Report on an inspection visit to court custody facilities in

Greater Manchester

by HM Chief Inspector of Prisons

2–12 December 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 Greater Manchester and included seven courts with custody facilities, plus an immigration asylum chamber.[1] 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. Leadership arrangements were effective and the three key agencies worked well together to deliver a shared aim which focused on trying to ensure good treatment and conditions for detainees. Custody staff were respectful and supportive of detainees, taking good care of those with specific needs. Detainees were very positive about the treatment they received in court custody. The overall approach to the identification and management of risk was good and detainees were given the means to return home safely. Liaison and diversion services were well embedded and valued, both by detainees and custody staff.

There were, however, a number of areas where improvement was required. Our main concern continued to be that detainees, including children, were routinely handcuffed in the secure and controlled custody environment without adequate and individualised justification. Notwithstanding a strong commitment to prioritising cases, and therefore minimising the length of time that detainees spent in court custody, this was not always achieved and more needed to be done to understand and address the reasons behind this. Although relatively few children were held in court custody, staff received no specific training to deal with them, and their experience was similar to that of adults and did not take account of their innate vulnerability.

At the conclusion of our inspection, we left managers with a number of recommendations which we were confident would be used to drive necessary improvements.

Peter Clarke CVO OBE QPM March 2020
HM Chief Inspector of Prisons

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[1] HMCTS Immigration and asylum chambers are responsible for handling appeals against some decisions made by the Home Office relating to:
- permission to stay in the UK
- deportation from the UK
- entry clearance to the UK

They also handle applications for immigration bail from people being held by the Home Office on immigration matters. They are also known as Tribunal Centres.

Fact page[2]

HMCTS Cluster	Greater Manchester
Cluster Manager	Clare Beech (Crime) Lorraine Edgar (Civil, Family & Tribunals)
Geographical area	Greater Manchester

Court Custody Suites	**Cell capacity**
Bolton Crown & Magistrates' Court	10 cells
Manchester Crown Court (Crown Square)	23 cells
Manchester Crown Court (Minshull Street)	16 cells
Manchester Magistrates' Court	49 cells
Stockport Magistrates' Court	18 cells
Tameside Magistrates' Court	17 cells
Wigan Magistrates' Court	12 cells
Manchester Immigration & Asylum Chamber (IAC)	1 secure holding room

Annual custody throughput
1 November 2018 to 31 October 2019

18,142 detainees (Crime)
94 detainees (IAC)

Custody and Escort Provider
GEOAmey (Courts)
Mitie (IAC)

Custody staffing

Courts
7 Court custody managers
2 Deputy court custody managers
84 Custody officers

IAC
As required

[2] Data supplied by HMCTS Greater Manchester 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*[3] 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 This inspection of court custody facilities in the Greater Manchester cluster was reasonably good, overall. There were many positive features, providing detainees with good care and generally decent conditions. The three key agencies delivering court custody services across the cluster – HM Courts & Tribunal Services (HMCTS), Prisoner Escort and Custody Services (PECS) and GEOAmey (the service provider) – worked well together. There was a clear focus and shared aim to improve outcomes for detainees. The cluster was open to external scrutiny and we were confident that action would be taken to address the main cause of concern and recommendations highlighted in this report.

1.4 HMCTS managers and relevant staff had good oversight of issues affecting custody and visited court cells regularly. While some audit regimes and visits to custody were more embedded than others, they were generally helpful in identifying and addressing the issues concerning the estate. Cleaning and maintenance contracts delivered by G4S provided some mixed results but were generally effective. Contractual challenges and budgetary constraints resulted in some delays in completing expensive tasks.

1.5 GEOAmey staff demonstrated good care for detainees. Custody was generally staffed sufficiently. However, some staff, particularly in the Manchester courts, were not always deployed effectively. Court custody managers generally provided good leadership within the suites but did not always proactively oversee important aspects of the detainee journey, such as reception and release processes. Initial training for custody staff was satisfactory and refresher training was properly focused but not all staff could adequately describe their understanding of additional inputs, particularly concerning mental health and safeguarding.

1.6 There was a strong commitment to ensuring that custody cases (cases concerning people who are detained in court custody) were prioritised for court but this was not always achieved. We found some unacceptable delays, when custody cases were not heard as promptly as we would have expected. We were told that a large proportion of eligible cases were heard via video-link.

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

1.7 There was no overarching HMCTS safeguarding policy. GEOAmey standard operating procedures and policies were well promoted but there was a lack of understanding about what would constitute a safeguarding concern, particularly for vulnerable adults.

1.8 A small group of independent lay observers provided independent scrutiny of custody facilities. Their reports were shared widely and were helpful in identifying issues pertaining to detainee care and welfare.

1.9 The environment in the immigration asylum chamber was stark. The distraction activities provided were limited but this was mitigated by the mostly short stays there. Staff there could provide hot drinks and food. HMCTS had access to travel warrants to help detainees without the means to travel home, if this was required.

Individual rights

1.10 There was generally good attention to ensuring that detainees received their legal rights in custody. Most 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 that some detainees could spend longer than necessary in police cells.

1.11 A substantial proportion of detainees at the magistrates' courts had their cases prioritised and fully dealt with before lunch. This was not, however, always the case, notably at less busy courts where delays that lengthened custody time were evident. Reasons included: delays in the attendance of solicitors; the non-receipt of court papers; delays in, or a lack of, attendance of court-appointed interpreters; children and women not always being transported to prison/secure accommodation promptly on completion of their hearing; and delays in receiving formal authority to release from prison. More positively, detainees who were remanded or sentenced in the morning were often moved to prison at lunchtime or in the early afternoon.

1.12 There were sufficient private interview rooms to accommodate legal and professional visits, and these were generally facilitated promptly.

