Report on an inspection visit to court custody facilities in

Lincolnshire, Leicestershire & Rutland and Northamptonshire

by HM Chief Inspector of Prisons

26 November–7 December 2018

Glossary of terms

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Introduction

HM Inspectorate of Prisons' inspections of court custody facilities contribute to the United Kingdom's response to its international obligation to ensure regular independent inspection of all places of detention. The inspections focus on outcomes for detainees in three areas: leadership, strategy and planning, individual rights, and treatment and conditions, including health care.

This inspection covered the court cluster in Lincolnshire, Leicestershire & Rutland and Northamptonshire and included nine courts in use with custody facilities, comprising three Crown courts and six magistrates' courts. The Prisoner Escort and Custody Services (PECS) arm of HM Prison and Probation Service (HMPPS) had contracted GEOAmey on behalf of HM Courts & Tribunals Service (HMCTS) to provide court custody and escort facilities in the region.

Overall, this was a reasonably good inspection and we identified no significant areas of concern. Of particular note, there was a positive staff culture and detainees were cared for and treated well during their time in court custody facilities. The estate was generally clean and, despite issues with the contracted maintenance provider, mostly in a reasonable state. There was a better focus than we usually find on ensuring detainees, particularly the most vulnerable, were released safely. We were pleased that the facilities had adopted a more proportionate approach to handcuffing detainees than in previous inspections.

Notwithstanding the positive features of the inspection, several areas required further attention. Although described as improving in parts of the cluster, the relationships between the three key agencies - HMCTS, PECS and GEOAmey - were, at times, strained and did not always work harmoniously to achieve good outcomes for detainees. For a variety of reasons, some detainees spent too long in court cells unnecessarily. Unusually, lay observer reports were not always completed with sufficient detail to be helpful, and were neither circulated widely or used proactively to drive improvements. There was also a gap in services to provide consistent support for detainees suffering from mental ill health or substance use issues.

We have made a number of recommendations that we hope will assist ongoing improvements.

Peter Clarke CVO OBE QPM January 2019
HM Chief Inspector of Prisons

Fact page[1]

HMCTS cluster
Lincolnshire, Leicestershire & Rutland and Northamptonshire

Cluster manager
Michelle Monk

Geographical area
Lincolnshire, Leicestershire & Rutland and Northamptonshire

Court custody suites	**Cell capacity**
Boston Magistrates' Court	7 cells
Leicester Magistrates' Court	16 cells
Lincoln Magistrates' Court	16 cells
Loughborough Magistrates' Court	12 cells
Northampton Magistrates' Court	12 cells
Wellingborough Justice Centre	7 cells
Leicester Crown Court	16 cells
Lincoln Crown Court	6 cells
Northampton Crown Court	9 cells

Annual custody throughput
1.11.17 – 31.10.18 — 9,615 detainees

Custody and escort provider
GEOAmey

Custody staffing
7 court custody managers
39 court detention officers (+ 6 vacant posts)

[1] Data supplied by HMCTS Lincolnshire, Leicestershire & Rutland and Northamptonshire Court Custody Cluster and GEOAmey, Custody and Escort Provider.

Section 1. Background and key findings

1.1 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.

1.2 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.

Leadership, strategy and planning

1.3 Three agencies worked together to deliver court custody services in Lincolnshire, Leicestershire & Rutland and Northamptonshire. HM Courts & Tribunal Services (HMCTS) had overall responsibility along with Prisoner Escort and Custody Services (PECS) and GEOAmey, the contracted service provider. HMCTS had a clear line management structure for the cluster.

1.4 Inter-agency relationships were underpinned by regular and mostly informal communication. Individually, managers from each of the three key agencies were focused on treating detainees well. Working relationships between the three key agencies were, however, not always harmonious. It was evident that they did not always fully understand the business of each other. Although this was a source of frustration among some staff and managers, outcomes for detainees were generally reasonably good.

1.5 The responsibility for cleaning and maintenance was provided through a contract with G4S. Cleaning arrangements were mostly effective but some faults and defects often took a long time to be addressed. Although there were some graffiti and potential ligature points across the estate, the environments in custody suites were acceptable overall.

1.6 The staffing of custody suites was adequate. There was a good culture among the GEOAmey court custody staff. Although they lacked training in some key areas, such as equality and diversity and mental health awareness, they tried their best to meet the individual needs of detainees in their care.

1.7 HMCTS was committed to using video-link to allow court cases to be heard from prisons, where possible, for eligible cases. When used, this avoided unnecessary disruption for prisoners.

1.8 There remained no overarching HMCTS safeguarding protocol. The GEOAmey safeguarding procedures were still not well embedded.

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[2] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

1.9 Lay observers provided regular, independent scrutiny of most custody facilities. However, their reports were not always sufficiently detailed to be useful, and were not circulated widely enough across the three key agencies to drive necessary improvements.

Individual rights

1.10 It was positive that court proceedings, particularly those involving children or vulnerable people, were generally prioritised for detainees in court custody. Some detainees were held in custody for longer than necessary. Reasons for this included delays in the attendance of solicitors, late or non-attendance of court-appointed interpreters, detainees not always transferred to prison promptly after their cases were dealt with, and delays in securing formal authority to release a person from prison.

