Report on an inspection visit to court custody facilities in

Hampshire, Wiltshire and the Isle of Wight

by HM Chief Inspector of Prisons

5–15 August 2019

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 Hampshire, Wiltshire and the Isle of Wight and included 12 courts in use with custody facilities. They comprised six crown courts and six magistrates' courts, including two combined facilities. The Prisoner Escort and Custody Services (PECS) arm of HM Prison and Probation Service (HMPPS) contracted GEOAmey on behalf of HM Courts & Tribunals Service (HMCTS) to provide court custody and escort facilities in the region.

This was a good inspection with many positive features. The three key agencies worked well together and were properly focused on ensuring safe and decent detention. Detainees were treated well and were held in reasonable conditions. For many, the custodial environment can be unfamiliar and stressful, but custody staff engaged with detainees in a compassionate and caring way and were skilled at allaying fears and defusing tension and anxieties.

There was, however, still room for improvement in a number of areas. While there was a commitment to prioritising the cases of those detained in court custody, it was not always possible to do so, and delays in solicitors attending court custody were more acute than we have seen elsewhere. We have made repeated recommendations concerning the lack of an individual and risk-based approach to handcuffing but continued to find that all detainees, including children, were routinely handcuffed in the secure custody environment.

We have made a number of recommendations and are confident that they will be used to deliver ongoing improvements.

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

Fact page[1]

HMCTS cluster
Hampshire, Wiltshire and the Isle of Wight

Cluster manager
Eve Miller MBE

Geographical area
All of Hampshire, Wiltshire and the Isle of Wight

Court custody suites	Cell capacity
Basingstoke Law Courts	7 cells
Newport Isle of Wight Combined Court and Magistrates' Court	9 cells
Portsmouth Combined Court	11 cells
Portsmouth Magistrates' Court	18 cells
Salisbury Law Courts	12 cells
Southampton Combined Court	8 cells
Southampton Magistrates' Court	22 cells
Swindon Combined Court	6 cells
Swindon Magistrates' Court	5 cells
Winchester Combined Court	26 cells

Annual custody throughput
1 June 2018 to 31 May 2019 — 8723 detainees

Custody and escort provider
GEOAmey

Custody staffing
10 court custody managers
62 prisoner custody officers (plus 37 vehicle staff)

1 Data supplied by HMCTS Thames Valley 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 The court custody service in the Hampshire, Wiltshire and Isle of Wight cluster had many positive features, providing detainees with good care and reasonable conditions. The cluster was open to external scrutiny and we were confident that action would be taken to address the two main causes for concern and recommendations highlighted in this report.

1.4 There was a clear strategic focus on promoting safe and decent escort, custody and court services. The inter-agency relationships between those involved in the delivery of court custody were good. HM Courts & Tribunals Service (HMCTS) managers had good oversight of issues affecting custody and visited court cells regularly. Their audit regime addressed current and ongoing issues. Cleaning and maintenance work was delivered by a contractor, Mitie, and was generally effective.

1.5 Custody staffing was adequate and included routine support from officers who staffed the escort vehicles. The officers were well integrated and effective when working in custody. Custody staff across the cluster consistently demonstrated that they offered detainees good care. Initial training for custody staff was sufficient and newly appointed staff told us they benefited from additional input on areas such as mental health and equality and diversity. We did not believe this had been effectively extended to established staff, many of whom told us that development opportunities were extremely limited. Some staff vacancies meant that not all courts had the consistent leadership of a GEOAmey court custody manager (CCM). Where CCMs were present, they generally did what was expected of them, although a few were more proactive.

1.6 There was a strong commitment to ensuring that custody cases were prioritised but, for a variety of reasons, this was not always achieved. We found some unacceptable delays when the cases of detainees in custody were not heard as promptly as we would have expected.

1.7 HMCTS managers told us they wanted to use the video-link more effectively but described barriers, such as insufficient infrastructure in prisons, that prevented them from doing so.

1.8 There was no overarching HMCTS safeguarding policy. Some GEOAmey staff were aware of their own standard operating procedure and policies. However, although they had a better

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

knowledge of safeguarding than we have experienced in recent inspections, more work to embed safeguarding and reporting mechanisms was required.

1.9 A small group of independent lay observers provided regular scrutiny of custody facilities. Their reports were shared widely and used to help drive necessary improvements.

Individual rights

1.10 Detainees generally arrived at court custody in the morning and were accepted from police custody until approximately 2pm, which was too early if the court was still sitting and meant some detainees spent too long in police cells. Despite the commitment to prioritise custody cases, particularly those involving women, children and vulnerable detainees, this did not always happen, and some detainees were held in court custody for longer than necessary. There were a number of reasons for this, including frequent delays in solicitors attending court custody, which was at times more acute than we have experienced elsewhere, and some lengthy delays awaiting decisions to release formally those who had been in a prison prior to their court appearance. Warrants for detention were mostly issued promptly.

1.11 Court enforcement officers, who executed warrants on behalf of the courts, delivered those who were compliant directly to the court room, which was positive and prevented them from being exposed to court custody unnecessarily.

