

Report on an inspection visit to court custody facilities in

# **Surrey and Sussex**

by HM Chief Inspector of Prisons

**11–20 August 2014**

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# Section 1. Introduction

This is the eighth 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 Surrey and Sussex, there were 13 courts currently in use that had custody facilities, including four Crown courts. GEOAmev had been contracted on behalf of HM Courts and Tribunals Service (HMCTS) to provide court custody and escort facilities in the two counties.

We found serious shortcomings in court custody in Surrey and Sussex, particularly in relation to safety, and in the care of children and other vulnerable detainees. Responsibilities for custody were split between several organisations that rarely met together, with none having overall responsibility for seeing the entire picture and driving forward urgently needed improvements. Each was aware of some of the problems, but no collective action had been taken to resolve them. The management of custody was diffused and fragmented.

In 2013 HMCTS had restructured its operations in Surrey and Sussex and had concentrated remand cases into a much smaller number of magistrates' courts, sitting on fewer days. This had resulted in the cells at those courts sometimes being overloaded, with detainees sitting on the floor on one day and all cells being empty the next. Physical conditions varied from good to very poor. Provision of basic toilet facilities, hygiene and cleanliness in some court custody suites was poor.

The lack of adequate cell capacity and the poor quality of information about risk, health and self-harm which came with detainees from prisons and police stations was a significant risk to staff and detainee welfare. In one case a cell share had to be reviewed once further information about the detainee's psychosis had been relayed. Essential information about health conditions was missing and despite the custody contractor knowing of these inadequacies, cell allocation was based on this chaotic information. There was no systematic assessment undertaken on detainees' arrival in court custody that would help clarify information.

Some custody staff attempted to address the needs of children by asking the court to deal with their cases first, but these efforts were undermined by the escort contractor being unable to provide prompt transfers of children to secure training centres and young offender institutions. As in other court areas we have inspected, women and children were transferred in cellular vehicles with male detainees (sometimes with all-male crews), which can result in women being harassed by male detainees.

Custody staff were expected to handcuff all detainees at all times when moving around the custody suites. Staff were permitted to apply additional restraints but they did not have the authority to not use any restraints with compliant detainees, including women and children.

Few detainees were offered information about their rights in custody, and they were not told they could complain. We saw some sketchy data about complaints that had been received, but it was not possible to establish if they had been thoroughly investigated.

We saw a few examples of custody staff taking great care to help vulnerable detainees, but these were exceptional. Most treated detainees politely on arrival, but made few efforts to interact with them thereafter. Any attempts to provide good care were undermined by the combined effects of the poor physical environment, inadequate information, extreme variations in workload and, at some courts, overcrowding.

This report raises a range of concerns about safety, risk management, and the care of people who are vulnerable and detained in court custody. We have made a number of recommendations, some to be resolved nationally, to improve the safety and care of people in court custody.

**Nick Hardwick**  
HM Chief Inspector of Prisons

February 2015

## 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*<sup>1</sup> about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.
- 2.3** Surrey and Sussex court custody suites comprised:

<b>Custody suites</b>	<b>Number of cells</b>
Lewes Crown Court	14
Hove Trial Centre	10
Chichester Crown Court	6
Guildford Crown Court	8
Brighton Law Courts	12
Eastbourne Magistrates' Court	5
Crawley Magistrates' Court	6
Horsham Magistrates' Court	10
Chichester Magistrates' Court	5
Worthing Magistrates' Court	8
Guildford Magistrates' Court	5
Redhill Magistrates' Court	6
Staines Magistrates' Court	7

### Leadership, strategy and planning

- 2.4** Management of court custody in Surrey and Sussex was fragmented, diffused and ineffective. Her Majesty's Courts and Tribunals Service (HMCTS) had restructured its Surrey and Sussex courts cluster and new management posts had been created. During this process, it had centralised the remand courts, hearing all custody cases in each county in fewer magistrates' courts that sat on selected days. This caused cells to be overloaded with detainees on some days, but empty on others. Consultation about these changes had been inadequate. The centralisation programme had failed to take account of the increased pressures that it would place on custody operations in the busiest courts. We found detainee care was adversely affected as a result: at one court, detainees had to be held in cellular vehicles due to lack of

<sup>1</sup>[www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/expectations-court-custody.pdf](http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/expectations-court-custody.pdf)

cells and at another, they experienced long waits in police custody because the court cells were too full to accommodate them. HMCTS knew of the problems but had done little to address them.

- 2.5** Court user groups met only in some of the Crown courts, and physical conditions and detainee care were not discussed. There were no occasions when all the agencies involved in court custody and escorts met together, and the meetings that were held between GEOAmeY (the court custody and escort contractor), HMCTS and the Prisoner Escort and Custody Services (PECS) contract delivery manager focused mainly on timely delivery of detainees to court. We saw many examples of how a failure to address other concerns led to poor outcomes for detainees. These included the failure to control graffiti and a lack of focus on the needs of detainees who were vulnerable.
- 2.6** These difficulties were compounded by the failure of other contractors to meet their obligations, including the contractual arrangements for court interpreters and for cleaning and maintenance. PECS oversight of GEOAmeY's operations, and the contractor's own quality assurance processes, had not improved the care of detainees or the management of risks. Cell sharing risk assessments (CSRAs) were completed badly, risk management information was poor and court custody staffing was barely adequate. Many detainees experienced unreasonably long stays in court custody. Lay observers<sup>2</sup> regularly reported their concerns about physical conditions to HMCTS and GEOAmeY, but many of the defects remained unresolved.

## Individual rights

- 2.7** Custody staff carefully checked the documentation that arrived with detainees to ensure they were detaining the right person, and there were no significant delays in receiving outgoing documentation from the courts.
- 2.8** At most but not all the courts, HMCTS staff were responsive to requests by custody staff to prioritise hearings for children and vulnerable detainees, but although most appeared in court early in the day, this did not reduce their time in court custody. Many had to wait until the end of the day to be transferred to custodial establishments.
- 2.9** We found some unacceptable examples of long delays in arranging transport for children to secure training centres. In one instance, a child had to be placed temporarily in police custody while waiting for the escort contractor to take him to the STC because he could not be collected until late at night.
- 2.10** Court custody staff rarely explained detainees' rights to them on arrival, nor did most offer them written information about rights. Practice in this area was inconsistent and unacceptable. As the inspection progressed, some staff made attempts to brief detainees properly about rights, but those improvements were not sustained.
- 2.11** A telephone interpreting service for non-English speaking detainees was available for custody staff, but access to it was difficult so it was not used. Court-appointed interpreters were not

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<sup>2</sup> Independent volunteers who check that detainees escorted by private escort companies in England and Wales are treated decently.

always at court when needed. We found examples of a court having little choice but to remand in custody detainees who could not speak English, because of the lack of an interpreter. Without access to telephone interpreting, custody staff could not explain to the detainee what had happened or where they were going, and they were unable to respond to any problems or concerns.

- 2.12** Detainees were not offered any information about how to complain. GEOAmeY data did not detail the outcomes of complaints, and from the information we were given it was not possible to ascertain how thoroughly they had been investigated.

