimes years later. Lay observer records were sent to GEOAmey managers, but HMCTS managers did not always see them. The lay observers met with PECS and GEOAmey but arrangements for contact between the lay observers and HMCTS managers were confused.

3.3 There were few structures to promote inter-agency communication. HMCTS representatives did not attend meetings between GEOAmey, PECS, and HMP Elmley regularly. The meetings discussed contract compliance and the prompt delivery of detainees, but they did not address other difficulties that were known about. These included the failure of HMP Elmley to authorise promptly the release of detainees directly from court, which unnecessarily prolonged the time some spent in court cells. There was little discussion of detainee care and there were no meetings that involved all the organisations responsible for court custody, so there was a lack of impetus to improve conditions. Court user groups did not meet regularly in all courts and where they did, not all were attended by GEOAmey staff. Minutes of a court user group, which involved GEOAmey representatives, showed no discussion of the deterioration in the physical condition of the cells.

3.4 HMCTS managers were unclear about their responsibilities regarding court custody. Some told us they were interested in GEOAmey policies about detainee care but did not believe they could influence them. Others acknowledged that they did not often visit the cells and knew little of what took place there. HMCTS told us the contractor Mitie had failed to meet the requirements of its contract with HMCTS. GEOAmey depended on Mitie for the cleaning and maintenance of cell areas, yet had little influence on its performance. The lack of control that organisations exerted over others contributed to the fragmentary and ineffectual nature of the management arrangements.

3.5 PECS regularly undertook court custody audits that focused on safety and decency, but there was little evidence that they led to better outcomes for detainees. For example, we found that an important procedure to protect vulnerable detainees, cell-sharing risk assessments, was often applied by staff largely as a box-ticking exercise, or not done at all (see section on treatment and conditions). Daily contact between GEOAmey senior custody officers (SCOs) and court clerks was good and relationships were mainly positive. However, a drawback of this was that informal arrangements were made between SCOs and ushers to not report instances when there was insufficient custody staff to provide a PCO in every court dock.

That resulted in PECS contract monitors not always being alerted to staffing difficulties in custody.

3.6 The GEOAmey policy, which allowed staff little discretion, led to some disproportionate and unreasonable treatment, such as the handcuffing of compliant detainees who posed little risk. We were told that these decisions were made following a systematic risk assessment, as staff were unable to show us any risk assessments, the process was therefore not open to scrutiny.

3.7 Quality assurance focused on security and timeliness, not on detainee care. At some courts, custody staff were not adequately supervised: at Maidstone Crown Court the SCO's heavy workload and the layout of the custody suite made it difficult for him to observe staff's interactions with detainees, including when they were being searched and placed in a cell. A detainee asked a PCO why he was handcuffed from the searching area to his cell. The PCO shouted at him that he should just get in the cell, and made no attempt to offer an explanation. The SCO knew nothing of that interaction until we brought it to his attention. There was little formal contact between SCOs, which might have enabled them to share good practice and develop better provision. We were told that a weekly telephone conference held between SCOs and GEOAmey local managers was concerned mainly with targets about the prompt delivery of detainees and staff deployment.

3.8 There was no HMCTS safeguarding protocol, and custody staff told us they would have liked to have had child protection training. They relied on other organisations to take appropriate steps to safeguard children and vulnerable adults, which was unsatisfactory.

3.9 The piloting of virtual courts in Kent, where detainees appear in court via a video link in the police station, was a welcome development. It reduced the number of journeys detainees had to make in cellular vehicles and prevented them from being held for long periods in court cells to attend short hearings for what were often procedural matters. However, some significant difficulties in the system had not been identified. The failure to collect detainees from police stations following a virtual court hearing often meant detainees spent longer than necessary in police cells. This was not included in management information reports and would not necessarily have come to the attention of PECS, despite the implications for detainees.

3.10 The virtual court did not inform staff in the court custody suites when someone had been remanded in custody to appear in person at a later date and not all SCOs at the magistrates' courts received court lists of detainees. This lack of communication meant SCOs could not bid for extra staff in advance, as they were not always aware of the demands that would be placed on their services. Arrangements to evaluate the virtual courts pilot were at the time of the inspection being put in place.

Recommendations

3.11 There should be regular inter-agency forums covering all courts in the cluster; their remit should include improvements in the care of detainees during escort and court custody.

3.12 Quality assurance processes should more effectively cover key elements of detainee care and rights during escort and court custody.

3.13 HMCTS should ensure custody staff receive information about virtual court hearing outcomes so that staffing and other resource needs can be planned for.

Housekeeping points

3.14 HMCTS managers at all courts should regularly visit the cells for which they are responsible so that any problems can be readily understood and resolved.

3.15 GEOAmey should facilitate communication between SCOs to develop and implement ideas for improving detainee care.

Section 4. Individual rights

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

4.1 At most courts, custody officers checked the documentation that accompanied each detainee to ensure they had the correct authority to detain, but this was usually done once the detainee had already been placed in their cell. Some custody staff told us that when court enforcement officers (CEOs) brought detainees into the cells, they did not see the warrant. In these circumstances, staff relied on CEOs having made all necessary checks prior to arrest to ensure they were detaining the correct person.

4.2 Custody staff checked the accuracy of outgoing warrants, which court clerks processed promptly. This worked well at Folkestone Magistrates' Court, where the senior custody officer identified an error in a remand warrant, which the clerk amended, alleviating any problems when the detainee was transferred to prison.

4.3 A regional policy prioritised cases involving young people and vulnerable adults, but it was not always implemented (see paragraph 4.5 below). Staff at most courts identified cases involving young people so that the court clerk could deal with them in the morning to minimise the time they spent in the cells. Staff at all courts said they had a good relationship with their local youth offending service (YOS). All courts had procedures to ensure that YOS staff were aware of all children and young people in the court cells. We observed YOS staff visiting the court cells promptly once a young person had been dealt with and placement orders for young people were processed quickly. However, this did not always mean young detainees were transferred promptly. We were told about a case at Maidstone Magistrates' Court on 9 June 2014, in which two young men were sentenced at 4.30pm, but were subsequently taken to a neighbouring police station at 9.30pm because the escort contractor failed to pick them up to transport them to Medway Secure Training Centre.