1.12 Information concerning detainees' rights in custody was available in a range of languages and was placed in each cell, but the document was not always in good condition. Staff did not always check if detainees could read or understand the documentation. Staff had a reasonable awareness of the complaints process, which was generally well promoted in custody suites. Relatively few complaints were received and those that were submitted were appropriately investigated and answered.

Treatment and conditions

1.13 Vehicles used to transport detainees from police custody and prisons were generally well equipped and clean. Women and children were often transported with men and partitions used to separate them were not always used. Most detainees were disembarked quickly, and staff focused on maintaining their privacy.

1.14 Staff treated detainees well and had a courteous and professional approach. Many could identify and respond appropriately to detainees' needs even when they had not been outlined in person escort records (PERs) or other information. Staff were honest and open with detainees at all times, which meant potential problems were dealt with early on rather than postponed.

1.15 Most staff were sensitive to equality issues, although many said they had not received training. Improvements had been made to the care provided to women – new information sheets and better menstrual provision were offered. There was also sufficient provision to meet detainees' religious needs. While Salisbury Law Courts provided a suitable environment for wheelchair users, there was insufficient provision elsewhere for those needing adjustments to assist mobility. Telephone interpreting facilities were available and had been used for those who spoke limited or no English, but they could have been used to help staff better assess detainees' risks and welfare needs.

1.16 Relatively few children were held in court custody. Transport and care for those moved to and from secure training centres and secure children's homes were mostly appropriate.

Otherwise, children were essentially treated the same as adults. They were still routinely handcuffed and accommodated in a cell, which did not make for a positive experience. There were few excessive delays in receiving placement orders and transporting children to their onward place of detention. GEOAmey had made significant efforts to raise awareness of its own safeguarding children and child protection policies. Although further work was required to embed them, some staff were familiar with the principles and reporting procedures outlined in the policies.

1.17 Detainees were positive about the treatment they received from custody staff. The food and drinks available were generally good and were provided regularly to detainees throughout their stay. A limited range of reading material was available, and usually offered, and distraction packs were used constructively.

1.18 The information contained in PERs frequently omitted important evidence of risks, but staff examined the full range of information to assist them in identifying them. However, most staff briefings were not comprehensive. Vulnerable detainees received sensitive support and CCMs often drew the court's attention to vulnerabilities assertively. The set frequency of observations was generally, but not always, adhered to. Some detainees were unnecessarily put on six checks per hour just to abide by prescribed operating procedures, which could tie up staff time and divert attention away from those who genuinely posed a higher risk. Cell call bells were generally answered promptly. Detainees were excessively and repeatedly searched during movements in the custody suite, much of which was very cursory.

1.19 Overall, staff were careful to ensure that those being released had the means to travel to their ultimate destination, helping them to plan routes where necessary. Some suites provided information about local support services, which was offered when appropriate. The suites had information about the specific prisons to which detainees were commonly transferred, and in some, but not all, cases good support was provided to those going to prison for the first time.

1.20 Staff were skilled in talking to distressed detainees and defusing tension, frustration and anxiety, which could lead to physical resistance. As a result, little force was used. There was no evidence of improper or excessive use of force, and records showed it was proportionate in all cases we examined. However, the oversight of use of force was not rigorous enough to be able to identify lessons to be learned or ensure proper records were kept. Detainees were routinely handcuffed within secure areas of the suite in the absence of an individual risk assessment and when the risk was very low.

1.21 Conditions across the suites were at least satisfactory. Cells were mostly clean and, while some contained significant amounts of graffiti, little of it was offensive. Efforts were made to improve the ventilation and temperatures in suites, particularly in hot weather. We were, however, advised that some cells were cold in winter. Many cells contained potential ligature points, primarily due to design issues. We provided an illustrative report detailing them, which received a positive response. Communal toilets were generally clean enough, and toilet paper and handwashing facilities were readily available. Emergency evacuation plans were displayed prominently, and most staff could describe how to evacuate the suites in an emergency. Desktop exercises (discussions about a simulated emergency situation) were carried out regularly, but participation in fire drills needed to be improved.

1.22 We found no unmet health needs during the inspection. All staff were aware that they could access advice through a telephone health service, but it was not widely used. Staff often reverted to calling emergency services as their first option or tried to prioritise detainees for court so they could be released or transferred to prison where their health issues could be dealt with. Few staff had received any mental health awareness or other training. Liaison and diversion services were embedded well in the police custody suites in the region, which

reduced the need for the provision in court custody. Mental health workers provided a reasonably consistent service at most magistrates' courts.

Main areas of concern and recommendations

1.23 Concern: Some detainees were held in court custody for longer than necessary. Delays occurred:

- for children who did not always have their cases prioritised
- for some detainees who arrived at the court in the morning but who did not appear in court until after lunchtime
- due to the late attendance of legal representatives, some of whom could be representing several of the detainees held in court custody
- when the court did not start promptly in the morning
- when waiting for a governor to authorise a detainee's release from prison.

Recommendation: Detainees should have their cases prioritised according to their needs and heard promptly. The reasons for delays should be explored and addressed.

1.24 Concern: Handcuffs were routinely applied to detainees, including children, older detainees and those with impaired mobility, even in the secure and controlled custody areas, without an individual risk assessment being undertaken.