1.11 Court enforcement officers (who executed warrants on behalf of the courts) frequently collected people for court and often delivered detainees to court custody. We did not believe that this was always justified, particularly when detainees were compliant and were generally only required in court for low-level matters.

1.12 Information leaflets detailing detainee rights in court custody, and complaints procedures, were generally placed in cells before their arrival. However, despite new reception processes, staff did not always check if detainees could read or understand them. Rights leaflets were available in a range of languages but not in easy-read format or Braille. Complaints procedures were reasonably well promoted and understood by staff.

1.13 Most custody suites had sufficient interview rooms for legal consultations. There were, however, too few facilities at both Lincoln courts, which led to queues, and the rooms in the magistrates' court also had inadequate soundproofing.

1.14 Professional telephone interpreting services were available in all court custody suites, but staff used them infrequently to assist assessment of the risks and welfare needs of non-English speaking detainees.

Treatment and conditions

1.15 Most detainees did not experience unnecessarily long journeys to reach the courts. Cellular vehicles were generally clean and well equipped. Detainees were disembarked quickly and their privacy maintained. However, it was not appropriate that women and children sometimes shared transport with adult men, and that partitions to safeguard them were not always used.

1.16 Court custody staff engaged well with detainees. Many were friendly and reassuring, and demonstrated genuine care for the detainees they were looking after. Staff displayed a willingness and ability to respond to and meet the diverse needs of detainees, despite a lack of training and awareness. Only one court in the cluster was accessible for detainees with physical disabilities and, while staff did their best to accommodate such detainees and mobility needs where possible, facilities overall were poor.

1.17 The individual needs of female detainees were generally well met. Religious artefacts for all the main faiths were available, and there was evidence that they were offered and provided to detainees. Staff were confident in dealing with and meeting the individual needs of transgender detainees.

1.18 It was positive that relatively few children were held in court custody. Those transferred from secure training centres and secure children's homes were transported in non-cellular vehicles and were accompanied by trained escort staff who stayed with them throughout. The needs of other children arriving from police custody or young offender institutions were, however, not sufficiently understood or met. There was little difference in the way these children and adults were treated; they were generally held in cells, sometimes for long periods with little to do.

1.19 Positively, GEOAmey had new children's safeguarding and child protection policies, but they were not well embedded. A training programme delivered by Barnardo's had been introduced, but few staff had completed it and most remained unfamiliar with safeguarding and child protection principles and reporting procedures. Custody staff had not been trained in child restraint procedures ('minimising and managing physical restraint').

1.20 The overall care given to detainees was good. They were offered drinks regularly and a sufficient range of food at mealtimes and when they said they were hungry, if supplies allowed. It was positive that reading material was routinely issued to detainees in most suites. The creation of distraction packs was a good initiative, but they were rarely distributed.

1.21 The initial assessment of detainee risk lacked rigour. The recently introduced reception checklist was a potentially useful tool but was not yet used consistently and staff were not always responsive to detainees' answers. The quality of information in person escort records (PERs) was variable but often not adequate to inform an assessment of risk. Those detained after appearing on bail were generally given a more careful initial risk assessment. Team briefings rarely involved all staff on duty, and there was no consistent approach to sharing important information about risks posed by individual detainees.

1.22 The management of risk was generally better. With relatively few exceptions, most detainees were checked at the required frequency, and cell sharing was not often required. It was positive that all staff carried anti-ligature knives and that they responded to cell call bells promptly.

1.23 Once summoned by the court, detainees were taken to the dock quickly, and there were sufficient affray alarms en route.

1.24 There was a good focus on ensuring detainees were released safely. Staff took considerable care to support the most vulnerable people to get home, and had a supply of travel warrants and petty cash to assist those without sufficient means. Support leaflets were available but were rarely given to detainees on their release. Few detainees transferring to prison were given any written information about what to expect on their arrival there.

1.25 Staff were patient and reassuring when dealing with challenging detainees, and de-escalated many situations well without resorting to the use of force. Force was used infrequently in custody and was generally proportionate to the risk posed. However, the documentation completed by individual officers to justify their use of force against detainees sometimes lacked sufficient detail. We found that one detainee had been left unsupervised in handcuffs in a cell following the use of force against him, and we referred this case back to GEOAmey for review.

1.26 There was too much unnecessary searching in court custody, and it was often inconsistent and cursory.

1.27 We found a more proportionate approach to handcuffing in the custody suites than in previous inspections. However, detainees, including children, were still routinely handcuffed

in secure areas, such as van docks and en route to court, with no individual risk assessment to justify this.

1.28 Conditions across suites were generally good. Most cells were clean, although many contained potential ligature points. Although there was graffiti in some cells, it was generally not offensive. Most communal toilets were clean and detainees had free access to toilet paper, soap and paper towels, although there were no soap dispensers in some suites.

1.29 Fire evacuation procedures were generally displayed prominently. Staff were aware of their responsibilities during emergency evacuations. Fire drills or desktop exercises had been carried out in some, but not all, suites.