4.4 Interim warrants were accepted at all local prisons so that detainees could be transferred; however transportation was not always readily available. We found several cases where adult detainees remained in court custody for an unreasonably long time. Most were brought to court early in the morning but only had their cases heard in the afternoon. At Maidstone Magistrates' Court we observed one detainee, who was remanded at 10.45am but was not transferred to prison until 5pm. At Dover Magistrates' Court on a Saturday, four detainees were dealt with by 11.45am and were remanded to prison. On being booked in at HMP Elmley, custody staff were advised they could not accept them before 1.30pm, when the prison reception opened. We were told that this was common at HMP Elmley and meant detainees waited too long in court cells before being taken to prison.

4.5 At some courts, we observed detainees being accepted from police custody throughout the day, when the virtual court, which allows a detainee to appear at a magistrates' court via a video link in the police station, was booked to capacity or when it was possible some cases might not be heard. At Medway Magistrates' Court one day, three detainees who had been in court custody since around 8am were not dealt with until 3pm. The delay was partly due to the virtual court also being the court dealing with custody cases that day, and it heard virtual court hearings first. This was a source of concern because two of the detainees were known to be at risk of self-harm and according to the local listings policy they should have been heard early in the day.

4.6 Custody staff informed us that there were often delays in securing the authority from HMP Elmley to release detainees who had come from prison and had then been bailed or released by the court. This could frequently take two hours, especially if authority was sought over lunchtime. We saw delays ranging from 45 minutes up to two hours 15 minutes; the latter (at Maidstone Crown Court) was excessive. This meant detainees, who should have been released, spent excessively long periods in court cells, often leading to avoidable stress and frustration. We were concerned to find a detainee who was made subject to a suspended sentence was returned to HMP Elmley to be released the next day. This was because the prison insisted they could not, after 5.00pm, authorise court custody staff to release prisoners.

4.7 At most courts, custody staff told us that they were not authorised to make telephone calls on detainees' behalf and would refer the matter to their legal representatives. A few staff told us that, in exceptional circumstances, they would make a telephone call to inform someone of a detainee's whereabouts.

4.8 We were concerned that at most courts and with some exceptions, detainees were told nothing about their rights, despite there being a small notice on the wall at each stating that they would be. Several detainees we spoke to confirmed that they had not been informed of their rights and were not aware of what they were. Some staff said to detainees on their arrival '… you know your rights …', but the overriding opinion from staff was that the detainees they dealt with were 'regulars' and therefore already knew their rights and did not need to be reminded of them. This was poor practice. Later during the inspection, we found some, but not all, custody staff providing detainees with information about their rights. At Canterbury Crown Court the rights notice was placed on the bench in each cell and detainees were told about it, but staff did not check whether or not detainees could read. At Canterbury Magistrates' Court two Romanian detainees were not issued with a notice of their rights in their first language, despite it being available in 32 different languages on the GEOAmey intranet. All courts had a rights poster in 28 different languages; however it was not used to help detainees who could not speak English.

4.9 Staff ensured that all detainees had legal representation when they arrived at the custody suite by liaising closely with court ushers. We saw legal representatives being allowed access to detainees in a suitable interview room. At all courts custody staff said they would provide detainees wishing to prepare for their defence with a pencil and paper if they asked for them and we saw this taking place at Maidstone Crown Court. But at Folkestone and Margate magistrates' courts, staff told us that, to try to prevent further graffiti in the cells, they would only give a detainee a pencil in the presence of a legal representative. The failure to control graffiti by legitimate means (see section on treatment and conditions) had unanticipated, wider implications for detainees; in this instance, depriving them of the means to make notes in preparation for their defence. Detainees at all courts were allowed to keep hold of legal documents relevant to their case.

4.10 There was a telephone interpretation service provided by GEOAmey, but in practice, access to the service was impossible at all but Canterbury Crown Court (where a member of staff had provided a portable telephone) because detainees were not permitted to enter staff offices where a telephone was installed.

4.11 Custody staff attempted to communicate with detainees who could not speak English through gestures to ensure their basic needs were met, for example, offering drinks and meals; however, they could not engage in any meaningful interaction about the detainee's emotional state following a court appearance, which was a significant risk. At Canterbury Magistrates' Court two Romanian detainees had been remanded in custody over the weekend when the court-appointed interpreter failed to attend court. When they returned to court, one of the detainees was found to have an outstanding warrant, which meant that

he needed to be taken to another court. Staff acknowledged it was unsatisfactory that they could not explain to him what was happening or ask him about his welfare.

4.12 Information about how to make a complaint was included in the rights documentation, which was not routinely handed out to detainees. Custody staff were aware of the complaints process; however they were unclear about who would investigate a complaint. Information about making a complaint was displayed in some, but not all, courts. GEOAmey data showed that 14 complaints about court custody had been received in the previous six months, mostly about detainees' property and long stays in custody. There was no information about the outcome of any investigations.

4.13 At Medway Magistrates' Court, a detainee was not asked if he wished to complain when his property, which escort staff had signed for, had been left behind at the police station. This resulted in the detainee having his bail conditions amended so he could enter the area where the police station was located to collect his property. Custody staff did not inform detainees of their right to make a complaint, even when they expressed dissatisfaction during their detention, this might account for so few complaints being received.

Recommendations

4.14 HMCTS should liaise with the young person escort contractor to reduce delays in transferring young people to more appropriate custodial facilities.

4.15 Escort vehicles should be available to take detainees to custodial establishments as soon after the completion of their court case as is practicable.

4.16 HMCTS should liaise with HMP Elmley regarding its hours of operation for receiving prisoners at the weekend and its arrangements for authorising release at court.

4.17 Detainees should be told about their rights on arrival at all courts, including the process for making a complaint; staff should find out if detainees can read and where they cannot, offer to read or explain the information to them.

4.18 The services of a telephone interpretation service and the means to contact it should be available to ensure detainees and court custody staff communicate effectively.