## Treatment and conditions

- 2.13** Many cellular vehicles that we inspected were dirty. The partitions, designed to separate male and female detainees and children, were not always used when they should have been. At some courts, detainees embarked and disembarked from cellular vehicles while handcuffed, this made them vulnerable to identification and comments from onlookers.
- 2.14** Custody staff were mostly friendly towards detainees. However, with some notable exceptions they interacted little with them, and we saw several very vulnerable detainees left alone in cells for long periods who would have benefited from an assessment of their needs and some support. Staff lacked knowledge about how to deal with people from different communities and had received little training about diversity. At some courts, there were no female custody staff on duty to care for women and girls in custody. Some vehicle crews were all male, even when transferring female detainees. Provisions for religious observance were inadequate. We were disturbed to hear a custody officer describe a transgender detainee as 'it' and 'the thing'.
- 2.15** Risk management was often poor. The vague and inaccurate information about risk contained in person escort records (PERs) from the local prisons in particular was the worst we have seen. Staff relied on information held on the GEOAmeY computer custody system, GEOTrack, which was often incomplete, yet decisions about which detainees would share cells were based on it. At the busier courts, senior custody officers (SCOs) were often too overloaded with work to complete cell sharing risk assessments, some of which were uselessly completed after the detainee had left custody. We were very concerned to find that at particularly busy times, some SCOs had not been keeping accurate records of visits to cells to check detainees. Many custody staff lacked knowledge of local safeguarding procedures.
- 2.16** Staffing was sometimes inadequate, with too few custody officers on duty to ensure that detainees, staff and visitors were safe. Because cellular vehicle crews were relied on to supplement staffing in the custody suites, it was often impossible to provide a vehicle to transfer detainees during the day, adding to pressures on cell capacity and increasing the time detainees spent in court custody.
- 2.17** Use of force was rare and staff used de-escalation skills well when dealing with challenging behaviour. Handcuffing was often disproportionate to risk. Although we were told that 'double-cuffing' (handcuffing a detainee's wrists together then applying a further handcuff to secure the detainee to an officer) was based on a risk assessment, we found the practice was in widespread use, often with no written assessments to justify it.
- 2.18** The physical conditions of the custody facilities varied: some were clean and well decorated, but many were cold, dirty, covered in graffiti and needed a deep clean. Lay observers had

reported defects regularly for months, but little effective action had been taken. Some toilets were insanitary and many offered little privacy: people in the corridor could easily look over the very low door at the person using the toilet.

- 2.19** There were generally good arrangements for medical assistance to the custody suites, although some staff found the response call-out time from TaylorMade health care professionals slow. Custody staff were qualified in first aid but did not receive refresher training often enough to maintain the skills they would need in the rare event of them having to respond to a health emergency.
- 2.20** Custody staff repeatedly told us that communications between the police, prisons and themselves required improvement. Health information in PERs was, like the information about risk, sometimes incomplete and lacking in sufficient detail to guide health care. Often, detainees arrived in court custody from prisons and police stations without medication for the day, which was unacceptable. Mental health professionals were available at most of the busier courts, although staff shortages meant they were not always able to supply a service to some of the Sussex courts.
- 2.21** Substance misuse workers were readily accessible to detainees in Surrey, but coverage was not universal in Sussex and some detainees there did not have good access to services. Custody staff had a reasonable awareness of substance misuse and mental health issues but lacked formal training.

## Main recommendations

- 2.22** **HMCTS should work with all the organisations involved in court custody and escort operations to identify the pressures following the centralisation programme, and put in place a multi-agency action plan to resolve the difficulties.**
- 2.23** **Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite and used as necessary.**
- 2.24** **Court custody staff should be trained to identify and refer appropriately detainees about whom they have child protection or safeguarding concerns.**
- 2.25** **Staff should complete a standard risk assessment form for each detainee, and be trained to do this.**
- 2.26** **There should be sufficient staff on duty at all times to ensure the safety of detainees, staff and visitors.**
- 2.27** **Handcuffs should only be used if necessary, justified and proportionate.**
- 2.28** **Person escort records should contain sufficient accurate, legible risk information and health care advice to inform risk assessment and facilitate the care of detainees; and they should be clearly signed.**

## National issues

- 2.29** **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.**

- 2.30 Prisoner Escort and Custody Services should revise the escort contract arrangements to eliminate the practice of transferring men, women and children in the same cellular vehicle.**

## 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** Her Majesty's Courts and Tribunals Service (HMCTS) in Surrey and Sussex had revised its management structure in the past year. New management posts have been created and different systems were still settling down. Courts in the two counties operated as a single 'cluster' led by a cluster manager and three operations managers, each of whom were responsible for the Crown courts, magistrates' courts and civil courts respectively. A facilities manager in each county was responsible for cleaning and maintenance of the courthouses, including the custody suites.
- 3.2** In 2011, the Prisoner Escort and Custody Services (PECS), part of the National Offender Management Service (NOMS), had contracted GEOAmeY on behalf of HMCTS to provide custody and escort services. HMCTS acknowledged that, until recently, not all its managers visited the cells regularly, but facilities managers were now expected to make a monthly visit to the custody suites for which they were responsible, which was a positive development. Interagency meetings focused mainly on holding the contractor to account for the timely delivery of detainees to court, while the major focus of HMCTS was on the efficient and cost-effective processing of cases. One HMCTS manager told us, 'my customer is the courts', and there was little consideration of the conditions in which detainees were held.
- 3.3** There was an active local Lay Observers group, which the PECS contract delivery manager met twice a year, but HMCTS no longer met with them. Court user groups had been discontinued at all but Guildford and Lewes Crown Courts, where they met twice a year. It was not clear if the relevant SCO was invited to the user group at Guildford. While informal relationships between the organisations were mainly positive, there were no occasions when all the organisations involved in custody and escort provision met together to share concerns and resolve problems. None had overall responsibility for court custody or a complete overview of it. These factors, and the complex range of agencies and contractors, contributed to the diffused and fragmented management of custody.
- 3.4** HMCTS in Surrey and Sussex had centralised its magistrates' court provision, concentrating custody cases in fewer courthouses. Detainee care and the cell capacity of the custody suites had received little consideration. HMCTS told us it had consulted stakeholders but GEOAmeY and PECS told us they raised concerns that they felt were not taken into account. Some SCOs told us that they were not briefed about the changes, only finding out about the new structure on the day before the changes were implemented. The busiest courts lacked cell capacity for their increased custody workload, and the pressures on cells and staffing (see paragraphs 4.4 and 5.29) of centralisation sometimes had a detrimental effect on detainee care. HMCTS was aware of the issues and had convened a meeting to discuss them in September 2013. The prisons did not attend it, and most of the difficulties described in the minutes remained unresolved at the time of the inspection. There was no inter-agency plan for remedial action, and progress had not been systematically reviewed (see main recommendation 2.22).
- 3.5** PECS contract management held a 'safe, secure, decent and compliant' audit once every two years of each court custody suite. HMCTS also conducted an annual audit of the cells, but none of these, nor GEOAmeY's own quality assurance processes, had led to any significant improvements in outcomes for detainees. There was little sharing of data between the agencies. While PECS sometimes received complaints about custody, the data were not

available to HMCTS to explore how changes in court processes would affect custody. PECS required that complaints from police and courts were followed up, but those from detainees were not. GEOAmeY did not provide us with detailed information about the outcomes of complaints they received.

