Report on an unannounced inspection visit to court custody facilities in

Humber and South Yorkshire

by HM Chief Inspector of Prisons

9–18 March 2015

Glossary of terms

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Section 1. Introduction

This is a report in a series of inspections of court custody facilities carried out by HM Inspectorate of Prisons. These inspections contribute to the United Kingdom's response to its international obligation to ensure regular 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 Humber and South Yorkshire, there were 13 courts currently in use that had custody facilities, including four Crown courts. GEOAmey had been contracted on behalf of HM Courts & Tribunals Service (HMCTS) to provide court custody and escort facilities in the two counties.

Strategic relationships between HMCTS and GEOAmey were positive and communication about changes to court processes or procedures were communicated to those primarily concerned with court custody. HMCTS understood their role in relation to the provision of custody facilities and delivery managers attended custody suites to monitor conditions and informally deal with any issues, however, arrangements should be formalised to ensure that all staff understand their obligations. There were a range of meetings attended by organisations with responsibilities for custody but there was insufficient focus on court custody at the meetings, consequently issues such as custody cases not being prioritised and poor conditions of some suites were left unresolved.

Custody staff treated detainees courteously and we saw examples of good detainee care. However, staff lacked training - they did not know about local safeguarding procedures and they had received no training on diversity or mental health awareness. Staff did not routinely inform detainees of their rights in court custody and not all staff had been briefed about the particular needs of detainees in their care. While custody staff strove to provide a good level of care, they sometimes failed to follow basic procedures to safeguard those who were potentially vulnerable, for example, not understanding their legal obligation to report safeguarding concerns and not being sufficiently trained or supported by operating procedures in recognising and responding to safeguarding issues.

Poorly completed person escort records accompanying detainees from local prisons and police stations, impacted upon custody staff and their ability to appropriately care for detainees.

Some custody staff attempted to address the needs of children by asking the court to deal with their cases first, However, these efforts were undermined by delays incurred in the system in allocating and transferring children to secure training centres.

Custody staff were expected to handcuff all detainees at all times when moving around the custody suites. The lack of a designated officer in charge at Grimsby Magistrates' Court was concerning. There was no one individual with oversight of the detainees, their risks or vulnerabilities or management of the custody suite.

GEOAmey had not received any written complaints and staff did not record verbal complaints made by detainees. It was not possible to establish if complaints had been thoroughly investigated.

The physical conditions of most of the suites were good except at the Sheffield Magistrates, and Crown court which were in a poor state of decoration and contained graffiti. Lay observers had been proactive in highlighting concerns about court cells and these had been escalated to the Prison Escort Contract Service (PECS), but there had been no significant improvement at the aforementioned courts.

This report raises a range of concerns about safety, risk management, and the training needs of staff to enable them to improve the care of people detained in court custody, particularly the most vulnerable. 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 August 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 Humber and South Yorkshire court custody suites comprised:

Custody suites	**Number of cells**
Humber	
Hull Crown Court	8
Grimsby Combined Court	6
Beverley Magistrates' Court	7
Bridlington Magistrates' Court	7
Grimsby Magistrates' Court	9
Hull Magistrates' Court	20
Scunthorpe Magistrates' Court	14 (shared with police)
South Yorkshire	
Sheffield Crown Court	16
Doncaster Crown Court	10
Sheffield Magistrates' Court	10
Doncaster Magistrates' Court	10
Rotherham Magistrates' Court	11
Barnsley Magistrates' Court	9

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

Leadership, strategy and planning

2.4 There were formal meeting structures that included Her Majesty's Courts and Tribunal Services (HMCTS), Prison Escort Contract Service (PECS) and GEOAmey but there was insufficient focus on court custody. GEOAmey staff and managers told us of the ongoing issue of custody cases not being prioritised, despite there being a court protocol. This had been reported by GEOAmey to HMCTS but the problem persisted at some courts. HMCTS court delivery managers had recently started to visit the custody suites regularly. This needed to be formalised, so that records of reported concerns could be monitored and resolved.

2.5 There was a good local lay observers group, which proactively reported concerns about the conditions of cells to HMCTS and PECS. As a result there were some improvements to the court cells at Rotherham and increased monitoring by HMCTS at Sheffield Courts, however the conditions remained unsatisfactory.

2.6 The outcome of audits was not effectively communicated to court custody staff. GEOAmey's quality assurance processes focused too much on completion of paperwork and security issues. Of particular concern, there had been no designated officer in charge at Grimsby Magistrates' Court for several months, with the court custody suite being managed by consensus. There was no one individual with oversight of the detainees, their risks or vulnerabilities, or operation management of the custody suite. Practices at Grimsby Magistrates' Court were not always consistent with GEOAmey policy or routinely risk assessed, for example, no risk assessment was completed to determine if a group of detainees were safe to be handcuffed together during their transfer from police custody.

2.7 GEOAmey had a safeguarding policy for children but not for adults. They had not provided sufficient guidance to staff about how to respond to safeguarding issues effectively. Staff were not aware of the central reporting process regarding safeguarding concerns about children.

Individual rights

2.8 Custody staff checked each incoming detainee's documentation to ensure they had the correct authority to detain, but this did not happen until after the detainee was located in the cell. HMCTS Managers told us that people arrested by Court Enforcement Officers (CEO) for issues such as fine default could be taken to court, in practice this did not happen and people were taken to the court custody suite. HMCTS were uninformed of practices in their custody suites.

2.9 All courts had procedures for informing the youth offending service (YOS) when there were children in custody. Courts were proactive in prioritising cases involving children to reduce their time in court custody. However, this attempt was undermined by either the Youth Justice Board (YJB) placement order being processed too late or the escort contractors not arriving for several hours. The system overall did not provide expediency or reduce time spent in custody for children.

2.10 In most suites, custody staff did not routinely offer detainees a copy of their rights, or ask if they were able to read. Some custody staff assumed that most detainees were familiar with court custody processes, which was not always the case.

2.11 Custody staff used court interpreters when they needed to communicate in the detainee's first language. They were not clear about how they would communicate welfare concerns if a court interpreter was not available.

2.12 At some courts staff were proactive in telling detainees how to make a complaint, but they did not record verbal complaints on site. There were no complaints recorded for any of the court custody sites in the previous six months.

Treatment and conditions

2.13 There were few excessively long journeys as most detainees were transported to and from local police stations and prisons. Many of the cellular vehicles we inspected were dirty. At two courts, detainees embarked and disembarked from cellular vehicles in easy view of passing members of the public.

