Report on an inspection visit to court custody facilities in

Wales

by HM Chief Inspector of Prisons

6–31 July 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 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. We expect there to be a clear strategy for and leadership of the custody function; that detainees are held for the shortest time possible; and that their rights are respected. While they are in custody we expect them to be safe and treated decently according to their individual needs. We expect any health needs they have to be dealt with effectively.

The inspection of court custody facilities in Wales was completed over four weeks between 6 July and 31 July; it included visits to court custody facilities and the Newport Asylum and Immigration Tribunal (AIT). The court custody facilities in Wales covered a large geographical area, from the busy city centre courts, predominantly located in South East Wales, to the periodic courts in Holyhead and Llandudno in the north of the country. The transfer of detainees to and from court custody facilities in South East Wales was easier to facilitate as there were two local prisons: HMP Cardiff and HMP Swansea. There were no prisons in Mid and West and North Wales which meant some detainees experienced longer journeys to court and on release. The periodic nature of some of the courts in Wales also meant that some detainees could travel some distance to attend their court appearance, depending on where in Wales the remand court sat. Despite all of this the contractor had to ensure that court custody facilities were adequately staffed, and that detainees were brought to court on time, kept safe, held in decent conditions and were transferred or released safely.

HM Courts & Tribunals Service (HMCTS) had overall responsibility for the administration of criminal, civil and family courts and tribunals in England and Wales. HMCTS in Wales was one 'cluster' but broadly organised into three areas, North Wales, Mid and West Wales and South East Wales. There were clear line management structures. Prisoner Escort and Custody Services (part of the National Offender Management Service) contracted GEOAmey on behalf of HMCTS to provide custody and escort services in Wales and held the contractor to account.

No one organisation took sole responsibility for court custody facilities. HMCTS was primarily concerned with the running of the courts, GEOAmey on the safe and secure transportation of detainees to and from court and PECS predominately on the contractor's compliance with the terms of the contract. Even though the agencies met at regular forums, detainee care and treatment did not receive the same level of attention as these other areas of concern.

Quality assurance processes, particularly those completed by the contractor, were too focused on security and not enough on the treatment of detainees. This might have accounted for some of the differences in practice between North and South East Wales and inconsistencies in standards across the country. In North Wales, various aspects of detainee care and safety were better than elsewhere, perhaps because custody staff had more time to develop and deliver better care. Some of this good practice could have been shared with court custody facilities in South East Wales.

Despite several recommendations following previous court custody facility inspections in other HMCTS clusters, neither HMCTS nor the contractor had a safeguarding procedure so that custody

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

staff could ensure detainees were released safely. The current pre-release process only involved giving a vulnerable detainee a travel warrant. Custody staff were not aware that they had a duty of care extending beyond the confines of the custody suite; the contractor and HMCTS were responsible for ensuring they were.

We were concerned about the amount of time some detainees spent in court cells. There was an apparent lack of communication between what happened in court and custody operations to either expedite the case or provide an explanation so detainees in cells could be reassured. There were some missed opportunities for resolving some of these issues at the forums that existed.

Custody staffing levels at some courts adversely affected the care of detainees and potentially compromised detainee safety. Some vulnerable detainees were not monitored regularly, there were delays to cell call bells and cell areas were not staffed consistently. There was no meaningful assessment of risk when detainees arrived in court custody. The process of identifying detainees who were vulnerable was inconsistent; staff had received no training and little guidance. Practice in North Wales was better, largely because staff used their skills and experience to provide the best outcomes for detainees.

Use of force to restrain non-compliant detainees was rare, and most custody staff had good interpersonal skills that enabled them to calm potential conflicts. However, handcuffs were used excessively and all detainees were handcuffed even within the secure area of the custody suite.

The response time of the contracted health provider was unsatisfactory. Detainees who were unwell usually had to be seen by the public emergency services. Custody staff required basic training to enhance their understanding of detainees experiencing mental health and drug and alcohol problems.

This report raises concerns about safety and risk management, as well as staff training, and we have made a number of recommendations, some to be resolved nationally, that would contribute to improvements in the care of detainees, particularly the most vulnerable.

Martin Lomas November 2015
HM Deputy 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*[2] about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders. The inspection, completed over four weeks, consisted of observations, talking to staff and detainees, as well as looking at policies and case records. We conducted 47 visits to 26 court custody suites, five of which were to courts operating on a Saturday. There were two visits to Newport Asylum and Immigration Tribunal (AIT).

2.3 Her Majesty's Courts and Tribunals Service (HMCTS) had overall responsibility for the administration of criminal, civil and family courts and tribunals in England and Wales and non-devolved tribunals in Scotland and Northern Ireland, including court custody. HMCTS in Wales was one 'cluster' but broadly organised into three areas – North Wales, Mid and West Wales and South East Wales – that covered all the criminal courts across counties.

2.4 The inspection of court custody in Wales included the Newport AIT, where detainees, usually from immigration removal centres, had their immigration cases heard. Tascor, was the escort company contracted to deliver immigration detainees from prisons and immigration removal centres to the tribunal centre and were responsible for their care and safety while held there.

2.5 Court custody and escort services were provided by GEOAmey. GEOAmey employed prisoner escort and custody officers (PCOs) who were based either at a particular court if they primarily staffed court custody, or at one of the regional vehicle bases if their role was mainly to collect and deliver detainees in cellular vehicles from police stations to court and to prison.

2.6 The busiest court houses were in South East Wales, which mainly received detainees from local police stations and prisons (Cardiff, Swansea and Parc). There was no local prison in North Wales and courts in North Wales predominantly dealt with prisoners coming from or going to HMP Altcourse in Liverpool.

2.7 The majority of periodic courts, which did not operate on a full-time basis, were in Mid and West Wales. Remand cases (those detained and brought to court for their court hearing) were not heard at periodic courts in Carmarthen, Haverfordwest, Welshpool, Llandrindod Wells, Dolgellau, Brecon and Aberystwyth magistrates' courts and there were no detainees in the custody suites when inspectors visited.

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

2.8 The table below outlines the location of the courts and AIT, number of cells and the throughput of each court custody suite in Wales.

Custody suites	**Number of cells**	**Throughput** (January to June 2015)
South East Wales		
Cardiff Crown Court	13	1405
Newport (South Wales) Crown Court	7	444
Merthyr Tydfil Combined Court Centre (crown and magistrates' court)	12	955
Bridgend Magistrates' Court	8	335
Caerphilly Magistrates' Court	9	11
Cardiff and the Vale of Glamorgan Magistrates' Court	23	1475
Cwmbran Magistrates' Court	9	80
Newport Magistrates' Court	12	1317
Pontypridd Magistrates' Court	5	523
Mid and West Wales		
Carmarthen Crown and Magistrates' Court	3	7
Swansea Crown Court	9	462
Swansea Crown Court (secondary site)	6	42
Aberystwyth Magistrates' Court	4	33
Brecon Magistrates' Court	5	41
Haverfordwest Magistrates' Court	5	134
Llandrindod Wells Magistrates' Court	2	22
Llanelli Magistrates' Court	6	332
Swansea Magistrates' Court	14	907
Welshpool Magistrates' Court	3	39
North Wales		
Caernarfon Crown and Magistrates' Court	9	702
Dolgellau Crown and Magistrates' Court	2	0
Mold Court Complex (crown and magistrates' court	12	584
Holyhead Magistrates' Court	2	54
Llandudno Magistrates' Court	7	328
Prestatyn Magistrates' Court	4	69
Wrexham Magistrates' Court	4	497
Asylum and Immigration Tribunal		
Newport Asylum and Immigration Tribunal	1 holding room	62 (December to May 2015)

Leadership, strategy and planning

2.9 HMCTS in Wales was one 'cluster' but broadly organised into three areas – North Wales, Mid and West Wales and South East Wales. Four operations managers (two for South Wales, one for Crown and one for magistrates' courts), supported by delivery managers, were responsible for all the court houses in each region.

2.10 Prisoner Escort and Custody Services (PECS, part of the National Offender Management Service) contracted GEOAmey on behalf of HMCTS to provide custody and escort services across most of England and across Wales.

2.11 Two GEOAmey general managers had overall oversight and responsibility for the court custody escort services in Wales, supported by four area business managers. The general managers oversaw performance across all the courts in Wales and the area business managers were responsible for day-to-day custody operations.

2.12 An HMCTS operations manager had overview of the running of the Newport AIT, while Tascor, the escort company contracted to deliver immigration detainees from prisons and immigration removal centres to the tribunal centre, was also responsible for detainee care and safety.

2.13 No one organisation took sole responsibility for court custody provision and there was insufficient focus on the treatment of detainees held in court custody at the range of local and strategic meetings convened. A quarterly prison escort and custody services meeting brought together court staff, GEOAmey and the PECS contract manager to primarily discuss matters that potentially affected the timely delivery and collection of detainees to and from court. It was commendable that regular court user groups took place across Wales at the majority of courts; however, court custody and outcomes for detainees also needed to be part of the agenda and considered at these meetings.

2.14 Despite the local and strategic meetings that existed, mechanisms for reporting, resolving and monitoring court custody issues were unclear. We routinely observed many detainees spending too much time in court cells – an experience that was repeated across the country. There was no evidence that these shortcomings were being challenged at any of the meetings convened.

2.15 Some children were 'lodged' in police custody while waiting for the young person's escort contractor to arrive, which was poor. Neither PECS nor HMCTS challenged this practice. Despite concerns being raised with the Youth Justice Board (YJB) about the timeliness of escorts collecting children, there continued to be some long delays.

2.16 The contractor's standard operating procedures did not always contribute to consistent good practice. GEOAmey's quality assurance focused too much on security and completing paperwork and not enough on detainee care, welfare or safety. Staff shortages in some of the custody suites adversely affected the care and consistency of provision that some detainees received. The contractor offered staff few training and development opportunities.