Recommendation: Handcuffs should only be used on detainees if proportionate and justified by an individual risk assessment.

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 Hampshire, Wiltshire and the Isle of Wight 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 HM Prison and Probation Service (HMPPS) and GEOAmey, the contracted service provider. HMCTS had a clear line management structure for the cluster. An HMCTS cluster manager was supported by four operations managers and was responsible for managing courts across the region, which included six magistrates' and six crown courts, two of which – Salisbury and the Isle of Wight – were combined facilities with both a crown and magistrates' court. Eight HMCTS delivery managers were responsible for the day-to-day running of court services in the courts we inspected. Senior HMCTS managers took responsibility for court custody facilities, and alongside their commitment to delivering court business, they were properly focused on ensuring conditions for detainees were good and trying to improve their experience.

2.2 PECS commissioned GEOAmey to manage the court custody provision and provide detainee escort services on behalf of HMCTS in Hampshire, Wiltshire and the Isle of Wight. The experienced PECS contract delivery manager had effective working relationships with the other key agencies. He supervised the contractual arrangements between PECS and GEOAmey and convened monthly performance and contract compliance meetings with them. Visits to custody suites took place reasonably regularly, and audits that focused on security arrangements and detainee care were completed every two years at each site. The contract delivery manager was committed to treating detainees well and providing them with good conditions.

2.3 A general manager from GEOAmey had oversight of and was responsible for court custody and was supported by two GEOAmey area business managers, who were in charge of the management of court custody services. Ten court custody managers, or staff acting in that role to cover vacancies, reported to the area business managers and were responsible for the day-to-day running of the custody suites.

2.4 Working arrangements between the three key agencies were effective – they communicated a shared aim to ensure that detainees were kept safe, treated well and held in appropriate conditions. Formal and informal meetings were well established. Relationships and channels of communication between managers in HMCTS and GEOAmey were good. HMCTS managers visited custody regularly and conducted a monthly audit of the conditions in custody suites. The audit findings were fed into discussions and meetings held by senior HMCTS managers, who had good oversight of the issues concerning the estate. GEOAmey court custody managers (CCMs) had at least daily contact with their counterparts in HMCTS so that they could share relevant information about the welfare of detainees.

2.5 Contractor Mitie provided cleaning and maintenance services, which were generally effective. HMCTS managers had good oversight of the environment and there had been a concerted effort to improve conditions in the custody suites, which were all now at least satisfactory. During the inspection we found potential ligature points across the estate, many of which were as a result of design issues, for example around cell doors. We reported them to HMCTS managers, who responded positively (see paragraph 4.42 and Appendix II).

2.6 GEOAmey staffing of court custody was generally adequate and routinely supported by officers who worked on escort vehicles. These staff were well integrated, knew about custody practices and contributed well to the effective running of the custody suites. Staff were caring and compassionate and dealt with detainees very well. Initial training for officers was sufficient and new staff told us they had received input on areas such as equality and mental health. Many established staff told us they received little ongoing development, and what they did was in the form of a presentation delivered locally by the CCM. We did not believe this was always effective in developing staff's knowledge or understanding of subjects such as safeguarding or mental health awareness. CCMs received no training and some courts did not have a consistent CCM due to staff vacancies. While those in post generally did what was expected of them, a few were more proactive and offered visible leadership.

2.7 The listing of cases is a judicial process, but an HMCTS listings protocol enables custody cases to be prioritised. Senior managers were committed to prioritising custody cases where possible, but this was not always achieved. GEOAmey staff generally requested that cases, particularly those involving children, women and other vulnerable detainees, be prioritised. When HMCTS failed to respond satisfactorily to requests, some CCMs were more proactive in following cases up. HMCTS staff often responded positively to requests, but we found a number of unacceptable delays when custody cases were not heard as promptly as we would have expected. (See paragraph 3.2 and main recommendation 1.23.)

2.8 Video-enabled courts allowed certain eligible cases to be heard from prison. This was often less disruptive to prisoners and meant they did not have to make sometimes long journeys on uncomfortable vehicles. HMCTS managers told us they were committed to using video links for eligible cases, but they believed there were some barriers that prevented them from being used more efficiently, including a lack of infrastructure in prisons to support better use.

2.9 There was 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 standard operating procedure and policies, and had undertaken, with some success, a significant amount of work to try to improve staff awareness and embed them, but further work was required with many staff (see also paragraph 4.17). We did, however, see one very good example in which safeguarding issues concerning a young adult were highlighted and followed up.

2.10 A small group of independent lay observers made regular visits to court custody suites. They were well integrated and attended key strategic meetings. Their reports were comprehensive and focused on detainee treatment and the conditions in which they were held. Reports were shared with representatives from the three key agencies who told us they found them helpful and used them to drive forward required improvements.

Recommendations

2.11 Ongoing training and development for court custody staff, including CCMs, should be improved.

2.12 HMCTS should develop a safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable 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 All courts had appropriate arrangements in place, including on Saturdays, for local youth offending teams to establish if a child was detained in the court cells and to help them present their needs, risks and circumstances to the court.