2.14 Custody staff were courteous and friendly with detainees throughout their detention period. They had not received any specific training on diversity, child protection or mental health awareness. There was no specific provision for children and no named member of staff allocated to their care. Detainees were not routinely asked about religious observance, dietary requirements or any other needs on arrival at court. At all of the suites, door mats or carpet samples were used as prayer mats, which was inappropriate.

2.15 Staff morning briefings did not include all staff and most were not sufficiently focused on planning for risk management and the care of vulnerable detainees. Many person escort records (PERs) accompanying detainees from local prisons and police stations were poorly completed, with vague or missing risk information. A reception information sheet, to support staff in the overall care of detainees, was being piloted across all the courts. Staff had not been adequately briefed on how to implement this, and not everyone was aware of the introduction of the form. Most of the custody suites had a whiteboard on which detainees' personal information was written. It was inappropriately located so detainees could see it.

2.16 Overall risk management was inconsistent. Staff interacted with detainees who were at risk of harming themselves, but did not always record the information on either GEOTrack (a computer system) or the PER, to assist in detainees' ongoing care. The quality of cell sharing risk assessments (CSRAs) was generally good but some were completed after detainees had been sharing cells for some time. There was no pre-release risk assessment for people leaving custody. We saw a significant number of people in handcuffs which was often unnecessary and disproportionate, in some cases this was simply down to the preference of individual staff.

2.17 The physical conditions of the custody facilities varied. Humber courts were clean and well maintained, with good mechanisms for reporting faults, which were dealt with efficiently. The condition of the cells at Sheffield courts was poor. Lay observers had been proactive in highlighting concerns about these cells but they still contained offensive, racist graffiti on the cell doors; some of which was removed during the inspection. At Rotherham Magistrates' Court, there was a swastika scratched into the frame of the cell door.

2.18 There were generally good arrangements for medical assistance to the custody suites, although at some courts staff found the response callout time from the medical provider slow. Health issues were not always adequately recorded on PER forms. Custody staff were proactive in clarifying health needs by asking police custody staff to check their records and telephoning prison health care departments.

2.19 Custody staff had a reasonable awareness of mental health issues, and established court liaison and diversion services were sited or easily accessible at most suites, with a primary focus on the magistrates' courts. They generally understood how to access mental health services and displayed concern about detainees' welfare, but lacked formal training in mental health awareness. They had a reasonable understanding of substance misuse issues and the

risks associated with alcohol withdrawal, but were not always aware of their local drug and alcohol services or how to contact them. They had received no formal drug and alcohol awareness training.

Main recommendations

2.20 Court custody staff should be trained to identify and refer detainees about whom they have child protection or safeguarding concerns.

2.21 A professional telephone interpreting service should be available in each custody suite and used as necessary.

2.22 Person escort records should contain sufficient accurate, legible risk information and health care advice to inform risk assessment and facilitate the care of detainees.

2.23 Staff should complete a standard risk assessment form for each detainee, and be trained to do this.

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

National issues

2.25 Her Majesty's Courts and Tribunal Services (HMCTS) and Prison Escort and Custody Services (PECS) should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody.

2.26 HMCTS and PECS should clarify the responsibilities of each organisation for resolving problems.

2.27 Complaints in court custody should be monitored and complaints should be included in the measurement of performance.

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 HMCTS in Humber and South Yorkshire operated as a single ‘cluster’, led by a cluster manager. At every court location there was an operations manager or delivery manager to oversee the efficient processing of cases. The day-to-day communication about court custody mainly involved the delivery managers. Across the courts, there were regular, informal meetings between the HMCTS delivery manager and the senior custody officer (SCO), held in the court custody suites, enabling the delivery managers to have oversight of the conditions there. This was a relatively new arrangement, and more formal structures between the court custody contractor (GEOAmey) and HMCTS were needed, so that records of reported concerns could be monitored and resolved. We were told that any changes to court process or procedures that might impact on the delivery of court custody provision were always raised with the contractor; an example given was the centralisation of Saturday courts, concentrating custody cases in fewer courts on a Saturday.

3.2 The number and location of court user groups had been streamlined some time ago. Currently there were two court user groups at Hull and Sheffield Crown Court and the other at Grimsby Magistrates’ Court, with specific focus on ‘transforming criminal justice’. GEOAmey was represented at these meetings by the relevant area business manager but there was no focus on custody provision. GEOAmey staff and managers told us of the ongoing issue of custody cases not being prioritised, despite there being a court protocol. This had been reported by GEOAmey to HMCTS but the problem continued at some courts (see also section on individual rights). HMCTS held a quarterly efficiency and effectiveness meeting which addressed the court processes and involved all court users except GEOAmey. This might have been an appropriate meeting for GEOAmey to be represented at to raise concerns about the prioritisation of custody cases.

3.3 There was a good local lay observers group; PECS met with them but HMCTS did not, which was a missed opportunity to have an ongoing independent oversight of the conditions of the custody suites. The lay observers group had reported the poor environment of some of the courts to HMCTS and PECS As a result there were some improvements to the court cells at Rotherham and increased monitoring by HMCTS at Sheffield Courts, however the conditions remained unsatisfactory.

3.4 The PECS quarterly meeting focused mainly on contract compliance but we were reassured that when issues regarding detainee welfare were raised they were dealt with, for example, a protocol had been put in place between GEOAmey and HMP Doncaster to manage and support the increasing number of prisoners self-harming.

3.5 PECS contract managers conducted a ‘safe, secure, decent and compliant’ audit of each court custody suite every two years. The audits were thorough and detailed and focused on relevant court custody processes and procedures as well as observations of staff practice in court custody. The most recent audits, completed in 2014, identified some clear actions that needed to be taken by the contractor. Improvements made at Rotherham Magistrates’ Court following the audit had strengthened communication between court custody staff and the delivery manager, and resolved some maintenance issues. The area business managers had overall oversight of the recommendations from the audit but these were not communicated effectively to court staff, and at some courts staff were unaware of them.