1.13 Information detailing detainees' rights in court custody was placed in each cell before their arrival and was pointed out to them on location there. Rights information was printed off for non-English-speaking detainees in their own language but was not available in an easy-read format or in Braille. Staff demonstrated a reasonable awareness of the complaints process and detainees were provided with details of this, and were helped to make a complaint if necessary. However, the information promoting the complaints processes was out of date.

Treatment and conditions

1.14 The vehicles used to transport detainees were generally clean and well equipped, although some were ageing and showing signs of wear. Women and children were regularly transported with men, which was inappropriate, and the available partition to keep them separate was not always used. All courts had secure vehicle docks, so that security and detainee privacy could be maintained. At the smaller courts, detainees were disembarked quickly but this was not the case at larger, busier courts where we observed delays.

1.15 Staff were respectful and supportive towards detainees, and many were experienced in the anticipation and management of a range of detainee behaviours and needs. Custody staff had received only a small amount of training on equality issues but showed awareness of the principles of equality and diversity, and took good care of those with specific needs.

Provision for women was generally good, with menstrual care products generally freely available. Few staff used professional telephone interpreting services for detainees who did not speak English, despite clear need. There was sufficient provision for religious and dietary needs. Only Manchester Magistrates' Court provided adequate access for detainees who used a wheelchair, and appropriate support was given to them. The other suites, however struggled to adequately support those with mobility issues.

1.16 Custody staff received little or no training to help them deal with those relatively few children requiring custody. Most cases were treated in the same way as adults. They were handcuffed routinely, accommodated in a cellular environment and not routinely prioritised for court. In the eight cases in which force had been used against children in the previous year, techniques designed for adults had been used. Children's safeguarding policies were in place and, although staff understanding of the principles of child safeguarding was mixed, they had confidence in the safeguarding team to respond when they identified concerns. There were some delays in receiving placement orders and in subsequently moving children to their place of detention. Transportation and care for those transferred to and from secure training centres and secure children's homes through a contract with the Youth Custody Service were generally appropriate.

1.17 Detainees we spoke to were positive about the standard of care that they received in court custody. There was an adequate supply of food and drink in most suites, and these were generally made available on request. However, at a few courts there was not sufficient access to a drink soon after arrival.

1.18 A limited range of books and free newspapers was available, and distraction packs were offered and often issued, in almost all courts. There was no material in languages other than English, and little suitable for children.

1.19 Detainees brought to court from police stations or prisons were accompanied by person escort records, but these often gave too imprecise an indication of risk factors to be of any use, and there were often gaps in the information. Nevertheless, staff were generally quick to pick up signs of risk and vulnerability, and to manage such risks effectively. Risk assessments for those received off-bail were thorough. Staff briefings were generally held each day, although often not in great detail. Staff were aware of the risks associated with specific detainees, but not all managers had a good grasp of individual risks and needs. Cell checks were carried out on time in most cases, but were late or missed in some suites at busy times, and were poorly recorded overall. In all suites, cell call bells were audible and mostly answered promptly. GEOAmey staff worked closely with court staff, police and other agencies to share relevant information to keep detainees safe. Searching practice varied, but in general there was too much searching before and after movements within the suite, and much of it was too cursory to be of use.

1.20 Staff took care to ensure that detainees being released had the means to get home and knew how to do so, issuing bus fares and travel warrants as required. However, apart from asking them, in general terms, if they were ok, this was as far as staff went in preparing detainees for release in most cases. Most suites had a supply of leaflets with details of where to find help after release, and the liaison and diversion staff produced useful information about local support services, but the availability of these was uneven across suites, and the information was rarely offered. Several courts had information leaflets about the individual prisons to which detainees were often sent from Manchester courts, but these too were not offered consistently.

1.21 Overall, there was little use of force, and we were reasonably confident that it was used only as a last resort. Staff were patient and generally engaged well with detainees to defuse their frustrations and anxieties. In the cases we reviewed, there was no evidence of excessive use of force, and records reflected that any force used had been necessary and reasonable. The

oversight of use of force was properly focused and was developing. Although some individual use of force reports lacked detail, most were at least of an adequate standard.

1.22 Handcuffs were used excessively. All detainees, including children, were routinely handcuffed within secure areas of custody suites, even when they had arrived without handcuffs and risks were deemed to be low. Only minimal discretion was applied to detainees with impaired mobility.

1.23 The cells were generally kept in a good condition but the daily cleaning arrangements were not always effective. There was extensive graffiti in some suites. We found potential ligature points across the estate and provided an illustrative report detailing these. Communal toilets were generally clean but often lacked privacy. Fire evacuation plans were displayed prominently in the suites but few staff had participated in a fire evacuation drill, which was potentially unsafe.

1.24 All staff were aware of the telephone health advice 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, to release them or transfer them to prison for their health issues to be dealt with. The procedures for helping detainees to take their prescribed medication were understood by staff and used appropriately. However, there was no provision for detainees experiencing drug and/or alcohol withdrawal, and we saw some detainees who appeared to be suffering unnecessarily. First-aid boxes were not checked regularly, and some items in them were out of date and some were not stocked appropriately. Most staff had received some mental health awareness training but few were able to describe their understanding of this or how it had influenced their care for detainees. Liaison and diversion services were well embedded within the court custody suites, and were valued by staff and detainees.