1.30 Staff were generally aware of the telephone medical advice service provided by Stadn Ltd but it was not often used. Staff were mostly up to date with their first aid training but the three-yearly refresher training was too infrequent to maintain a sufficient level of competence. First aid kits were adequately stocked.

1.31 The police rarely arranged for sufficient medication to accompany a detainee to court, which posed potential risks to their safety and welfare, particularly those withdrawing from alcohol or drugs. In these cases, court custody staff told us they would try to prioritise detainees for court, and if remanded to prison arrange for their early onward transfer. While well-intentioned, this was unsatisfactory as a substitute for giving detainees access to their medication.

1.32 The lack of embedded liaison and diversion practitioners was a significant gap in many courts. Some benefited from a service provided by mental health practitioners, which was invaluable to both detainees and court custody staff. However, the inequitable service affected the care and support provided to some detainees. Most staff told us that they had not received any training in identifying and supporting detainees experiencing mental health or substance use problems, which was a gap.

Section 2. 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.

2.1 HM Courts & Tribunals Service (HMCTS) in Lincolnshire, Leicestershire & Rutland and Northamptonshire operated as a single cluster. Three key agencies delivered court custody services across the cluster: HMCTS, which had overall responsibility; Prisoner Escort and Custody Services (PECS), part of Her Majesty's Prison and Probation Service (HMPPS); and GEOAmey, the contracted service provider. HMCTS had a clear line management structure for the cluster.

2.2 An HMCTS cluster manager was supported by three operations managers (one post was vacant at the time of the inspection) and was responsible for managing courts across the region, which included six magistrates' and three Crown courts. Seven HMCTS court delivery managers were responsible for the day-to-day provision of court services in the courts we inspected. Senior HMCTS managers told us that they took responsibility for court custody facilities and were focused on outcomes for detainees.

2.3 PECS commissioned GEOAmey to manage the court custody provision and provide detainee escort services on behalf of HMCTS in the cluster. The PECS contract delivery manager engaged with key personnel from the other agencies. He supervised the contractual arrangement between PECS and GEOAmey, and convened monthly performance and contract compliance meetings with them. He visited most custody suites regularly. Although not always evident in minutes from custody-related meetings, the contract delivery manager was sighted on providing good outcomes for detainees and improving their care and welfare. 'Safe, secure, decent and compliant' audits were completed every two years for each court, and included some focus on the conditions for and treatment of detainees.

2.4 A general manager for GEOAmey had oversight and responsibility for court custody and was supported by two GEOAmey area business managers, who managed services in court custody facilities. Seven court custody managers, supported by three deputy court custody managers, reported to the area business managers and were responsible for the daily running of the custody suites.

2.5 The management of the court custody provision was complex and relied on effective working arrangements between the three key agencies, yet formal meetings between them were infrequent and tended to be county-based rather than across the court cluster as a whole. For the previous six months, we were only provided with minutes from the meetings held in Northamptonshire. These contained little focus on the care and welfare of detainees.

2.6 In our interviews with managers from each agency, they showed concern about the treatment of detainees. Although some relationships were described as improving, it was evident that working relationships between the three key agencies were not always harmonious. They did not always understand each other's business and how they needed to inter-relate to deliver consistently good outcomes for detainees. We were told repeatedly that this was particularly acute in the courts in Northamptonshire.

2.7 PECS convened a quarterly forum for the East Midlands, covering this cluster, that was reasonably well attended by a wider group of stakeholders, including representatives from the local police and prisons. This meeting took a strategic approach, particularly on the

logistics of moving detainees effectively between the different agencies in the criminal justice system. There was, however, little recorded focus on the care of detainees.

2.8 We were told that few HMCTS managers visited the custody suites regularly. Most communication between GEOAmey and HMCTS staff was informal, by telephone and on an ad hoc daily basis or as required. In many cases this was sufficient to ensure reasonable working relationships were maintained but this was not always the case, particularly in Northamptonshire where we were told that engagement had been poor. It was positive that there were efforts to improve the working relationships across the cluster, but this poor engagement was clearly a source of some frustration, particularly among GEOAmey staff and managers.

2.9 There was reasonable attention to ensuring that environments in most custody suites were clean and well maintained. Most cleaning and maintenance arrangements were contracted to another company, G4S. Although there had been some problems across the cluster, the cleaning arrangements were mostly effective. However, the arrangements to maintain the custody suites were not always as good. Some defects and faults remained outstanding for long periods before they were adequately dealt with, even though these concerns were often escalated to a senior level (see recommendation 4.46). We found potential ligature points across the estate, many of which were easy to rectify. At the end of the inspection we provided HMCTS with a comprehensive, illustrative report detailing these, to which they responded positively.

2.10 An HMCTS listings protocol enabled custody cases to be prioritised for production to court, and we saw positive action from GEOAmey staff to request cases to be prioritised, particularly for children and other vulnerable detainees. However, their requests were not always facilitated, and the reason for not prioritising cases was often not clear (see paragraph 3.2 and recommendation 3.14).