2.17 There was no HMCTS safeguarding policy or protocol and custody staff were unclear about their role in ensuring detainees' wellbeing and safe release from their care. GEOAmey had a child protection policy but custody staff were not sufficiently aware of what it entailed or how to report a safeguarding concern.

Individual rights

2.18 Custody officers appropriately checked the warrants and documentation that accompanied each detainee to ensure they had the correct authority to detain them. There was no arrangement for court enforcement officers to deliver compliant individuals directly to the court room to avoid unnecessary detention in cells or the contractor's excessive searching and handcuffing procedures.

2.19 Courts generally prioritised cases involving vulnerable adults and children to reduce their time in court custody. However, where children were concerned, YJB placement orders were processed too late or escort contractors did not arrive for several hours, undermining efforts by staff to process these cases promptly.

2.20 Despite detainees arriving in court to ensure judicial proceedings started promptly, some, particularly in North Wales, remained in cells until late in the afternoon. A lack of communication between the courts and custody staff meant that detainees did not receive an explanation or were not reassured about their prolonged detention in court cells.

2.21 Records supplied by GEOAmey revealed that warrants and other documentation relating to the release or transfer of a detainee took too long to be produced. There were examples of delays of up to three hours at Newport and Cardiff Magistrates' courts, Cardiff Crown Court and Merthyr Tydfil Combined Court Centre.

2.22 In courts across Wales where remand cases were heard, magistrates accepted detainees throughout the day, and as late as 4pm, which was commendable. There was no consistent approach across all the courts to ensuring detainees could exercise their rights. Most courts offered detainees information outlining their rights, but staff did not sufficiently check whether they could read or understand the document. There was better practice at Newport Magistrates' Court and Mold Court Complex. Detainees mostly had good access to legal representatives and visiting facilities except at Wrexham Magistrates' Court.

2.23 We were concerned about court custody staff's reluctance to use telephone interpretation services for detainees whose first language was not English or Welsh. This meant they were unable to determine if they had any health problems or ensure their basic needs were met. We saw a range of information in Welsh; detainees could have their hearing conducted in Welsh if they wished.

2.24 Most detainees were not routinely told about the complaints procedure but staff did not proactively take complaints even when detainees expressed their dissatisfaction. In the previous six months, three complaints were recorded across all the court custody suites; there were none at Newport AIT.

Treatment and conditions

2.25 Cleaning arrangements for vehicles used to transport detainees were not sufficient and many of the vehicles inspected were dirty and unpleasant. The partition was not always used to separate women transported in the same vehicle as men, which did not comply with the contractor's policy.

2.26 The location of some of the courthouses limited detainees' privacy, and at some courts, they had to get in and out of the vehicle on public roads or paths, which often compromised their privacy and safety. Merthyr Tydfil Combined Court Centre had a good local operating procedure for disembarking detainees in public, which needed to be replicated at other

court houses. Detainees brought to the Newport AIT were transported in transit vehicles suited to longer distances and disembarked where the public could not see them.

2.27 Staff in court custody across Wales interacted well with detainees; most were courteous, friendly and respectful and some demonstrated genuine compassion for those in their care. This was exemplified at Mold Court Complex and Caernarfon Magistrates' Court.

2.28 GEOAmey did not provide any specific equality and diversity training to support custody staff in their work, which was unsatisfactory. All Tascor staff received annual diversity and equality training, which was good. Custody staff had good access to standard operating procedures (SOPs) to help them with various aspects of their work. Implementation of the guidelines was rarely checked to reinforce appropriate practice.

2.29 Women, more often than men, spent unreasonably long periods in custody waiting for transport. There were insufficient safeguards in place to protect the most vulnerable detainees when men and women were located in the same area. Very few custody suites were suitable for detainees with limited or poor mobility. Few staff knew how transgender detainees would be treated, in particular how they would be searched.

2.30 We saw relatively few children in court custody during our inspection. Children were usually transported separately from adults. Children were normally put in cells, searched frequently and handcuffed routinely, some of which was contrary to the contractor's policy. Custody staff did not receive training on the treatment of children or safeguarding.

2.31 We were concerned that some custody staffing levels compromised detainees' safety and care; at Wrexham Magistrates' Court in particular, cell bells were not answered promptly, some detainees did not receive regular checks and single members of staff were left alone in the custody suite.

2.32 GEOAmey had no formal systematic risk assessment at any of the courts to inform the care a detainee should receive. We were not confident detainees' risks and vulnerabilities were always properly identified or acted on. There was better practice in North Wales; it was good to see many custody staff discussing potential vulnerabilities with escort staff prior to disembarking detainees.

2.33 Staff, mostly in North Wales, interacted well with detainees who were at risk of harming themselves. We were not assured that observational checks always took place at the required frequency at all the courts. Detainees did not have a formal pre-release risk assessment even if they were considered vulnerable, which was poor.

2.34 Handcuffs were frequently used when they were unnecessary[3]. At most courts, level one handcuffing was used when moving compliant detainees within the secure environment of the custody suite and to court. Too much routine searching took place without a comprehensive risk assessment having been carried out to support it.

2.35 The court custody estate was in good condition. The facilities in North Wales, particularly at Mold Court Complex and Caernarfon Crown and Magistrates' Court, were excellent. The holding room at Newport AIT was clean, free of graffiti and detainees had access to two private toilets and hand-washing facilities.

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[3] There were three levels of handcuffing which could be applied depending on the risk posed: Level 1 is where the detainee has a pair of handcuffs applied to their own wrists; level 2 is where the detainee is handcuffed by one wrist to a member of staff; and level 3 is where a pair of handcuffs is applied to each wrist and a second pair is attached to one of their wrists and to a member of staff.

2.36 The shared facility with the police at Wrexham Magistrates' Court was not suitable for court custody use. There was no interview room and solicitors were locked in cells with detainees or conducted interviews through cell door hatches. Neither of these consultations were appropriate or confidential.

2.37 All staff were trained in first aid during induction and received periodic updates as part of their mandatory training. Health interventions were recorded on person escort records (PER) but they were not always clear and we found inappropriate confidential medical information had been recorded, in some cases of a prejudicial nature, which was unacceptable.

2.38 Custody staff were fully aware of the requirement for safe drug administration, and sought advice appropriately from the sending establishment or specialist health adviser, Taylormade, when medication queries arose. Detainees' medicines were managed appropriately and stored safely.

2.39 Detainees with mental health needs had usually been identified and assessed prior to arriving from prison or police custody. Established court liaison and diversion services were available at most magistrates' courts. Nevertheless all staff we spoke to at crown courts had established relationships with the local mental health provider and knew whom to contact for support. Custody staff did not receive any mental health awareness training.

2.40 Onsite input from specialist substance misuse workers did not take place routinely in Mid and West Wales and South East Wales courts, but a number of different agencies provided support. In North Wales a single agency (ARCH Initiatives) offered more comprehensive coverage and a routine presence in court custody areas. However, detainees arriving with ongoing withdrawal symptoms did not receive symptomatic relief unless it had been authorised, supplied and recorded on the PER prior to their arrival in custody. Custody staff did not receive any formal training on drug- or alcohol-related risks.

Main recommendations

2.41 HMCTS should ensure that interagency meetings include a focus on court custody operations, particularly on improving the care and safety of detainees in court custody.

2.42 HMCTS, PECS and the escort and court custody contractor should investigate the reasons for the prolonged periods that detainees, including children, spend in court custody cells. Measures should be put in place to ensure detainees in custody have their cases prioritised where possible and are transferred and released without delay.

2.43 Sufficient staff should be on duty at all times so that the safety and welfare of detainees and staff are maintained.

2.44 Staff should complete a standard risk assessment for each detainee, and receive training to do this.

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

National issues

2.46 HMCTS and PECS should establish agreed standards in staff training, detainee treatment and conditions, and detainees' rights during escort and in court custody.

2.47 HMCTS and PECS should clarify the responsibilities of each organisation for resolving problems that have an impact on outcomes for detainees.

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 Three organisations were responsible for the strategic leadership and planning of court custody and escort services: HM Courts & Tribunals Service (HMCTS) in Wales, Prisoner Escort and Custody Services (PECS), and the custody and escort contractor GEOAmey. Other organisations, including youth offending services (YOS), probation, prisons, police and the cleaning and maintenance contractor G4S, also had key roles.

3.2 HMCTS in Wales was one 'cluster' but broadly organised into three areas – North Wales, Mid and West Wales and South East Wales. Four operations managers (two in South Wales, one for Crown and one for magistrates' courts), supported by delivery managers, were responsible for court houses across each region. The delivery managers took charge of the day-to-day processing of court cases and were the first point of contact for court custody staff if any problems impacting on court custody provision arose. The operations managers, who reported to a single crime cluster manager, only became involved in court custody matters if it significantly affected the running of the courts.

3.3 PECS commissioned GEOAmey to staff court custody and provide escort services on behalf of HMCTS in Wales. The contractual arrangement between PECS and GEOAmey was supervised by a PECS contract delivery manager. Two GEOAmey general managers had overall oversight and responsibility for the court custody escort services but the day-to-day management was delegated to four area business managers (ABMs). The general managers oversaw performance across all the courts in Wales, as well as complaints and welfare; they also attended contract operational meetings with the PECS contract delivery manager.

3.4 An HMCTS operations manager had overview of the Newport Asylum and Immigration Tribunal (AIT). The escort company contracted to deliver immigration detainees from prisons and immigration removal centres to the AIT, was also responsible for detainee care and safety.

3.5 No one organisation took sole responsibility for court custody provision. There was insufficient focus on the treatment of detainees held in court custody at the range of local and strategic meetings convened. A quarterly prison escort and custody services meeting, chaired by HMCTS, brought together court staff, GEOAmey and the PECS contract manager to primarily discuss matters that potentially affected the timely delivery and collection of detainees to and from court. Minutes we reviewed highlighted that GEOAmey and PECS had raised the issue of custody warrants taking too long to be produced, prolonging detainees' detention, but the meeting was not being used effectively to review or monitor whether detainees' basic needs were being met.