Main recommendation

1.25 Concern: Handcuffs were routinely applied to detainees, including children 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 this is 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 Overall, leadership arrangements were reasonably good and were contributing to delivering some good outcomes for detainees. HM Courts & Tribunals Service (HMCTS) in Greater Manchester 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 five magistrates' and three Crown courts, one of which – Bolton – was a combined facility, with both a Crown and magistrates' court. Six HMCTS delivery managers were responsible for overseeing the day-to-day running of court services, including custody, in the courts we inspected. The immigration asylum chamber (IAC) was managed by a separate team. Alongside their commitment to delivering court business, senior HMCTS managers took responsibility for court custody facilities and were properly focused on ensuring that conditions for detainees were good, and on 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 the Greater Manchester cluster. The experienced PECS contract delivery manager had effective working relationships with the other key agencies. She 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 the PECS contract delivery manager conducted audits that focused on security arrangements and detainee care 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 a GEOAmey area business manager, who was in charge of the management of court custody services. Seven court custody managers (CCMs), supported by two deputy CCMs, reported to the area business manager and were responsible for the day-to-day running of the custody suites.

2.4 Working arrangements and relationships between the three key agencies were well developed. There was a shared aim to ensure that detainees were held in appropriate conditions and were treated well. Formal and informal meetings provided good oversight of the court custody provision. HMCTS managers, or their designated representative, visited custody regularly. While their monthly audits varied in content and were not yet well embedded across the cluster, HMCTS managers had a good understanding of the issues concerning the estate and used this to try to drive improvements where necessary. GEOAmey CCMs had at least daily contact with colleagues in HMCTS, to share information about the welfare of detainees.

2.5 Cleaning and maintenance services were provided by a contractor, G4S. These arrangements were mostly responsive and effective, but contractual complexities and budgetary constraints, had meant that some maintenance work – in particular, expensive tasks – were proving difficult to progress. During the inspection, we found potential ligature points across the estate, many of which resulted from the design of cell doors. We provided HMCTS

managers with a comprehensive report concerning the physical conditions in court custody facilities (see also paragraph 4.44).

2.6 The GEOAmey staffing of court custody was generally sufficient, and routinely supported by officers who worked on escort vehicles. The latter were well integrated, understood custody practices and mostly contributed well to the running of the custody suites. Staff were caring and compassionate, and dealt with detainees very well. The initial training for officers was adequate. In addition to training in control and restraint every year, and in first aid every three years (see also paragraph 4.54), established staff were required to undertake a day of refresher training every three years. We were told that this included input on mental health and safeguarding, but most staff told us that the focus of this training was fire safety. We were not confident about the effectiveness of this training, as many staff could not adequately describe what they had learned, particularly about dealing with detainees suffering from mental ill-health or how to identify safeguarding concerns, particularly for vulnerable adults (see also paragraph 4.58). CCMs offered visible leadership but in the busier courts did not always proactively oversee important aspects of the detainee journey, such as reception and release processes. Also notable, particularly in the Manchester courts, was the rigid demarcation of officer roles and responsibilities, which was not always conducive to deploying staff in the most effective way.

2.7 The listing of cases is a judicial responsibility and process, but an HMCTS listings protocol allows for custody cases to be prioritised. Senior managers were committed to prioritising custody cases where possible, but this was not always achieved. GEOAmey staff were proactive in communicating the need for cases, particularly those involving children, women or other vulnerable detainees, to be prioritised. Although a large proportion of custody cases were dealt with before lunchtime, we found some frustrating delays, resulting in custody cases not being heard as promptly as expected (see also paragraph 3.7).

2.8 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 these were well promoted. Staff generally knew who to report safeguarding concerns to but their limited understanding in this area, particularly concerning vulnerable adults, did not satisfy us that concerns would be identified consistently (see also paragraph 4.16).

2.9 There had been substantial investment in video-link facilities and infrastructure in local prisons, enabling eligible cases to be heard from prison. This was often less disruptive to prisoners and meant that they did not have to make sometimes long journeys to court, on uncomfortable vehicles. HMCTS managers told us that they were committed to using video-link for eligible cases, and believed that most of those who were eligible were produced at court via video-link.

2.10 A small group of independent lay observers visited court custody suites, with busier courts receiving more frequent attention. Their reports 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 that they found them helpful for identifying and addressing concerns.

2.11 The cluster included one IAC, based in Manchester. The IAC handled appeals against Home Office decisions concerning permission to stay in the UK, deportation from the UK and entry clearance to the UK, as well as applications for immigration bail for people held by the Home Office on immigration matters. Mitie, a privately contracted company, was responsible for transporting detainees to the IAC and for supervising them during their stay. An average of one to two detainees a week were held in the IAC detention suite, always on an individual basis, but we saw no detainees there during the inspection.

2.12 There was one holding room in the IAC; this was clean but stark and contained no information. The toilets there were clean and sufficiently private. Mitie staff carried a range of microwaveable meals and snacks for detainees held in the IAC, and could access a microwave oven and facilities to make them hot drinks in the detention suite. There was little to keep detainees occupied during their stay in the detention suite, but this was mitigated slightly by the relatively short stays there.

2.13 A senior manager from Mitie told us that detainees held in the IAC would only be handcuffed by risk assessment, which was positive. If detainees were to be released, it was policy to escort them back to their originating place of detention, to ensure that release arrangements could be conducted appropriately. HMCTS had access to travel warrants to help detainees without the means to travel home, if this was required.

Recommendations

2.14 Staff understanding and implementation of the content of ongoing training and development should be improved.

2.15 HM Courts & Tribunals Service (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.

2.16 The environment for detainees held in the IAC should be improved.

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 There was good attention to ensuring that detainees received their legal rights in custody. Despite a commitment to prioritising custody cases, our biggest concern in this area was that, often without good reason, this did not always happen and meant that some detainees spent longer in custody than necessary.