4.19 Complaints should be logged and there should be a process for monitoring and analysing trends.

Housekeeping point

4.20 Writing material should be provided at all courts to detainees who wish to prepare for their court appearance.

Section 5. Treatment and conditions

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

Respect

5.1 Many of the cellular vehicles we inspected required a deep clean and one we saw at Maidstone Magistrates' Court had graffiti in it. Escort staff told us that other than being swept, the vehicles were only cleaned once a month, which was inadequate. Cellular vehicles had first aid kits containing anti-ligature knives, and drinking water was available.

5.2 Staff told us that they regularly carried women, young people and adult men in the same vehicle but they did not always use the partition to screen the front and rear section of the vehicle. We checked one vehicle to see if the partition worked and found it could not be put in place. The lack of separation could have adverse consequences because women and young people are sometimes subject to harassment or verbal abuse from other detainees on cellular vehicles.

5.3 Journeys from police custody to court were mostly short, as were those from local prisons (HMP Elmley and HMYOI Cookham Wood). Female detainees held at HMP Bronzefield had a longer journey (over two hours). In the case of one woman at Canterbury Crown Court, the judge took this into consideration, ensuring that proceedings ended at 4pm each day, which allowed her to return to prison at a reasonable time.

5.4 Escort staff in most instances ensured that all necessary information about detainees accompanied them to court, although there was a notable exception during the inspection when a detainee arrived At Canterbury Magistrates' Court with another detainee's person escort records (PER). Detainees arriving at court from prison were accompanied by part of their prison files in case they were further remanded or sentenced and returned to a different establishment. These files were bagged and securely sealed.

5.5 PERs accompanying detainees from prison were mostly completed to a reasonable standard but we saw some from HMP Elmley that were poor: for example, they contained self-harm markers but no detail of what was involved or when the self-harm had occurred. Custody staff told us this was a continuing problem and we were advised that during Crown court trials it was not unusual for detainees' PERs to contain different markers on different days. Court custody staff checked PERs to ensure that all relevant information was transferred to GEOtrack (the custody computer system); however, in the majority of cases this was done after detainees had already been placed in their cells.

5.6 All detainees disembarked promptly from vehicles into court buildings. The vehicle bays at Dartford, Margate and Medway magistrates' courts offered detainees getting on and off the escort vehicles little or no privacy. The vehicle bay at Dover Magistrates' Court was too small for most of the cellular vehicles, which meant detainees had to enter and leave vehicles in the unsecure rear yard, overlooked by flats and a bandstand in an adjacent park.

5.7 Custody staff were mainly courteous and had good inter-personal skills. However, once detainees had been placed in a cell, many staff interacted very little with them. Observations were mostly done through the cell door window or observation panel instead of opening the door. Staff said they had received little specific training on diversity, child protection or mental health, but thought they would have benefited had this been provided. The need for staff development was apparent on several occasions. For example, we were very concerned when we heard a custody officer describe a transgender detainee as 'it' and another refer to a mentally ill detainee as a 'nutter'.

5.8 Most courts had a separate female corridor; in the courts where this was not available staff took some steps to consider where they should be located. Female detainees were not routinely asked if they were pregnant or routinely offered feminine hygiene products. At some courts feminine hygiene products were available in the toilet area; others had notices indicating their availability. At Maidstone and Sevenoaks Magistrates' courts, staff struggled to find feminine hygiene products.

5.9 There were no blankets and no pillows, so pregnant, elderly or disabled detainees had to wait on hard benches. At Maidstone Crown Court we were told that the SCO had purchased some blankets for detainees to use when the heating had been faulty, but that GEOAmey management had withdrawn them two days later on the grounds that they could be used for self-harming.

5.10 Detainees were not asked about religious observance, dietary requirements or any other needs on arrival at court. Some of the custody suites had religious books but none had access to prayer mats. Staff thought that if a detainee required a prayer mat, they would bring one with them, failing to take into account the fact that some detainees arrived at court from police custody and not necessarily from prison. Some courts had a compass and at Maidstone Magistrates' Court a poorly drawn Qibla (which shows the direction of Mecca) was on some cell walls, but it was difficult to differentiate it from the graffiti (see section on physical conditions).

5.11 We were told that Maidstone Magistrates' and Crown courts were designated for disabled detainees, but other than a ramp at the rear door, no adaptations had been made in any of the cells. The magistrates' court dock that was designated for disabled detainees could not accommodate a wheelchair. At Maidstone Crown Court the stair lift into the custody suite had not worked for over a month. There were no hearing loops in any of the custody suites and none had any information in Braille.

5.12 Custody staff told us of various approaches to searching a transgender detainee, not all of which were appropriate. Some said the search would be conducted by a female prison custody officer as they were authorised to search both sexes, which is reasonable; though it would be better to ask a transgender person about their preferences. The GEOAmey standard operating procedure (SOP) continued to provide unclear advice and should be consistent with police and Prison Service guidance.

5.13 There was no specific provision for children and young people and no named member of staff allocated to their care. At some courts there was a designated cell for young people and at others, staff tried to ensure that they were not located close to adults. At Maidstone Magistrates' Court it was clear from records that most young people were held in a single female cell with the door left open, but with the corridor gate secured. This allowed the young person access to the adjacent toilet and was a positive attempt to reduce the impact of detention. At Canterbury Crown Court young people could wait with their carers in a family visits room. However, it was only used when the cells were full. Staff were unclear about safeguarding procedures for young people or vulnerable adults. The GEOAmey standard operating procedure (SOP) on young people contained minimal guidance. Custody staff told us they would contact their line manager, probation or the youth offending service

(YOS) if they were concerned about a detainee in their care. They knew little about what they should do if such advice was not readily available.

5.14 Custody staff at all courts generously brought in old newspapers and magazines for detainees as GEOAmey did not provide reading material; we saw staff handing them out to detainees at most courts. At Canterbury Crown Court staff had also supplied crosswords and word search booklets. At most courts, there was no reading material in foreign languages or easy-read format, and nothing suitable for young people.

5.15 Arrangements for securing detainees' property were mostly satisfactory. At Canterbury Crown Court we observed that HMP Elmley failed to send any property with detainees attending court. We saw two detainees sentenced and released by the court. Both were provided with a travel warrant to return to their home address, but were advised to contact the prison by telephone to arrange a suitable time to collect their property. Both detainees were understandably upset that they were unable to retrieve their property that day. It was unclear if the issue, which had persisted for some time, had been raised as a concern with the prison.