3.6 It was commendable that regular quarterly court user group meetings were held at the majority of courts and were used to resolve operational problems among the various organisations involved in the local courts, including statutory agencies and local solicitors. The remit of these meetings was broad but mainly focused on court hearings and procedure. From the minutes we reviewed from 14 meetings, we found the court custody contractor was represented but custody was rarely discussed and court custody operations were not part of the agenda.

3.7 Regular contract operational meetings were held with the main agencies, including the prisons and police services, to hold GEOAmey to account and ensure escort and court custody services were being delivered safely, efficiently and according to the terms of the contract. While none of the meetings focused on detainee care to any great extent, there had been some positive practical outcomes as a result of the meetings: for example, HMP Altcourse in Liverpool and GEOAmey reached an agreement to ensure detainees were collected from and delivered to courts in North Wales earlier so they could arrive on time; they had previously often arrived late because of the distance of the prison.

3.8 Weekly team information briefing meetings (TIB), where any court users could attend and discuss issues affecting their work with HMCTS operational and delivery manager, took place at courts in South East and Mid and West Wales. There were no TIB meetings in North Wales. The meetings appeared to be a good forum for dealing with immediate concerns at a local level. However, senior custody officers (SCOs) were not always able to attend. The courts in North Wales relied on the positive relationships between some court custody staff and HMCTS staff to resolve issues but this was not formal enough to ensure ongoing concerns were effectively managed.

3.9 Despite the local and strategic meetings, the mechanisms for reporting, resolving and monitoring court custody issues across the country were unclear. We routinely observed many detainees spending too much time in court cells. There were a number of reasons for this: custody cases were not sufficiently prioritised (see case study 2); warrants, according to data collected by GEOAmey, were taking, in some instances, more than three hours to produce; and there were unacceptable delays in receiving probation licences and authority to release detainees. In addition, insufficient escort staff contributed to detainees remaining in court cells instead of being transferred (see section on individual rights). There was no evidence that all of these issues were being taken forward at the meetings convened.

3.10 PECS and GEOAmey had escalated to the Youth Justice Board (YJB) the unreasonable waiting time for the young person's escort contractor to collect and transport children to secure accommodation, but there were still too many cases of children remaining in custody for longer than necessary. As a consequence, GEOAmey had sought the agreement of North and South Wales police for children to be 'lodged' in police cells after the courts were closed and until the young person's escort contractor (SERCO) arrived. This arrangement was wholly unsuitable and PECS and HMCTS failed to challenge it. There were no formal links with Welsh Assembly Government or Children's Commissioner for Wales to raise some of the concerns about children's prolonged detention in court custody.

Case study 1

D, a 16-year-old boy appearing at Swansea Magistrates' Court, was sentenced to a detention and training order at 12.40pm. At approximately 1.11pm it was recorded that he would be moved to a vulnerable person's cell as he was getting upset; this was the first time he had been sentenced. At 2.40pm a custody officer was told that the young person's escort contractor would not arrive until 5.45pm. The notes stated: 'He will have been sitting in these cells for 5+ hours awaiting transport to take him 20 minutes down the road.' At 3.15pm it was recorded that D was 'getting upset and tearful, he knows where he is going and how far away it is and doesn't understand why the process of getting there is taking so long …' At 4.15pm, D was handed over to GEOAmey escort staff to be transported to Swansea police station to be held in another cell while he waited for the young person's escort contractor to collect him. D was collected one hour and 45 minutes after his arrival at the police station. It was unclear who was ultimately responsible for D when he was in a cell in the police custody suite.

3.11 A range of standard operating procedures (SOPs) outlined the expected practice of court custody staff and should have resulted in consistent practice across all court custody suites, but this was not the case (see sections on individual rights and treatment and conditions). GEOAmey's quality assurance focused too much on security and administrative process and not enough on outcomes for detainee care or safety. PECS undertook court custody audits every two years, which covered safety and decency and identified areas for improvement. The audit was thorough and action plans from the audits were monitored but follow-up was insufficient. The contractor offered staff few training and development opportunities.

3.12 There was a local lay observers' group in South East Wales but not in the north, despite attempts to recruit volunteers. PECS and GEOAmey met with the group but HMCTS did not. Most of the HMCTS operations managers were unaware of the lay observers' role in monitoring court custody facilities independently, which was a missed opportunity.

3.13 We observed and GEOAmey confirmed during the inspection that there were staff shortages in some of the custody suites, particularly in Wrexham and Caernarfon magistrates' courts and some of the busier courts in South East Wales. Some of these shortages in staffing were adversely affecting the care and the consistency of the provision some detainees received. For example, some vulnerable detainees were not monitored regularly and cell areas were not staffed consistently (see paragraph 5.32).

3.14 HMCTS was aware of the process for reporting GEOAmey's failure to supervise court docks and reported this appropriately to PECS. However, the courts and escort contractor was not held accountable for the impact of inadequate staffing on detainees.

3.15 Court and immigration hearings were conducted remotely via video link where possible and monitoring took place to improve its use. Figures supplied by HMCTS highlighted that courts in Wales were using the video link more frequently than the national average.

3.16 There was no HMCTS safeguarding policy or protocol. Although there were agencies that worked in the courts whose remit included the welfare and safety of detainees (probation and community psychiatric nurses), custody staff received no guidance on ensuring that vulnerable detainees, including children, received appropriate care, that referrals were made where significant concerns were identified or that detainees were safely released or transferred. GEOAmey had a child protection policy, including a reporting process. Despite this, most court custody staff across Wales were not sufficiently aware of the policy's contents or how to report a safeguarding concern if one arose and staff training in this area was required. A small number of staff had completed a one-day security refresher training course, which included aspects of safeguarding (see paragraph 5.12).

Recommendations

3.17 HMCTS should engage with all partner agencies to ensure there are no unnecessary delays causing detainees to be held in court custody for longer than necessary.

3.18 Quality assurance processes should be more effective in addressing key elements of detainee care during escorts and court custody.

3.19 There should be a safeguarding policy and all staff should be made aware of safeguarding procedures for children and adults at risk.

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 officers we observed thoroughly checked the warrants and documentation that accompanied each detainee to ensure they had the correct authority to detain them. HMCTS operations managers confirmed that there was no arrangement for court enforcement officers, who executed warrants on behalf of courts, to deliver compliant individuals directly to the court room and avoid unnecessary detention in cells or excessive handcuffing and searching procedures in the custody suites (see section on use of force).

4.2 Custody staff at all courts we visited said they had a good relationship with their local youth offending service (YOS). Procedures were normally in place to ensure that YOS staff were informed of the children held in court cells each day, so visits could be made and their needs, risks and circumstances presented to the court. Where we saw children detained, we observed custody staff notifying the court clerk that a child was in the court custody suite so their cases could be prioritised, which was in line with their standard operating procedure (SOP) for children. HM Courts & Tribunals Service (HMCTS) ensured this whenever possible. Delays were, however, recorded at several courts, where during a six- to eight-week period prior to our inspection, some children had been held in court custody for up to five hours before they appeared in court.

4.3 There were delays in obtaining placement orders (which determine where children under the age of 18 should be held securely) from the Youth Justice Board (YJB). The contractor's area business managers (ABMs) monitored when court custody staff received placement orders and referred any delay in excess of 60 minutes to the YJB for investigation. Throughout the inspection, across the majority of courts in North and South East Wales, records detailed two- and three-hour waits to receive the placement orders, which in turn meant transport to take children to secure accommodation was not booked promptly. Such delays were poor.

4.4 HMCTS' local operating procedure for Wales outlined that the judiciary and justices' clerks should prioritise custody cases before bail cases where possible; we saw this happen to good effect in all the courts in South East Wales. However, in North Wales at Wrexham, Caernarfon, Holyhead, Llandudno and Prestatyn magistrates' courts, we saw the first detainee appearing in court late in the day and in the worst case not until 1.50pm, despite the fact that they had arrived in court cells by 9am (see case study 2). HMCTS operations managers told us that other factors needed to be considered when prioritising cases, such as the availability of paperwork and legal representatives and the nature of the cases, particularly where witnesses and victims were involved. However, these considerations were not communicated to court custody staff when custody cases could not be prioritised and consequently they could not sufficiently reassure detainees about what was happening.

Case study 2

Mr G appeared at Wrexham Magistrates' Court on Saturday 4 July, having spent the previous night in a cell in a police custody suite in Manchester. He arrived at Wrexham custody suite at 8.26am. He was called to court at 4.42pm and returned from court at 4.55pm after he was remanded into custody until the following Monday. He should have been taken to HMP Altcourse but the reception was closed and he was taken through to the police side of the custody suite to spend a further two nights in police cells. On Monday 6 July Mr G was taken back through to the court side of the custody suite at 09.13am. He was the first custody case called up to court at 2.38pm; he was sentenced at 3.29pm but had to wait until 6.27pm for GEOAmey escort staff to collect him and other detainees who were being transported to HMP Altcourse. Mr G spent three nights in police custody and two days in court custody cells.

4.5 National guidance for all courts specified that a detention warrant should be produced within 30 minutes of a court hearing or appearance. Despite this, throughout Wales, particularly at the busier courts in South East Wales, we observed and were shown evidence by the contractor that indicated court custody staff did not receive warrants for up to two hours after the detainees' court appearance and in some cases in excess of this. Local prisons did not accept interim warrants; consequently transport could not be organised and detainees could not be transferred without the document. HMCTS managers accepted that there were some lengthy waits for warrants but told us this legal document needed to be accurate, checked and then issued. Although there was a need to ensure the documents were correct, the time it took to produce some of them was excessive and resulted in detainees remaining in court custody cells for longer than necessary.