3.2 There was a clear focus on prioritising custody cases in most courts, particularly those of children, women and vulnerable detainees. Attempts were made to bring detainees promptly before the court. However, we saw that for a variety of reasons, this did not always occur. We saw very few children in court custody, but those that were did not always have their cases prioritised so they could appear in court as soon as reasonably practicable to minimise the time they spent in the cells. At Portsmouth and Southampton magistrates' courts, for example, we saw adults being dealt with before children when no good reason for this was apparent. This led to excessive delays and these children remained in court custody for longer than necessary.

3.3 Some detainees did not appear in court promptly after their arrival. A number who arrived in the early morning were not dealt with by the court until after lunch. In the data supplied to us for the four weeks before the inspection, we found that at least 15% of detainees appearing at the magistrates' courts did not appear in court until after 2pm. The figure could have been higher, as there were some significant gaps in the information provided.

3.4 Delays in being presented to court were often caused by delays in solicitors attending court custody promptly. Some delays in solicitors attending court custody were on occasion more acute than we have encountered elsewhere. This may have been because some solicitors dealt in the first instance with clients who were not in custody, rather than those who were. Some solicitors, particularly duty solicitors, were dealing with up to as many as four or five detainees on occasion, which meant that if consultations were lengthy, they were delayed and could not represent their clients in court promptly. In a few cases, we were told the delays were due to problems with the transfer of electronic case papers from the Crown Prosecution Service (CPS). In addition, courts did not always start promptly. Data supplied for the four weeks prior to the inspection showed detainees did not start to be presented to court before 10.30am in at least 25% of sittings.

3.5 Detainees' length of time in custody was also often extended when there were delays in transporting them to prison following their court appearance. Data supplied for the four-week period prior to the inspection suggested almost half of those remanded or sentenced before lunchtime were still in court after 2.30pm following the conclusion of their cases. However, few remained in custody after 5.30pm and it was slightly better for those held in custody in crown courts.

3.6 Detainees who are bailed or acquitted by the courts but who were previously remanded in custody, must wait in cells until the prison they came from formally authorises their release. In the records we reviewed, we found it was not uncommon for detainees to be held for over two hours and, in the most extreme case, five hours and 48 minutes, waiting for their release from prison to be authorised. This was too long and did not appear to be escalated effectively to offset the impact on detainees who were essentially free to leave court custody but were held in cells and continued to be moved around the custody suites in handcuffs. (See also paragraph 4.40 and main recommendation 1.24.)

3.7 Detainees held in police custody should have been able to appear before a magistrates' court if the court was sitting and there was capacity to hear their cases. Custody staff advised us that the clerk of the court decided whether or not detainees could appear in court, but that they routinely accepted detainees throughout the day up to 2pm when asked to do so. We saw a small number of detainees arrive from police custody after 2pm and data provided confirmed that few detainees arrived after that time. During the inspection on a Saturday at 9.55am, the police requested that the court accept a female detainee. This request was declined, which meant the woman remained in police custody over the weekend until the following Monday morning, for what was a relatively minor offence. Such practices did not convince us that detainees were always seen by the first available court, and some of them remained in police custody for longer than necessary.

3.8 Detention warrants, which are required when a detainee is remanded into custody or sentenced to a term of imprisonment and which should be produced within 60 minutes of a court hearing or appearance, were produced electronically and forwarded directly to local prisons. It was positive that most warrants were issued in a timely manner.

3.9 Custody staff advised us that court enforcement officers (CEOs) or bailiffs, who executed warrants on behalf of the court, could deliver compliant individuals directly to the courtroom, which was appropriate. Data provided by GEOAmey before the inspection demonstrated that it was very rare for CEOs to deliver detainees into court custody.

3.10 Printed information about detainees' rights and complaints procedures was provided in cells before a detainee's arrival, except at one court, which only provided information about detainees' rights. A small number of these documents were in poor condition. As part of the reception process, detainees were advised that the documents were in their cells. Custody staff did not routinely ask if detainees could read and did not explain the information consistently. We saw two cases where a detainee divulged that they could not read or write but staff made no attempt to explain to them their rights or the complaints processes. The information about detainees' rights was available in a range of foreign languages and was appropriately issued to non-English speaking detainees. However, it was not available in Braille or in an easy-read format to assist those needing help with understanding or reading.

3.11 On arrival at court, detainees were asked who their legal representative was, and arrangements were in place at all courts to ensure representatives were informed of their client's arrival. All courts had sufficient interview rooms that were adequately soundproofed. Detainees at all courts could retain legal documents that were relevant to their case in their possession.

3.12 Data supplied by GEOAmey showed that its telephone interpreting service had only been used once across all the courts in the area over the 13-month period between 1 June 2018 and 30 June 2019. A few custody staff described having used the service, but generally they were reluctant to do so – they frequently told us that they preferred instead to use court-appointed interpreters to communicate with detainees. This approach had implications for risk assessments and detainees' welfare as interpreters were generally not in custody suites when detainees first arrived. Portable handsets were available in all court custody suites, except at Southampton Magistrates' Court. They provided access to the interpreting service and documents were displayed at most of the courts to guide staff through how to use the service (see paragraph 4.10).