5.16 All courts provided detainees with hot and cold drinks on arrival and at regular intervals. Food was provided only at standard mealtimes at Medway Magistrates' Court, although other courts had more flexibility, depending on when the detainee had last eaten. At all the courts staff provided detainees with a hot microwave meal before they returned to prison in the evening. We found a small number of microwave meals that were out of date at a few courts. Food preparation areas were normally shared with the staff kitchen and were mostly hygienic, however the microwave ovens at a number of courts needed to be cleaned.

Recommendations

5.17 Cellular vehicles should be clean and free of graffiti.

5.18 Custody officers should receive sufficient training to meet the diverse needs of the detainees held in court custody.

5.19 All court custody suites should have a copy of the holy books of the main religions, a suitable prayer mat that is respectfully stored and a reliable means of determining the direction of Mecca.

5.20 Designated courts that meet the needs of disabled detainees should be accessible and all court custody suites should have hearing loops as well as Braille versions of key information.

5.21 GEOAmey should produce a policy, in line with police and Prison Service guidance, setting out the correct approach to caring for transgender detainees and ensure that staff implement it.

5.22 Staff should be briefed on how to make referrals under the local authority's safeguarding procedures if they have concerns about any young people or vulnerable detainees.

5.23 Young people in court custody should be supported by a named staff member trained to work with young people

5.24 GEOAmey should liaise with HMP Elmley to improve the transfer of information and completion of detainees' PERs and ensure that property belonging to detainees travels with them to court.

5.25 All courts should have a stock of appropriate reading material, including some suitable for young people and non-English speakers.

Housekeeping points

5.26 Staff should routinely inform all female detainees of the availability of feminine hygiene packs.

5.27 Mattresses and blankets or warm clothing should be available for all detainees.

5.28 Microwave ovens should be kept clean.

Safety

5.29 Custody staff at all courts received an early morning briefing, which varied in quality. At some courts SCOs convened briefings about detainees coming into custody to highlight any warning markers, discuss cell allocations and confirm staff duties. Elsewhere the briefing did not include anything about detainees, but focused mainly on security and details of any changes in GEOAmey policy; not all staff on duty were always at the briefings.

5.30 During the inspection we had significant concerns over staffing levels. At Dartford Magistrates' Court only one permanent custody officer was on duty. As a result, the officer had to anticipate if a defendant was going to be remanded or sentenced to custody so that additional staff could be requested. On one day a detainee was unexpectedly remanded into custody, which meant the prisoner custody officer (PCO) had to sit in the dock with the detainee until a vehicle crew arrived to escort the detainee to the court cells. The practice of having court custody staffed by only one permanent officer incurred unacceptable risk.

5.31 At Maidstone Crown Court the cell block was sometimes left unsupervised when staff were dealing with legal representatives or female detainees in a separate corridor some distance from the main cell block. At Medway Magistrates' Court, the SCO could not allocate an officer to a court dock on two occasions because it would have left her on her own with two detainees. There were further examples of detainee care and safety being compromised.

5.32 Court custody staff did not complete a systematic risk assessment when detainees arrived. Other than responding to obvious vulnerabilities, such as medical issues, staff did not routinely interact with detainees to determine how they were or if there was anything to be concerned about while they were in their care. The exception to this was the SCO at Canterbury Crown Court who spoke to a vulnerable detainee at Dover Magistrates' Court, whom police had earlier placed on a constant watch. Staff were aware of the process involved when supporting detainees subject to assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm and adopted the level of observations indicated on the document.

5.33 Staff knew they had to carry out cell-sharing risk assessments (CSRAs). Nevertheless, CSRAs were either not completed or were based solely on information from PERs, which was often vague or incorrect. At Canterbury Crown Court we found that eight CSRAs had been completed on the same day, but this had been done en masse and failed to identify who shared which cells with whom. At Medway Magistrates' Court we observed that two men,

who had self-harm markers, shared a cell for a whole day; their CSRAs were only completed once they had been released. This potentially put them at risk.

5.34 We were concerned that staff told us differing and inconsistent information about frequency of observations. They were unclear about how often they should conduct standard checks, though it was good that they all knew they should observe vulnerable detainees every 10 minutes. Staff at most courts checked cells regularly but most only took a cursory look through the cell door or observation window without interacting with the detainee. Sometimes, the checks were not recorded on the GEOtrack detention log. At Dover Magistrates' Court too few staff were available to conduct a constant watch. As a result the SCO placed the detainee in a glass-fronted interview room directly opposite the main office so that he could be observed intermittently. The detainee's case was subsequently expedited by the court, allowing him to be released within a short period of time, which was good.

5.35 None of the staff on cell duties carried anti-ligature knives. In the majority of the custody suites, the anti-ligature knives were held inside first aid kits or, in desk or filing cabinet drawers, delaying access if they were required in an emergency. The anti-ligature knives were only suitable for cutting thin ligatures, except at Sevenoaks Magistrates' Court and Canterbury Crown Court, where the cutters were more robust. Detainees could not have social or domestic visits, unless directed by the court.

5.36 Other than at Medway Magistrates' Court, there were no significant delays in transferring detainees from cells to the courtroom. Routes to courts were not always secure and some passed through public areas where detainees would be escorted in handcuffs, which was unacceptable. At Sevenoaks Magistrates' Court the route to court was unsafe because it was cluttered with old court furniture, electrical equipment and a spiked umbrella.

5.37 Most courts had affray alarms in the docks, corridors and stairs, while at some, custody staff had access to personal affray alarms attached to their belts. During the inspection, an affray alarm was activated in the dock at Folkestone Magistrates' Court but it was not audible in the cell area, and court staff had to telephone the custody suite for assistance. It was claimed the alarms had been checked that morning, but when the alarm was activated again in the cell area, it still did not sound; demonstrating that the programme of daily checks was not always effective.

5.38 Use of force was rare but all staff received annual training in control and restraint techniques. Staff advised us they would initially use communication skills to de-escalate any potentially volatile situations, which is what happened at Folkestone Magistrates' Court when a detainee conducted a 'dirty protest' in the court dock. Staff were aware of the need to record use of force but not all of them knew that GEOAmey policy required them to complete five different forms, which was excessive.