3.6 GEOAmey's quality control focused mainly on paperwork and security issues. It did not check on the compliance of policies and procedures in ensuring good standards of detainee care across the courts. Detainees were not routinely informed of their rights, cell sharing risk assessments were not consistently completed, important information about detainees' care was not always recorded, and graffiti remained in some courts. Of particular concern, there was no designated officer in charge at Grimsby Magistrates' Court during the inspection, with the custody suite being managed by consensus. There was no one individual with oversight of the detainees, their risks or vulnerabilities, and how they might need to be responded to, or operation management of the custody suite. Practices were not always consistent with GEOAmey policy or routinely risk assessed for example no risk assessment was completed to determine if a group of detainees were safe to be handcuffed together during their transfer from police custody (see section on use of force).

3.7 GEOAmey handcuffing policy was unnecessary and disproportionate. It seemed particularly harsh for compliant children. The GEOAmey safeguarding policy outlined that children should be handcuffed as a last resort but this was not known to staff. We were told that handcuffing decisions were made following a systematic risk assessment, yet we could find no records that would have been open to scrutiny (see also section on safety and main recommendation 2.24).

3.8 GEOAmey had a safeguarding policy for children but not for adults, with one manager stating: 'It is not in the contract', which was unacceptable, particularly as some serious gaps in the knowledge and understanding of staff were highlighted during the inspection. In addition, they had not provided sufficient guidance to staff about how to respond to safeguarding issues effectively. Staff were not aware of the central reporting process regarding safeguarding concerns about children (see main recommendation 2.20).

Recommendations

3.9 **There should be regular inter-agency forums covering all courts in the cluster, and their remit should include improvements in the care of detainees in court custody.**

3.10 **Quality assurance processes should be more effective in encompassing key elements of detainee care and rights during escorts and court custody.**

3.11 **There should be a designated officer in charge, responsible for the safe, respectful and decent delivery of court custody.**

Housekeeping point

3.12 Recommendations from the 'safe, secure, decent and compliant' audit should be communicated effectively to court staff.

Section 4. Individual rights

Expected outcomes:

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

4.1 At most courts, custody officers checked the documentation that accompanied each detainee, to ensure that they had the correct authority to detain; however, this was usually done once the detainee had already been placed in their cell.

4.2 At most magistrates' courts, we saw remand cases being dealt with promptly, with many cases being concluded in the morning. However at Scunthorpe Magistrates' Court we saw long delays. In one case a detainee, the first to be dealt with that morning did not go to court until 12.05pm. In Sheffield some detainees were not seen until late afternoon, having spent a night in police custody, with no reason for the delay, staff told us this was a common occurrence. This issue had already been escalated to HMCTS, but there had been no improvement.

4.3 Warrants of detention were received from courts in a timely manner, sometimes within 30 minutes of remand or sentence, which was excellent. This enabled them to be checked before onward transport to prison was arranged. Interim warrants were accepted at all local prisons, so that detainees could be transferred without delay, which was a good arrangement. Escort vehicles often arrived at court in the late morning to convey detainees to prison, avoiding long periods of detention in the cells. During the inspection, HMPs Doncaster and Hull received detainees at 11am on a Saturday, and we were told that they would have received them even later in the day if the court was still sitting.

4.4 HMCTS managers told us that people arrested by CEOs could be taken to court to wait, rather than being detained in the custody suite, but this was not the case in practice and was not recognised as practice by a CEO we spoke to. We saw virtually no arrangements for the CEOs to deliver compliant individuals directly to the court room, thereby avoiding unnecessary detention in the cells and the accompanying handcuffing procedures (see section on safety). We were made aware of examples which demonstrated this point; at Barnsley, a woman had voluntarily surrendered at court at 9.30am and had been taken promptly into custody by a CEO and lodged in the court cells. She had not appeared in court until 3.50pm, despite the efforts of custody officers to have her case prioritised. In another case, at Doncaster, a man had surrendered voluntarily by appointment to the court for a non-payment of fine warrant at approximately 2pm, and been placed in a cell. Two hours later, he had been released to attend voluntarily at the court where his case was to be heard, which raised the issue of whether he should have been detained in a cell in the first place. We were told that these detentions were commonplace, often for minor issues and when people had attended by appointment at the court. HMCTS were uninformed of these practices in their custody suites.

4.5 Staff at all courts described a good relationship with their local YOS, and YOS staff were proactive in contacting the court cells every morning to identify if any children were in custody, including on Saturdays. We saw YOS workers visiting the court cells promptly, including on a Saturday, after learning that children were in custody.

4.6 The court clerk was notified when children were in the court custody suite and custody staff told us that cases involving children were usually prioritised by the courts, to ensure that they did not remain in custody too long. We witnessed this taking place and also saw from the records we reviewed that children were dealt with promptly in most cases.

4.7 However, in cases of remand to secure training centres, these prompt hearings did not necessarily result in children leaving court custody at the earliest possible opportunity. We were told that placement orders from the Youth Justice Board were not always processed quickly. For example, at Barnsley Magistrates' Court during the inspection, a 15-year-old boy was sentenced at 3.40pm, but he was not picked up by the escort contractor until 7.40pm owing to delays in identifying a placement for him. There then followed a further one-hour transport to the secure training centre. Records completed on children did not always record when placement orders were processed or the time that they were called to court. The system overall did not provide expediency or reduced time spent in custody for children.

4.8 Detainees were accepted from police custody throughout the day. For example, at Sheffield Magistrates' Court we saw one detainee being accepted at 2pm and another being received at 3.35pm from the adjacent police station; this was positive as it prevented the detainee having to spend a night in police custody.

4.9 Custody staff reported some delays in obtaining authority to release detainees who had come from prison and had then been bailed or released by the court, mainly between 1pm and 2pm. We did not observe any significant delays, we saw the authority to release being given verbally by HMP Doncaster on receipt of a telephone call (from Sheffield Magistrates' Court) which had been made to confirm receipt of the formal fax notification, and at Hull Crown Court authorisation was obtained from the local prison within the hour.

4.10 Court custody staff in some of the magistrates' courts told us that, in exceptional circumstances, if a detainee was sentenced to prison, they would make a telephone call to inform someone of the detainee's whereabouts which was good, or refer the matter to the detainee's legal representative, and we saw an example of this.

