Report on an announced inspection visit to court custody facilities in

Derbyshire and Nottinghamshire

by HM Chief Inspector of Prisons

23–30 September 2020

Any enquiries regarding this publication should be sent to us at the address below or:
hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England

Contents

Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Cell-sharing risk assessment
A risk assessment undertaken on all prisoners to assess their suitability for sharing a cell. A prisoner assessed as high risk would not normally share a cell.

Minimising and managing physical restraint
A behaviour management and restraint system, aiming to provide secure estate staff with the ability to recognise young people's behaviour, use de-escalation and diversion strategies and apply behaviour management techniques to minimise the use of restraint. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/456672/minimising-managing-physical-restraint.pdf.

National Referral Mechanism
The National Referral Mechanism was put in place in the UK in April 2009 to identify, protect and support victims of trafficking.

Off-bail
A person is received 'off-bail' into court custody directly from the courtroom when they are on bail for offences and have not been detained in custody but are subsequently remanded into custody or given a custodial sentence.

Personal protective equipment
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

Social/physical distancing
The practice of staying two metres apart from other individuals, recommended by Public Health England as a measure to reduce the transmission of COVID-19.

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 five areas:

- leadership and multi-agency relationships
- transfer to court custody
- in the custody suite reception processes: individual needs and legal rights
- in the custody cell: safeguarding and health care
- release and transfer from court custody.

This inspection covered the court cluster in Derbyshire and Nottinghamshire and included six courts with custody facilities, comprising two crown courts and four magistrates' courts. 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 the second inspection of court custody in this cluster and only eight of the 29 recommendations made in 2013 had been achieved.

The restrictions imposed to manage and mitigate the risks of COVID-19 meant the throughput at court custody across England and Wales had declined significantly since April 2020. Video facilities in police stations had instead been used to deal with detainees' first hearings in magistrates' courts and, where necessary, similar technology was used to deal with those in prisons. The system had started to recover by the time we inspected the custody facilities in Derbyshire and Nottinghamshire courts. Court activity and the number of detainees held were still substantially below pre-COVID-19 levels.

HMCTS, PECS and GEOAmey worked together to risk assess the reintroduction of in-person hearings to make court custody safe for detainees and staff who worked there. A risk-assessed and proportionate approach to arrangements, such as searching and handcuffing, had been adopted, which was positive. However, insufficient attention was paid to social distancing (see Glossary of terms), and cleaning regimes were not as thorough or robust as we would have expected. Detainees were not provided with face coverings or encouraged to wear them, nor were they given the opportunity to wash and/or sanitise their hands regularly enough.

Effective communication between the three key agencies responsible for the delivery of court custody is key to ensuring the needs of detainees are recognised and that outcomes for them are good. We found that more needed to be done to understand and address issues that adversely impacted on those in court custody. Formal structures and meetings between the three key agencies had lapsed or ceased since March 2020 and needed to re-focus on improving the detainee experience of custody. While relationships were described as good, there were ongoing issues relating to communication between key personnel to make sure that detainees were dealt with as swiftly as possible and that their time in custody was minimised.

GEOAmey had again secured the contract to deliver court custody and escort services in the region from August 2020. There were sufficient custody staff but they frequently lacked an awareness and understanding of some issues key to managing detainees effectively, such as equality and diversity, mental health, working with children and safeguarding. Despite this, we saw many staff take a generally respectful and empathetic approach towards detainees. They understood the impact custody could have on detainees and focused well on de-escalating potentially volatile situations to avoid having to use force, which was deployed only as a last resort.

The new contract has the scope to deliver changes in the way detainees were treated. Health provision had been radically overhauled and, although it was too early to assess it effectively, the developments were positive. Plans had been somewhat stymied by COVID-19, but we were hopeful that progress would be made soon.

We have made 21 recommendations that we hope will help HMCTS to make the necessary improvements.

Charlie Taylor
HM Chief Inspector of Prisons
November 2020

Fact page

Data supplied by HMCTS Derbyshire and Nottinghamshire Cluster and GEOAmey, Custody and Escort Provider.