3.13 Custody staff had a reasonable awareness of the complaints process and generally informed detainees about it on arrival. Information promoting complaints procedures was displayed in cell areas but not always in locations where detainees had ready access. Minor amendments to the complaints process had not been clearly communicated to custody staff. Nine complaints had been made at four of the court custody suites between 1 June 2018 and 31

July 2019. They were thoroughly investigated by a senior GEOAmey manager in a timely manner and a number had been upheld in favour of the detainee.

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 Cellular vehicles were generally clean and mostly free of graffiti, although we saw one vehicle which contained some offensive words. Some journeys could be relatively long, including for those travelling by ferry to the Isle of Wight, as well as for women and children who might be allocated to prisons and secure accommodation some distance from the court they were attending. Vehicles were equipped with food and water for such journeys. Disposable urinal bags were also carried and although some journeys could take longer than two and a half hours, there was little evidence of comfort stops being made.

4.2 Women and children were routinely transported from police stations on vehicles with men, which was not acceptable. This was offset slightly when partitions in vans were used to maintain some degree of separation and protection. They were not, however, always used. Detainees generally arrived wearing clothing suitable for court.

4.3 Most courts had secure vehicle docks where detainees were disembarked, usually promptly after their arrival. We did, however, see some detainees waiting for up to half an hour on vehicles that were stifling in the hot weather experienced during the inspection. Where there was no private area to disembark detainees, staff paid attention to minimising the risk of detainees being seen or identified by the public.

4.4 Staff spoke with detainees calmly and acted professionally across all the custody suites. They showed kindness and cared for them appropriately, while being clear about boundaries. There was a strong core of experienced custody officers in all the suites, who spoke freely about how they enjoyed their work, which enabled them to make a difference to people at a stressful time and support some who had complex needs. Newer staff were learning from the example of these long-serving colleagues. Experienced officers were aware of the needs and vulnerabilities of detainees as they arrived into their custody, whether or not they were documented in the person escort record (PERs) or other documentation. The officers were especially supportive of those who were anxious because they had not been in custody before.

4.5 A structured reception checklist was in place for those received into custody. It consisted of a sheet briefly covering key issues. In some suites, staff went through the checklist systematically; in others, they asked the questions from memory as they escorted the person from the van to the cell, then completed the form, which meant not all the topics were covered on every occasion.

4.6 Personal information about detainees was not always kept sufficiently private. For example, in one suite the whiteboard, which had names and other information about individual detainees, could be seen by detainees. In another, a reception checklist with a list of detainees and their individual needs was left in full view of a detainee who was standing waiting to be escorted elsewhere.

4.7 Custody officers felt it was important to be honest and truthful with detainees at all times. They were keen not to make promises which they knew they might not be able to keep or provide false reassurance, for example, stating that the person would be able to return to the prison from which they had come, if that was in practice unlikely.

4.8 Most staff said they had not received training on equality and diversity issues, although those who had started more recently had received some input in this area during their initial training. However, officers showed a reasonable awareness of the rights and needs of those with protected characteristics.

4.9 There had been improvements in the treatment of women in custody. Women were generally kept separately from men in custody suites and received good support from female staff. A new information sheet on females in custody was displayed in suites and handed out to women on arrival. A wider range of menstrual care products was now available in all women's toilet areas, and managers checked that the boxes containing them were kept fully stocked.

4.10 Foreign national detainees received reasonable support, but staff relied on court-appointed interpreters who were not always able to visit the custody suite. They did not normally use interpreters for the reception process, nor did they use telephone interpretation except on rare occasions. This meant that some detainees' needs might have been overlooked (see paragraph 3.12).

4.11 All suites had a sufficient range of religious items for the most commonly observed faiths. They were appropriately stored, and all new arrivals were asked if they had any religious needs. We saw one being given a rosary, for example, in response to his request.

4.12 Some staff could describe how they had responded to a transgender detainee and, while they were not all confident in this area, they had grasped the main principles of respecting a person's preferences and declaration of their own identity.

4.13 Considerable efforts were made to ensure that those with mobility difficulties had their cases listed for a hearing at the Salisbury courts. The Salisbury custody suite was designed for access by wheelchair users and was suitable in most respects, although some features were absent, such as lowered cell call bells. We saw court custody managers (CCMs) in courts other than Salisbury being appropriately robust in refusing to accept wheelchair users from court. It was not possible to divert all cases to Salisbury, however, and there was a lack of sufficient adjustments in other custody suites to cater for exceptional occasions when a wheelchair user had to be accommodated (see also paragraph 4.45).

4.14 Only about 4.5% of the throughput of court custody in the year before the inspection were children. Those arriving from, or being transported to, local authority accommodation or secure training centres were transported in non-cellular vehicles under a contract with the youth custody service. They were accompanied by trained staff, who remained with them and looked after them during their stay in custody. We spoke with some GEOAmey staff who undertook this role and they told us that some children in their care were still handcuffed routinely and located in a cell, which was poor practice.

4.15 Most custody staff received little or no training to help them deal with children and few had a good understanding of their distinct needs. There was little specific provision for children arriving directly from a police station or young offender institution and their experience of custody was similar to that of an adult. Children were separated from adults but were still accommodated in cells. They generally travelled in cellular vehicles and if they arrived from police stations often shared transport with adults. They were routinely handcuffed in the same way as adults with no regard to the risk they posed or their innate vulnerability (see paragraph 4.40 and main recommendation 1.24). There were limited activities to keep

children purposefully occupied during their time in court custody, but distraction packs were offered (see paragraph 4.19).