3.2 All courts had appropriate arrangements, including on Saturdays, for the youth offending service (YOS) to establish if a child was being held in court custody. If this was the case, YOS workers attended, so that they could present the child's needs, risks and circumstances to the court. We saw relatively few children being held, and those we saw were not always prioritised, with often long delays before they appeared in court. We also found that, once sentenced or remanded, children were not always moved to secure accommodation promptly, with one child waiting in excess of five and a half hours; this meant that children sometimes remained in court custody for longer than necessary (see also paragraph 4.15).

3.3 There was a variety of reasons why detainees were not always prioritised for court, and we found this to be more acute at the quieter magistrates' courts. Courts did not always start to deal with custody cases at 10am, the scheduled time. In our review of the data supplied, 58% of magistrates' courts did not call for their first detainee until after 10.30am, and in the worst case the only detainee in custody was held in the cells for seven hours before appearing in court at 3.20pm. The courts did not always progress requests from custody staff to prioritise the cases of vulnerable detainees (for example, when there were mental health concerns), and the reasons for this were often unclear. Other delays in detainees appearing in court, particularly Crown courts, arose as a result of their arrival at court in the morning, when their cases were listed in the afternoon.

3.4 Cases involving women were not always prioritised either, and sometimes were the last to be dealt with. During the inspection, some women waited up to seven hours before appearing in court, with no good reason for the delay. For those who were remanded or sentenced during the morning court session, there was evidence of waits of up to three hours before transportation arrived to move them to prison.

3.5 There were sometimes delays in the attendance of solicitors, which we were told could be due to problems concerning the transfer of electronic case papers from the Crown Prosecution Service to solicitors. This, in turn, delayed consultations with detainees until the solicitors were in full possession of the facts relating to their clients' cases. Duty solicitors often dealt with their off-bail clients rather than prioritising their clients held in custody. At some courts, non-English-speaking detainees were held in custody for longer than necessary owing to delays in, or a lack of, attendance of court-appointed interpreters, which sometimes resulted in the detainee being remanded to prison for an additional night.

3.6 We also found delays for detainees who had been bailed or acquitted by the courts but previously remanded in custody, who had to wait for their originating prison to authorise their release. In the records we reviewed, such detainees had often been held for from 90 minutes to over five hours, waiting for the authority to be released from prison. These delays were excessive, and meant that people who were essentially free to leave court custody continued to be treated as detainees and were held in cells, and moved around the custody suites in handcuffs.

3.7 Despite delays, most (around 67%) detainees were dealt with before the court broke for lunch. If remanded or sentenced to prison, these detainees were often transferred before 2pm, and in some cases earlier, which was positive. However, more could have been done to understand and address the reasons for delays, to ensure that, where possible, unnecessary delays were avoided, and that all detainees had their cases prioritised and were dealt with promptly.

3.8 Detainees held in police custody should have been able to appear before a magistrates' court at the earliest opportunity if the court was sitting and there was capacity to hear their cases. Custody staff told 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 when asked to do so. Our observations and review of data showed that only a few detainees were accepted directly from police custody, with the latest arriving at 2.10pm, even though magistrates' courts sat until much later in the day. This did not assure us that detainees were always seen by the first available court, and we were concerned that some could potentially have remained in police custody for longer than necessary.

3.9 Detention warrants, which are required when a detainee is remanded 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. We were confident that most warrants were issued in a timely manner and caused no delay in onward transportation of detainees to their place of detention.

3.10 Custody staff told us that if a detainee wanted to tell someone where they were being held, this was referred to their legal representative.

3.11 Printed copies of rights and complaints information were placed in cells before a detainee's arrival. A few were in a poor condition, and different versions were used across the cluster. As part of the reception process on arrival at a court, detainees were told that these documents were in their cells, and were asked if they could read and understand them. During the inspection, we observed one detainee who stated that he was dyslexic, and was subsequently offered appropriate support. The rights information was available in a range of languages, and an appropriate translated version was issued when detainees spoke limited or no English; however, it was not available in Braille or in an easy-read format.

3.12 Custody staff asked all detainees who their legal representative was, and these individuals were contacted to advise them of their client's arrival. There were sufficient sound-proofed interview rooms at all courts and we found no delays in facilitating visits once legal representatives or other professional visitors arrived in custody. Detainees could retain legal documents that were relevant to their case.

3.13 Data supplied by GEOAmey showed that professional telephone interpreting services had not been used by any of the courts in the area since 1 October 2018. A few custody staff told us that they had used the service recently, mainly to facilitate a conversation between a legal representative and their client in the absence of a court-appointed interpreter (see also paragraphs 3.5 and 4.9, and recommendation 4.22).

3.14 Only two complaints had been submitted in the year to 30 September 2019. Most court custody staff had a reasonable awareness of the complaints process and knew to offer assistance to detainees to make a complaint if necessary, and we saw this happen during the inspection. Detainees at all courts were provided with written information about this, although it was out of date, and were told on arrival that there was a complaints procedure; however, it was not always comprehensively explained that this related to their treatment in court custody or experience in court. Information promoting the complaints procedure was displayed in custody suites but this was also out of date. Some staff were not aware that the

complaints information was available in a range of languages, and this was not issued to any of the detainees who had been given a translation of the rights information (see above).

Recommendation

3.15 Cases involving detainees should be prioritised. HMCTS, Prisoner Escort and Custody Services, and the escort and custody contractor should investigate and address the reasons for the prolonged periods that some detainees, including children, spend in court custody cells.

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 Except for a small number of children transferred to and from often distant young offender institutions (YOIs) or secure training centres (STCs), most detainees arrived at court from local police custody or prisons, and did not experience long journeys. The cellular vehicles used to transport detainees were generally clean and well equipped, and included drinking water, first-aid kits, disposable urine bags and menstrual care products. However, some vans were ageing and showing signs of wear and tear. There had been efforts to remove graffiti but this was still evident in some cellular compartments. The vehicles used to transport children, pregnant women or detainees with mobility issues were generally in a better condition and provided the added safety feature of seatbelts, missing from regular cellular vehicles.