4.6 Long periods in court custody were also caused by other factors. It was common for detainees who had been bailed or acquitted, but previously remanded in custody, to have to wait long periods before the prison they had come from authorised their release. We observed delays at Newport and Cardiff magistrates' courts and Cardiff Crown Court of up to three hours before the authority from prisons was secured. This was confirmed in records we reviewed at courts in North and South East Wales.

4.7 Custody staff told us they had started to experience some significant delays before they received the authority to release detainees who were subject to licence conditions. We saw one detainee at Merthyr Tydfil Combined Court Centre released at 10.30am and returned to his cell. Court custody staff sent the necessary paperwork to the prison promptly, but the licence was not received at the court until 3.20pm and the detainee was not released until 3.30pm. Custody staff appropriately kept the detainee informed, reassured him of his release and contacted the prison and probation staff to progress matters.

4.8 Across all magistrates' courts in England and Wales detainees in police custody should be accepted by the magistrates' courts as long as the court is sitting and there is capacity to hear the case. In courts across Wales where remand cases were held, magistrates' courts accepted detainees throughout the day and as late as 4pm. We saw detainees even being accepted late morning on a Saturday at Swansea and Llanelli magistrates' courts, which meant they did not have to be held in police custody over the weekend, which was commendable. In North Wales, magistrates' courts accepted detainees arrested on a warrant from the police without them having to be booked in at a police station first, which streamlined and speeded up the judicial process.

4.9 There was no SOP outlining whether court custody staff could make telephone calls on behalf of detainees who wanted someone informed of their whereabouts. Custody staff at all courts were cautious about doing this and only did so in exceptional circumstances, when they knew that they were not contacting a possible victim in a case. Common practice

across all the courts was firstly to refer the request to the detainee's legal representative which was sensible in some cases. Detainees who attended the Asylum and Immigration Tribunal Centre (AIT) could make a telephone call to family members once in the holding room. This was particularly useful for those who might have potentially received bail and wanted to make arrangements with friends or family for their release.

4.10 We saw a comprehensive range of written information available and displayed in Welsh, as well as notices outlining that a detainee could have their hearing conducted in Welsh if they wished. Printed copies of rights in Welsh were accessible to all staff across the suites, but detainees were not asked, primarily at courts in the South East, if they would like the information offered to them in Welsh. Few custody staff spoke Welsh and there were currently no opportunities provided by the contractor to learn or improve their Welsh. There was no list maintained of custody staff who spoke Welsh and could be accessed at short notice to assist with communication at any of the suites. There were some differences in North Wales, where some of the staff spoke Welsh; we observed them greeting detainees and court staff initially in Welsh and ensuring that detainees were offered information in Welsh. Some staff at Caernarfon Magistrates' Court were aware of colleagues and court staff who were able to speak Welsh, but this information was not documented.

4.11 Across the courts, practices relating to staff advising detainees about their rights were inconsistent. At Cardiff Magistrates' Court a leaflet outlining detainees' rights was placed in every cell allocated to a detainee, but custody staff did not check if the detainee could read it or if they required it in a language other than English. At Mold and Newport magistrates' courts, however, we saw custody staff ask detainees if they knew their rights, offer them information and appropriately check whether they could read the document or required it in a foreign language. Elsewhere detainees were informed of their rights in a variety of ways, none of which were likely to have ensured that staff were confident the detainee fully understood.

4.12 All the court custody suites had been issued with a GEOAmey leaflet 'Let us look after you', which contained useful information regarding detainees' rights and entitlements. The document was clear, concise and helpful, so it was unfortunate that we saw very few of them handed out.

4.13 Custody staff at all the courts liaised well with either court ushers or security staff to ensure all detainees had legal representation when they arrived at the court custody suite. We saw legal representatives allowed access to detainees in suitable interview rooms at the majority of courts. At Wrexham Magistrates' Court, legal representatives were locked into the detainee's cell, which needlessly exposed them to unacceptable risks, as GEOAmey was not permitted to use police interview rooms. A custody officer also had to stand outside the locked cell, compromising privacy (see paragraphs 4.13 and 5.63).

4.14 There were notices in all court custody suites outlining how to use the telephone interpretation service, provided by the contractor at all the suites. The SOP instructed custody staff to carry out a risk assessment to ensure it was appropriate to take detainees into the staff office, where the telephone was located at the majority of the courts, to access the service. Despite this clear procedure, custody staff across all the courts were reluctant to use telephone interpretation services and at Bridgend Magistrates' Court staff were not aware of the service. Custody staff told us it was impractical as they had concerns about detainees accessing offices.

4.15 Custody staff attempted to communicate with detainees who could not speak English through gestures to ensure their basic needs were met, for example, when they offered drinks and meals. However, they could not interact with them in a meaningful way about their emotional or physical state and relied on issues having been identified earlier by the police or prison, prior to receiving the detainee. Custody staff at all the courts told us they

used the court-appointed interpreter to check how a detainee was feeling, but the service was not routinely available when a detainee was initially received.

Case study 3

A Romanian man, Mr J, arrived at Newport Magistrates' Court from police custody at 09.15am. His PER was completed poorly and no risks were highlighted. The separate risk assessment form from the police stated that he spoke no English and required an interpreter in court. He was placed in a cell and staff explained his rights and how the cell bell worked in English to which he just nodded. Staff told an HM Inspectorate of Prisons inspector that 'His English isn't good enough for court but we can get by with tea, coffee, toilet.' A custody officer provided Mr J with information outlining his rights in Romanian about half an hour after his arrival, but they were not explained to him in a language he understood. Checks were frequent but communication with him was at best perfunctory and did not involve any meaningful interaction. There were no checks in his own language to assess his welfare or safety on arrival or throughout his stay. Mr J saw his legal representative and a court-appointed interpreter at 11.25am and was sentenced at 12.40pm. A custody officer needed to complete the prison admission form but was reluctant to use the telephone interpretation facility, choosing instead to wait until the interpreter and legal adviser revisited the suite almost an hour later.

4.16 Data provided by GEOAmey recorded that there had only been three complaints in the six months prior to our inspection across all the court custody suites in Wales. Detainees were not routinely told on arrival that there was a complaints procedure which might have accounted for so few complaints being received. Custody staff did not inform or remind detainees of their right to make a complaint even when they expressed dissatisfaction during their detention. Information provided by the contractor for Newport AIT recorded that no complaints had been received from detainees' attending Newport AIT. The PECS contract manager monitored all complaints and confirmed that none concerned the conduct or treatment of detainees in court custody.

Recommendations

4.17 HMCTS should ensure that compliant defendants apprehended by court and civil enforcement officers are not taken into court custody unless there are good reasons to do so.

4.18 There should be sufficient private consultation rooms at Wrexham Magistrates' Court and visitors to Wrexham court cells should not be locked in with detainees.

4.19 All court custody staff should be made aware of the availability of a professional telephone interpreting service, which should be readily accessible in each custody suite and used as necessary.

4.20 All detainees should be informed of the complaints process. Complaints should be recorded on behalf of detainees who make verbal complaints about any aspect of their period in detention. There should be a process for monitoring complaints and analysing trends.

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 The cellular vehicles that transported detainees to court mainly came from the vehicle bases at Bridgend for South East Wales and Chester for North Wales. Many vehicles we inspected evidenced accumulated dirt throughout, including cellular compartments which had ingrained dirt and unpleasant stains. The cleaning arrangements for vehicles were inadequate. Escort staff were only responsible for sweeping the vehicles and making sure the exterior was clean each day and the interior was deep cleaned every six months, which was not enough. Vehicles carried stocks of water and a first aid kit. Some also transported food. (See Appendix II: Photographs.)

5.2 We saw few women detained during the inspection. Escort staff we spoke to across the court locations in Wales told us that women and men – but not children – could be transported on the same vehicle. We were not assured that escort staff routinely used the partitions in cellular vehicles (sliding doors that separate the front half from the rear, ensuring women or children are not at risk as a result of predatory or abusive behaviour), and observed this to be the case one day at Newport Magistrates' Court. Some escort staff felt the partition was ineffective as detainees could be heard through it; however, the screen did isolate those at the front of the vehicles and GEOAmey managers needed to ensure escort staff understood its importance. Despite the rural location of some of the courthouses, particularly in Mid and West Wales, and a few journeys that took up to four hours, most journeys from police stations and prisons were short and detainees were manageable, and detainees disembarked promptly on arrival at courts.

5.3 The location of some of the courthouses limited detainees' privacy. Several courts, including the busier courts in Swansea, Cardiff and Merthyr Tydfil did not have secure vehicle bays, which meant detainees got in and out of the vehicles on public roads or paths, which was not sufficiently private. At Cardiff Magistrates' Court detainees embarked and disembarked on a particularly busy road near a footpath that members of the public used and we were not convinced that vehicle staff took all reasonable steps to protect detainees from public attention during transitions. The secure vehicle bay at Cardiff Crown Court, which 10 cellular vehicles could not access, was not always used for smaller vehicles and we observed that some staff had become complacent about disembarking detainees in public. At Merthyr Tydfil Combined Court Centre, a local operating procedure had identified safeguards that should be put in place for escorting detainees from vehicles into the custody suite. Staff at Merthyr Tydfil Court acted proactively to try to offset the lack of a secure vehicle bay, which could have been replicated at the other courthouses.

5.4 Detainees being brought to the Newport Asylum and Immigration Tribunal (AIT) experienced long journeys but the vehicles were transit vans; they were comfortable and more suitable for longer distances. The vehicle dock, although not secure, was not visible to the general public. During the journey detainees had access to a useful booklet about their rights and the tribunal process. The information was available in a range of languages.