5.39 Detainees were routinely handcuffed when entering and leaving cellular vehicles. If this meant entering an insecure area, the detainees were double-cuffed to a member of staff; within secure areas, they were single-cuffed to a member of staff. At most courts detainees were handcuffed to and from legal interviews. The GEOAmey policy, which allowed staff little discretion, led to some disproportionate and unreasonable treatment, including the handcuffing of compliant men, women and children. We were told that detainees were handcuffed if a risk assessment indicated this was required, but we saw no evidence of risk assessments to justify it. Although the SOP stated that detainees who were bailed or acquitted should be returned to the cell area for release without the use of handcuffs, this was not consistently applied across all courts.

5.40 Custody staff were diligent in ensuring that information about risk was passed on to the prison when necessary. They completed a Prison Service personal record form and, if required, a suicide or self-harm warning form. However, with detainees that were released,

no pre-release risk assessments were carried out and there was no systematic way of checking if they had any immediate needs that should be addressed as they left court. GEOAmey required staff to complete a checklist on release that focused on security, but mostly staff completed it after the detainee had left the custody suite.

5.41 All courts had copies of documentation containing information about what to expect in prison for newly remanded or sentenced detainees and we saw this being given to detainees on a number of occasions. It was also available in a range of languages on the GEOAmey intranet; we saw a Lithuanian detainee at Dover Magistrates' Court receive a copy in his first language. The majority of courts had information leaflets outlining what to expect in the first 24 hours of arriving at HMP Elmley, HMP Bronzefield and HMYOI Cookham Wood. However, a 16-year-old who was sentenced at the youth court at Folkestone Magistrates' Court did not receive information about HMYOI Cookham Wood.

5.42 None of the custody suites had any information leaflets about local support organisations for potentially vulnerable detainees. Travel warrants for trains were available at all courts; however, despite petty cash being available, it was not used to provide cash for bus fares.

Recommendations

5.43 CSRAs should be completed for all detainees who are subject to them prior to any cell-sharing taking place.

5.44 The outcome of cell visits should be communicated to the member of staff updating GEOtrack and records should properly reflect this.

5.45 Staff undertaking observations and cell visits should carry anti-ligature knives at all times.

5.46 Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave custody.

5.47 Each court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages.

Housekeeping points

5.48 Vulnerable detainees should be able to receive social visits in exceptional circumstances.

5.49 Personal affray alarms should be checked on issue.

5.50 Prisoner release check lists should be completed prior to a detainee being released.

5.51 Cash for bus fares should be available where travel by train is not suitable to allow a detainee to return home.

Physical conditions

5.52 The majority of court cells were filthy and in a deplorable condition with ingrained dirt in corners and stains down the walls. It was apparent that cells had not been deep cleaned for some time; SCOs at many of the courts had requested that a deep clean be undertaken but they had not materialised. There was graffiti in almost all cells, some of which was offensive, pornographic, racist and misogynist, and in some cases had obviously been there for years. In one cell at Folkestone Magistrates' Court there was a swastika and graffiti containing the phrase 'Muslim scum'; the graffiti at Medway Magistrates' Court was particularly offensive. The exception was at Dartford and Sevenoaks Magistrates' courts, and Canterbury Crown Court where there was a little graffiti; however cleaning at the Crown court was unsatisfactory. Lay observer reports that had been forwarded to GEOAmey managers demonstrated that the poor condition of the estate had been highlighted for many months but no action had been taken. Many custody officers appeared to have become used to the poor condition of the cells.

5.53 Detainees at all courts could use a toilet in a cell corridor in privacy. However, some toilets were dirty and unhygienic. The toilets at Folkestone and Margate Magistrates' courts needed to be de-scaled. Toilet paper was available in all toilets, but in some cases it was lying on the floor. Hand-washing facilities and a supply of soap and paper towels were also available.

5.54 Staff at all courts carried out daily checks of the cells, which included ensuring no property had been left behind or hidden. They reported that there were often significant delays in getting basic faults repaired. Staff often failed to note the prevalence of offensive graffiti in their records of cell checks.

5.55 All courts had fire evacuation procedures with which staff were familiar, however some were unclear where they should go in the event of a fire. The confusion appeared to have occurred due to a very recent change in GEOAmey policy. During the inspection Maidstone Crown Court held a full evacuation, which was well conducted. Most staff could not recall when there had last been a fire drill. Staff told us they had valued training recently organised by GEOAmey at Folkestone Magistrates' Court and Canterbury Crown Court to simulate how to deal with bomb threats and a death in court custody.

5.56 Staff checked call bells were working on a daily basis. They did not routinely explain the use of cell call bells to detainees, except when it had been established that it was a detainee's first time in custody. At all courts, staff answered cell call bells promptly, which is good.

Housekeeping point

5.57 Emergency evacuation drills should be conducted and recorded at all courts.

Health

5.58 Taylor-Made provided telephone medical advice and site visits if required. Custody staff knew there was a health provider, although not all were aware that site visits were possible and the service was not adequately advertised in most suites. Custody staff reported that the demand for health services was low and they would usually call the establishment from which detainees had first come for advice. Taylor-Made staff had attended two separate court custody suites in the six months to June 2014 within contracted response times. Ambulance response times for emergencies were reported to be good.

5.59 Custody staff said that incidents requiring first aid intervention were rare. All staff were qualified first aiders and received updates every three years; however, we were concerned that the low number of reported problems meant training every three years was too infrequent to maintain an adequate skills level among staff. None of the court buildings had an automated external defibrillator (AED), oxygen or suction, which could have delayed an appropriate emergency response. The first aid kit in each suite was inadequate for predictable emergencies, such as heart attacks, major self-harm or scalds, and the standardised kit list had insufficient stock for the larger sites. Checking procedures were inconsistent and we found expired or insufficient stock in several suites.

5.60 Custody staff identified health concerns from the PER forms and did not ask detainees about their health on arrival. Most PER forms we examined contained little health information and generally did not clarify health risks, which made it difficult for custody staff to provide effective care. Health interventions were consistently recorded on the PER form.