4.2 All escort staff carried individual anti-ligature knives. Women and children were regularly transported from police custody with adult men, which was inappropriate; although the vehicles had partitions to safeguard detainees, these were not always used.

4.3 In transit, vehicles were kept sufficiently warm during the cold weather experienced during the inspection. However, heating systems operated only while engines were running, and while most detainees were disembarked quickly, we observed some long delays, particularly at busier courts, which left some waiting in the cold. All courts had secure vehicle docks to protect detainees from media or public attention.

4.4 Staff treated detainees with respect and courtesy at all times, using humour and reassurance when appropriate. Many of the staff were experienced in their role, and were able to pick up on signs of the person's mood and emotional state and calibrate their own words and actions accordingly (see also paragraph 4.25). They were often able to anticipate the needs and concerns of an individual detainee. Many detainees spoke highly of the standard of care that they had received from custody staff, and no detainees criticised staff behaviour.

4.5 In some suites, the standard checklist of questions put to all arriving detainees, to ascertain their needs, was gone through thoroughly and in reasonable privacy; in others, the questions were asked quickly or incompletely, often while walking or in communal areas, where other detainees were sometimes present.

4.6 Staff were reasonably familiar with the general principles of equality and diversity. They received some input on this topic at their annual 'refresher training' day (see also paragraph 2.6), but many of them did not feel well equipped to address equality issues, especially in areas of current social change, such as gender identity. Nevertheless, they showed mature and reliable instincts in responding to those with protected characteristics, and could describe appropriate support given in the past to transgender people, for example.

4.7 Female detainees were generally treated well, although we saw some women not being offered menstrual products or told that they could speak to a female officer. The new 'Females in custody' information sheet was given to each woman in some custody suites, but not in all. In general, women no longer had to ask for menstrual products if they needed them, as boxes with a reasonable variety of these items were placed in the toilets used by female detainees, although they were not always hygienically stored. We saw pregnant women being given good support, and a new mother being helped sensitively by female staff. Women were generally kept in separate areas from men, where possible, but at Crown Square there was insufficient separation, and insufficient privacy for women using the toilet.

4.8 The privacy of detainees was respected, with the exception that whiteboards giving names and other details (although not offence-related information), together with standard risk codes, were visible to all detainees in several locations.

4.9 There was insufficient provision for detainees who did not speak or understand English well. Portable telephone handsets were provided, to enable custody staff to contact professional telephone interpreters through a contracted service when required. A few staff had used this service, and said that it was very useful, but most had not used it. There was a strong dependence on court interpreters to give assistance. This normally left an important gap when a non-English-speaking detainee first arrived in court custody, before they were able to be helped by a court-appointed interpreter for issues concerning the legal process. The vital initial assessment of risks and needs when a detainee first arrived, therefore, was almost always conducted on the basis of far too limited communication when the detainee did not speak English well. It was clear from our observations that it did not normally occur to staff to consider using the available professional telephone interpreting service in these cases, and during the inspection we saw several detainees who would have benefited from this (see also paragraph 3.13).

4.10 At each suite, there was a box of books and items for religious observance. These were well stocked for the main faiths, and the items were stored appropriately and respectfully. Detainees were asked if they had religious requirements, and we saw some of these items being issued to them. Qibla arrows, pointing the direction for Muslim prayer, were displayed in the cell areas.

4.11 Manchester Magistrates' Court was the only court building suitable for detainees who used a wheelchair or had other mobility issues (see also paragraph 4.46). As this was by far the busiest court in the cluster, this presented challenges but, in spite of this, we saw appropriate care being given to those using a wheelchair. At other courts, there were sometimes difficulties in helping people who had restricted mobility, such as those using crutches and also those for whom the need for mobility support had not been communicated in advance. Hearing loops were not available in the custody suites, and there was no material (such as information in Braille) to help those with impaired vision.

4.12 Detainees' property was accounted for carefully, and stored in a secure location at each custody suite.

4.13 Relatively few children, around 5% of the throughput in the previous year, were held in court custody. The Youth Custody Service was contracted to transport children to and from court in non-cellular vehicles when they were located in secure training centres or local authority accommodation. These children were accompanied by trained staff, who remained with them and looked after them during their stay in custody. The GEOAmey staff who undertook this role told us that they engaged with the children in their care, and that if there were no other options they would locate the child in a cell in a discreet area of the custody suite; they also said that they would leave the cell door open, which was positive. However, they told us that children were routinely handcuffed, which was poor practice.

4.14 Most custody staff received little or no training to help them deal with children, and few had a sufficient understanding of their distinct needs. There was no 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. They were routinely handcuffed, regardless of the risk they posed or their innate vulnerability (see also paragraph 4.43 and main recommendation 1.25). Children were also held in cells and, with the exception of distraction packs, were offered few activities to keep them purposefully occupied (see also paragraph 4.19). We also found little evidence that the hearings for children were prioritised or expedited (see also paragraph 3.2 and recommendation 3.15).

4.15 Children who were remanded or sentenced to custody needed a placement order, which dictated where they would be detained. Although this applied to relatively few children, we found that placement orders were not always received promptly. The subsequent onward movement was delayed until the placement order had been received meaning some children spent longer in custody than was strictly necessary (see also paragraph 3.2).

4.16 Several GEOAmey safeguarding managers worked across the organisation and offered advice to staff. Although staff had the confidence to refer the concerns that they identified to the safeguarding managers, they were not always fully sighted on the contents of children's safeguarding policies or what constituted a safeguarding concern. Few custody staff were trained in minimising and managing physical restraint[4] techniques, for use with children, which meant that they had to resort to using control and restraint techniques (designed for use on adults) on children (which was inappropriate), and had done so eight times in the previous year.