4.16 Children who were remanded or sentenced to custody required a placement order, which dictated where they would be detained. We were told that placement orders were not always received promptly, but we found few excessive delays in the six months preceding the inspection. Children were transferred to their allocated place of detention reasonably promptly after the placement order was received.

4.17 GEOAmey had a number of safeguarding managers who worked centrally and could offer advice to staff. A concerted effort had been made to raise custody staff's awareness of their role and of children's safeguarding policies. Some, but not all, staff demonstrated a good awareness of safeguarding and reporting mechanisms should such a concern arise. Few custody staff were trained in minimising or managing physical restraint (MMPR) techniques, which meant they had to resort to using control and restraint, which was not suitable for children, but which had been used on three children in the previous year.

4.18 Detainees we spoke with were complimentary about court custody staff and the way they were treated during their stay in court cells. Detainees were generally provided with drinks promptly after their arrival. A good range of microwave meals that catered for most diets was available in all custody suites, although the notices showing which diets they were suitable for were missing in some. A range of sandwiches was also available in most suites and there was a good supply of crisps and biscuits. Detainees were generally provided with something to eat on request or at recognised mealtimes and no detainees complained about going hungry. Staff were confident that if they could not meet a particular dietary requirement, they would buy something suitable. There was access to drinking water in all suites. Food preparation areas were generally clean and tidy, but some were in staff rest areas or offices, which was not ideal.

4.19 Some reading material was available in all suites. It generally consisted of popular novels, recent magazines and newspapers. In several suites, staff collected copies of the current day's free newspapers from a transport hub on the way to work, in some cases putting a newspaper in each cell, which was positive. Reading material was not available in languages other than English. Distraction packs were offered to detainees in all suites – they contained puzzles, quizzes and other activities. They were useful, especially because staff in some suites chose those parts of the pack best suited to the individual person.

Recommendations

4.20 Women and children should be transported separately from adult men.

4.21 Staff should use telephone interpreting services promptly whenever a person who speaks limited or no English is received into custody to check on their welfare and risks and ensure they understand their rights in court custody.

4.22 The individual needs of children transported to, and held in, court custody should be understood and consistently met.

4.23 Custody staff who deal with children should receive specific training, including on the use of MMPR techniques.

Good practice

4.24 *The new information sheet on females in custody displayed in suites and handed out to women on arrival and the wider range of menstrual care products available in women's toilet areas meant that women's needs were now being met consistently.*

Safety

4.25 The PERs accompanying detainees arriving from police or prison custody often gave an incomplete picture of the risk profile of the individual. Key areas of risk, such as self-harm, were sometimes omitted, or the information might be so sketchy as to be of little use (see paragraph 4.52). We saw staff working through other documentation to gain other information about areas of risk, which enabled them to act on a fuller picture which should have been summarised in the PER. However, this went against the PER being the authoritative risk document. The reception checklist was not always completed in full, which could leave some risks, as well as needs, unidentified (see paragraph 4.5). All staff carried anti-ligature knives.

4.26 Staff provided detainees who showed vulnerability with sufficiently sensitive support. In several cases it was appropriate that the court should prioritise detainees for whom a long wait in the cells could be harmful. In general, CCMs liaised with court officials to prioritise the hearing of these cases – one or two of them were especially effective and assertive to good effect (see paragraph 3.2).

4.27 It is good practice for staff to be briefed as a team towards the beginning of a shift on the risk profile of the detainees in custody that day, to ensure all have a shared understanding of the situation in the suite. In this respect, practice was very patchy across the region. At few suites was there a comprehensive morning briefing. At others, a printed briefing sheet was available and was signed by each member of staff to show it had been read. However, it did not usually contain information about individual detainees.

4.28 All cells were fitted with emergency call bells. In a few suites it was not easy to hear the bells, although we did not find that call bells were frequently missed in any of the suites. Staff generally responded to them promptly, although there were some delays when a suite was busy. Some custody suites had facilities for visits, but they rarely took place. However, one young man had been able to receive a visit from his mother in the suite shortly before the inspection on the instructions of a judge owing to exceptional circumstances.

4.29 Each detainee was placed on a minimum number of observations per hour – one, two or six. Operating procedures prescribed that certain detainees, such as those subject to a self-harm monitoring form, should be placed on six observations an hour. Because these forms had sometimes been opened and signed (usually in police custody) without any actual evidence of the detainee's self-harm risk, there was not always good reason to put the person on such frequent observations. Staff sometimes, therefore spent much of their time carrying out these frequent observations, taking them away from other duties and diverting attention from those who posed the highest risks. The set frequency of observations for each person was generally maintained, but we saw some being missed, including for those considered more vulnerable and posing a higher risk. Some records did not document checks accurately.

4.30 Staff shared information about the risks and needs presented by individual detainees with other statutory agencies, health providers and local services. There were better working relationships with court staff than we often find, and good joint working with police and other agencies to help keep people safe, especially when they left court custody.