5.5 Escort staff ensured that all necessary information accompanied detainees. Police, prisons and secure accommodation representatives were required to complete person escort records (PERs) for all detainees but they often contained little or vague information about potential risks. PERs were not always checked before detainees were located in cells and information contained in them was not always acted on. At Newport Crown Court we saw a PER for a man with a disability, which stated that he had threatened self-harm in the police station on the morning of his court appearance, but staff did not pick up or act on this information. GEOAmey staff generally ensured all relevant information from court custody was recorded on PERs for detainees transferring to prison or other secure accommodation.

5.6 Staff in court custody across Wales interacted well with detainees; most were courteous, friendly and respectful and some demonstrated genuine compassion for those in their care. This was particularly exemplified at Mold and Caernarfon Magistrates' Courts where custody staff were patient and often took the time to communicate with detainees who appeared anxious. They used their strong interpersonal skills to de-escalate some potentially volatile and challenging situations well. A minority of interactions were, however, less positive. At the crown and magistrates' courts in Cardiff, for example, we observed staff who were too focused on the process of getting detainees in cells and, at times, displayed dismissive attitudes. Nevertheless, most of the detainees we spoke to suggested they felt well treated.

5.7 Despite the diversity of the population entering court custody GEOAmey did not provide any specific equality and diversity training to support custody staff in their work, which was unsatisfactory. Conversely, all Tascor staff received annual diversity and equality training.

5.8 Women's individual needs were not always at the forefront of the care provided. Efforts were made to ensure female officers were available to staff escort vehicles transporting women and custody suites where women were detained, but this was not always possible. Although there were relatively fewer women detainees than men, they more often experienced unacceptably lengthy waits in court custody after their cases were completed before being transferred to prison. GEOAmey records, for example, outlined a case at Bridgend Magistrates' Court where a woman detainee was remanded by the court at 11.33am. The warrant was received at 12.15pm but she had to wait until 5pm before she was picked up to be transported to HMP Eastwood Park because no vehicles or staff were available. There were several more cases of such delays throughout the inspection at Haverfordwest, Cardiff and Swansea magistrates' courts. Such delays meant women arrived at the prison late, and reduced the likelihood of them having access to the full range of support and services that they might need.

5.9 The majority of court custody facilities across Wales had designated corridors where women and children were held separately from men. However, when they were busy we observed these corridors being used to house both men and women, often without sufficient safeguards in place to protect more vulnerable detainees (see paragraph 5.9.) Except at Mold Court Complex, women detainees were not routinely asked if they were pregnant and were generally not offered hygiene products on arrival.

5.10 Detainees were not asked about religious observance on arrival. It was positive that most courts in North Wales and Newport AIT had access to prayer mats and compasses but religious items were mostly inadequate elsewhere. A few of the custody suites had signs that indicated the direction of Mecca. Custody staff were generally aware that Ramadan was taking place at the beginning of the inspection.

5.11 With the exception of court cells in police custody suites at Wrexham and Holyhead magistrates' courts, the contractor did not provide a stock of mattresses or blankets, so pregnant, elderly or disabled detainees could be more comfortable sitting on hard wooden benches. Custody staff at Cardiff and Newport Crown Court had acquired items over time including mattresses and cushions, which they offered to some detainees to try to make

them more comfortable during their time in the court cells. Custody staff at Mold Court Complex and Merthyr Tydfil Combined Court had a small stock of clothing they kept when detainees left items behind after leaving custody. There were, however, no facilities to launder this clothing.

5.12 While it was positive that cases for detainees with recognised disabilities were generally listed at courts with accessible facilities, few others were suitable for detainees with limited or poor mobility as there were often steep stairs to the courts. Newer suites at Aberystwyth and Llandrindod Wells magistrates' courts had good purpose-built facilities that had wheelchair access, at least one adapted cell and an accessible toilet. Most custody suites had access to hearing loops but none of the material was available in Braille. The contractor had not provided staff with any guidance or training regarding safeguarding vulnerable adults at risk and consequently staff were generally not aware of their duties towards these detainees (see paragraph 3.16).

5.13 Few staff knew how transgender detainees would be treated, particularly how they would be searched. The contractor's policies were unclear and contained outdated advice. A minority of staff correctly told us that they would ask the detainee by whom they wished to be searched and how they wished to be referred to.

5.14 We saw relatively few children in court custody during our inspection. Children were generally transported separately from adults. There was otherwise limited provision specific to children and in many respects we found that children were treated in much the same way as adults. Children were almost always put in cells, searched frequently and handcuffed routinely, contrary to the contractors' SOP, which stated that children should only be handcuffed in exceptional circumstances and following a risk assessment. Children were not allocated a named member of staff during their detention in court custody and very little attention was paid to their individual needs. No additional care was offered in acknowledgement of their vulnerability, although exceptionally at Newport Crown Court custody staff handled a situation involving a vulnerable boy extremely well (see case study 4).

Case study 4

The young person's escort contractor (Serco) brought K, a 15-year-old boy suffering from attention deficit hyperactivity disorder, to Newport Crown Court. The boy was resident in a secure children's home. Staff initially considered placing him in a small room rather than a cell, but the senior custody officer (SCO) felt he had insufficient staff to manage this safely. Staff checked on the boy frequently and the designated cells officer built up a good rapport with him. Nevertheless, he became bored and frustrated and started punching the walls and door in his cell. Efforts to have his case prioritised were unsuccessful. The SCO decided to cancel staffing an 'off bail' court (where people appearing have been bailed straight from the police to attend court without being held in custody) to free up a member of staff to look after the boy more appropriately. He was placed in a small room with an officer who chatted to him and kept him calm until he attended court at 2.20pm. When an HM Inspectorate of Prisons (HMI Prisons) inspector pointed out that children should only be handcuffed following a risk assessment, the SCO decided not to handcuff K. After his case was concluded, K was extremely upset and agitated and acted aggressively towards staff. The designated cells officer tried to communicate with him and de-escalated a potentially volatile situation. K was returned to the secure children's home, escorted by Serco staff. Overall, court custody staff treated K very well, managing him in a proportionate, measured way and caring for him according to his individual needs.

5.15 GEOAmey did not provide a supply of reading material at any of the courts and detainees had very little to keep them occupied during their, sometimes, lengthy stays in court cells. Across all the custody suites staff brought in free or old newspapers, magazines and books and some even photocopied puzzle books. Custody staff at Mold Court Complex had

brought in a small stock of reading material for children. Most detainees were given or requested something to read on their arrival but despite staff's generosity, reading material was very limited. There were no books or magazines in Welsh, other languages or in an easy-read format and very limited material for children. Custody staff at Llanelli, and Newport magistrates' courts allowed detainees to have access to books from their own property, which was good. Detainees at the AIT could bring a book, subject to a risk assessment, and newspapers were provided. Arrangements for securing detainees' property were adequate at all courts and the tribunal centre.

5.16 Detainees in court custody and at the AIT received a hot drink on arrival and at frequent intervals or on request at other times. A range of microwave meals, suitable for a variety of diets including vegetarian, vegan and halal, was available. Some escort staff brought a supply of sandwiches, biscuits and crisps, but they were not always available at all courts. Despite this we saw all detainees being provided with a meal if they wanted one. We found a small sample of microwave meals that were out of date and some food preparation areas, including microwaves, were dirty at a few of the courts. It was good that some detainees arriving from prison received something to eat if they were hungry.

Recommendations

5.17 Cellular vehicles should always be clean and well maintained.

5.18 Men and women should not be transported in the same escort vehicle, and detainees should be transferred from cellular vehicles to court cells out of public view. Where this is not possible safeguards should be put in place to protect detainees from public view.

5.19 The quality of PERs should be improved and should include more specific information about all risks posed by the detainee.

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

5.21 There should be a small stock of mattresses and blankets or warm clothing for detainees who are elderly, pregnant or disabled.

5.22 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.

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

Housekeeping points

5.24 Staff should routinely inform female detainees of the availability of hygiene packs.

Safety

5.25 Custody staff at all courts received an early morning briefing and handovers should have taken place when new staff arrived. The briefings, conducted mainly by SCOs, were inconsistent across the courts. We were not confident that all SCOs understood the purpose of the briefing. Verbal briefings did not take place at all courts and we saw that some staff were merely required to read and sign a written briefing sheet at some stage throughout the day, which was inadequate. As examples, the briefings we saw at Mold Magistrates' Court were clear, appropriately focused on security and the safety of detainees and all staff attended. Conversely during a visit to Newport Crown Court on a particularly busy day, no formal briefing took place before or following the reception of detainees.

5.26 All full-time court custody suites had a small core staff group supported by staff from escort crews. During the inspection we observed that at some of the busier courts, there appeared to be insufficient staff to undertake safely all the tasks they needed to carry out. At Cardiff and Newport crown courts, for example, there were insufficient staff to supervise the cell areas and conduct cell checks at the required intervals. The designated cells officers at these courts changed several times throughout the day as the staff were redeployed elsewhere and replaced with other custody staff, which affected the consistency of care. For example, we observed no handover with staff taking over cell visits; this meant they were not updated on any specific concerns about the detainees in their care. Anti-ligature knives, always allocated to cells officers in case of an emergency, were also not passed on. During a visit to Cardiff Crown Court only one member of staff was designated to patrol the busy cell areas, which meant that the designated female and children's corridor was not staffed and did not benefit from regular supervision. A detainee who was in custody for the first time was located on this corridor; custody staff told us that he would be checked every 15 or 20 minutes; however checks were not as frequent as this and did not comply with the contractor's procedures (see paragraph 5.31).

5.27 We were particularly concerned about the staffing at Wrexham Magistrates' Court, which comprised two custody officers and an SCO. The local operating procedure at Wrexham required a minimum of two custody officers to escort all detainees to court because of the considerable distance from the cells to the court building and a lack of strip alarms (see paragraph 5.63). As a consequence, the SCO was left alone in the court cells for long periods throughout the day, which led to delays in responding to cell call bells, cell doors that were not unlocked even in an emergency situation and legal visits that could not be facilitated. Overall, we were concerned that some staffing levels at the busier courts, compromised detainees' safety and care.