2.11 Although GEOAmey regularly bolstered its court custody staffing complement with officers who usually staffed escort vehicles, this was seamless and did not affect detainee care. Ongoing recruitment was addressing the small shortfalls in staffing numbers. While data suggested that most staff were up to date with their training, many we spoke to said that they had not received refresher training for a considerable time, and did not always feel sufficiently trained to meet the individual needs of detainees. Despite this, we found a good culture where staff tried their best to meet the needs of detainees and to care for them well during their stay in court custody.

2.12 Video-enabled courts (video-link) allowed court cases to be heard from prisons. This was generally less disruptive to prisoners and avoided the need for them to make journeys to court on uncomfortable vehicles for sometimes very short appearances, and with relatively lengthy waits in court cells. HMCTS was committed to using video-link for all eligible cases but arranged these hearings without the express agreement of the detainee. Although we were told that its use was increasing, we were given no data to support this perception.

2.13 There was still no overarching HMCTS safeguarding policy that set out how detainees at risk, including children, would be protected from harm, abuse or maltreatment. GEOAmey had its own policies but these were still not well embedded or sufficiently understood by staff (see paragraph 4.14).

2.14 Lay observers regularly visited most of the court custody suites. The format of their reports focused on detainee treatment and their conditions, but were not always completed thoroughly and often lacked sufficient detail to be useful to the key agencies. We were told that HMCTS managers did not routinely receive the lay observer reports, and so could not use them to drive forward necessary improvements.

Recommendations

2.15 The three key agencies should improve their relationships and communication, and focus consistently on good outcomes for detainees.

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

Section 3. Individual rights

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

3.1 Court custody staff said they had a good relationship with their local youth offending service (YOS). All courts had appropriate arrangements, including Saturday cover, for the YOS to establish if a child was held in court custody. YOS workers attended when a child was detained in the court cells so that they could present their needs, risks and circumstances to the court. The very few children we saw in court custody had their cases prioritised to reduce the time they spent in the cells. There was also evidence of this in the records we reviewed for the three weeks to 3 November 2018. Once sentenced or remanded, most children were moved on to secure accommodation promptly, but in the records we reviewed at least one child had waited almost five hours before they were transported to a more suitable location; it was unclear if this was due to a delay in receipt of the placement order or in the arrival of suitable transport.

3.2 We saw most courts dealing with remand cases promptly, including those involving vulnerable detainees. However, the courts did not always progress requests from custody staff to prioritise the cases of vulnerable detainees (for example, when there were self-harm concerns), and the reasons for this were unclear. We observed requests made at Northampton magistrates' court to prioritise three cases involving vulnerable detainees, yet they had to wait for no apparent reason. (See paragraph 2.10.)

3.3 Detainees were held in court custody for longer than necessary for a variety of reasons. We were told than many of the delays in the attendance of solicitors that we observed were due to the transfer of electronic case papers from the Crown Prosecution Service (CPS) to solicitors. This, in turn, delayed solicitor consultations with their clients. At some courts, non-English speaking detainees were held in custody for longer than necessary due to delays or non-attendance of court-appointed interpreters. At Northampton Magistrates' Court on separate days we observed two detainees returned to police custody as no interpreter had arrived to assist them, which meant that they were held in police custody for an additional night unnecessarily.

3.4 When detainees had been remanded or sentenced before midday, courts made efforts, where possible, particularly at the Lincoln courts, to return them to prison at lunchtime, which helped to minimise some stays in court custody. We found evidence of this in the data the three weeks to 3 November 2018. However, we also found a few cases where detainees who had been dealt with by the court before 11am did not leave to travel to prison until 5.30pm. In addition, we saw two detainees who HMP Leicester had refused to accept at 11.20am as the prison reception was reportedly closed over lunchtime. In another case, a young male detainee who had been dealt with by the court at 10.45am did not leave to travel to HMYOI Brinsford until 4.30pm because of a wait to transport another detainee to the same YOI at the end of the day.

3.5 There were also lengthy delays in court custody for detainees who had been bailed or acquitted but previously remanded in custody who had to wait for their originating prison to authorise their release. In the records we reviewed, we found it was not uncommon for detainees to be held from 70 minutes up to five hours 30 minutes waiting for the authority to be released from prison. This was too long for people who were essentially free to leave court custody to be held in cells (see paragraph 4.29).

3.6 Court custody staff at the busier magistrates' courts told us that court enforcement officers (CEOs), who executed warrants on behalf of the court, regularly lodged detainees in court custody rather than bring them straight into the courtroom. This was unusual and meant that some compliant individuals were subjected to unnecessary detention in cells, usually for low-level matters.

3.7 Detention warrants, which should be produced within 60 minutes of a court hearing or appearance, were produced electronically and forwarded direct to local prisons. Most warrants were issued promptly.

3.8 Detainees in police custody should be able to appear before the first available magistrates' court if the court is sitting and there is capacity to hear the cases. Custody staff told us that the clerk of the court routinely accepted detainees up to 2.30pm, which was too early an acceptance time. In the records we reviewed, few detainees were received after 2pm. This did not assure us that detainees were always seen by the first available court, and so potentially remained in police custody for longer than necessary.