- 3.6** Transferring women and children to prison with adult men in cellular vehicles can provide opportunities for male detainees to harass women and it might expose children to risks if there are sex offenders present. As in other areas we have inspected, we were told in Surrey and Sussex that escort crews often delivered women and children after they had made stops at the adult male prisons, where the reception areas closed earlier than those in female establishments or YOIs. That meant some women and children experienced longer journeys and more time in court custody than men, yet the contract management process had not eliminated such disadvantage. This practice may achieve economies in escort arrangements but it is potentially detrimental to the wellbeing of vulnerable detainees.
- 3.7** PECS scrutinised all reports of force used in court custody, but there was little follow through to ensure improvements in practice. Because custody staff did not complete documentation consistently, use of force data could not be relied upon.
- 3.8** There were some significant gaps between GEOAmeY policy and day-to-day practice. For example, GEOAmeY's standard operating procedure for handcuffing specified that 'double-cuffing' (see paragraph 2.17) would be based on risk assessment, but custody staff described making such decisions largely on the basis of custom and practice, which varied widely. Much handcuffing was disproportionate, and detainees were placed in unnecessarily demeaning situations as a result of its routine use. Some SCOs told us it was legitimate to handcuff all children because, as one described it, 'they will have been in trouble already on more than one occasion'. This was unacceptable.
- 3.9** HMCTS had introduced a new process for making maintenance requests, but GEOAmeY told us they knew nothing about it. Custody staff believed they were doing all they could to eliminate graffiti but felt more could be done to pursue sanctions against detainees who damaged cells, by prosecution or through the prisons' discipline systems. Mitie held the contract for cleaning and maintenance, but HMCTS told us they were not performing adequately. GEOAmeY staff had to cope with the resulting poor standards, yet they had little influence on Mitie's performance. The failure to rectify faults often resulted in much-needed cells being taken out of use.
- 3.10** There was no HMCTS safeguarding policy and no perceived need to have one. While some custody staff knew how to alert statutory organisations with concerns about children or vulnerable adults, many did not. GEOAmeY had not briefed its staff about how local safeguarding procedures worked (see recommendation 2.24).
- 3.11** There was little provision for virtual court hearings – where detainees appear in court via video link from a police station – except at Hastings, which would soon incorporate work from Eastbourne, but there were no plans to extend virtual court provision to Surrey.

## Recommendations

- 3.12** **There should be regular interagency forums covering all courts in the cluster, and their remit should include improvements in the care of detainees during escort and in court custody.**
- 3.13** **Quality assurance processes should be more effective in encompassing key elements of detainee care and rights during escort and court custody.**

## 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 Custody staff checked each incoming detainee's documentation to ensure they had the correct authority to detain, but not until after the detainee had been placed in a cell (see paragraph 5.30). We did not see anyone brought into court custody by court enforcement officers. We were told that those brought in for fine default were taken to wait in the court rather than being detained, which was reasonable. Custody staff routinely checked the accuracy of outgoing warrants, which court clerks processed promptly.
- 4.2 There was a good system for ensuring that the court clerk was notified when children were in the court custody suite, and at most courts, Her Majesty's Courts and Tribunals Service (HMCTS) prioritised their hearings whenever possible. However, this was not the case at Worthing and Chichester magistrates' courts. At Guildford Magistrates' Court, four children brought into custody in the morning were all dealt with and released by noon, which was good. Staff at all courts said they had a positive relationship with their local youth offending service (YOS). All courts had procedures to ensure that YOS staff were aware of all children in court custody.
- 4.3 Records confirmed that placement orders for children were processed quickly, but this did not always mean young detainees were promptly transferred. In two instances, children going to secure training centres (STCs) had very long waits to be transferred. A young detainee at Lewes Crown Court was lodged at a police station until 2am due to the late arrival of the STC escort contractor, Serco. He had been compliant, but he was reluctant to go back into police custody and was then removed from his court cell by force. At Eastbourne Magistrates' Court, a 16-year-old girl was not collected by Serco until 11.15pm despite being sentenced at 3.15pm. Such delays can have serious consequences for children. The PECS contract manager told us that PECS regularly reported them, but knew nothing about any action taken to address the problem.
- 4.4 We found cell overcrowding and prolonged stays in custody. At Redhill Magistrates' Court, four detainees had to be held in a cellular vehicle for two hours and others had to sit on cell floors because the custody suite was too full, which was unacceptable and unsafe. At Crawley, insufficient cell capacity meant that some detainees had to wait in police cells until 4.30pm, although their cases were listed for court that morning. One detainee had to be held overnight at Crawley police station due to lack of court cell capacity. The problem was compounded by insufficient escort staff to collect detainees at lunchtime. Although a lunchtime run would have greatly reduced the time in court custody, most detainees were not transferred until the end of the day. At Guildford Crown Court we met a detainee who was brought to court unnecessarily on two consecutive days from HMP High Down and not dealt with until the third day.
- 4.5 On Saturdays, detainees could not be transferred to HMP Lewes before 1.45pm as the prison reception was closed until then, and we were told that detainees would not be accepted at High Down after 2pm.
- 4.6 There were significant delays in obtaining authority to release detainees who had come from prison and had then been bailed or released by the court. At Guildford Crown Court, a detainee given a suspended sentence of imprisonment was not released immediately because High Down would not authorise release at that time of day. Despite his legal adviser intervening, the detainee was returned to prison and eventually released at 11.56am the

following day. We contacted the prison and were told, several weeks later, that his release had been delayed because it was necessary to ensure public protection measures were in place before releasing him. While we understand the importance of that imperative, it seems he was held without lawful authority; and arrangements for his possible release could have been made before he went to court. It is also unacceptable that custody staff were told nothing about the reason for the delay and could not explain to him why he was being returned to prison. We saw records of a similar incident at Chichester Crown Court.

- 4.7** At most courts, custody staff told us that they could not 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** Most detainees told us they did not know about their rights and had not received an explanation of them; our observations confirmed this. Staff did not tell detainees about their rights and did not offer them a rights information leaflet. We found that at some courts, staff were unable to locate and print the rights information in foreign languages, even though it was available to them on the GEOAmev intranet. At some courts, a poster about rights in other languages was displayed, but it was in poor condition and unreadable. Later in the inspection, some custody staff commendably made attempts to brief detainees about their rights but their efforts were not sustained on subsequent days.
- 4.9** Custody staff liaised well with court ushers to ensure that all detainees had legal representation. We saw legal representatives allowed access to detainees in suitable interview rooms, although those at Chichester Crown Court were in a very poor condition. At Guildford Crown Court, legal representatives were locked into the interview rooms with their clients, which needlessly exposed them to unacceptable risks. A female barrister objected, but staff would not agree to her request that the door be left unlocked. Detainees at all courts were allowed to keep legal documents, and staff provided pencils on request.
- 4.10** Court interpreter services were inadequate. As in other areas we have inspected, we found instances where the court had little choice but to remand a non-English speaking detainee in custody because no interpreter was available. At Guildford Magistrates' Court, the court-appointed interpreter failed to attend for the hearing of a Romanian detainee, who had arrived in custody at 8.49am and was not taken up to court until 5.20pm, when he was remanded in custody. The lack of court interpreters was compounded by the inability of custody staff (except at Worthing Magistrates' Court) to use the telephone interpreting service because detainees were not permitted to enter the office where the telephone was installed. Consequently, custody staff could not explain to such detainees why they had been remanded in custody or where they were going. Nor could they respond to questions or any problems experienced by non-English speaking detainees following their court appearance (see main recommendation 2.23).
- 4.11** Information about how to make a complaint was included in the rights leaflet, but it was not normally offered to detainees. Not all staff could locate complaint forms and there were different versions in use, including some with outdated information. Few complaints were recorded. Neither GEOAmev nor PECS used complaints data to identify concerns and make improvements. Complaints data were vague, and from the information the contractor provided it was not possible to ascertain how thoroughly investigations had been conducted or establish their outcomes.