4.11 Practices varied across the courts in relation to staff advising detainees about their rights and entitlements, and at some courts detainees were not asked on arrival if they were aware of these. Occasionally, a copy of the rights was offered to detainees (and usually accepted). It was only at Doncaster Magistrates' Court that we observed custody staff consistently offering a printed sheet of rights and entitlements to detainees as they arrived. Some custody staff assumed that most detainees were familiar with court custody processes; although this was the case with many detainees during the inspection, we also saw some who had never been in custody before, did not understand what was happening and would have benefitted from having the rights leaflet. Staff sometimes failed to identify whether the detainees could read. Most courts had a rights poster displayed in 28 different languages. Custody staff were aware of how to access the rights notice in foreign languages on the intranet and we saw copies being appropriately issued to Kurdish, Slovakian and Romanian nationals.

4.12 Staff ensured that all detainees had access to legal representation when they arrived at the custody suite. We saw legal representatives being allowed access to detainees in a suitable interview room. However, some of these rooms were closed visits rooms and not all solicitors we spoke to were satisfied with this.

4.13 At Scunthorpe Magistrates' Court, the police custody suite was shared with the court. Although there were sufficient, adequately equipped consultation and interview rooms there, staff told us that they were not able to use these, and we saw legal representatives consulting with detainees in cells, with custody staff standing outside the open door. Thus undermining detainees' right to confidentiality. We were told this was also the case for staff from YOS and Probation services. This practice was unsatisfactory as detainees had no access to private legal consultation and had no privacy when meeting with staff from key support services.

4.14 A professional telephone interpreting service was provided by GEOAmey, but not all custody staff were aware of this. With the exception of Doncaster Magistrates' Court and Sheffield Crown Court, where portable telephones were available or a telephone was available on a desk in the reception, staff denied detainees' access to this service as the telephone was situated in an office that detainees were not normally permitted to enter. There was a standard operating procedure for use of interpreting services, giving staff the discretion to risk assess taking a detainee into the office; however, staff we spoke to were unaware of this and were reluctant to take this action, preferring instead to access the services of the court-appointed interpreter. During the inspection we saw a young adult (15 years), with limited English who had been detained overnight by police, the next day he was transferred to court and bailed to appear again the following day, because there was no interpreter. It was unclear if he understood what was happening and that he had to return to court the following day. (See main recommendation 2.21).

4.15 Information about how to make a complaint was included in the rights and entitlement documentation, but this was not routinely handed out to detainees (see above), which might, in part, have accounted for there being no complaints recorded for any of the court custody suites in the previous six months. It was therefore not possible to ascertain how thoroughly complaints were investigated or how organizational learning was obtained from them. A notice detailing the complaints procedure was displayed on the wall in most suites but detainees were not given time to read it. At some courts staff proactively told detainees that there was a complaints procedure. Most custody staff told us that they would try to resolve complaints informally but that if this failed, they would issue the detainee with a complaint form. At Sheffield Crown Court, staff told us that detainees often verbally complained about the state of the cells, but this did not result in a formal complaint being made.

Recommendations

4.16 **HMCTS should ensure that custody cases are prioritised where possible, and this should be monitored.**

4.17 **Detainees who have attended court voluntarily, and who can be dealt with at court on the same day, should not be detained in cells unless there is good reason to do so.**

4.18 **HMCTS and PECS should liaise with the Youth Justice Board to reduce delays in transferring children to secure training centres.**

4.19 **All courts should offer detainees information about their rights, including the process for making a complaint, and staff should offer to read or explain the information if necessary.**

4.20 **There should be sufficient comfortable, private consultation rooms at all courts.**

Housekeeping points

4.21 Custody staff should ensure that all relevant information, including the time that the detainee is dealt with by the court and that a placement order is received, is recorded on a young person's cell allocation form.

4.22 Custody staff should check that they have the correct authority to detain a person at the earliest opportunity.

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 were dirty, and came from a range of depots from outside the Humber and South Yorkshire region. They all had first-aid kits containing anti-ligature knives, and drinking water was available. In a vehicle at Grimsby Crown Court, there was graffiti naming an individual as a 'grass' and what looked like saliva on the floor, which was unhygienic and should have been removed before the van was used. An adapted vehicle had been secured for a mentally vulnerable detainee, but the electronic step was faulty. We did not see any women, children and adult men in the same vehicle but most staff told us that when this did occur, they would use the vehicle's partition to separate them.

5.2 There were few excessively long journeys as most detainees were transported to and from local police stations and prisons. In many cases, direct, private access was available between neighbouring police stations and the court custody suites via underground tunnels or staircases.

5.3 All detainees were disembarked promptly from vehicles into court buildings. The van bays at most courts were private and secure, but those at Sheffield and Doncaster Magistrates' Courts afforded disembarking detainees little or no privacy and they could be observed by passing members of the public.

5.4 Escort staff ensured that all necessary information about detainees accompanied them to court, although sometimes this was only checked 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 appropriately bagged and securely sealed.

5.5 Most of the custody suites had a whiteboard on which detainees' names, cell numbers and the outcome of the court appearance was written; this was inappropriately sited where others could view it. At several courts, we saw detainees studying the whiteboard when they arrived and commenting on who else was in custody.

5.6 Custody staff were courteous and friendly with detainees throughout their detention, understood that the court appearances were stressful for detainees and showed empathy. Generally, we saw them using good interpersonal skills to de-escalate difficult situations. They were familiar with some of the detainees who had been in custody before and responded with an appropriate level of vigilance to those who had previously been challenging. However, in most cases, once a detainee had been placed in their cell, most staff made little effort to interact with them, even when they were not busy.

5.7 Custody staff had not received any specific training on diversity, child protection or mental health awareness. At most courts, they were unaware of the GEOAmey policy on searching transgender detainees, although most staff said that they would get a female member of staff to search the detainee or ask the detainee their preference. The GEOAmey standard operating procedure for searching such detainees provided unclear advice.

5.8 There was no specific provision for children and no named member of staff allocated to their care. A 'young person's cell allocation form' was completed before deciding how to care for a child. The forms we reviewed were not always fully completed, and staff were unclear about safeguarding procedures for children or vulnerable adults (see section on safety). A vulnerable 13-year-old at Grimsby Magistrates' Court was treated no differently to adult detainees, other than being placed in a cell on a separate corridor from them, and staff showed little interest in him.

5.9 Most courts had a separate corridor for female detainees and children but in the courts without one, staff took 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 helpfully located in the women's toilet at Beverley and Bridlington courts, although not advertised.