4.17 Detainees spoke in positive terms about the care that they received from staff. When detainees attended daily for a trial lasting several days, staff knew their preferences and needs well.

4.18 Food preparation areas were clean, properly equipped and generally well maintained. The main food available for detainees was sandwiches, and these were popular; the quality had improved with a change of supplier. Fresh sandwiches were brought daily from the vehicle base to most custody suites, and most had a range of in-date sandwiches suitable for most dietary and religious requirements. However, some smaller courts did not receive this delivery on some mornings, and so supplies were short in this case. Microwaveable meals were also available in all suites, and were normally used for any detainees who stayed in court custody into the late afternoon, or as an alternative if there were no suitable sandwiches available. Hot drinks were generally offered regularly or provided on request in most suites.

4.19 There were books and some magazines available at all suites, and many detainees were asked on arrival if they would like something to read, although this did not happen reliably at the busier suites. The books were almost exclusively light novels in English, which met the needs of some. In almost all sites, staff helpfully brought in multiple copies of free newspapers, and these were given to many detainees. Distraction packs, originally produced by the charity RECOOP (Resettlement and Care of Older ex-Offenders and Prisoners), were issued to many detainees, in almost all courts, with pencils for the puzzles and quizzes included. There was nothing to read in languages other than English, and little suitable for children in custody, except at Wigan Magistrates' Court, where the manager had procured suitable materials for children.

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[4] The new behaviour management and restraint system, minimising and managing physical restraint, aims to provide secure estate staff with the ability to recognise young people's behaviour, and use de-escalation and diversion strategies to minimise the use of restraint through the application of behaviour management techniques. 'Minimising and Managing Physical Restraint Safeguarding Processes, Governance Arrangements, and Roles and Responsibilities'. NOMS, Young People's Estate, Ministry of Justice, Youth Justice Board.

Recommendations

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

4.21 Staff should use professional telephone interpreting services, to check on the welfare, risk management and understanding of detainees who speak little or no English, on arrival and throughout their stay in court custody.

4.22 The individual needs of all 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 minimising and managing physical restraint techniques.

Safety

4.24 Detainees brought to court from police stations or prisons were accompanied by person escort records (PERs), which should have provided an up-to-date assessment of the risks associated with the individual. However, the risk factors included in the PERs were mainly delineated in such a broad-brush way, using single words, such as 'violence' or 'drugs', that it was not possible to derive useful information about the likely current situation. This was also the case for health-related risks; for example, in one PER, 'known to services' was written in the mental health box (see also paragraph 4.54). In some of the police PERs, the year of the relevant incident was helpfully added, but still without further relevant information, and the PERs from prisons generally lacked details or dates. In some cases, key information was missing which was found later from other sources; for example, a previous conviction for murder only became known to staff when it was mentioned in court.

4.25 In spite of this, the experienced staff were adept at picking up verbal and non-verbal signs of risk in the way that a detainee presented, and acting to mitigate potential risks of harm. Many of them had a keen eye for signs of vulnerability, instability and low mood in detainees (see also paragraph 4.4), and were ready to probe sensitively, even without direct evidence of risk. However, they did not always make thorough use of the reception checklist to identify risks and needs (see also paragraph 4.5).

4.26 At most, but not all, suites, the CCM (or delegated representative) gathered all their staff for a briefing each day, usually once most detainees had arrived in the morning. Staff were usually asked to sign to confirm that they had received this and also seen the briefing sheet, which was the basis for it. In several cases we observed, however, these briefings were very short, and did not include reference to individual detainees who might need particular staff attention or vigilance. The staff designated to supervise the cells were generally familiar with the needs and situations of individuals, but some of the CCMs had not familiarised themselves with the details of the detainees for whom they were responsible.

4.27 Staff checked that detainees knew about the cell call bells, and these were audible in all suites. In almost every case in our observation, they were answered promptly. All staff wore an anti-ligature knife, and appropriate additional monitoring was carried out on detainees for whom a risk of self-harm had been identified. Regular observations to check detainees' well-being took place consistently and on time in many cases, but in some suites they were missed, especially at busy times, and we saw some detainees not being checked for over an hour at Manchester Magistrates' Court. The PER often recorded a 'visual check'; however, this comprised a glance through a cell observation panel, which is not a substitute for interaction with the person. The recording of these checks, which had to be done both in

the paper PER and on the electronic custody record, was poor overall, and too patchy to provide consistent evidence of checks being carried out.

4.28 The good partnership working at the strategic level (see also paragraph 2.4) was matched by operational cooperation at individual courts. Safety issues were discussed between CCMs and court managers, not only in formal encounters, but also as situations arose, which was often several times a day. CCMs had strong enough working relationships with court staff to take the initiative often in drawing attention to, and, if necessary, chasing the need for, action such as prioritising hearings involving vulnerable detainees, although this did not always result in appropriate action by court staff (see also paragraphs 2.7 and 3.3, and recommendation 3.15).

4.29 Detainees were searched relatively often when moving within the custody suite – for example, when going to or from the toilet, or on returning from a legal visit. We also saw inconsistent practice, both between suites and between staff, concerning the frequency of searches, which, regardless, were often so cursory that they gave no assurance that a secreted item would be found.

4.30 The suites were never overcrowded during the inspection, and we saw no sharing of cells. Staff told us that cell sharing was rare, although might happen occasionally if there was a clear benefit, such as offering appropriate support for detainees who had been identified as vulnerable. Several courts had separate areas in which men, women and children could be located in separate corridors. In a few cases, women were located in the same area as men, but usually with a degree of separation (see also paragraph 4.7).