3.9 Court custody staff in the magistrates' courts told us that, where possible, they would facilitate a request by a detainee to tell somebody where they were, or would refer this to their legal representative to progress.

3.10 Copies of rights and complaints information were provided in most cells before a detainee's arrival, although some were in a poor condition. Where this information was available, custody staff did not always explain this to detainees or check that they were able to read and understand it. We saw one detainee disclose that he was dyslexic but staff did not check that he could read the documentation or offer to read it to him. The rights information was available in a range of foreign languages and in most, but not all cases, staff issued these when a detainee required an interpreter. However, the rights information was not available in Braille or in an easy-read format.

3.11 Custody staff at all the courts asked detainees when they arrived who their legal representative was and arranged for them to be contacted through the court ushers. There were not enough legal interview rooms in the Lincoln courts, which sometimes resulted in lengthy queues, and those at Lincoln Magistrates' Court were insufficiently soundproofed, which compromised privacy. We saw legal representatives sometimes being allowed to speak to their clients at cell doors or inside cells, which was not appropriate. Detainees at all courts could retain legal documents relevant to their case.

3.12 Data supplied by GEOAmey showed that the telephone interpreting service had been used only once across the courts cluster in the year to 30 September 2018, which was significantly lower than we have found in other recent court custody inspections. Custody staff knew how to use the service, and other than at Leicester Crown Court, there were portable handsets to facilitate access. However, most staff confirmed they had not used the service and preferred to use court-appointed interpreters instead. We saw a few interpreters in the custody suites and, although they were used to facilitate legal consultations, custody staff did not use them to check on the well-being of the detainees they were visiting. The court-appointed interpreters were also not available in the custody suites when detainees first arrived, and were often late or failed to attend at the court. We saw one member of staff using the service with a detainee to complete his prison reception documentation, but not to check on his welfare or how he was feeling.

3.13 There had been three complaints made at two of the court custody suites in the year to 30 September 2018. A senior GEOAmey manager had investigated these and one had been upheld. Detainees at some, but not all, the courts were told on arrival that there was a complaints procedure. The complaints information was available in foreign languages, but was not always issued to detainees who required this. Notices detailing the complaints procedure

and right to appeal to an independent body were displayed in most custody suites, but were in the main reception areas where detainees did not have time to read them. Court custody staff had a reasonable awareness of the complaints process.

Recommendations

3.14 The courts should prioritise cases where detainees have been held in court custody, particularly those with vulnerabilities.

3.15 HMCTS, PECS and the escort and custody contractor should investigate and address the reasons for the prolonged periods that some detainees spend in court custody cells.

3.16 All detainees should be informed of their rights while in court custody in a language and format that they understand.

3.17 HMCTS should ensure that there are enough interview rooms at each court, and that they are soundproofed for confidentiality.

3.18 Staff should use telephone interpreting services as necessary to check on the welfare, risk management and understanding of non-English speaking detainees.

Section 4. 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

4.1 Most detainees arrived from local prisons or police custody suites and so did not have unnecessarily long journeys. The cellular vehicles used to transport them were adequately equipped, mostly clean, tidy and with minimal graffiti. Vehicles carried sufficient drinking water, first aid kits and a range of sanitary products. Women and children were transported together with adult men, which was inappropriate, and the partitions available in vehicles were not always used.

4.2 Detainees were disembarked promptly on arrival at court. Vehicle docks were generally secure and protected detainees from media or public attention, but at Lincoln Crown Court vehicles were parked in public view; staff were sensitive to this and did what they could to protect detainees from public view, but options were limited.

4.3 Most court custody staff we observed interacted well with detainees. Many showed good interpersonal skills and genuine care, particularly when dealing with arrivals where they were friendly and reassuring. This helped staff identify the detainee's demeanour. We also saw staff demonstrate excellent ability to calm distressed detainees on several occasions, which helped neutralise potential incidents (see paragraph 4.36).

4.4 Although court custody staff had not received training on how to identify and meet the diverse needs of detainees, and sometimes lacked awareness of these, their willingness and ability to respond individually to detainees meant their needs were generally met.

4.5 Facilities for detainees with physical disabilities were limited and only one court provided disability access in accordance with the Equality Act, which was insufficient. Another had a lift but it was out of order during the inspection. Detainees with mobility problems faced difficulties in most courts when negotiating the stairs from cells to the court, but staff were patient and assisted where possible.

4.6 Staff dealing with detainees who had learning or developmental disorders drew mainly on their own experience, although limited training had begun in this area, Staff had a reasonable understanding of how to respond to detainees with such difficulties, but detainees with poor reading skills did not always receive the help they needed (see paragraph 3.10).

4.7 There was a range of sanitary items for women available in all court custody suites and posters advertising their availability in most women's toilets. However, women were not routinely offered these items so we were not assured that all who needed them received them.

4.8 Detainees arriving in court custody were generally asked whether they had any religious needs, and there was a range of religious artefacts that were used with some frequency.

Unfortunately, these were not always stored respectfully and staff were often unaware of the full range of faiths they covered, as boxes did not identify the relevant religion.