5.10 There were no blankets or pillows in the cells, except at Scunthorpe Magistrates' Court, which shared the suite with the police station. Pregnant or older detainees, or those with disabilities, therefore had to wait on hard benches. Detainees were not routinely asked about religious observance, dietary requirements or any other needs on arrival at court, despite the introduction of a reception information form that required these questions to be asked (see section on safety). Most of the custody suites did not have a copy of the Bible, or Qur'an. Some cells had the direction of Mecca displayed on the cell wall or corridor. All suites used door mats or small carpet sample tiles as prayer mats, which was inappropriate.

5.11 Hull Magistrates' Court, with an adapted toilet and access to courts by lift, was the designated court for detainees with disabilities, but staff at most courts in the cluster seemed unaware of this. There were no hearing loops in any of the custody suites; in some court custody areas, there was a sign suggesting that there were, when in fact the hearing loops were only available in the court itself, which was potentially misleading. There was no information in Braille at any custody suite.

5.12 Custody officers at all courts brought in old newspapers and magazines for detainees, as GEOAmey did not provide reading material. Some courts were proactive in handing these out to detainees, but others did not do so until a detainee asked for something to read. At some courts, staff allowed detainees to keep books and puzzle books they had being using in police custody, subject to a search of the items and no risk markers. The quantity and quality of the reading material available were limited. There was no reading material in foreign languages or easy-read format, and nothing suitable for children.

5.13 At all courts, arrangements for securing detainees' property were adequate.

5.14 Detainees were given a hot drink on arrival and further drinks during the day, and offered microwave meals or sandwiches at lunchtime. Further meals were offered to detainees who had been detained late at court. Microwave ovens and food preparation areas were mostly clean.

Recommendations

5.15 Cellular vehicles should be clean and free of graffiti.

5.16 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. Detainees should not be embarked or disembarked from escort vehicles in public view.

5.17 Children in court custody should be supported by a specifically trained and named staff member.

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

5.19 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.

5.20 There should be a small stock of mattresses and blankets or warm clothing for detainees who are pregnant, older or have disabilities.

5.21 All court custody suites should have materials for observance of the main religions. Materials should be suitable and be respectfully stored. There should be a means for determining points of the compass.

5.22 All court custody suites should have hearing loops as well as Braille versions of key information.

5.23 All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers, and this should be offered to detainees routinely.

5.24 Information about detainees should not be displayed in public view.

Housekeeping points

5.25 Staff should routinely inform all female detainees of the availability of sanitary packs.

5.26 All staff in the cluster should be made aware that Hull Magistrates' Court is the designated court for detainees with disabilities.

Safety

5.27 All custody staff were required to receive early morning briefings but the quality of these varied most were not sufficiently focused on planning for risk management and the care of vulnerable detainees. Not all staff, particularly escort staff who arrived later in the morning to provide support, received them. Some SCOs handed round a briefing sheet requiring all staff to sign that they had read and understood the information. There was often a reliance on self-briefing, which was not adequate.

5.28 Overall, we had no concerns about the staffing of courts during the inspection, but we were told by a range of staff that they did not always receive additional staffing when requested, and that they occasionally had too few staff adequately to run the custody suite. HMCTS managers did not have any concerns about staffing in the custody suites or their ability to staff the court docks.

5.29 Many person escort records (PERs) accompanying detainees from local prisons and police stations were poorly completed, with vague or missing risk information that did not assist custody staff in looking after some very vulnerable detainees. For example, in one case the detainee was known to the court staff but his PER failed to detail that he had had previous thoughts of self-harm. In addition, several failed to identify that the detainees were foreign nationals and that their knowledge of English was limited or non-existent. (See main recommendation 2.22).

5.30 Custody officers did not complete a systematic risk assessment when detainees arrived at court. At all courts, custody staff allocated cells on the basis of inadequate GEOtrack (a computer system) information before 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 seek clarification about concerns. There were some exceptions to this; for example, at Barnsley Magistrates' Court we saw a member of staff spend a considerable length of time in a cell calming down a young male detainee suffering from attention-deficit hyperactivity disorder who had became upset and volatile.

5.31 A prisoner reception information sheet was being piloted across all the courts and had been introduced a week before the announced inspection. It required staff to ask detainees questions about their literacy, dietary needs, health and any vulnerabilities or risk. It also prompted staff to tell detainees about their rights, the complaints process and other relevant information. This form, alongside information from PERs, should have enabled court custody officers to improve the care of detainees in their custody, but during the inspection staff were confused about what they were required to do with it. At most courts, it had been introduced via email, with no clear instructions about how to introduce it and what they were required to record. As a consequence, some courts were using this sheet but not asking all the questions, at another court they had forgotten to complete it on any detainees and at one court staff were not aware that it had been introduced. Some staff were asking detainees to sign the form to confirm that they had been asked the questions and given the required information; this was not appropriate as we saw few instances where staff went through the entire sheet with detainees. While this sheet appeared to have been introduced as a form of risk assessment, its content, purpose and use needed to be reviewed to clarify to custody staff its intended aims (see main recommendation 2.23).

5.32 Due to the low numbers of detainees entering the custody suite at many of the courts, detainees were often not required to share a cell. When they were required to share cells, their allocation was decided based on information contained in PERs, and the detainee's demeanour. Generally, CSRAs were fully completed, highlighting any warning markers, but some were completed after detainees had been sharing cells for some time (in one instance, 90 minutes later) and staff did not always complete a CSRA on both detainees. Custody staff did not fully understand the importance of CSRAs, and some were more concerned about having all the paperwork in order than using the document to ensure that detainees were safe.

5.33 The frequency of observations varied from court to court. Staff were unclear about how often they should check on 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 saw no additional interaction with children in custody (see recommendation 5.18). Checks were not always communicated to the officer

inputting information on GEOTrack, who generally assumed that all was in order as they were not told otherwise.

5.34 At Grimsby Crown Court, we saw staff conducting a constant observation on a detainee who was harming himself by pulling dressings off his arms. They were respectful and interacted with him throughout his detention, and he told us that he appreciated the care that he was being offered. We saw staff engaging with all detainees with a self-harm warning marker, to establish how they were feeling. Staff at all courts were aware of the process involved when supporting detainees subject to ACCT case management.

5.35 In most suites, anti-ligature knives were kept in the first-aid kit, with spare knives in the office, but staff on cell duties did not carry them, which could potentially have delayed access to them in an emergency situation. Detainees could not have social or domestic visits, unless directed by the court.

5.36 There were no significant delays in transferring detainees from cells to the courtroom. Several routes to court had steep staircases and we were concerned about risks to staff and detainees in suites where there were affray alarms only on the landings and not on the stairs.