4.31 Detainees were taken to the courtrooms promptly when called for, and the routes from the cells to courtrooms, although long in some cases, were generally safe and equipped with alarm bells at regular intervals; when this was not the case, personal alarms were issued to staff. Closed-circuit television (CCTV) was located only in the approaches and entrances to the custody suite, and not within the suites or on the routes to courtrooms, although in Manchester Magistrates' Court some of the cells were monitored by CCTV. Staff said that the general lack of CCTV had not had an adverse effect on safety. It was never necessary to take a detainee from the cells to a courtroom through a public area.

4.32 Staff in all the suites asked each departing detainee where they were going, whether they knew how to get home and whether they had the means to do so. In all suites, staff provided money for the bus fare (or taxi, if deemed necessary), and travel warrants if train travel was needed. With more vulnerable people, they took extra care to check that the person was confident about accessing public transport to their home.

4.33 At most suites, there was a supply of written information to help people to access support after leaving court custody; however, in several suites the leaflets were not easily accessible, and they were rarely offered. The liaison and diversion service (see also paragraph 4.56) had produced a useful set of information sheets about seven local services and charities offering support, especially with accommodation, and staff gave these out when necessary. Liaison and diversion practitioners often attached relevant information, including letters of referral to community services, to detainees' property for their attention on release or transfer.

4.34 Those who came down from court, having been on bail, to be transferred to prison were given a detailed private interview, to start to assess risks and vulnerability, and this was conducted in a considerate way. Several courts had information leaflets about the individual prisons to which people were often sent from Manchester courts, but they were rarely given to detainees.

4.35 Those about to be released who were wearing institutional clothing, having had some of their clothes removed by the police for safety or other reasons, were generally not allowed

to change into their own clothes on discharge from the custody suites. Many therefore had to leave the building with this clearly visible indication that they had been in the cells, and some of them then had to re-enter the court building in order to report to probation staff.

Recommendations

4.36 Detainees coming from prison or police custody should be accompanied by a person escort record that includes clear and accurate information of any current risks to themselves or others.

4.37 Regular cell checks should be carried out on time, should normally include interaction with the detainee and should be recorded accurately.

4.38 Court custody managers should understand the main risks associated with detainees in their suite, and provide a briefing for their staff accordingly.

4.39 Searching of detainees should be carried out effectively and consistently across all suites, in line with a policy which restricts it to situations where it is clearly necessary.

4.40 All detainees should be helped to prepare for leaving custody with practical consideration of any imminent risks and needs, and with the opportunity to wear their own clothes as they leave.

Use of force

4.41 Incidents involving the use of force against detainees were relatively infrequent, and low in number overall. Staff were patient and generally engaged well with detainees to defuse their frustrations and anxieties, and to de-escalate situations without resorting to using force. We saw no force being used during the inspection and were reasonably confident that force was used only as a last resort.

4.42 We examined the written records for 37 instances where force had been used against detainees. The records reflected that, when used, force had been necessary and reasonable, and there was no evidence that it had been used excessively. Many of the recorded uses of force had been low level, including to prevent self-harm or to guide reluctant detainees from the dock once remanded or sentenced. Staff involved in the use of force understood the requirement to submit an individual statement concerning their part in the restraint, and we found that these were completed consistently. The quality of most completed documentation was at least adequate, with only a minority of reports lacking detail, and some was of a high standard. The oversight of incidents was properly focused and was developing but had not always identified examples of poor practice, such as in one case where a detainee had been inappropriately left handcuffed in a cell.

4.43 Handcuffs were used excessively. They were used even within secure areas, on all detainees, including children, with no individual assessments of risk to ascertain if this was necessary. Even those who arrived without handcuffs or who were deemed to present no or low risks were handcuffed within the secure and controlled areas of the custody suite and vehicle docks. Only minimal discretion was applied to detainees with severely impaired mobility. Detainees being moved to the courtroom were also always handcuffed, despite being escorted by at least one member of custody staff (see main recommendation 1.25).

Physical conditions

4.44 The physical conditions in court custody suites were generally good. The daily cleaning arrangements, provided by G4S, were mostly, but not always, effective. We carried out checks on a random sample of cells in each suite and found potential ligature points in several of these, mainly due to the design of doors and some poor maintenance. We provided a comprehensive report detailing these. Graffiti was prevalent across the estate but it was generally inoffensive, and, owing to cost, was only prioritised for removal when it was offensive.

4.45 In all the suites, cells lacked natural light and the ventilation was inadequate. Staff could not control the level of heating, which they said could lead to cells being either too hot in the summer or too cold in the winter. All facilities had recently been issued with an electronic thermometer, and readings were recorded and monitored twice daily. Staff were aware of the appropriate temperature ranges within which the suites should be operating, and avoided using colder cells where possible.

4.46 Manchester Magistrates' Court was the only court in the cluster recognised for scheduling cases under the Equality Act. It was equipped with a lift from the van dock up to the custody suite, and further lifts to the courts and an adapted toilet, making it suitable for detainees with disabilities. There were, however, no adaptations in any of the cells (see also paragraph 4.11).

4.47 Cells were cleaned daily, including after the Saturday court at Manchester Magistrates' Court. Communal toilets were generally clean, and toilet paper, soap and hand towels were mostly freely available, although a shortage of hand towel and toilet paper dispensers resulted in supplies not always being stored hygienically. The use of stable doors in some toilet areas afforded insufficient privacy.

4.48 The effectiveness of maintenance arrangements was mixed. Some defects were dealt with promptly but others were not, depending on the nature of, and expense associated with, the repair. Some court custody staff had become desensitised to graffiti, poor cleaning and damage/defects, and did not always report issues.