## Recommendations

- 4.12 HMCTS and PECS should liaise with the Youth Justice Board to reduce delays in transferring children to secure training centres.**
- 4.13 Escort vehicles should be available to take detainees to custodial establishments as soon after the completion of their court case as possible.**
- 4.14 HMCTS should liaise with local prisons about their hours for receiving prisoners at weekends and, in all applicable cases, obtain the prison's authority to release detainees promptly, directly from court.**
- 4.15 Detainees should not be held in custody without lawful authority to detain.**
- 4.16 All courts should offer all detainees information, in a range of languages, about their rights, including the process for making a complaint, and staff should offer to read or explain the information if necessary.**
- 4.17 There should be sufficient comfortable and private consultation rooms at all courts.**
- 4.18 Visitors to the court cells should not be locked in interview rooms with detainees.**

## 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** Escort staff regularly carried women, children and adult men in the same vehicle but did not always use the vehicle's partition to separate them. Many of the cellular vehicles we inspected were dirty, particularly those from the Burgess Hill depot. They all had first aid kits containing anti-ligature knives, and drinking water was available. In a vehicle at Lewes Crown Court, it took staff five minutes to open the box that held the anti-ligature knife as it had been incorrectly sealed.
- 5.2** Journeys from police custody to court were mostly short, as were those from local prisons, but there were some excessively long journeys. For example, one detainee had a circuitous journey of over four hours from HMP Winchester to Aldershot to Basingstoke court, and then past Winchester again to reach Brighton Magistrates' Court. We were told that such a long journey was necessary because the prison only allowed detainees to be collected first thing in the morning. A detainee with a recently reconstructed knee joint taken to Guildford Crown Court had to stand in a cellular vehicle for around 50 minutes because HMP High Down had failed to book suitable transport for him. To ensure his case was progressed that day, he chose to travel on the cellular vehicle rather than wait a further day (see also health section). While he was not handcuffed when disembarking from the vehicle, he was restrained with handcuffs and a closet chain when boarding a more suitable vehicle to return to the prison, which was unreasonable.
- 5.3** The location of some of the older courthouses imposed limitations on privacy, but we were not convinced that vehicle crews took all reasonable steps to protect detainees from public attention on entering and leaving vehicles. At some courts there was no privacy: at Lewes Crown Court, detainees entered and left cellular vehicles in the street and staff showed us many photographs of detainees that had been taken by press photographers there. At Worthing as well, detainees entered and left cellular vehicles in the street, where, according to custody staff, they sometimes received verbal abuse from onlookers. At Chichester Crown Court, the van dock was overlooked by buses waiting at the bus station.
- 5.4** Escort staff ensured that all necessary information about detainees accompanied them to court, although custody staff only checked if any information was missing or needed clarification after the detainee was accepted into custody (see section on safety). 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, which was good.
- 5.5** Information about risks was poorly managed and the content of person escort records (PERs) accompanying detainees from local prisons were among the worst we have seen. Risk information was often incorrect or vague: one PER we inspected was simply annotated with the word 'risk'. There was an over-reliance by the police on attaching additional paperwork instead of completing PERs properly: for example, the PER for a woman detainee at Brighton

Magistrates' Court failed to specify that she suffered from depression and psychosis – that information was in an attached file of additional documentation, which was not read until later in the day. Custody staff told us that during lengthy Crown court trials it was not unusual for a detainee's PER to contain different information about risk each day. Custody staff checked PERs to ensure that all relevant information was transferred to GEOTrack (the custody computer system), but in most cases this was done after detainees had already been placed in their cells. GEOTrack often did not contain information about areas of serious concern, such as self-harm. These sometimes only came to light when custody staff recognised the detainee on their arrival and recalled concerns noted on previous occasions. This entailed serious risks. On one occasion during the inspection, custody staff had to separate two detainees sharing a cell when they noticed further information about risk contained in their PERs.

- 5.6** Many custody suites had a whiteboard with detainees' information, including their names and cell numbers, sited where others could view it. At Guildford Crown Court and Brighton Magistrates' Court, we saw some detainees studying the whiteboard when they arrived and commenting on who else was in custody.
- 5.7** Custody staff were mainly courteous and most, but not all, were friendly with detainees on their arrival and when going up to court. Generally, we saw custody staff using good interpersonal skills to de-escalate difficult situations. Some staff offered good support to detainees: at Chichester Crown Court, the SCO gave one detainee a word puzzle to reduce his anxiety about being in court custody for so long. At Crawley Magistrates', staff sat in the cell with a child who disclosed he had been bullied, and contacted the appropriate agencies to arrange further support after he left custody. However, these were exceptional and there were also many examples of poor care (see also health section). At Redhill Magistrates' Court, custody staff did not realise that a detainee required an interpreter, and by the time his legal adviser saw him at lunchtime, it was too late to obtain one and the detainee was remanded in custody. This significant need might have been identified if a basic assessment had been done on arrival. Once detainees had been placed in their cells, most staff made little effort to interact with them, even when they were not busy. A vulnerable 17-year-old at Guildford Crown Court, being tried for a very serious offence, was treated no differently to anyone else, other than being placed in a cell near the office, and staff showed no interest in him. Good detainee care was far too dependent on each individual staff member's commitment and skills.
- 5.8** Custody staff said they had received little specific training on diversity, child protection or mental health, and it was only at Eastbourne Magistrates' Court that they had good awareness of diversity. At one court, a custody officer described a transgender detainee as 'it' and 'the thing', and these comments were not challenged by the SCO. At all courts, except Eastbourne, custody staff were unclear about how they should search a transgender detainee. Some told us, correctly, that they would ask the detainee their preference, but at Lewes Crown Court, staff told us a woman prison custody officer (PCO) would search a transgender detainee above the waist and a man search below the waist. The GEOAmev standard operating procedure provided unclear advice and was not consistent with police and Prison Service guidance.
- 5.9** There were too few female PCOs, particularly in Surrey courts, to care for female detainees and ensure their safety. On one day there were three male staff at Eastbourne Magistrates' Court when a young woman was remanded, and subsequently a delay while they waited for a female PCO. Escort staff told us that all-male vehicle crews often transferred female detainees. Most courts had a separate female corridor, but in the courts without one, PCOs took some steps to consider where they should be located. Female detainees were not routinely asked if they might be pregnant or offered sanitary packs. Sanitary packs were available in the toilet at some courts, although not advertised.