5.37 There was no systematic pre-release risk assessment for people leaving custody. At Grimsby Crown Court, a very vulnerable detainee had made concerning disclosures that were not initially acted on by court custody staff. Although he was treated well by staff, there was no safeguarding policy or training, or support to assist court custody staff in responding adequately to this situation (see paragraph 5.71). Following guidance from an inspector, court staff and managers responded to the detainee's disclosures and the matter was investigated. At Grimsby Magistrates' Court we saw a 13-year-old boy (see also paragraph 5.8) being released from custody with no questioning about who would be meeting him; the focus was solely on whether he needed the bus fare home. Before his release, we had in fact determined that the child`s mother and YOS worker were waiting to meet him, but this was unknown to custody staff.

5.38 Few staff we spoke to understood that they had a duty to `refer on` if they had concerns about someone leaving court custody. At most courts, staff told us they would contact their line manager, probation staff or the 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 2.20). Overall detainee care was too reliant on individual staff's awareness and knowledge.

5.39 In most cases, staff completed the prisoner release checklist before a detainee left the custody suite, but this focused on security issues and was completed with no input from the detainee. When a detainee was remanded or sentenced, court custody staff ensured that 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.

5.40 With the exception of Doncaster and Barnsley Magistrates' Courts, no courts had a leaflet about local support organisations. Most courts had a helpful leaflet entitled `What happens next`. This was aimed at detainees who had recently been sentenced to a period of imprisonment and gave details of first night procedures in prison, and was available in many foreign languages, although not all staff were aware of this. There was a specific leaflet (in English only) for HMP and YOI New Hall, but not for the local prisons of HMPs Hull and Doncaster. Travel warrants for trains were available at all courts and petty cash was used to pay for bus fares.

Use of force

5.41 We were told that use of force was rare, and all staff received annual training in control and restraint techniques. Staff used their interpersonal skills to de-escalate potential conflict and we saw this to good effect during the inspection. The few completed use of force forms that we reviewed contained a thorough account of the incident. Custody staff received no feedback after they reported use of force to their managers.

5.42 All detainees had rub-down searches after using the toilet, seeing legal advisers and returning from the courtroom, which was excessive.

5.43 Handcuffing practices varied between courts. Much handcuffing was disproportionate, such as the routine handcuffing of all detainees in secure areas, including all women and children. We were told that the level of handcuffing was determined following a risk assessment, but we could find no systematic written risk assessments to justify the practice (see main recommendation 2.24).

5.44 With the exception of the insecure vehicle bays at Doncaster and Sheffield Magistrates' Courts, detainees were single-handcuffed (that is, their wrists were handcuffed together) when entering and leaving the cellular vehicle at courts, which was better practice than we have seen elsewhere (where we have often seen double-handcuffing, where a detainee is also handcuffed to a member of custody staff). When detainees were collected from neighbouring police stations, via underground tunnels and staircases, they were mostly double-handcuffed, which staff told us was due to these routes being remote.

5.45 There was variable practice of handcuffing detainees to be taken to the court dock, much of which was inconsistent, disproportionate and based on the availability and/or preference of staff. At Grimsby Magistrates' Court, where there was no designated manager taking responsibility for the operation of the custody suite, we saw three members of staff collecting five detainees, including a 13-year-old child, from police custody (see paragraph 5.8). Two sets of two detainees were single-cuffed to each other and the child was handcuffed to a member of staff. No risk assessment was completed to determine if these detainees were safe to be handcuffed together. These practices were unacceptable (see main recommendation 2.24).

Recommendations

5.46 **All custody staff should receive a briefing focused on risk management and the care of vulnerable detainees at the start of duty.**

5.47 **Cell sharing risk assessments should be completed for all detainees before they share a cell.**

5.48 **Staff should record the outcome of all cell visits accurately in the detention log.**

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

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

5.51 **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.**

5.52 **The searching of detainees should be proportionate to the risks posed.**

Housekeeping points

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

5.54 All routes to court should be covered by adequate affray alarms.

5.55 Staff should be made aware that the `What happens next` leaflet (informing recently sentenced detainees about first night procedures in prison) is available in foreign languages.

Physical conditions

5.56 Staff at all courts carried out daily checks of the cells, including checking that the call bells were functioning. At Bridlington, Beverley and Hull Magistrates' Courts, all maintenance issues were reported to the private contractor responsible for the health and safety of the building, allocated a level of priority and then dealt with. We were told, and records we reviewed at these courts showed, that any issues that might result in the cells being taken out of use were resolved within 24 hours. At the other courts, the court staff and HMCTS delivery managers liaised about any maintenance issues; these were then referred to the estates team to prioritise what could be funded for repair. At Hull Combined Court and Barnsley Magistrates' Court, there were outstanding repairs concerning the lighting and a leak.

5.57 The custody suite estate in Humber was in good condition; all suites had recently been deep-cleaned, and remedial decoration had been undertaken in some of the cells at Beverley Magistrates' Court to remove graffiti behind the doors. The conditions of the court cells in Sheffield Magistrates' and Crown Court were in a poor state of decoration and contained graffiti. Lay observers had been proactive in highlighting concerns about court cells in a few courts. Racist graffiti on the cell doors at Sheffield Magistrates' Court was removed during the inspection. At Sheffield Crown Court, it was unclear how staff could enforce the notice on the door stating that they would prosecute anyone found to have damaged the cells, and most of the cells had graffiti and burn marks on the floor, benches, doors and ceilings. At Rotherham Magistrates' Court, there was a swastika scratched into the frame of the cell door.

5.58 HMCTS delivery managers met SCOs informally at most of the courts to discuss the conditions of the cells, among other issues, but this was a recent arrangement and had not yet resulted in any significant improvements. Although cleaning contactors attended all the courts, some of the cleaning did not remove spillages adequately from the cell floors and walls. There were also some ligature points in some cells, which we pointed out to managers during the inspection.

5.59 At some courts, detainees could not use the toilet in privacy because the doors were too low. Toilet paper was available at all courts but was sometimes left lying on the floor. Hand-washing facilities and supplies of soap and paper towels were adequate.

5.60 All courts had fire evacuation procedures, which were clearly displayed and with which staff were familiar. At some, 'desktop fire evacuations drills' had been completed but there had been few emergency evacuation fire drills.