4.9 Staff generally showed good understanding of managing transgender detainees, even though their experience was limited. Some staff who had dealt with transgender detainees previously could provide details of their approach to ensure the detainee was addressed in their preferred way.

4.10 Detainees were offered tea, coffee and water on arrival and frequently thereafter. Kitchens were generally in good condition and clean. Food was served regularly, including outside regular mealtimes if detainees were hungry and sufficient supplies were available. In addition to sandwiches, biscuits and crisps, microwave meals were available on request or to meet religious and ethical diets.

4.11 Staff at most suites provided copies of the free local newspaper in cells, which was positive although the Lincoln courts did not have access to them. The reading materials in those courts were less up to date, although there was now a budget for purchasing reading matter, including daily newspapers, which was due to be used. However, there were no reading materials in foreign languages, and although there were new distraction packs, with word games and puzzles, they were not often distributed.

4.12 The diverse needs of children were not sufficiently understood or met. Although most children were located in custody areas away from adult males, their cells made no acknowledgement of children's needs. Basic activity packs were available in some suites but they were not distributed, and children were left alone in cells with little to distract them. However, managers did liaise with courts to prioritise their cases.

4.13 Children transported from secure training centres (STCs) and secure children's homes travelled in specialist vehicles with trained staff who stayed with them throughout the day. However, those travelling from young offender institutions (YOIs) or police custody were transported in adult cellular vehicles without specialist trained staff.

4.14 The courts had updated children's safeguarding and child protection policies but these were not well embedded and staff did not have a good understanding of children's safeguarding. A new training programme, delivered by Barnardo's, was being rolled out but only three staff had so far received this. Although the child protection policy required the use of minimising and managing physical restraint (MMPR – child restraint procedures) where possible, court custody staff had not received training in this. The only option that staff had was to use control and restraint techniques, which are not suitable for children.

Recommendations

4.15 Women and children should always be transported separately from adult men.

4.16 Sanitary items should be routinely offered to women on arrival in court custody.

4.17 All suites should provide a range of reading materials for detainees, including those in foreign languages.

4.18 Staff should receive diversity and mental health training.

4.19 Staff should be trained in the use of minimising and managing physical restraint (MMPR) techniques.

Safety

4.20 When a detainee arrived at the custody suite, most staff used a reception checklist to find out their needs but the form was not completed consistently and staff were not always responsive to the answers supplied by detainees. Although potentially useful, the checklist did not provide sufficient focus on the identification and management of risk. Staff checked the information provided by the police and prison staff recorded in the detainee's person escort record (PER) to assess their risk, but they did not always check additional documentation with the PERs before speaking to them. Detainees identified as being at risk of self-harm were questioned, but this was mostly rudimentary.

4.21 All risk information should be clearly recorded in the PER but this was not always the case. The risk information in PERs we examined was often limited, and entries were not always specific enough to indicate the type of risk or whether it was current or historic. Several PERs received from the police contained information on additional loose-leaf sheets, some of which was confidential and should not have been shared with court custody staff, including medical details.

4.22 Detainees who were remanded or sentenced into custody after appearing at court on bail ('off-bailers') were generally given a more considered initial risk assessment. We saw court custody staff dealing with several such individuals in a calm and compassionate manner.

4.23 Staff briefings were not consistent across the suites. We observed few that were thorough, included an appropriate focus on risks and detainee vulnerabilities, and involved all staff on duty. In most courts, however, information about detainee risks and vulnerabilities were not shared sufficiently well. There was an over-reliance on using the whiteboards to indicate the codes associated with different risks but staff were generally not properly briefed about these, which was a potential threat to detainee safety.

4.24 Most staff checks on the welfare of detainees were set at appropriate intervals of 30 minutes, and some detainees, such as those with self-harm concerns or in custody for the first time, had enhanced checks of six an hour. The majority of checks we observed took place at the required frequency but a few enhanced checks were not carried out on time, which ran risks.

4.25 We were told that detainees were rarely required to share cells but, where necessary, the decision was generally based on a considered and justified risk assessment, although using information in the PER, which was not always accurate or adequate (see paragraph 4.21). We saw a few detainees sharing cells; in one case a cell sharing risk assessment (CSRA) was completed for one detainee but not for the individual he was sharing with, and in another case, there were no CSRAs for either detainee.

4.26 Women and children were mostly held separately from men in specific designated cells and facilities.

4.27 All court custody and escort staff carried personal issue anti-ligature knives, regardless of the duties they were carrying out, which was appropriate. Cell call bells that we tested were in working order. Detainees were generally told about the cell call bells and we observed staff responding to them promptly.

4.28 Detainees were transferred from the custody area to the court dock promptly. All routes to the courtrooms and the court docks had sufficient affray alarms to summon assistance if required.

4.29 Most detainees were released quickly from court once their cases were dealt with, but there were some excessive delays in releasing detainees who had previously been in prison and had to wait for the prison to authorise their release (see paragraph 3.5).

4.30 Most court custody staff took care to ensure that those being released had somewhere to go and the means to get there, especially the most vulnerable detainees. In one case, a member of court staff walked a vulnerable detainee to the nearby bus station to make sure he caught the right bus to get home. All suites had rail travel warrants and petty cash for bus and taxi fares, and we saw these being readily offered and issued to ensure that detainees could travel home safely after release.