- 5.10** There were no blankets or pillows, so pregnant, elderly or disabled detainees had to wait on hard benches. Detainees were not asked about religious observance, dietary requirements or any other needs on arrival at court. Most of the custody suites had a copy of the Bible, some had a Qur'an and a compass, but none had access to prayer mats.
- 5.11** We were told that Crawley Magistrates' Court, with an adapted toilet, was the designated court for detainees with disabilities, but staff at most courts seemed unaware of this. At Guildford Magistrates', staff said they would have to keep a disabled detainee on the third floor public waiting area in handcuffs, which was not appropriate. Custody staff believed that Hove Trial Centre was compliant with equalities legislation, but the SCO confirmed that there were no adaptations in the toilets and wheelchairs did not fit in the lift, so detainees in wheelchairs had to be taken through public areas in handcuffs. There were no hearing loops or any information in Braille at any custody suite.
- 5.12** There was no specific provision for children and no named member of staff allocated to their care. Staff had received little training in looking after children and their lack of knowledge was often evident. Not all SCOs remembered to complete a young person's cell allocation form before deciding how to care for a child. We were very concerned to find that an SCO was unaware that children (boys in particular) should not share cells with female detainees. Staff were also unclear about safeguarding procedures for children or vulnerable adults. Few understood they had a duty to refer concerns about someone who was leaving court custody. At Worthing, staff believed they should not pass on safeguarding concerns as the detainee would have told them about their problems in confidence. At Guildford Magistrates', custody staff had good relationships with the mental health practitioners and told us they would liaise with them if they had concerns about someone. At most courts, staff told us they would contact their line manager, probation or the youth offending service (YOS) if they were concerned about a detainee. This was inadequate, particularly if immediate action, such as a referral to child protection services, was required (see main recommendation 2.24).
- 5.13** Custody officers at all courts brought in old newspapers and magazines for detainees, as GEOAmev did not provide reading material. Despite staff's generosity, the quantity and quality of the reading material was very limited. Staff acknowledged that some detainees became frustrated at spending long periods in court cells with nothing to occupy them. There was no reading material in foreign languages or easy-read format, and nothing suitable for children.
- 5.14** At all courts, arrangements for securing detainees' property were adequate.
- 5.15** Detainees were given a hot drink on arrival and further drinks during the day, and offered microwave meals or sandwiches at lunchtime. At Crawley, meals were offered to detainees still waiting for transfer to prison late in the afternoon, which was good practice. Several courts displayed notices telling detainees that refreshments would be restricted to 'one drink in the morning and one in the afternoon', and a SCO quickly removed the notice when he saw our inspector walking towards it. Contrary to the message in the notice, at all courts we saw detainees offered meals at various times on request, which was good. Microwave ovens and food preparation areas were mostly clean, but the food preparation area at Chichester Magistrates' Court was unhygienic.

## Recommendations

- 5.16** Cellular vehicles should be clean and free of graffiti, with readily accessible anti-ligature knives.
- 5.17** Adult men, women and children should not be carried in the same escort vehicle, and detainees should be transferred from cellular vehicles to the court cells out of public view.
- 5.18** Custody officers should receive sufficient training to meet the diverse needs of 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** 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** Children in court custody should be supported by a specifically trained named staff member.
- 5.23** All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers.
- 5.24** There should be a small stock of mattresses and blankets or warm clothing for detainees who are elderly, pregnant or disabled.

## Housekeeping points

- 5.25** Staff should routinely inform all female detainees of the availability of sanitary packs.
- 5.26** There should be a female member of staff in cellular vehicles when female detainees are transferred.
- 5.27** Information about detainees should not be displayed in public view.

## Safety

- 5.28** Custody staff at all courts received an early morning briefing, but none had any planning for risk management or the care of vulnerable detainees. Briefings focused mainly on security and details of any changes in GEOAmeY policy. Not all staff on duty attended the briefings.
- 5.29** We were concerned that at some courts there were too few custody staff to ensure the safety of detainees. For example, on one day at Guildford Crown Court and one at Redhill Magistrates', there were two officers in the cell area, which according to GEOAmeY policy was too few to open cell doors. Some courts had custody suites that were sometimes packed beyond capacity one day but empty the next, and few staffing models could be

expected to accommodate such variations. There was an over-reliance on escort staff to provide back up in courts (see main recommendation 2.26).

- 5.30** Court custody officers did not complete a systematic assessment when detainees arrived. Staff did not routinely interact with detainees to find out how they were feeling or if they had specific needs. This was a particular concern at the busy remand courts where large numbers of detainees shared cells. At all courts, SCOs allocated cells on the basis of inadequate GEOTrack information before detainees arrived. They did not ask detainees how they were or sought clarification about concerns. When we asked why not, one SCO said, 'well, they could tell you anything couldn't they'. Very few cell sharing risk assessments were conducted properly. At Guildford Magistrates' Court, staff had to separate two women they had initially placed together when they found their PERs specified significant risks that were not on GEOTrack. Cell sharing risk assessments (CSRAs) were not completed for children at Brighton Magistrates', although they shared with each other. At one of the Saturday courts, CSRAs were completed after detainees had been sharing cells for two hours, by which time one had been released – and, although they were completed after 11am, the completion time recorded on the CSRA was 10.10am. The SCO told us there was too little time to complete CSRAs properly, but acknowledged that the task could be delegated to a PCO if they were trained for the task. Custody staff did not understand the importance of CSRAs, and most were more concerned about having all the paperwork in order than using the document to ensure detainees were safe (see main recommendation 2.25).
- 5.31** Frequency of observations varied from court to court. Staff were unclear about how often they should check detainees, unless there was a self-harm risk or a new 'off-bail' detainee (one previously on bail and then remanded in custody or given a prison sentence), in which case they made six checks an hour. We observed good care provided to several high risk detainees in cells and interview rooms with the doors open and custody staff talking to them, which was good practice. But at Lewes Crown Court, we were told that those on constant watch would be viewed through the observation window with the door closed, which was unsafe and disrespectful. 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. While staff adopted the level of observations specified in the ACCT, we saw them make no effort to talk with detainees on ACCTs.
- 5.32** Cell checks were regular but mostly consisted of a cursory look through the cell door or observation window, with no physical interaction with detainees. Checks were not always communicated to the officer inputting information on GEOTrack. Not all cell checks were recorded. We were particularly concerned to find that the SCO at one magistrates' court admitted not having had time on a day when the cells were too full to record any checks on GEOTrack.
- 5.33** Practice on anti-ligature knives varied. Some but not all staff on cell duties carried them. At some courts, the only anti-ligature knives available were kept in the first aid kit and in filing cabinets. At Worthing, the filing cabinet was padlocked shut, delaying access if the anti-ligature knife was needed.
- 5.34** Detainees could not have social or domestic visits, unless directed by the court.
- 5.35** There were no significant delays in transferring detainees from cells to the courtroom. Several routes to court had steep long stairs, and we were concerned about risks to staff and detainees where there were affray alarms only on the landings and not on the stairs. At Lewes Crown Court, a corridor to one court had no affray alarm coverage, and the CCTV image of the street where detainees entered and left cellular vehicles was so indistinct that it was useless.