5.61 Staff explained the use of the cell call bells to some detainees, particularly when they knew it was a person's first time in detention. At all courts, staff answered cell call bells promptly.

Recommendations

5.62 **A programme of regular deep-cleaning, graffiti removal and cell repairs should be implemented immediately.**

5.63 **All detainees should be able to use the toilet in privacy.**

Housekeeping point

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

Health

5.65 All custody staff were familiar with how to contact Taylor Made (the medical advice service), and the telephone number was easily accessible in the custody offices, but few said that they had contacted them. Custody staff who had requested a visit from a health care professional (HCP) said that there was often a long wait, of several hours, for them to attend, and in all but one case reported to us, either the detainee had returned to prison or an ambulance had been called by the time the HCP had arrived.

5.66 The previous six months' data from Taylor Made showed a total of seven calls across the 13 courts, including three requested callouts. GeoAmey staff logged calls on individual detainee records and the occurrence log but there was no formal monitoring of the use of the service. Several custody staff told us that the service was purely telephone based, to provide advice and verify prescribed medication, and were not aware that HCPs would attend in person.

5.67 Custody officers told us that they would always call an ambulance if there was an emergency situation, such as chest pain or a loss of consciousness. It was not clear how often ambulances were called to the custody suites; responses from staff seemed to indicate that if they were unsure, they were more likely to call an ambulance, rather than Taylor Made, to be assured of a fast response.

5.68 All custody officers we spoke to were confident and clear about how they would respond to a potential medical emergency, although they seemed more reliant on their previous life experience and commonsense than on any training they had received. Staff in all the suites received a three-yearly first-aid update, including basic life support; most had no experience of using their skills. No custody staff had been trained to use an automated defibrillator.

5.69 First-aid boxes were kept in the main custody offices. They all contained anti-ligature knives (see also section on safety), bandages, plasters, dressing pads, gloves and disposable resuscitation facemasks. Boxes were restocked from a standard list and there was a weekly check process as part of the standard operating procedures; staff told us that they automatically reordered when an item was used. At Sheffield and Scunthorpe Magistrates'

Courts, there were single-use containers of sterile eyewash, and at Scunthorpe Magistrates' Court these, and some antiseptic wipes, were out of date. At Rotherham Magistrates' Court, the box was missing several items, including vent aids (resuscitation face masks). None of the boxes contained airway aids and there was no access to automated external defibrillators, oxygen or suction at any of the court buildings.

5.70 Custody officers relied on information on the PER form and information from detainees, but health issues were not always adequately identified on the PER form. Custody staff were suitably proactive in clarifying health needs by asking police custody staff to check national strategy for police information systems (NSPIS) records and telephoning prison health care departments; in some cases, the NSPIS medical form was transferred with the PER form. We saw some instances of the medical form being faxed to the custody suite.

5.71 One of the PERs we saw at Grimsby Crown Court contained inadequate health information to enable custody staff to understand or cope with the complex needs of the detainee. There were some serious safeguarding concerns relating to this detainee but, despite their individual concern and caring approach, custody staff had no formal process to invoke; this detainee was appropriately put on a constant watch following attempts to injure himself (see paragraph 5.37).

5.72 Detainees usually arrived from police custody or prison with their prescribed medication and with clear instructions, and custody staff were able to administer accordingly; staff said that they regularly called Taylor Made to verify medications but only two such calls had been recorded by Taylor Made in the previous six months.

5.73 Detainees were allowed to keep their asthma inhalers (to relieve difficulty in breathing) and angina sprays (to relieve heart pain or tightness) with them, except at Sheffield Magistrates' Court, where asthma inhalers were kept in the locked property store. Insulin pens and blood sugar testing equipment were usually stored in custody office refrigerators, which was unnecessary. We did not see formal risk assessments relating to the retention of medicines by detainees.

5.74 Prescribed medication was stored in the locked property store, access to which was by one key, usually held by the desk control officer or the SCO. At Sheffield Crown Court, we were told that medicines that were due to be given during the day were clipped to the detainee's PER form in a filing tray, to act as an additional reminder; we were assured that this would apply only to non-scheduled medicines.

5.75 Detainees with mental health problems were usually identified by the sending prison or police custody staff on the PER form (see also paragraph 5.71) and would already had been seen while in police custody or at the sending prison. There were established court liaison and diversion services sited or easily accessible at most suites, with a primary focus on the magistrates' courts. Barnsley Magistrates' Court was due to adopt one of the next wave of new court and liaison diversion schemes (on 1 April 2015) and at Scunthorpe Magistrates' Court there were good links with the local community mental health team. Custody officers were generally aware of how to access mental health services, although at Hull Crown Court this was more limited.

5.76 Detainees with drug and alcohol issues were usually identified on PER forms. At the time of the inspection, at Hull Magistrates' Court, several detainees with known drug problems had transferred from police custody with no information on the PER forms. There were drug and alcohol services based at, or linked with, several courts. Custody officers were not always aware of their local drug and alcohol services or how to contact them but we saw drug and alcohol workers attending the suites. Staff had a reasonable understanding of the risks associated with alcohol withdrawal, but had received no formal drug and alcohol awareness training.

5.77 There was a standard operating procedure (SOP) for the response to an emergency health incident, which included actions expected following a death in custody, unhelpfully described as 'Death in custody at court', but none of the officers seemed to be aware of it.

5.78 A second SOP detailed expectations relating to medical issues and was titled 'Medical requirements'. Exception 1 (medical emergency) detailed the need to call emergency services if there was a 'clear medical emergency'; however, this appeared to be commonly used for issues that might have been more appropriately dealt with by Taylor Made.

Recommendations

5.79 Custody staff should understand how and when to call Taylor Made, including its role in providing advice and medical triage.

5.80 Custody staff should be appropriately trained in: emergency response skills, including the use of automated external defibrillators, with annual refresher training; mental health awareness; and drug and alcohol awareness.

5.81 First-aid equipment should include sufficient in-date kit to manage all predictable incidents, including automated external defibrillators and equipment to maintain an airway.

5.82 All detainees should be able to have asthma inhalers and glucose blood testing equipment with them at all times, unless a formal risk assessment indicates otherwise.

5.83 Where sending establishments have omitted vital information from the person escort record (PER) pertaining to the health and welfare of a detainee, there should be formal escalation process to ensure lessons are learnt and mistakes are not repeated.