4.31 All suites had a helpful support leaflet to give detainees information about community support services on release, but this was very rarely issued. Suites were inconsistent in providing information to detainees being transferred to local prisons, and in some cases it was out of date. We saw very few detainees given any written information about what to expect on their arrival in prison.

Recommendations

4.32 Every detainee in court custody should have a written assessment that gives clear summary information about their risks and needs.

4.33 Person escort records should include detailed and specific information concerning risks posed by or to detainees to ensure they can be properly looked after in court custody.

4.34 All custody staff should receive a comprehensive briefing at the start of duty that is focused on risk management and the care of detainees, particularly the most vulnerable.

4.35 Staff should always adhere to set levels of observation.

Use of force

4.36 The use of force was reasonably low, with 35 incidents across the six busiest court custody suites in the year to 30 September 2018. We observed staff being patient and reassuring when dealing with challenging detainees, which de-escalated situations and avoided the need to resort to force (see paragraph 4.3). In the cases that we reviewed, force was only used as a last resort following efforts to de-escalate. Incidents were recorded routinely. Independent staff statements were written promptly after an incident but in the sample we reviewed, they often lacked sufficient detail and control and restraint techniques not always fully described. However, the use of force seemed reasonable and proportionate. We referred one case to GEOAmey for review in which a detainee had been inappropriately left unsupervised in handcuffs in a cell following the use of force against him.

4.37 Searches of detainees were not consistent in the suites. In some we observed that all detainees were searched thoroughly whether they arrived from police custody or from a prison, while in others no detainees were searched on arrival wherever they had arrived from. Although staff carried out most searches respectfully, some were cursory and too many were repeated in secure custody areas. In most suites, staff searched detainees to and from legal visits, when they left their cells to go to and from the toilet, and when they went to and from court; these searches were unnecessary, excessive and not applied consistently.

4.38 Positively, in contrast to previous inspections, we found that handcuffs were used less frequently in the court custody suites in this cluster than we have seen elsewhere. Despite this, handcuffs were still routinely applied to all detainees, including children, in secure areas such as van docks and routes to courtrooms. There were no individual risk assessments to justify the use of handcuffs.

Recommendations

4.39 Detainees should only be searched in secure areas on the basis of a robust and individual risk assessment.

4.40 Handcuffs should only be used on detainees if justified and proportionate.

Physical conditions

4.41 The physical conditions in the suites were generally good and better than we have seen in other court clusters. In our checks on a random sample of cells in each suite, we found that most had potential ligature points; we provided an illustrative report to HM Courts & Tribunals Service (HMCTS) shortly after the inspection. In some suites, there was less graffiti than we usually see and, where it was prevalent, it was generally inoffensive.

4.42 Most cells lacked natural light but ventilation was adequate. In some suites, staff could not control the level of heating and they said cells could become too hot or too cold. Blankets were generally not available, although some suites had blankets that had been brought in by detainees from police custody and staff said they would provide these on request, but they had not been laundered.

4.43 Most cells and communal areas, including toilets, were cleaned daily, although not always after Saturday courts, which meant that detainees were placed in dirty cells on Monday mornings. Toilet paper, soap and hand towels were freely available although a lack of soap dispensers and the subsequent use of bars of soap was not hygienic. The stable doors in some toilets lacked sufficient privacy.

4.44 Maintenance arrangements were mixed, and while some defects were dealt with promptly, others were not. An interview room at Northampton Crown Court and four cells at Leicester Crown Court had been out of use for an extended time, which reduced the number of available cells.

4.45 Fire evacuation procedures were displayed on noticeboards, and staff were aware of how and where to evacuate people in the court cell area in an emergency. Positively, fire drills or desktop exercises had been carried out in some but not all suites.

Recommendation

4.46 Repairs to court detention facilities should be carried promptly.

Health

4.47 The court custody suites had access to telephone health care advice from a specialist health adviser, Stadn Limited. The contract also provided a health professional to attend within

between two and three hours if clinically required. Posters displaying contact numbers for the medical services provider were clearly displayed in each suite.

4.48 Data provided by GEOAmey indicated that the health provider had been called 42 times in the year to 30 September 2018, which was lower than we have seen in other areas covered by GEOAmey. Northampton Magistrates' Court had made only three calls and Leicester Magistrates' Court only two, but Lincoln Magistrates' Court had made 24 calls (57% of the total). Most calls were for advice or to verify the issue of medication to detainees. During the same period, medical staff had been requested to attend the court custody suites on five occasions, but the request had been cancelled in four cases and the provider was unable to supply anyone in the fifth case. Custody staff understood the service that was available but indicated that it was used infrequently, mainly due to perceived delays in attendance times. All staff we spoke to said they would contact the ambulance service in an emergency.

4.49 All staff were required to complete a first aid at work qualification, although training records indicated only 91% of court custody staff were currently in date with their training. First aid training was normally updated every three years, which was not often enough to maintain an adequate skill level as many staff had not used or practised these skills for some time. Automated external defibrillators (AEDs) were available at some courts, but not suction or oxygen. The contents of first aid boxes were mostly in date and contained sufficient stocks.