5.61 Some detainees arrived from prison with medication and clear instructions for administering it; staff recorded the information on the PER at relevant times. The medication was generally stapled to the PER and stored in the office. Staff reported that detainees sometimes arrived from police custody without medication that was due to be administered while they were at court. Most staff we spoke to were not aware of the GeoAmey drug administration policy, but they all described appropriate safe practices.

5.62 Kent and Medway NHS and Social Care Partnership Trust provided court mental health diversion and liaison services (so that detainees with a mental health problem could be referred to appropriate specialist provision) since June 2013 at four designated mental health magistrates' courts. The trust also provided input at the Crown courts when required. Police and probation staff could refer people who were due to attend court and had mental health problems for assessment and guidance on sentencing options. A forensic mental health nurse was based at Folkestone Magistrates' Court on Monday, Maidstone on Wednesday, Medway on Thursday and Margate on Friday. A consultant forensic psychiatrist was available for advice and to carry out assessments. Maidstone had generated 104 (38%) of the 271 referrals received in the first year. Court and probation feedback about the service was very positive, but there was no clear process for custody staff to raise concerns about detainees' mental health. Young people received mental health support through the YOS.

5.63 Although court mental health diversion services were responsive and attended court when needed, mental health services in the community were difficult to engage. We observed an excessive delay in a detainee's transfer to NHS mental health facilities because of a lack of community mental health staff to complete the necessary assessments. As a result he was remanded in custody, experiencing a weekend in prison and a further long stay in court custody.

5.64 Most custody staff we spoke to demonstrated a reasonable awareness of mental health issues, but had not received any formal mental health awareness training to enable them to identify or manage mental illness effectively. We heard custody staff at two courts use unacceptable disrespectful language about a detainee with enduring mental health problems including the terms 'nutter', 'not the full ticket' and 'a bit simple' (see also paragraph 5.7).

5.65 Custody staff reported, and we observed, a minimal demand for substance misuse services, which were available in both the police suites and in relevant prisons. However, no information on local services was available. The probation service referred detainees who were being considered for drug treatment orders to the local drug agency. Custody staff had a reasonable awareness of substance misuse issues but most lacked any formal training.

Recommendations

5.66 All staff should receive annual updates in first aid training tailored for the environment to maintain an adequate skill level.

5.67 First aid kits should contain sufficient up-to-date equipment, including an AED and devices for maintaining an airway and staff should be trained to use the equipment.

5.68 PERs should clearly identify the health risks for each detainee and ensure confidentiality is appropriately maintained.

5.69 All detainees who require prescribed medication while in court custody should have access to it.

5.70 Emergency assessments under the Mental Health Act should be available within the designated response time.

5.71 Custody staff should have regular training and clear guidance to identify, support and appropriately refer detainees who may be experiencing mental health or substance use-related problems.

Housekeeping points

5.72 Custody staff should confirm with detainees if they have any medical issues on arrival.

5.73 The service offered by the medical provider should be well advertised within each suite and fully understood by all staff.

5.74 All custody staff should be conversant with the GEOAmey drug administration policy.

5.75 Detainees should have access to literature on local and national substance misuse support services.

Good practice

5.76 The designated mental health courts provided targeted support to detainees with mental health problems

Section 6. Summary of recommendations and housekeeping points

Main recommendations

6.1 Adult men, women and young people should not be carried in the same escort vehicle and detainees should be transferred from cellular vehicles to the court cells in private. (2.18)

6.2 Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite. (2.19)

6.3 Court custody staff should be trained to identify child protection or adult safeguarding concerns and when necessary refer vulnerable detainees to suitable agencies for support and protection. (2.20)

6.4 A standard risk assessment pro-forma should be completed for each detainee, and staff should be trained in completing it. (2.21)

6.5 Handcuffs should only be used if necessary, justified and proportionate. (2.22)

6.6 There should be sufficient staff on duty at all times to ensure the safety of detainees, staff and visitors. (2.23)

6.7 An immediate programme of redecoration should be put in place, with a regular programme of deep cleaning; and all graffiti should be removed. (2.24)

National issues

6.8 HMCTS and Prison Escort and Custody Services should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody. Standards should address detainee care and risk assessment, clarify the responsibilities of each organisation for resolving problems, and enable complaints in court custody to be monitored. Complaints should be included in the measurement of performance. (2.25)

6.9 HMCTS should ensure that the virtual court facilities are properly monitored and evaluated so that any adverse consequences for detainees are identified and reduced. (2.26)

Recommendations

Leadership, strategy and planning

6.10 There should be regular inter-agency forums covering all courts in the cluster; their remit should include improvements in the care of detainees during escort and court custody. (3.11)

6.11 Quality assurance processes should more effectively cover key elements of detainee care and rights during escort and court custody. (3.12)

6.12 HMCTS should ensure custody staff receive information about virtual court hearing outcomes so that staffing and other resource needs can be planned for. (3.13)

Individual rights

6.13 HMCTS should liaise with the young person escort contractor to reduce delays in transferring young people to more appropriate custodial facilities. (4.14)

6.14 Escort vehicles should be available to take detainees to custodial establishments as soon after the completion of their court case as is practicable. (4.15)

6.15 HMCTS should liaise with HMP Elmley regarding its hours of operation for receiving prisoners at the weekend and its arrangements for authorising release at court. (4.16)

6.16 Detainees should be told about their rights on arrival at all courts, including the process for making a complaint; staff should find out if detainees can read and where they cannot, offer to read or explain the information to them. (4.17)

6.17 The services of a telephone interpretation service and the means to contact it should be available to ensure detainees and court custody staff communicate effectively. (4.18)

6.18 Complaints should be logged and there should be a process for monitoring and analysing trends. (4.19)

Treatment and conditions

6.19 Cellular vehicles should be clean and free of graffiti. (5.17)

6.20 Custody officers should receive sufficient training to meet the diverse needs of the detainees held in court custody. (5.18)

6.21 All court custody suites should have a copy of the holy books of the main religions, a suitable prayer mat that is respectfully stored and a reliable means of determining the direction of Mecca. (5.19)

6.22 Designated courts that meet the needs of disabled detainees should be accessible and all court custody suites should have hearing loops as well as Braille versions of key information. (5.20)