4.49 Fire evacuation plans were displayed prominently in the suites and most staff were aware of how and where to evacuate people in the court cell area in an emergency. Desktop exercises were carried out regularly but fire evacuation drills had not been carried out routinely across all the suites. This did not provide assurance that evacuation plans were tested with sufficient regularity or that they would be effective in a real emergency.

Recommendations

4.50 All court cells should be clean and free from graffiti, and all ligature points should be removed.

4.51 Fire drills to practise emergency evacuations should be carried out in all the court custody suites.

Health

4.52 The court custody staff had access to a telephone medical helpline, which provided advice from a specialist health adviser through a contract with Stadn Limited. The contract could

also provide the attendance of a health professional (via another contractor, United Safe Care), within two to three hours if clinically required.

4.53 Data provided by Stadn Limited indicated that they had not been contacted by any of the courts in the area in the previous six months but we saw them being contacted on two occasions for advice during the inspection. Custody staff we spoke to understood the service that was available but told us that they would rather contact the ambulance service in an emergency. They also told us that that they would try to get a detainee with health issues prioritised by the court, so that they could be quickly released or transferred to prison, to get their health issues dealt with.

4.54 All staff were required to complete a first aid at work qualification, and most staff were currently in date with their training or had this arranged for the near future. First-aid training updates were normally conducted every three years, which was not sufficient to maintain an adequate skill level. Automated external defibrillators (AEDs) were available at all the courts, except for one, where this was available in neighbouring NHS premises, but no oxygen or suction was available, contrary to our expectations. First-aid boxes varied in their contents, with some being either under- or overstocked; these were not routinely checked and some contained out-of-date stock.

4.55 Custody staff relied on health information on the PER, but health issues were not always adequately identified there (see also paragraph 4.23), and detainees often disclosed issues not otherwise recorded. The PER for one detainee who had been taken to the court from a police station failed to identify any health conditions, despite there being unmarked medication among his property.

4.56 Custody staff said that they frequently received detainees from police custody who had been given medication there, and often told staff that they required further medication during the day, but this rarely accompanied them. This was particularly concerning for detainees with ongoing alcohol and/or drug withdrawal symptoms as there was a risk of severe health complications if they were not dealt with quickly, and we saw some detainees who appeared to be suffering as a result. Staff said that in these cases they would normally ask the court to expedite the detainee's case and that, if remanded to prison, they would arrange their onward transfer at the earliest opportunity, and we saw this happen. Custody staff were aware of the requirements for safe drug administration, and medicines were stored appropriately. When detainees arrived from a police station or prison with their own prescribed medication and clear instructions, staff handed these to detainees at required times for self-medication and recorded this on the PER, which was appropriate. Detainees were allowed to keep some medications, such as asthma inhalers, with them in their cells for use as required.

4.57 Most detainees with mental health issues who arrived from police custody had been seen by mental health staff as part of the Greater Manchester Integrated Custody Healthcare and Wider Liaison and Diversion Service. Northwest Boroughs Healthcare NHS Foundation Trust mental health workers, who formed part of the integrated service, provided an embedded service daily at all the courts, including the Crown courts. Detainees and custody staff told us that these services were invaluable.

4.58 Most custody staff told us that they had received mental health awareness training but few were able to describe their understanding of this or how it had influenced their care for detainees (see also paragraph 2.6). Custody staff demonstrated a reasonable understanding of drug and alcohol issues, but had had no formal training in drug- and alcohol-related risks.

Recommendations

4.59 All custody staff should receive annual first-aid refresher training, to maintain their skills.

4.60 All custody staff should have regular mental health and substance misuse awareness training.

Section 5. Summary of recommendations and good practice

Main recommendations

5.1 Handcuffs should only be used on detainees if this is proportionate and justified by an individual risk assessment. (1.25)

Recommendations

Leadership, strategy and planning

5.2 Staff understanding and implementation of the content of ongoing training and development should be improved. (2.14)

5.3 HM Courts & Tribunals Service (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. (2.15)

5.4 The environment for detainees held in the IAC should be improved. (2.16)

Individual rights

5.5 Cases involving detainees should be prioritised. HMCTS, Prisoner Escort and Custody Services, and the escort and custody contractor should investigate and address the reasons for the prolonged periods that some detainees, including children, spend in court custody cells. (3.15)

Treatment and conditions

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

5.7 Staff should use professional telephone interpreting services, to check on the welfare, risk management and understanding of detainees who speak little or no English, on arrival and throughout their stay in court custody. (4.21)

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

5.9 Custody staff who deal with children should receive specific training, including on the use of minimising and managing physical restraint techniques. (4.23)

5.10 Detainees coming from prison or police custody should be accompanied by a person escort record that includes clear and accurate information of any current risks to themselves or others. (4.36)

5.11 Regular cell checks should be carried out on time, should normally include interaction with the detainee and should be recorded accurately. (4.37)

5.12 Court custody managers should understand the main risks associated with detainees in their suite, and provide a briefing for their staff accordingly. (4.38)

5.13 Searching of detainees should be carried out effectively and consistently across all suites, in line with a policy which restricts it to situations where it is clearly necessary. (4.39)

5.14 All detainees should be helped to prepare for leaving custody with practical consideration of any imminent risks and needs, and with the opportunity to wear their own clothes as they leave. (4.40)

5.15 All court cells should be clean and free from graffiti, and all ligature points should be removed. (4.50)

5.16 Fire drills to practise emergency evacuations should be carried out in all the court custody suites. (4.51)

5.17 All custody staff should receive annual first-aid refresher training, to maintain their skills. (4.59)

5.18 All custody staff should have regular mental health and substance misuse awareness training. (4.60)

Section 6. Appendices

Appendix I: Inspection team

Kellie Reeve	Team leader
Fiona Shearlaw	Inspector
Martin Kettle	Inspector