Risk assessment

5.28 There was no formal systematic risk assessment at any of the courts to inform the care a detainee should receive and the contractor did not have a clear procedure for even a basic risk assessment. We were not confident detainees' risks and vulnerabilities were always properly identified or acted on. In North Wales, we saw custody staff discussing potential vulnerabilities with escort staff prior to disembarking detainees, which was good. Elsewhere, detainees were disembarked from vehicles individually and custody staff had a brief conversation with the detainee before placing them in cells; however, the conversation did not always focus on detainees' potential risks or welfare. Additionally, PERs were not routinely reviewed prior to locating a detainee to a cell (see paragraph 5.5). However, where they had been reviewed and there were warning markers about self-harm, some staff observed at Mold Court Complex and Llanelli, Caernarfon, Wrexham and Llandudno magistrates' courts spoke to the detainee sensitively about how they felt, whether they had any thoughts of suicide or self-harm and how to alert staff if they were feeling low in mood.

At Cardiff Magistrates' Court the PER for a detainee with severe alcohol withdrawal recorded that he was fit to be detained but it was unclear if he had been given or was due any medication for his condition. No separate risk assessment was carried out until an inspector raised concerns about the detainee's demeanour (see case study 6).

5.29 Where capacity allowed, detainees were not required to share cells. There were no designated levels of occupancy for custody suites and in some busier suites in South East Wales detainees regularly shared cells. Decisions about the allocation of cells were generally made before detainees arrived but cell-sharing risk assessments, which systematically highlighted risk factors to consider before detainees shared a cell, were often completed after the detainee was already in a cell with another detainee. At Cardiff Crown Court a detainee who was about to be placed in a cell with another detainee commented that he would kill anyone with whom he shared a cell. The custody officer took the correct decision to locate him on his own, but when asked why he had initially decided to allocate him to a shared cell, the response was 'They are both young adults', reflecting a poor initial risk assessment.

5.30 At Wrexham Magistrates' Court where the court cells were part of the police custody suite, detainees had corded clothing and footwear removed routinely, which was disproportionate and not normal practice elsewhere. We observed a detainee having a pair of police issued pumps with no laces removed and left outside his cell with no justification.

Risk management

5.31 All staff across Wales were aware of the contractor's procedure for conducting cells checks on detainees. The SOP clearly outlined that the routine level of observations for detainees about whom there were no concerns was once per hour and six times intermittently for anyone who was considered to be at risk of suicide or self-harm or was received 'off bail' (where someone is bailed straight from the police to attend court without being held in custody). In South East Wales vulnerable people or those identified as being at risk of suicide or self-harm were often placed in cells with CCTV that could be viewed via a monitor in the staff office. Across Wales cells with larger windows, often close to the staff office, made observing detainees easier, which was helpful.

5.32 The officer conducting observational checks was not the same person who entered the outcome of the checks on to GEOtrack (the electronic custody computer system), this was the same process across all the courts; communication between these staff was therefore important. We were not confident that checks always took place at the required frequency. We did not always see cells officers conducting checks at regular intervals and at a few of the busier and larger court complexes there was limited, if any, communication with the person entering information on GEOtrack about what was observed when the checks had been completed. Court staff told us they did not need to inform the officer recording checks that they had been carried out as they knew they would be completed; this could have resulted in inaccurate data being recorded. As the inspection progressed, the staff responsible for undertaking the checks improved their communication with the person responsible for updating GEOtrack.

5.33 The quality of checks varied across the courts: many involved the officer looking through the observation panel, with very little face-to-face interaction. At Cardiff Crown Court, we reviewed the records of detainees in cells and the entries for one detainee indicated that he had not been checked for three hours. We did, however, also observe some very good care, including that of an older man at Mold Court Complex, who threatened to harm himself; he was immediately moved to the larger observation cell and placed on constant watch, while

an officer remained with him. The SCO ensured he was prioritised for transport back to prison, which happened promptly.

5.34 Staff in the cellular part of vehicles, did not always carry anti-ligature knives, although this improved as the inspection progressed. Most officers working in the court cells area carried them, but when other staff relieved them of their duties, they did not always carry the tool, which was a risk. Many cells contained a number of ligature points (see paragraph 5.55), but there was no enhanced risk assessment for anyone located in them, even if there were suicide or self-harm concerns.

5.35 Once detainees were required in court they were generally delivered promptly. Affray alarms, used to alert staff if there were problems, were not always within ready reach along some of the routes to the court dock, such as in Cardiff, Wrexham and Bridgend magistrates' courts.

5.36 Custody staff consistently highlighted any concerns about detainees who were being transferred to prison; they were recorded on suicide and self-harm warning forms, which logged not only actual self-harm and when detainees had communicated thoughts of self-harm, but also when staff thought a detainees' demeanour or mood had changed. Even vulnerable detainees, including children, could not have social or family visits unless directed by the court.

Release and transfer

Case study 5

At Swansea Magistrates' Court, Mr R, a 72-year-old detainee, arrived at the custody suite after being transported from a police station on a GEOAmey van. He was unsteady on his feet, struggled to get off the vehicle and was handcuffed. As the stairs to the dock at the court were very steep, the acting SCO decided not to place him in handcuffs when entering and leaving the courtroom. Mr R was subsequently sentenced and released by the court. The acting SCO decided to issue him with a rail warrant to get the train to Port Talbot as he had no money or travel pass. An HMIP inspector asked where the detainee lived and was told he stayed in a small village outside Port Talbot. The acting SCO reluctantly agreed they would also have to issue the detainee with some petty cash to get the bus home to complete his journey. Staff then tried to find the petty cash tin, which was eventually located, but it did not contain sufficient change. However, one of the custody officers was willing to donate £1 towards the detainee's fare. Staff wrote down what Mr R needed to do with the travel warrant and put his bus fare into an envelope. They also wrote down where he should catch the bus once he reached Port Talbot. On his release, staff directed him towards the railway station, a 0.4 mile walk; staff did not have a map they could issue him with to keep him in the right direction.

5.37 No pre-release procedure that focused on detainees' individual needs or welfare, even for the most vulnerable, was available. A pre-release check list was completed for each detainee leaving court custody to ensure they were releasing the correct person but it did not address vulnerabilities or risks.

5.38 Detainees were provided with a travel warrant to the nearest town, which did not always guarantee that detainees got home safely, particularly in rural areas. Rail warrants to allow detainees to access trains were held at all courts. Bus warrants were generally only available in custody suites in North Wales and small amounts of petty cash were maintained on site at most of courts. Staff received no guidance on what action they should take if they were releasing a detainee about whom they had concerns. Most custody staff across the suites told us they would raise any concerns with the detainees' legal representative who might

arrange to take the detainee home. This was unsatisfactory, particularly if there were safeguarding concerns and agencies needed to be notified to offer support following release.

5.39 All courts had new support leaflets 'Onwards and upwards' containing telephone numbers for support services, which was helpful, but they were only available in English and not all detainees who were released received them.

5.40 A bus service was provided throughout the day to take detainees and their families from Newport AIT to the local train station. Staff we spoke to told us that prior to detainees leaving the immigration removal centre, they advised them to bring sufficient funds with them to the tribunal in case they received bail. In the event that this was not possible staff said they would give them the opportunity to contact family and friends to assist them in getting home, as Tascor, unlike GEOAmey, did not provide any rail warrants or bus fares.

5.41 Staff filled in suicide and self-harm warning forms, which accompanied the detainee, when they believed there was a potential risk. Most courts held basic information in English and Welsh about the local prisons to which they regularly sent detainees, but they were not always offered to those who were remanded or sentenced to custody, even if it was their first time, which was poor practice.

Recommendations

5.42 Cell-sharing risk assessments should be completed for all detainees before they are required to share a cell.

5.43 Staff should complete observations at the required frequency, including for detainees identified as being at risk of self-harm or suicide, and there should be a formal process to amend levels of observation. The outcome of all cell visits should be recorded accurately in the detention log on GEOtrack.

5.44 All staff undertaking observations and cell visits should carry anti-ligature knives at all times.

5.45 Detainees handed over to court custody suites shared with the police should be able to keep their clothing and footwear.

5.46 Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave and offer them a leaflet detailing local support agencies.

Housekeeping points

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

5.48 Support leaflets offered to detainees on release should be available in a range of languages.

5.49 Information about local prisons should be available in a range of languages and offered to all detainees who are remanded or sentenced to prison.

Use of force

5.50 All staff received annual refresher training in control and restraint techniques. The PECS contract manager confirmed that force was used an average of six times a month in court custody across Wales. Staff we spoke with were aware they should only use force as a last resort. Use of force incident reports we reviewed were completed well and generally reflected low level force that was de-escalated promptly. We observed a well-managed incident at Caernarfon Magistrates' Court where staff spent time trying to calm down a detainee who did not want to board the escort vehicle. As a last resort staff put on personal protection equipment when it seemed that he might have had to be physically removed from the cell; however, following further negotiation, the detainee agreed to board the vehicle without any force having been required.

5.51 Detainees were handcuffed when embarking and disembarking vehicles in accordance with the contractor's policy, even when the vehicle bays were in secure areas, which was potentially disproportionate. All court custody suites were secure areas, yet staff were allowed very little discretion about handcuffing if the contractor's policy was to be complied with. All detainees were persistently handcuffed even from cells to legal visits in the consultation room, and at Caernarfon Magistrates' Court, detainees were handcuffed to the toilet door (located outside of the cell corridor), regardless of their behaviour, which was unnecessary. Handcuffing throughout court custody in Wales was mostly routine and different levels of handcuffing were often applied inconsistently without any clear justification, which meant it was at times excessive. (See main recommendation 2.45.)

5.52 All staff we spoke with said children would also be handcuffed in the custody suite. We found very few cases where staff carried out a dynamic risk assessment to consider not applying handcuffs; in the one case where we saw this take place, it was appropriate.