- 5.36** Hastings Magistrates' Court had a virtual court in the custody suite, which allowed detainees to have their cases heard at Brighton Magistrates' Court via video-link from the custody suite. Staff did not report any significant delays in getting detainees before the virtual court promptly.
- 5.37** There was no systematic or consistent pre-release risk assessment in place for vulnerable people leaving custody. We observed very poor care for a man with tuberculosis at Redhill Magistrates', who had been brought on a cellular vehicle from the West Midlands. He had been described as contagious and the court bailed him in his absence. He was released from the cellular vehicle without coming into custody and was given a travel warrant. Custody staff made no effort to find out what his home situation was and if he knew about sources of treatment and support or how to have safe contact with other people (see also health section). By contrast, at Crawley Magistrates' Court, we saw an exceptional example of safeguarding for a person with mental health problems living in assisted housing. Custody staff liaised with housing staff, and then provided advice about travel. Overall detainee care was too dependent on individual staff's awareness and knowledge.
- 5.38** In most cases, staff completed the prisoner release checklist after detainees had left the custody suite, but this focused on security issues. When a detainee was remanded or sentenced, court custody staff ensured the risk information was passed on to the prison by printing the electronic record from GEOTrack, which they attached to the PER. They also completed a Prison Service personal record form and, if required, a suicide or self-harm warning form.
- 5.39** With the exception of Brighton Magistrates', no courts had a leaflet about local support organisations. Most but not all courts had prison leaflets, including an excellent one about Bronzefield women's prison. Travel warrants for trains were available at all courts, but petty cash was not used to pay for bus fares.

## Recommendations

- 5.40** Cell sharing risk assessments should be completed for all detainees before they share a cell.
- 5.41** Staff should record the outcome of all cell visits accurately in the detention log.
- 5.42** Staff undertaking observations and cell visits should carry anti-ligature knives at all times.
- 5.43** Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave custody.
- 5.44** Each court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages for detainees leaving custody.

## Housekeeping points

- 5.45** All routes to court should be covered by adequate affray alarms.
- 5.46** Vulnerable detainees should be able to receive social visits in exceptional circumstances.

- 5.47** Detainees leaving custody should be provided with cash for bus fares home, where appropriate.

## Use of force

- 5.48** We were told use of force was rare, but all staff received annual training in control and restraint techniques. Staff told us they would always try to talk to a detainee to de-escalate the situation, which we saw done successfully on several occasions at Guildford Magistrates' Court. The few completed use of force forms that we reviewed contained a thorough account. Custody staff received no feedback after they reported use of force to their managers.
- 5.49** Handcuffing practices varied between courts and between staff at each court. Much handcuffing was excessive and disproportionate, such as the routine handcuffing of compliant women and children. We were told that detainees were 'double-cuffed' if a risk assessment indicated it was required, but we could find no systematic written risk assessments to justify the practice.
- 5.50** At some courts detainees were searched while handcuffed to a member of staff, which made it difficult for them to remove shoes. Detainees had rub-down searches far too frequently and apparently unnecessarily, in the absence of a robust risk assessment. We saw detainees struggling to keep their trousers up when double-cuffed<sup>3</sup> on and off vehicles, which was demeaning, particularly when it took place in public. Detainees were routinely double-cuffed when entering and leaving the cellular vehicle, even in secure vehicle docks, even though the GEOAmev standard operating procedure required only single handcuffing<sup>4</sup>. At Hastings Magistrates' Court, staff routinely handcuffed detainees to the virtual courtroom, which was just a few yards from the cells. In all courts, staff told us that they had to handcuff all detainees to interviews with their legal representatives, even when they were held next door to the interview room.
- 5.51** Handcuffing policy, and its inconsistent application, was deeply flawed. While staff were allowed to handcuff excessively, as in double-handcuffing detainees on and off cellular vehicles, they were not allowed to exercise a judgment about the need to handcuff compliant detainees who were unlikely to escape or who might be affected by the use of restraints. SCOs demonstrated no leadership regarding the use of restraints, allowing staff to double-cuff if it was customary (see main recommendation 2.27).

## Physical conditions

- 5.52** Staff at all courts carried out daily checks of the cells, including checking the call bells were functioning. However, at many courts there were delays in repairs to faults, and at the busier courts this meant cells were taken out of use, exacerbating the occasional overcrowding. There had been several complaints about cold cells at Hove Trial Centre, but repairs had not yet been made. Similarly, cells often had to be taken out of use at Lewes Crown Court due to longstanding problems with heating.

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<sup>3</sup> Where the detainee's wrists are handcuffed together and a further handcuff is applied to secure them to a member of staff.

<sup>4</sup> Where the detainee is handcuffed by one wrist to an officer, leaving the detainee's other hand free.

- 5.53** Some of the custody suites, such as Crawley, were clean and largely free of graffiti. However many, including Staines, Guildford Crown Court and Lewes, were in a poor state, and required deep cleans, redecoration, graffiti removal and improvements to the heating systems (see photographs, Appendix II). At Staines, paint on the cell floors was coming away in sharp flakes. At some courts, graffiti was offensive, contained serious allegations about named individuals, and had been there for years. Chichester Crown Court was an old suite that appeared neglected, with subterranean cells that were poorly lit, with much ingrained dirt and floors that needed painting. It was not cleaned daily or thoroughly enough. Custody officers had attempted to remove offensive graffiti but some could still be seen. Staff told us that their requests to get the custody suite deep cleaned and redecorated had not been successful, and they had recently painted the cells themselves to improve conditions. Lay observer records showed that they had often raised concerns about the poor condition of some suites.
- 5.54** The refurbished cells at Horsham Magistrates' Court were in good condition. The suite was well decorated, clean, had plenty of graffiti-free cells and was well equipped. Despite these excellent conditions, the suite was used very little following the new centralisation of cases.
- 5.55** At some courts, detainees could not use the toilet in privacy because the toilet doors were too low or inadequate. This was a particular problem at Chichester, Staines and Guildford magistrates' courts, and on the women's corridor at Redhill (see photographs, Appendix II). Some toilets, including at Chichester Crown Court and Eastbourne, were unhygienic, with broken toilet seats. Toilet paper was available but sometimes left lying on the floor. Handwashing facilities and supplies of soap and paper towels were adequate.
- 5.56** All courts had fire evacuation procedures with which staff were familiar. At some, desktop fire evacuations had been completed but there had been few emergency evacuation fire drills.
- 5.57** Staff explained the use of the cell call bells if they knew it was someone's first time in detention. At all courts, staff answered cell call bells promptly.

## Recommendations

- 5.58** **A programme of regular deep cleaning, graffiti removal and cell repairs should be implemented immediately.**
- 5.59** **All detainees should be able to use the toilet in privacy, and toilets should be kept in a hygienic state.**
- 5.60** **All court custody suites should be maintained at a comfortable temperature.**

## Housekeeping points

- 5.61** Emergency evacuation drills should be conducted and recorded at all courts.
- 5.62** Staff should routinely explain how cell call bells work to all detainees.