6.23 GEOAmey should produce a policy, in line with police and Prison Service guidance, setting out the correct approach to caring for transgender detainees and ensure that staff implement it. (5.21)

6.24 Staff should be briefed on how to make referrals under the local authority's safeguarding procedures if they have concerns about any young people or vulnerable detainees. (5.22)

6.25 Young people in court custody should be supported by a named staff member trained to work with young people. (5.23)

6.26 GEOAmey should liaise with HMP Elmley to improve the transfer of information and completion of detainees' PERs and ensure that property belonging to detainees travels with them to court. (5.24)

6.27 All courts should have a stock of appropriate reading material, including some suitable for young people and non-English speakers. (5.25)

6.28 CSRAs should be completed for all detainees who are subject to them prior to any cell-sharing taking place. (5.43)

6.29 The outcome of cell visits should be communicated to the member of staff updating GEOtrack and records should properly reflect this. (5.44)

6.30 Staff undertaking observations and cell visits should carry anti-ligature knives at all times. (5.45)

6.31 Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave custody. (5.46)

6.32 Each court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages. (5.47)

6.33 All staff should receive annual updates in first aid training tailored for the environment to maintain an adequate skill level. (5.66)

6.34 First aid kits should contain sufficient up-to-date equipment, including an AED and devices for maintaining an airway and staff should be trained to use the equipment. (5.67)

6.35 PERs should clearly identify the health risks for each detainee and ensure confidentiality is appropriately maintained. (5.68)

6.36 All detainees who require prescribed medications while in court custody should have access to it. (5.69)

6.37 Emergency assessments under the Mental Health Act should be available within the designated response time. (5.70)

6.38 Custody staff should have regular training and clear guidance to identify, support and appropriately refer detainees who may be experiencing mental health or substance use-related problems. (5.71)

Housekeeping points

Leadership, strategy and planning

6.39 HMCTS managers at all courts should regularly visit the cells for which they are responsible so that any problems can be readily understood and resolved. (3.14)

6.40 GEOAmey should hold regular meetings with SCOs to share ideas and develop practice. (3.15)

Individual rights

6.41 Writing material should be provided at all courts to detainees who wish to prepare for their court appearance. (4.20)

Treatment and conditions

6.42 Staff should routinely inform all female detainees of the availability of feminine hygiene packs. (5.26)

6.43 Mattresses and blankets or warm clothing should be available for all detainees. (5.27)

6.44 Microwave ovens should be kept clean. (5.28)

6.45 Vulnerable detainees should be able to receive social visits in exceptional circumstances. (5.48)

6.46 Personal affray alarms should be checked on issue. (5.49)

6.47 Prisoner release check lists should be completed prior to a detainee being released. (5.50)

6.48 Cash for bus fares should be available where travel by train is not suitable to allow a detainee to return home. (5.51)

6.49 Emergency evacuation drills should be conducted and recorded at all courts. (5.57)

6.50 Custody staff should confirm with detainees if they have any medical issues on arrival. (5.72)

6.51 The service offered by the medical provider should be well advertised within each suite and fully understood by all staff. (5.73)

6.52 All custody staff should be conversant with the GEOAmey drug administration policy. (5.74)

6.53 Detainees should have access to literature on local and national substance misuse support services. (5.75)

Good practice

6.54 The designated mental health courts provided targeted support to detainees with mental health problems. (5.76)

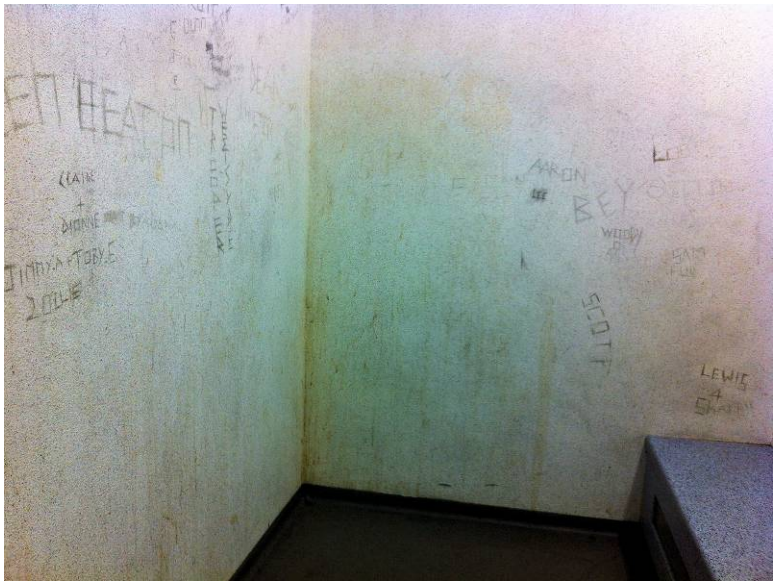
Section 7. Appendices

Appendix I: Inspection team

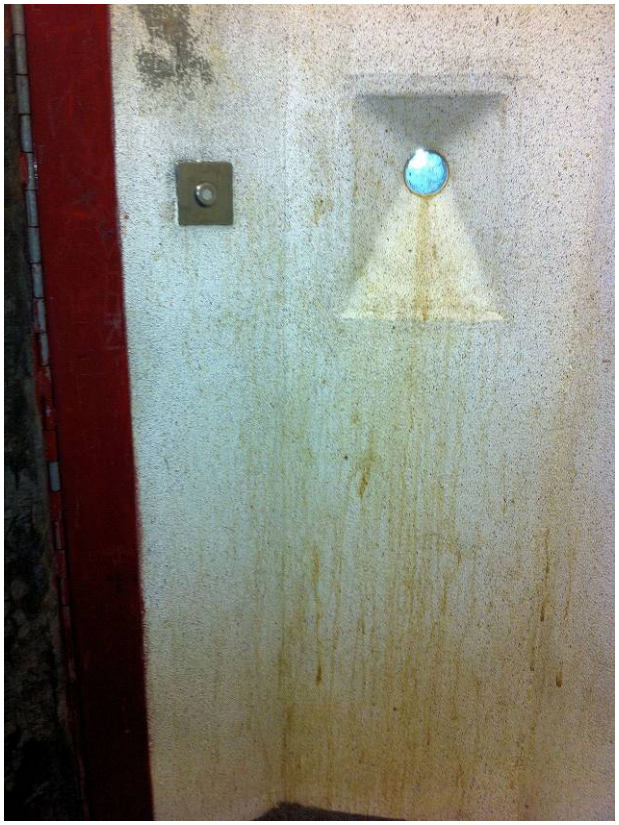
Peter Dunn	Lead inspector
Vinnett Pearcy	Inspector
Fiona Shearlaw	Inspector
Majella Pearce	Health care inspector