5.53 Notices throughout the custody suites stated that searching was not always necessary and detainees were not routinely searched when they came from prisons where they had already undergone the procedure, which was appropriate. Searching of detainees arriving from police stations was, however, inconsistent. We observed much disproportionate and unnecessary searching in custody suites, including before and after closed visits and following an appearance in the dock when a detainee had been in constant contact with two officers. We also observed some inconsistent approaches to searching: detainees were sometimes, but not always, searched after visiting the toilet.

Recommendation

5.54 Detainees should only be searched if necessary and justified by a thorough, dynamic risk assessment.

Physical conditions

5.55 The court custody estate was in a generally good condition. The facilities in North Wales, particularly at Mold Court Complex and Caernarfon Crown and Magistrates' Court were excellent. Staff at all courts checked the cells every day, including the cell call bells, and monitored the overall condition of the cells. Part of the process included checking for ligature points, but despite this we found too many cells and toilet areas that had them. There was only evidence in a small number of cells across the estate that ligature points had been removed. Some of the safety concerns we identified during the inspection were not flagged up on the cell-checking forms that custody staff completed, which highlighted the

inadequacy of the process at some courts. There was no procedure for identifying which cells could not be used for detainees who were most at risk of harming themselves.

5.56 The holding room at Newport AIT was clean, free of graffiti and detainees had access to two private toilets and hand-washing facilities. HM Courts & Tribunals Service (HMCTS) had reported that Tascor had not recently raised any concerns regarding the condition of the holding room and Tascor confirmed this. The facility was not used frequently and cleaning arrangements were adequate.

5.57 There was a programme of deep cleaning and some of the courts had been redecorated. However, a small number of the custody areas and cells were not systematically cleaned according to agreed schedules and the condition of some courts cells were at risk of deteriorating if they were not adequately cleaned on a daily basis.

5.58 Lay observers' reports, available to HMCTS and GEOAmey, highlighted a few issues; poor cleaning and graffiti in the suites were among them. SCOs at some courts told us they reported any inadequate cleaning to a member of staff employed by the cleaning contractor, but at other courts they accepted the state of the cells and generally did not make any complaints. Not all court custody staff were aware of the process for reporting cleaning concerns to HMCTS across the custody estate. Consequently ongoing concerns about the quality of the cleaning in some of the custody suites were not consistently brought to the attention of the cleaning contractor so improvements could be made.

5.59 There was a system for reporting basic maintenance defects to the private contractor at both the courts and the AIT. Any issues that might have resulted in the cells being taken out of use or security being compromised were resolved within 24 hours according to the records we reviewed. We saw this happen when the vehicle dock door was damaged at Cardiff Magistrates' Court and a panic alarm was found not to be working at Newport Magistrates' Court; both were fixed within a few hours, which was good.

5.60 More serious issues with the physical condition were reported to HMCTS and then referred to the estates team to prioritise repairs. We were aware that the graffiti in cells had been reported to HMCTS so it could be removed. Cells in Cardiff, Swansea Caerphilly, Bridgend and Merthyr Tydfil magistrates' courts had extensive graffiti on cell doors, some of which was offensive. PECS had closed cells in Cwmbran and Prestatyn magistrates' courts during their 'safe, secure, decent and compliant' audit owing to the offensive nature of some of the graffiti and a potential ligature point. It was a concern that staff at these courts had not identified these issues during their daily cell checks and it was clear that some custody staff were not rigorous enough when they checked cells or scrutinised the graffiti for offensive remarks. (See Appendix II: Photographs.)

5.61 While on site at Prestatyn Magistrates' Court, a detainee who had only been placed in his cell for a short time was found to have written graffiti on his cell wall. The police was contacted; police officers attended, took statements and interviewed and charged the detainee. This matter was dealt with alongside his original charges when he appeared in the court later that day and he received a fine. This was good proactive and collaborative action.

5.62 Detainees could use the toilets privately, except at Swansea and Cardiff crown courts and Aberystwyth Magistrates' Court, the toilets were not sufficiently private because the doors were too low. The men's toilets at Cardiff and Brecon magistrates' courts smelled of urine and were stained and dirty. Toilet paper was available at all courts. Hand-washing facilities and supplies of soap and paper towels were adequate.

5.63 The shared facility with the police at Wrexham Magistrates' Court was unsuitable for court custody use. Court custody staff were allocated four cells at one side of the building to which they had immediate access. However, if they required more cells, detainees were

located on the police custody side of the suite and custody staff relied on police staff to inform them if detainees had rung the cell call bell or needed attention. There was no interview room, solicitors were locked in cells with detainees or, as we saw on one day, solicitors conducted interviews through cell door hatches, neither of which was appropriate or confidential (see paragraph 4.13). There was no dedicated kitchen area to prepare drinks or meals for detainees; the microwave was on top of a storage unit in the small office used by court custody staff. There were insufficient strip alarms running along the side of the wall on the route to court. The generally inadequate facilities for court custody staff affected their ability to meet detainees' needs and had an impact on staff and agency representatives who attended the court custody suite.

5.64 Most courts had fire evacuation procedures, which were clearly displayed and with which some staff were familiar. Few emergency evacuation fire drills had taken place. It was a concern that at some of the busy courts, a number of staff were unsure of emergency evacuation procedures.

5.65 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. Aside from the poor arrangements at Wrexham Magistrates' Court, staff answered cell call bells promptly at all courts.

Recommendations

5.66 Cell checking procedures should include identifying ligature points and inadequate cleaning, which should be recorded, reported and rectified immediately.

5.67 HMCTS should ensure that graffiti is removed from all cells immediately; cells should remain graffiti free.

5.68 All detainees should have access to clean toilets, which they should be able to use in privacy.

5.69 Emergency evacuation drills should be conducted and recorded at all courts. All staff should be familiar with emergency evacuation procedures.

Health

5.70 Each court custody suite had access to health care advice from a specialist health adviser, Taylormade Medical Services, which could also provide a paramedic if needed. A protocol was in place to deal with health emergencies. All the custody staff we spoke to across the custody suites were aware of it and used it appropriately to seek telephone advice. However, we found very limited evidence of any significant onsite attendance and staff commonly described contacting Taylormade as being simply a precursor to calling the public emergency services (through a 999 call). This appeared to be in part due to Taylormade's response times. For example, we came across one detainee at Cardiff Magistrates' Court with severe alcohol withdrawal symptoms. Taylormade informed the SCO that staff could not respond within two hours and that emergency services should be contacted if required, which was inefficient.

5.71 Medical emergency arrangements at the AIT, involved Tascor staff contacting a triage line for advice or calling emergency services if medical attention was urgent.

Case study 6

Mr V was detained at Cardiff Magistrates' Court. An HMIP inspector was told at 11.30am that he was suffering from alcohol withdrawal. He was continually vomiting and shaking and complained of feeling extremely unwell. Inspectors were concerned and asked the SCO what action was being taken. There was no formal risk assessment at the court and no special measures were put in place. When inspectors expressed concerns after speaking with Mr V, the SCO spoke with him and agreed that he required medical attention. Inspectors examined the PER and found an entry that a nurse had made at the police cells at 6am, which certified Mr V was fit to be detained. The only entry under care given was 'For medication' but no further information about what medication was required or whether any had been given was recorded. The SCO did not know what the entry meant. The SCO telephoned Taylormade, asking for a medical practitioner to attend to examine Mr V. A doctor told him that staff were busy and that there would be a two-hour wait. The doctor said that Mr V should be fast-tracked to court; if he was released he should visit the emergency department at the local hospital and if he was remanded, NHS emergency services should be called. The SCO was frustrated at this response. Mr V was fast-tracked to court. The SCO contacted NHS emergency services; NHS staff said they would call back and did so within 15 minutes. They spoke by telephone with Mr V in the staff office. A paramedic arrived half an hour later and Mr V was taken to the local hospital's emergency department.

5.72 All staff received first aid training on induction, which included basic life support skills and periodic updates, as part of GEOAmey's mandatory training programme. However, many staff had not used or practised these skills and there were no onsite resuscitation equipment, suction, oxygen or automated external defibrillators (AEDs). The very basic first aid kits we found in most suites were not suitable for dealing with most predictable emergencies. The contents varied, were not routinely checked and in some cases contained out-of-date stock.

5.73 Health interventions were recorded on the PERs but they were not always clear and we found confidential medical information of a prejudicial nature recorded in some cases, which was unacceptable. For example, at one South East Wales court we found a PER originating from police custody indicating the detainee was 'hepatitis C positive', which was not relevant for the general PER form. If this had been considered clinically relevant, it should have been recorded as a confidential note or health summary in a sealed envelope. In another PER received from the police, an envelope was attached to the front marked 'For the attention of CJMHLT' (Criminal Justice Mental Health Liaison Team), but it was not sealed or marked as being 'medical in confidence'.

5.74 Health interventions during custody, including the medicine supply, were appropriately noted on the PER. However, custody staff told us that information related to detainees who arrived from prison or police custody could be inconsistent, which we also observed: at one court the abbreviation 'MI' was noted but was not explained. Custody staff were not sure what it meant and they appropriately contacted the police custody suite for clarification (in this case 'MI' referred to a previous myocardial infarction).

5.75 Custody staff were aware of the requirement for safe drug administration and appropriately sought advice from the prison or police custody health care professionals who had previously seen the detainee or from Taylormade when medication queries arose. Detainees' medicines were managed appropriately and safely stored. We found, that where clinically indicated, detainees who arrived from prison or police custody with risk-related conditions such as asthma, angina and diabetes generally had appropriate and timely access to their medicines. Obtaining medication for detainees who arrived in custody 'off bail' and required medication but who might not have been seen by a health care professional proved more problematic, particularly given the difficulties arranging prompt contact with the contracted specialist health adviser. At Llandudno Magistrates' Court we were told about one detainee

with severely ulcerated legs who had had a single dose of pain relief in police custody, which had subsequently worn off. The individual had to be sent to hospital as the alternative involved the Taylormade health care practitioner travelling from Birmingham to assess the detainee.