## Health

- 5.63** Custody staff knew how to gain medical assistance. TaylorMade provided telephone medical advice and health care professionals (HCPs) visited if necessary. TaylorMade had received 56 calls from Surrey and Sussex courts in the five months to the end of July 2014; 31 (55.3%) had required the response of a doctor, of which 17 (54.8%) were for Brighton Magistrates' Court. Over 90% of all calls were to gain advice about or verify medications. GEOAmeY call monitoring data lacked sufficient detail to monitor the TaylorMade contract.
- 5.64** Custody staff were generally satisfied with the advice and visits by HCPs, although some courts on the East Sussex coast said that visit response times were slow – up to two hours. At Brighton Magistrates' Court, we observed difficulty for the custody staff in getting through to a HCP by telephone. We tested the telephone response time for TaylorMade and were able to speak directly with a doctor in 40 seconds. In emergencies, custody staff called paramedics, and responses were said to be very quick.
- 5.65** At Redhill Magistrates' Court we found a detainee who had medication to treat tuberculosis (an infectious disease). Police medical records attached to the PER advised that he was 'still in the contagious stage' and 'masks to be worn'. Although custody staff took appropriate precautions, they seemed unaware of the guidance in the GEOAmeY standard operating procedure and did not consult TaylorMade about the care of the detainee.
- 5.66** Custody staff in the magistrates' courts we visited described detainees developing symptoms of alcohol withdrawal in the afternoon. Such detainees had arrived from police custody with medication for symptoms of alcohol withdrawal, but no medication for the rest of the day. In busier courts, this was said to occur two or three times a week.
- 5.67** Almost all custody staff, 98%, were in-date for first aid training. However, with the low level of reported incidents, the triennial updates were too infrequent to maintain competency. There was no automated external defibrillator, oxygen or suction in any court building, which would delay the appropriate response in an emergency. All staff carried personal resuscitation face shields.
- 5.68** The first aid kit in each suite was inadequate for predictable emergencies, such as major self-harm and scalds, and, despite regular checks, most contained some out-of-date stock. The poor condition of some of the detainee toilets (see paragraph 5.55) had the potential to cause cross-infection.
- 5.69** Custody staff repeatedly told us of inadequate communications about health care between the police, prisons and themselves, and we saw evidence of this in the PERs. Most PERs we examined included little or inconsistent medical information and only one clarified the health risks associated with a diagnosis, making it difficult for custody staff to provide appropriate care. Many medical entries were incomplete, unsigned or illegible. For example, at Guildford Crown Court we spoke with a detainee who wore a knee brace as he had had knee surgery six weeks earlier; the ankle and foot of his affected leg were swollen and he was beginning to experience pain. The PER gave no advice on how to manage this situation, and there was no accompanying medication for pain relief. A PER for a detainee at Redhill Magistrates' Court indicated a 'hole in the lung' – this alarming phrase was not accompanied by advice about the care of the detainee. At Brighton Magistrates' Court, one PER failed to mention that the detainee suffered from depression and psychosis, despite this being recorded on other accompanying documentation. At Guildford Magistrates' Court, the medical form with a PER for a detainee who spoke of multiple health problems and who had been seen by a HCP in police custody was impossible to read. Another PER stated 'bad back', but gave no throughcare advice.

- 5.70** Some detainees arrived from police custody or prison with medication, along with clear instructions, which staff administered and recorded on the PER at the relevant times. However, at Lewes Crown Court we observed that custody staff had failed to administer medication for one detainee at the prescribed time. Detainees requiring self-administered inhalers and emergency medication for heart pain were allowed to keep them in possession, following risk assessment, which was good practice.
- 5.71** Staff reported, and we saw, that detainees often arrived from prison and police custody without their prescribed medication, which was unacceptable. At Brighton Magistrates' Court, custody staff telephoned Brighton police to clarify the nature of a detainee's medication (contained in an unlabelled blister foil), as the detainee demanded to receive it for his anxiety. The police advised that their nurse had prescribed antibiotics, not the medication in the blister pack. But there was no note of this on the detainee's PER and no accompanying antibiotics.
- 5.72** Custody staff demonstrated a good understanding of safe drug administration, and sought advice appropriately from the sending establishment or TaylorMade for medication concerns. Medication in some suites was stored unsecured with the PERs.
- 5.73** Most detainees with mental health issues had been seen by mental health staff in police custody. Surrey Partnership Trust mental health workers regularly visited the courts in Surrey, but in Sussex, mental health workers were unable to visit all active courts every day due to staff shortages (although three new appointments were due to start). At Crawley Magistrates' Court we observed that a detainee who needed to see a mental health worker was not able to because of this. Custody staff had a reasonable awareness of mental health issues but lacked any formal training.
- 5.74** Drugs workers from the Crime Reduction Initiative (CRI) saw most detainees with substance misuse issues in the police custody suites. Drug workers in Surrey regularly visited the courts, but this was rare in Sussex. CRI also provided advice on benefits and housing. Custody staff had a reasonable awareness of substance misuse issues but lacked any formal training.

## Recommendations

- 5.75** **GEOAmev should monitor the health contract to ensure that it performs as agreed.**
- 5.76** **All staff should receive first aid training that is appropriate to maintain competency.**
- 5.77** **First aid kits should contain sufficient in-date equipment to manage all predictable incidents, including an automated external defibrillator and equipment to maintain an airway.**
- 5.78** **All detainees who require prescribed medications while in court custody should have access to them.**
- 5.79** **All detainees should have access to mental health and substance misuse support at all times that the courts are open.**
- 5.80** **Court custody staff should receive regular training to identify, support and refer appropriately detainees experiencing mental health or substance misuse problems.**

## Housekeeping points

- 5.81** All staff should be aware of and implement relevant GEOAmeY standard operating procedures for health care.
- 5.82** Detainees' medication should be stored securely in all court custody suites.

# Section 6. Summary of recommendations and housekeeping points

## Main recommendations

- 6.1** HMCTS should work with all the organisations involved in court custody and escort operations to identify the pressures following the centralisation programme, and put in place a multiagency action plan to resolve the difficulties. (2.22)
- 6.2** Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite and used as necessary. (2.23)
- 6.3** Court custody staff should be trained to identify and refer appropriately detainees about whom they have child protection or safeguarding concerns. (2.24)
- 6.4** Staff should complete a standard risk assessment form for each detainee, and be trained to do this. (2.25)
- 6.5** There should be sufficient staff on duty at all times to ensure the safety of detainees, staff and visitors. (2.26)
- 6.6** Handcuffs should only be used if necessary, justified and proportionate. (2.27)
- 6.7** Person escort records should contain sufficient accurate, legible risk information and health care advice to inform risk assessment and facilitate the care of detainees; and they should be clearly signed. (2.28)

## 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. (2.29)
- 6.9** Prisoner Escort and Custody Services should revise the escort contract arrangements to eliminate the practice of transferring men, women and children in the same cellular vehicle. (2.30)

## Recommendations

### Leadership, strategy and planning

- 6.10** There should be regular interagency forums covering all courts in the cluster, and their remit should include improvements in the care of detainees during escort and in court custody. (3.12)

- 6.11** Quality assurance processes should be more effective in encompassing key elements of detainee care and rights during escort and court custody. (3.13)

### **Individual rights**

- 6.12** HMCTS and PECS should liaise with the Youth Justice Board to reduce delays in transferring children to secure training centres. (4.12)
- 6.13** Escort vehicles should be available to take detainees to custodial establishments as soon after the completion of their court case as possible. (4.13)
- 6.14** HMCTS should liaise with local prisons about their hours for receiving prisoners at weekends and, in all applicable cases, obtain the prison's authority to release detainees promptly, directly from court. (4.14)
- 6.15** Detainees should not be held in custody without lawful authority to detain.(4.15)
- 6.16** All courts should offer all detainees information, in a range of languages, about their rights, including the process for making a complaint, and staff should offer to read or explain the information if necessary. (4.16)
- 6.17** There should be sufficient comfortable and private consultation rooms at all courts. (4.17)
- 6.18** Visitors to the court cells should not be locked in interview rooms with detainees. (4.18)