4.31 Searches carried out on detainees on entry to the suites were thorough and took place in private. However, there were often excessive searches within the secure area of the custody suite before and after each movement to and from the cell: for example, each detainee was given a rubdown search when they were moved from their cell to an interview room to see a legal adviser, and when they returned to the cell afterwards. Much of this searching within the suite was cursory and partial, and did not seem to serve a practical purpose.

4.32 Some suites had more cells than there were ever likely to be detainees, while at a few suites staff frequently had to put more than one person in a cell. Not all cells were suitable for occupation by more than one person and in one case, where 12 people were held in a five-cell suite, four women were put together in one cell, which was too small to accommodate them. Staff ensured that men, women and children were separated as far as possible, although a (female) child, four women and seven men were held within the same area. Cell-sharing risk assessment forms were completed in every case, but they did not contain all the relevant information on risks and detainees were not asked if they were willing to share a cell, before being placed in a cell with someone else.

4.33 Detainees were mostly taken to court promptly when they were called. The routes to court from the custody suites were generally safe, although there was no CCTV on the stairways, and in some suites there was only a small number of alarm bells along the route. In normal circumstances the privacy of detainees was respected. Occasionally a detainee, especially if they were a wheelchair user, had to be taken through a public area, but this was usually when the area was not being used by the public.

4.34 We saw many examples of staff taking care to help those being released from custody, to ensure that they had the means and the ability to travel home. They did not just issue travel warrants, but researched routes and onward travel from a rail station to the actual address. Fares for buses or taxis were carefully researched, and the right money provided in appropriate cases.

4.35 Some suites, especially at magistrates' courts, held a useful range of leaflets about support services available in the local area. We saw them being offered to detainees who might need them. One or two suites had also produced small maps of the local area, marking bus and rail stations and the walking routes to them. A leaflet about support for those who might have been a victim of modern slavery was available in 12 languages. At one suite a chaplain was actively involved in helping detainees who were homeless to find accommodation.

4.36 Many suites, especially at crown courts, had printed out detailed information about the specific prisons to which detainees were commonly transferred. We saw them being given in some instances to detainees who were to be taken to a prison, although this did not always happen. Information about what happened on arrival in prison were in some cases given to those going to prison for the first time.

Recommendation

4.37 **The frequency of cell observations should be set according to the specific risks associated with the individual, and should be carried out as required and documented accurately.**

Use of force

4.38 On many occasions staff de-escalated situations of potential confrontation, and defused tension by using good interpersonal skills. They understood that detainees threatening

violence might be experiencing anger, anxiety or frustration, and responded well to these underlying issues. The number of incidents involving force was therefore low.

4.39 We examined records for a number of instances involving force and witnessed some incidents in person. Most force was of the lowest level necessary and there was no evidence of improper or excessive use of force. Written records pointed to proportionate use of control and restraint techniques. However, there was insufficient oversight of the use of force – where managers did check records, they were not always able to identify examples of inadequate practice, such as one case where a detainee was inappropriately left handcuffed in a cell, or draw out lessons learned for future training. They did not ensure that each person involved in force provided a full written record of the incident as soon as possible after its conclusion.

4.40 Detainees, including children, were routinely handcuffed when they moved between their cell and another room within secure areas of the custody suite (see paragraph 3.6). There was no consideration of the level of risk in each case, nor of the fact that they were moved in a secure environment. Detainees being moved to court were also always handcuffed, even though the risks of escaping from the staircase through the dock, when escorted by a member of staff, were in most cases very low. (See main recommendation 1.24.)

Recommendation

4.41 **Each member of staff involved in an incident involving force should promptly complete an account of what happened. A manager trained in this area should check that the force used was legitimate, ensuring that any lessons are learned.**

Physical conditions

4.42 The physical conditions in the suites were satisfactory overall. We carried out checks on a random sample of cells in each suite and found potential ligature points in the majority, primarily due to the design of doors and benches. Efforts had been made to improve the decorative order of some suites. However, in a few, graffiti was prevalent, but it was generally inoffensive. An illustrative report outlining ligature points and other deficiencies was provided to HMCTS during the inspection. It received a positive response.

4.43 The sizes of cells varied and some were small and cramped, but staff tried to avoid using them where possible. Cells lacked natural light and in some of the suites the ventilation was inadequate. Staff could not control the heating temperature, which they reported could cause cells to be too hot in the summer and too cold in the winter. Temporary air conditioning had been installed in a few suites to improve conditions for detainees and staff during a hot spell.

4.44 Cells and communal areas, including toilets, were cleaned every day, but not before Saturday courts. Toilet paper and hand-washing facilities, including soap and hand towels, were freely available in all suites.

4.45 Salisbury Law Courts were the only facilities in the area with a readily accessible lift to the courts and an adapted toilet, making it suitable for wheelchair users. However, it had no adaptations in the cells and did not operate on a Saturday (see also paragraph 4.13).

4.46 There was a system for reporting basic maintenance defects, which were generally dealt with promptly, but this depended on the type of repair required and the cost.

4.47 Fire evacuation plans were displayed prominently and most staff knew how and where to evacuate people in the court cell area in an emergency. Desktop exercises (involving discussions about a simulated emergency situation) were carried out regularly, but fire drills had not been undertaken routinely across all the suites. This meant we were not convinced that evacuation plans were tested regularly enough or that they would be effective in a real emergency.