5.76 Detainees with mental health issues were usually identified and assessed prior to arriving from prison or police custody. Established court liaison and diversion services were available at most magistrates' courts, although all staff we spoke to at crown courts had established relationships with the local mental health provider and knew whom to contact for support.

5.77 The North Wales mental health team led by Betsi Cadwallader University Health Board was particularly proactive. However, across all courts, no custody staff received any mental health awareness training.

5.78 Detainees with substance misuse problems had usually been seen in police custody or at the transferring prison. Onsite input from specialist substance misuse workers was not routine in Mid and West Wales or South East Wales, but a number of different agencies provided support. Except for those at West Magistrates' Court, custody staff had access to advice, although detainees themselves were not routinely approached to see if they needed any assistance with drug or alcohol problems. Referrals generally had been identified in police custody or by probation services where detainees were being considered for drug treatment orders.

5.79 In North Wales, a single agency ARCH Initiatives provided comprehensive coverage and a routine presence within court custody areas. However, detainees arriving with ongoing withdrawal symptoms did not receive symptomatic relief unless it was authorised and recorded on the PER prior to arriving in custody. Overall custody staff demonstrated a reasonable understanding of drugs and alcohol issues and most were aware of the particular risks associated with alcohol withdrawal. However, they lacked formal training in drug- and alcohol-related risks.

Recommendations

5.80 GEOAmey should routinely review the effectiveness and clinical performance of Taylormade Medical Services.

5.81 Custody staff should be appropriately trained and annually updated in emergency response skills, including basic life support and the use of automated external defibrillators.

5.82 First aid equipment should include sufficient up-to-date kit, including basic equipment to maintain an airway and automated external defibrillators in custody areas.

5.83 PERs should clearly identify each detainee's health risks while ensuring confidentiality is appropriately maintained. All inadequately completed PERs that have the potential to affect the safe provision of health care should be captured on the incident reporting system and the information formally escalated to the sending establishment.

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

5.85 Custody staff should have regular training to enhance their mental health and drug and alcohol awareness.

Section 6. Summary of recommendations

Main recommendations

6.1 HMCTS should ensure that interagency meetings include a focus on court custody operations, particularly on improving the care and safety of detainees in court custody. (2.41)

6.2 HMCTS, PECS and the escort and court custody contractor should investigate the reasons for the prolonged periods that detainees, including children, spend in court custody cells. Measures should be put in place to ensure detainees in custody have their cases prioritised where possible and are transferred and released without delay. (2.42)

6.3 Sufficient staff should be on duty at all times so that the safety and welfare of detainees and staff are maintained. (2.43)

6.4 Staff should complete a standard risk assessment for each detainee, and receive training to do this. (2.44)

6.5 Handcuffs should only be used if necessary, justified and proportionate. (2.45)

National issues

6.6 HMCTS and PECS should establish agreed standards in staff training, detainee treatment and conditions, and detainees' rights during escort and in court custody. (2.46)

6.7 HMCTS and PECS should clarify the responsibilities of each organisation for resolving problems that have an impact on outcomes for detainees. (2.47)

Recommendations

Leadership, strategy and planning

6.8 HMCTS should engage with all partner agencies to ensure there are no unnecessary delays causing detainees to be held in court custody for longer than necessary. (3.17)

6.9 Quality assurance processes should be more effective in addressing key elements of detainee care during escorts and court custody. (3.18)

6.10 There should be a safeguarding policy and all staff should be made aware of safeguarding procedures for children and adults at risk. (3.19)

Individual rights

6.11 HMCTS should ensure that compliant defendants apprehended by court and civil enforcement officers are not taken into court custody unless there are good reasons to do so. (4.17)

6.12 There should be sufficient private consultation rooms at Wrexham Magistrates' Court and visitors to Wrexham court cells should not be locked in with detainees. (4.18)

6.13 All court custody staff should be made aware of the availability of a professional telephone interpreting service, which should be readily accessible in each custody suite and used as necessary. (4.19)

6.14 All detainees should be informed of the complaints process. Complaints should be recorded on behalf of detainees who make verbal complaints about any aspect of their period in detention. There should be a process for monitoring complaints and analysing trends. (4.20)

Treatment and conditions

6.15 Cellular vehicles should always be clean and well maintained. (5.17)

6.16 Men and women should not be transported in the same escort vehicle, and detainees should be transferred from cellular vehicles to court cells out of public view. Where this is not possible safeguards should be put in place to protect detainees from public view. (5.18)

6.17 The quality of PERs should be improved and should include more specific information about all risks posed by the detainee. (5.19)

6.18 Custody officers should receive sufficient training to meet the diverse needs of detainees held in court custody. (5.20)

6.19 There should be a small stock of mattresses and blankets or warm clothing for detainees who are elderly, pregnant or disabled. (5.21)

6.20 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. (5.22)

6.21 All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers. (5.23)

6.22 Cell-sharing risk assessments should be completed for all detainees before they are required to share a cell. (5.42)

6.23 Staff should complete observations at the required frequency, including for detainees identified as being at risk of self-harm or suicide, and there should be a formal process to amend levels of observation. The outcome of all cell visits should be recorded accurately in the detention log on GEOtrack. (5.43)

6.24 All staff undertaking observations and cell visits should carry anti-ligature knives at all times. (5.44)

6.25 Detainees handed over to court custody suites shared with the police should be able to keep their clothing and footwear. (5.45)

6.26 Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave and offer them a leaflet detailing local support agencies. (5.46)

6.27 Detainees should only be searched if necessary and justified by a thorough, dynamic risk assessment. (5.54)

6.28 Cell checking procedures should include identifying ligature points and inadequate cleaning, which should be recorded, reported and rectified immediately. (5.66)

6.29 HMCTS should ensure that graffiti is removed from all cells immediately; cells should remain graffiti free. (5.67)

6.30 All detainees should have access to clean toilets, which they should be able to use in privacy. (5.68)

6.31 Emergency evacuation drills should be conducted and recorded at all courts. All staff should be familiar with emergency evacuation procedures. (5.69)

6.32 GEOAmey should routinely review the effectiveness and clinical performance of Taylormade Medical Services. (5.80)

6.33 Custody staff should be appropriately trained and annually updated in emergency response skills, including basic life support and the use of automated external defibrillators. (5.81)

6.34 First aid equipment should include sufficient up-to-date kit, including basic equipment to maintain an airway and automated external defibrillators in custody areas. (5.82)

6.35 PERs should clearly identify each detainee's health risks while ensuring confidentiality is appropriately maintained. All inadequately completed PERs that have the potential to affect the safe provision of health care should be captured on the incident reporting system and the information formally escalated to the sending establishment. (5.83)

6.36 All detainees who require prescribed medication while in court custody should have access to it. (5.84)

6.37 Custody staff should have regular training to enhance their mental health and drug and alcohol awareness. (5.85)

Housekeeping points

Treatment and conditions

6.38 Staff should routinely inform female detainees of the availability of hygiene packs. (5.24)

6.39 Vulnerable detainees should be able to receive social visits in exceptional circumstances. (5.47)

6.40 Support leaflets offered to detainees on release should be available in a range of languages. (5.48)

6.41 Information about local prisons should be available in a range of languages and offered to all detainees who are remanded or sentenced to prison. (5.49)

Section 7. Appendices

Appendix I: Inspection team

Vinnett Pearcy	Lead inspector
Kellie Reeve	Inspector
Andrew Rooke	Inspector
Fiona Shearlaw	Inspector
Steve Eley	Health services inspector
Nicola Rabjohns	Health services inspector

Appendix II: Photographs

Cell door with detainee rights displayed

Adapted toilet, Aberystwyth

Clean toilet area at periodic court

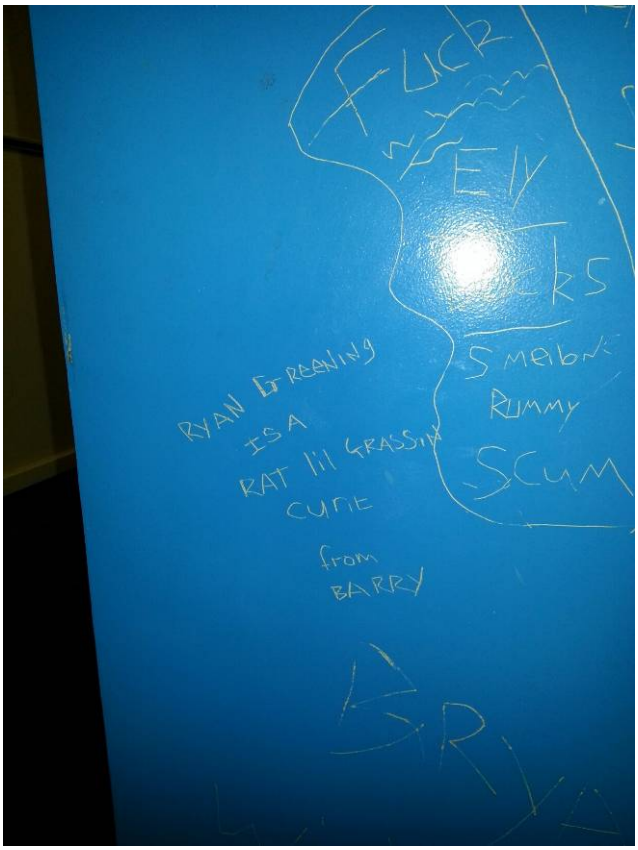
Missing toilet seat, Prestatyn

Clean cell, Haverfordwest

Dirty Bridgend escort vehicle

Dirty escort vehicle from Chester base

Graffiti on cell door, Bridgend



Offensive graffiti, Cardiff

Offensive graffiti, Cardiff