### **Treatment and conditions**

- 6.19** Cellular vehicles should be clean and free of graffiti, with readily accessible anti-ligature knives. (5.16)
- 6.20** Adult men, women and children should not be carried in the same escort vehicle, and detainees should be transferred from cellular vehicles to the court cells out of public view. (5.17)
- 6.21** Custody officers should receive sufficient training to meet the diverse needs of detainees held in court custody. (5.18)
- 6.22** 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)
- 6.23** All court custody suites should have hearing loops as well as Braille versions of key information. (5.20)
- 6.24** GEOAmev 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)
- 6.25** Children in court custody should be supported by a specifically trained named staff member. (5.22)
- 6.26** All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers. (5.23)

- 6.27** There should be a small stock of mattresses and blankets or warm clothing for detainees who are elderly, pregnant or disabled. (5.24)
- 6.28** Cell sharing risk assessments should be completed for all detainees before they share a cell. (5.40)
- 6.29** Staff should record the outcome of all cell visits accurately in the detention log. (5.41)
- 6.30** Staff undertaking observations and cell visits should carry anti-ligature knives at all times. (5.42)
- 6.31** Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave custody. (5.43)
- 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 for detainees leaving custody. (5.44)
- 6.33** A programme of regular deep cleaning, graffiti removal and cell repairs should be implemented immediately. (5.58)
- 6.34** All detainees should be able to use the toilet in privacy, and toilets should be kept in a hygienic state. (5.59)
- 6.35** All court custody suites should be maintained at a comfortable temperature. (5.60)
- 6.36** GEOAmev should monitor the health contract to ensure that it performs as agreed. (5.75)
- 6.37** All staff should receive first aid training that is appropriate to maintain competency. (5.76)
- 6.38** First aid kits should contain sufficient in-date equipment to manage all predictable incidents, including an automated external defibrillator and equipment to maintain an airway. (5.77)
- 6.39** All detainees who require prescribed medications while in court custody should have access to them. (5.78)
- 6.40** All detainees should have access to mental health and substance misuse support at all times that the courts are open. (5.79)
- 6.41** Court custody staff should receive regular training to identify, support and refer appropriately detainees experiencing mental health or substance misuse problems. (5.80)

## Housekeeping points

### Treatment and conditions

- 6.42** Staff should routinely inform all female detainees of the availability of sanitary packs. (5.25)
- 6.43** There should be a female member of staff in cellular vehicles when female detainees are transferred. (5.26)
- 6.44** Information about detainees should not be displayed in public view. (5.27)

- 6.45** All routes to court should be covered by adequate affray alarms. (5.45)
- 6.46** Vulnerable detainees should be able to receive social visits in exceptional circumstances. (5.46)
- 6.47** Detainees leaving custody should be provided with cash for bus fares home, where appropriate. (5.47)
- 6.48** Emergency evacuation drills should be conducted and recorded at all courts. (5.61)
- 6.49** Staff should routinely explain how cell call bells work to all detainees. (5.62)
- 6.50** All staff should be aware of and implement relevant GEOAmev standard operating procedures for health care. (5.81)
- 6.51** Detainees' medication should be stored securely in all court custody suites. (5.82)

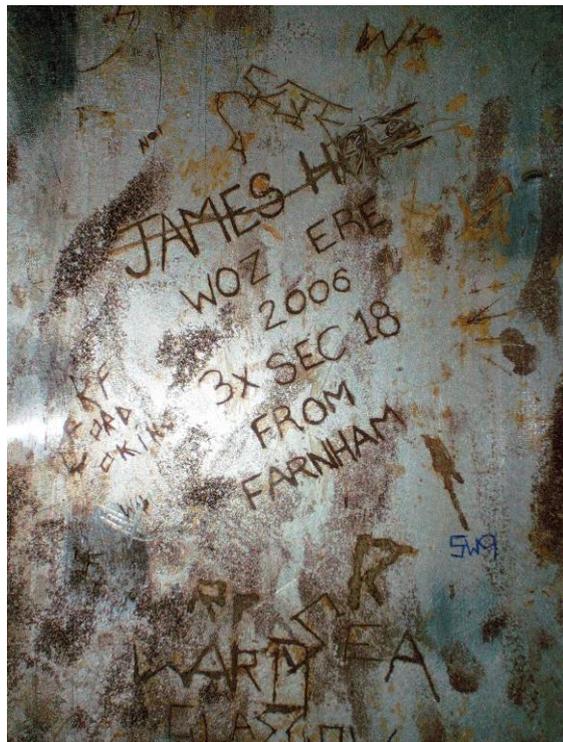
# Section 7. Appendices

## Appendix I: Inspection team

Peter Dunn	Inspection leader
Vinnett Percy	Inspector
Kellie Reeve	Inspector
Fiona Shearlaw	Inspector
Paul Tarbuck	Health services inspector

## Appendix II: Photographs

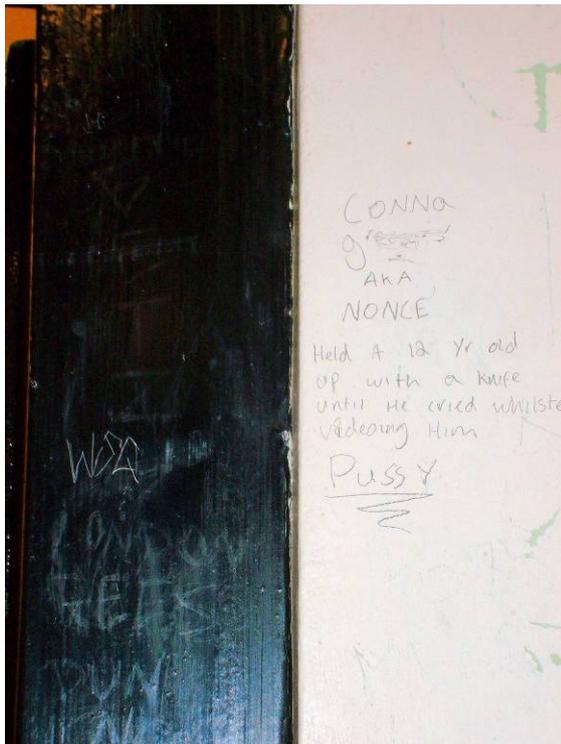
Graffiti dating from 2006 on the back of a cell door at Guildford Crown Court



Graffiti on cell door frame at Hove Trial Centre (the person's name and prison number have been obscured)



Graffiti on cell door frame at Hove Trial Centre (the person's name and prison number have been obscured)



Notice on entrance to the cells at Hove Trial Centre that refers to 'feed the custodies'



**Accumulated dirt and stains in the corner of a cell at Lewes Crown Court**



**Graffiti and accumulated dirt in a women's cell at Lewes Crown Court**





### Group cell at Staines Magistrates' Court



### Lack of privacy and insanitary conditions in men's cell corridor at Staines Magistrates' Court



**Lack of privacy in women's cell corridor toilet at Redhill Magistrates' Court**