Appendix II: Photographs

Cell wall, floor and bench at Maidstone Magistrates' Court



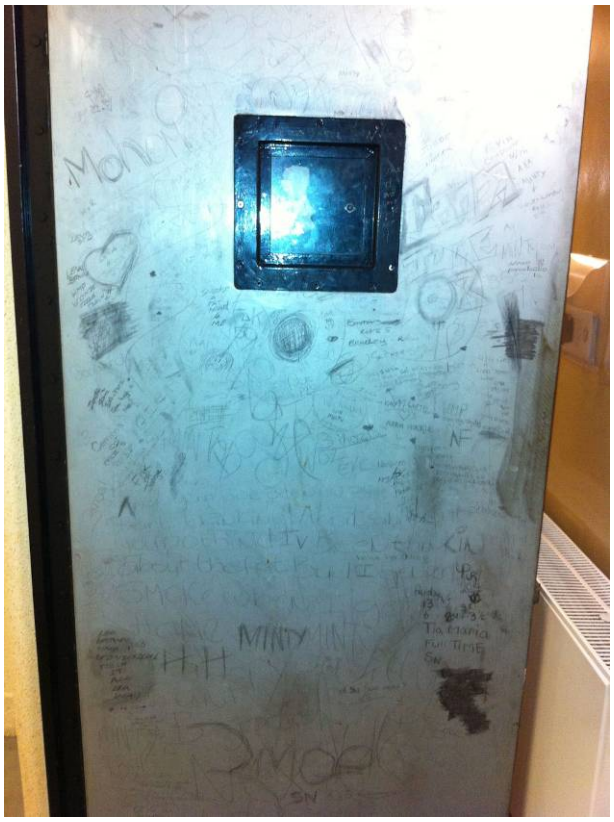
Cell wall, observation window and door frame at Maidstone Magistrates' Court



Obscene graffiti on a cell wall at Maidstone Crown Court

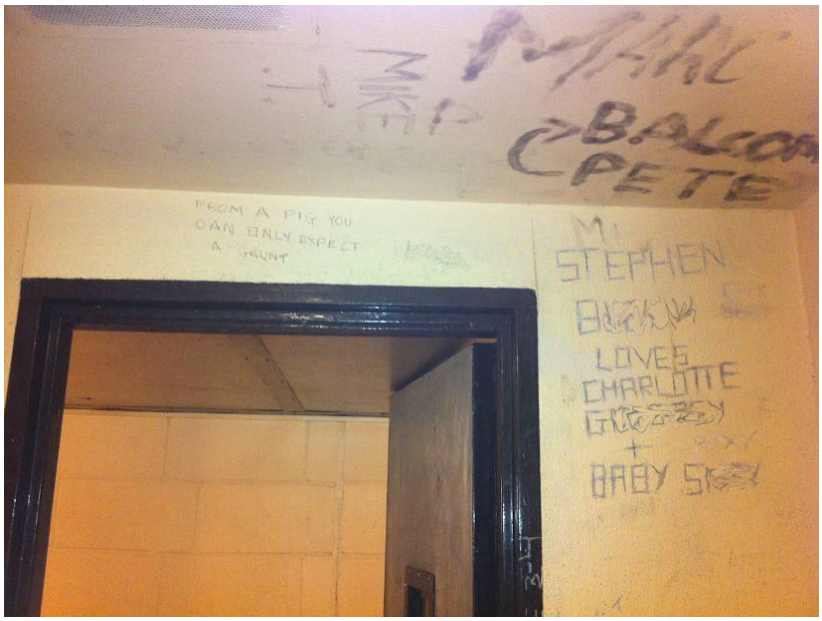
Dirty toilets in male cell corridor, Margate Magistrates' Court

Graffiti on back of cell door at Margate Magistrates' Court

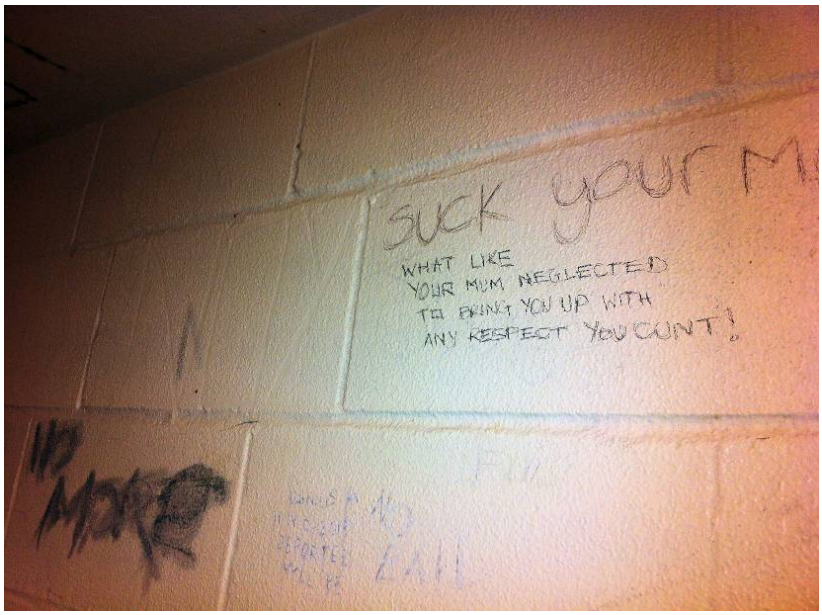


Graffiti and dirt on cell wall at Medway Magistrates' Court

Graffiti on cell wall and ceiling at Medway Magistrates' Court



Graffiti on cell wall at Medway Magistrates' Court



Racist graffiti on cell door frame at Folkestone Magistrates' Court