4.50 Court custody staff told us that detainees rarely arrived from the police with any medications, even if prescribed and administered while they had been in police custody. This was of particular concern for detainees arriving with ongoing alcohol or drug withdrawal symptoms, who risked severe health complications if they remained in court custody for prolonged periods without treatment. Staff explained that in such cases they would normally ask the court to deal with the detainee promptly if they were concerned for their health and, if remanded to prison, they would arrange for the detainee's onward transfer at the earliest opportunity; while well intentioned, this approach was unsatisfactory as their health need were not adequately met. We were told that a few detainees arrived from prison with their own prescribed medication, along with clear instructions, which staff handed to them for self-administration; they recorded this on the PER at the relevant times. Court custody staff were aware of the appropriate requirements for safe drug administration, and medicines were stored appropriately.

4.51 Custody staff relied on information on the PER and from detainees, but health issues were not always adequately identified on the PER, and the many loose-leaf sheets attached to the PERs for detainees received from the police contained medical information that could have become detached. The PER for one detainee had no record that he was an alcoholic, with the information on an additional sheet rather than clearly marked in the PER. (See paragraph 4.21 and recommendation 4.31.)

4.52 There was varied access to liaison and diversion mental health practitioners and support across the cluster. Embedded services were provided at Leicester Magistrates' Court by Leicestershire Partnership NHS Trust and at Northampton Magistrates' Court by Northamptonshire Health Foundation Trust. Custody staff found these services to be invaluable, although they only operated Monday to Friday. The courts elsewhere had little or no service, which was inequitable and affected the care and support of some detainees. We saw a few detainees who would have benefited from such a service.

4.53 Custody staff in all the courts told us they had not received any training to help identify and support detainees experiencing mental health or substance use problems. Although GEOAmey had introduced a new course to provide mental health awareness training, very few staff had yet received or been scheduled for this.

Recommendations

4.54 All custody staff should receive annual first aid refresher courses to maintain their skills, and should have access to regularly checked equipment, including an automated external defibrillator.

4.55 HMCTS/PECS should liaise with local police forces to ensure that all detainees who require prescribed medication while in court custody have access to it.

4.56 Detainees should have prompt access at all times to mental health services.

4.57 Custody staff should have regular mental health and substance use awareness training.

Section 5. Summary of recommendations

Recommendations

Leadership, strategy and planning

5.1 The three key agencies should improve their relationships and communication, and focus consistently on good outcomes for detainees. (2.15)

5.2 There should be a safeguarding policy, and all staff should be made aware of safeguarding procedures for children and adults at risk. (2.16)

Individual rights

5.3 The courts should prioritise cases where detainees have been held in court custody, particularly those with vulnerabilities. (3.14)

5.4 HMCTS, PECS and the escort and custody contractor should investigate and address the reasons for the prolonged periods that some detainees spend in court custody cells. (3.15)

5.5 All detainees should be informed of their rights while in court custody in a language and format that they understand. (3.16)

5.6 HMCTS should ensure that there are enough interview rooms at each court, and that they are soundproofed for confidentiality. (3.17)

5.7 Staff should use telephone interpreting services as necessary to check on the welfare, risk management and understanding of non-English speaking detainees. (3.18)

Treatment and conditions

5.8 Women and children should always be transported separately from adult men. (4.15)

5.9 Sanitary items should be routinely offered to women on arrival in court custody. (4.16)

5.10 All suites should provide a range of reading materials for detainees, including those in foreign languages. (4.17)

5.11 Staff should receive diversity and mental health training. (4.18)

5.12 Staff should be trained in the use of minimising and managing physical restraint (MMPR) techniques. (4.19)

5.13 Every detainee in court custody should have a written assessment that gives clear summary information about their risks and needs. (4.32)

5.14 Person escort records should include detailed and specific information concerning risks posed by or to detainees to ensure they can be properly looked after in court custody. (4.33)

5.15 All custody staff should receive a comprehensive briefing at the start of duty that is focused on risk management and the care of detainees, particularly the most vulnerable. (4.34)

5.16 Staff should always adhere to set levels of observation. (4.35)

5.17 Detainees should only be searched in secure areas on the basis of a robust and individual risk assessment. (4.39)

5.18 Handcuffs should only be used on detainees if justified and proportionate. (4.40)

5.19 Repairs to court detention facilities should be carried promptly. (4.46)

5.20 All custody staff should receive annual first aid refresher courses to maintain their skills, and should have access to regularly checked equipment, including an automated external defibrillator. (4.54)

5.21 HMCTS/PECS should liaise with local police forces to ensure that all detainees who require prescribed medication while in court custody have access to it. (4.55)

5.22 Detainees should have prompt access at all times to mental health services. (4.56)

5.23 Custody staff should have regular mental health and substance use awareness training. (4.57)

Section 6. Appendices

Appendix I: Inspection team

Kellie Reeve	Team leader
Lee Bruckshaw	Inspector
Fran Russell	Inspector
Fiona Shearlaw	Inspector