Housekeeping points

5.84 Blood sugar testing equipment should not be stored in the refrigerator. Insulin for use on the same day can be stored at room temperature, but only if this is below 25 degrees centigrade.

5.85 The standard operating procedure described as 'Death in custody in court' should be revised to ensure that its title reflects the expectations of custody staff in an emergency situation; it should be easily accessible and staff should be reminded of its purpose.

Section 6. Summary of recommendations and housekeeping points

Main recommendations

6.1 Court custody staff should be trained to identify and refer detainees about whom they have child protection or safeguarding concerns. (2.20)

6.2 A professional telephone interpreting service should be available in each custody suite and used as necessary. (2.21)

6.3 Person escort records should contain sufficient accurate, legible risk information and health care advice to inform risk assessment and facilitate the care of detainees. (2.22)

6.4 Staff should complete a standard risk assessment form for each detainee, and be trained to do this. (2.23)

6.5 Handcuffs should only be used if necessary, justified and proportionate. (2.24)

National issues

6.6 Her Majesty's Courts and Tribunal Services (HMCTS) and Prison Escort and Custody Services (PECS) should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody. (2.25)

6.7 HMCTS and PECS should clarify the responsibilities of each organisation for resolving problems. (2.26)

6.8 Complaints in court custody should be monitored and complaints should be included in the measurement of performance. (2.27)

Recommendations

Leadership, strategy and planning

6.9 There should be regular inter-agency forums covering all courts in the cluster, and their remit should include improvements in the care of detainees in court custody. (3.9)

6.10 Quality assurance processes should be more effective in encompassing key elements of detainee care and rights during escorts and court custody. (3.10)

6.11 There should be a designated officer in charge, responsible for the safe, respectful and decent delivery of court custody. (3.11)

Individual rights

6.12 HMCTS should ensure that custody cases are prioritised where possible, and this should be monitored. (4.16)

6.13 Detainees who have attended court voluntarily, and who can be dealt with at court on the same day, should not be detained in cells unless there is good reason to do so. (4.17)

6.14 HMCTS and PECS should liaise with the Youth Justice Board to reduce delays in transferring children to secure training centres. (4.18)

6.15 All courts should offer detainees information about their rights, including the process for making a complaint, and staff should offer to read or explain the information if necessary. (4.19)

6.16 There should be sufficient comfortable, private consultation rooms at all courts. (4.20)

Treatment and conditions

6.17 Cellular vehicles should be clean and free of graffiti. (5.15)

6.18 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. Detainees should not be embarked or disembarked from escort vehicles in public view. (5.16)

6.19 Children in court custody should be supported by a specifically trained named staff member. (5.17)

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

6.21 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. (5.19)

6.22 There should be a small stock of mattresses and blankets or warm clothing for detainees who are pregnant, older or have disabilities. (5.20)

6.23 All court custody suites should have materials for observance of the main religions. Materials should be suitable and be respectfully stored. There should be a means for determining points of the compass. (5.21)

6.24 All court custody suites should have hearing loops as well as Braille versions of key information. (5.22)

6.25 All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers, and this should be offered to detainees routinely. (5.23)

6.26 Information about detainees should not be displayed in public view. (5.24)

6.27 All custody staff should receive a briefing focused on risk management and the care of vulnerable detainees at the start of duty. (5.46)

6.28 Cell sharing risk assessments should be completed for all detainees before they share a cell. (5.47)

6.29 Staff should record the outcome of all cell visits accurately in the detention log. (5.48)

6.30 Staff undertaking observations and cell visits should carry anti-ligature knives at all times. (5.49)

6.31 Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave custody. (5.50)

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. (5.51)

6.33 The searching of detainees should be proportionate to the risks posed. (5.52)

6.34 A programme of regular deep-cleaning, graffiti removal and cell repairs should be implemented immediately. (5.62)

6.35 All detainees should be able to use the toilet in privacy. (5.63)

6.36 Custody staff should understand how and when to call Taylor Made, including its role in providing advice and medical triage. (5.79)

6.37 Custody staff should be appropriately trained in: emergency response skills, including the use of automated external defibrillators, with annual refresher training; mental health awareness; and drug and alcohol awareness. (5.80)

6.38 First-aid equipment should include sufficient in-date kit to manage all predictable incidents, including automated external defibrillators and equipment to maintain an airway. (5.81)

6.39 All detainees should be able to have asthma inhalers and glucose blood testing equipment with them at all times, unless a formal risk assessment indicates otherwise. (5.82)

6.40 Where sending establishments have omitted vital information from the person escort record (PER) pertaining to the health and welfare of a detainee, there should be formal escalation process to ensure lessons are learnt and mistakes are not repeated. (5.83)

Housekeeping points

Leadership, strategy and planning

6.41 Recommendations from the ‘safe, secure, decent and compliant’ audit should be communicated effectively to court staff. (3.12)

Individual rights

6.42 Custody staff should ensure that all relevant information, including the time that the detainee is dealt with by the court and that a placement order is received, is recorded on a young person’s cell allocation form. (4.21)

6.43 Custody staff should check that they have the correct authority to detain a person at the earliest opportunity. (4.22)

Treatment and conditions

6.44 Staff should routinely inform all female detainees of the availability of sanitary packs. (5.25)

6.45 All staff in the cluster should be made aware that Hull Magistrates' Court is the designated court for detainees with disabilities. (5.26)

6.46 Vulnerable detainees should be able to receive social visits in exceptional circumstances. (5.53)

6.47 All routes to court should be covered by adequate affray alarms. (5.54)

6.48 Staff should be made aware that the `What happens next` leaflet (informing recently sentenced detainees about first night procedures in prison) is available in foreign languages. (5.55)

6.49 Emergency evacuation drills should be conducted and recorded at all courts. (5.64)

6.50 Blood sugar testing equipment should not be stored in the refrigerator. Insulin for use on the same day can be stored at room temperature, but only if this is below 25 degrees centigrade. (5.84)

6.51 The standard operating procedure described as 'Death in custody in court' should be revised to ensure that its title reflects the expectations of custody staff in an emergency situation; it should be easily accessible and staff should be reminded of its purpose. (5.85)

Section 7. Appendices

Appendix I: Inspection team

Vinnett Pearcy	Inspection leader
Maneer Afsar	Inspector
Gary Boughen	Inspector
Fiona Shearlaw	Inspector
Nicola Rabjohns	Health care inspector