Recommendation

4.48 **Regular fire drills should be carried out in all the court custody suites.**

Health

4.49 The court custody suites had access to telephone health care advice from a specialist health adviser, and posters displaying the company's contact number were clearly displayed in each suite. The health adviser could also provide a health professional who could visit the suites within two to three hours, if clinically required.

4.50 Data indicated that the health adviser had been contacted by courts in the area on 29 occasions between 1 June 2018 and 31 May 2019 for advice or to verify whether a detainee should receive a certain medication. In two of these cases, medical staff had also been asked to attend the court custody suite, but in one case nobody had been available and in the other, it was unclear why the person did not attend. During our inspection, the staff at Salisbury Law Courts requested a visit from a health professional to treat a detainee in custody, but four hours after the request was made, the health professional had still not arrived and the detainee was released in the meantime. Custody staff we spoke to understood the service that was available but told us they would rather contact the ambulance service in an emergency or try to get a detainee prioritised by the court so they could be released promptly or be transferred to prison for health issues to be dealt with there. Although we found detainees' needs did not go unmet, this was not the most appropriate response to dealing with health concerns. Staff contacted the ambulance service on a number of occasions during the inspection, including following an incident of self-harm.

4.51 Staff were required to complete a first aid at work qualification and all of them had received up-to-date training or it had been arranged for the near future. First aid training updates were normally conducted every three years, which was not 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 kept at all courts, but no oxygen or suction was available. The contents of first aid boxes were mostly within their expiry dates, but processes were not always in place to identify when they were used, and the boxes were not always routinely checked.

4.52 Custody staff relied on information from the PER and from detainees, but health issues were not always adequately identified on the PER (see also paragraph 4.25). The PER for one detainee from a prison failed to identify any health conditions or that he was required to use inhalers, despite two of them being in a bag attached to his PER. The court custody manager contacted the health department at the prison and was advised that the detainee was required to use one of his inhalers in the afternoon and the other when required, but the PER did not indicate this. Another PER from the police simply stated a detainee had 'back pain', but gave no advice about their ongoing care.

4.53 Court custody staff were aware of the appropriate requirements for safe drug administration, and medicines were stored appropriately.

4.54 Most detainees with mental health issues had been seen by mental health staff while in police custody, where services were well embedded. Mental health workers from Berkshire Healthcare Foundation NHS Trust regularly visited the magistrates' courts in Hampshire, but in Wiltshire, mental health workers from Avon and Wiltshire Mental Health Partnership NHS Trust could not visit all active courts every day due to staff shortages. Custody staff had contact numbers and knew how to access the mental health services in their areas if they required this service to support detainees.

4.55 Drug and alcohol workers from Turning Point saw most detainees with substance use issues in the magistrates' courts in Wiltshire but in Hampshire, this service was covered by the mental health workers who informed detainees of the relevant services.

4.56 Most custody staff told us they had not received any training to help identify or support detainees experiencing mental health or substance use problems, but felt they would benefit from such training.

Recommendations

4.57 All custody staff should undertake annual first aid refresher courses to maintain their skills.

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

Section 5. Summary of recommendations and good practice

Main recommendations

5.1 Detainees should have their cases prioritised according to their needs and heard promptly. The reasons for delays should be explored and addressed. (1.23)

5.2 Handcuffs should only be used on detainees if proportionate and justified by an individual risk assessment. (1.24)

Recommendations

Leadership, strategy and planning

5.3 Ongoing training and development for court custody staff, including CCMs, should be improved. (2.11)

5.4 HMCTS should develop a safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable adults at risk. (2.12)

Treatment and conditions

5.5 Women and children should be transported separately from adult men. (4.20)

5.6 Staff should use telephone interpreting services promptly whenever a person who speaks limited or no English is received into custody to check on their welfare and risks and ensure they understand their rights in court custody. (4.21)

5.7 The individual needs of children transported to, and held in, court custody should be understood and consistently met. (4.22)

5.8 Custody staff who deal with children should receive specific training, including on the use of MMPR techniques. (4.23)

5.9 The frequency of cell observations should be set according to the specific risks associated with the individual, and should be carried out as required and documented accurately. (4.37)

5.10 Each member of staff involved in an incident involving force should promptly complete an account of what happened. A manager trained in this area should check that the force used was legitimate, ensuring that any lessons are learned. (4.41)

5.11 Regular fire drills should be carried out in all the court custody suites. (4.48)

5.12 All custody staff should undertake annual first aid refresher courses to maintain their skills. (4.57)

5.13 Custody staff should have regular mental health and substance use awareness training. (4.58)

Good practice

5.14 The new information sheet on females in custody displayed in suites and handed out to women on arrival and the wider range of menstrual care products available in women's toilet areas meant that women's needs were now being met consistently. (4.24)

Section 6. Appendices

Appendix I: Inspection team

Kellie Reeve	Team leader
Martin Kettle	Inspector
Fiona Shearlaw	Inspector

Appendix II: Photographs

Small cell at Winchester Combined Court.

Cell in Swindon Magistrates' Court, which held four women.

Small bench in Southampton Combined Court.