HMCTS cluster	Derbyshire and Nottinghamshire
Temporary cluster manager	Sharon Studholme
Geographical area	Derbyshire and Nottinghamshire

Court custody suites and cell capacity

Derby Crown Court	9 cells
Nottingham Crown Court	26 cells
Chesterfield Magistrates' Court	15 cells
Derby Magistrates' Court	23 cells
Mansfield Magistrates' Court	17 cells
Nottingham Magistrates' Court	30 cells

Annual custody throughput

1 September 2019 to 31 August 2020	7,231 detainees

Custody and escort provider

GEOAmey

Custody staffing

Two senior court custody managers
Four court custody managers
Forty-eight prisoner custody officers, including three deputy court custody managers

Background and key findings

S1 Key concerns and recommendations identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.

S2 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.

S3 The inspections of court custody look at leadership and multi-agency relationships; transfer to court custody; reception processes, individual needs and legal rights; safeguarding and health care; and release and transfer from court custody. They are informed by a set of *Expectations for Court Custody,* available at http://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/court-custody-expectations, about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.

S4 HM Inspectorate of Prisons last inspected court custody suites in Derbyshire and Nottinghamshire in July 2013. Since then, there has been insufficient progress and only eight of the 29 recommendations have been achieved.

Leadership and multi-agency relationships

S5 The working environment in courts and court custody had changed significantly since the introduction of restrictions to manage the outbreak of COVID-19. For a short period at the beginning of the outbreak, courts had stopped operating. Operations were subsequently reintroduced, but far fewer detainees experienced court custody due to the implementation of video facilities enabling remote court attendance in police custody suites and greater use of similar technology in prisons. Since June, however, the use of court custody for in-person hearings, had slowly begun to increase.

S6 Multi-agency risk assessments had been completed to make court custody safer for staff and detainees and certain arrangements contributed to safer working practices. We were, however, concerned that insufficient attention was paid to social distancing. Cleaning regimes were not as effective as they should have been, and touchpoints and vehicles were not wiped down regularly or between use. Detainees were not routinely or comprehensively briefed about the impact of COVID-19 on their court custody experience and were not provided with face coverings or encouraged to wear them. Not all staff wore personal protective equipment (see Glossary of terms) (PPE) when interacting with detainees in close proximity. Detainees could not wash or sanitise their hands regularly enough.

S7 At a strategic level, inter-agency relationships between HM Courts & Tribunals Service (HMCTS), prisoner escort and custody services (PECS) and GEOAmey had been affected by the lack of face-to-face contact. Multi-agency meetings, where outcomes for detainees were discussed, lacked an appropriate focus or had lapsed during the COVID-19 crisis. Managers from the three key agencies described good relationships and a shared aim to deliver good

outcomes for detainees. However, this aim was not always realised, for example, the commitment to prioritise court custody cases did not always happen in practice, which meant detainees potentially spent longer in custody than necessary.

S8 There were sufficient court custody staff. They were properly vetted and received adequate initial training, but there were gaps in their ongoing development and awareness in key areas, including in safeguarding, equality and diversity, working with children and mental health.

S9 Since the outbreak of COVID-19 there had been no external scrutiny of court custody.

S10 Data were not collated or analysed sufficiently robustly nor were they used well enough to drive required improvements in outcomes for detainees.

Transfer to court custody

S11 Although they were not wiped down between use, vehicles were generally clean and well equipped. Secure vehicle docks meant detainee privacy was maintained and detainees we saw were disembarked promptly. Detainees arrived at court adequately dressed.

In the custody suite: reception process, individual needs and legal rights

S12 Staff behaved respectfully towards detainees and interactions were friendly. Most staff showed kindness and empathy and the detainees we met were content with their treatment. In some courts, detainees' full names were displayed where they could be seen by other detainees, which undermined confidentiality.

S13 Most staff had little formal or effective training in equality and diversity, but most understood the importance of meeting detainees' individual needs. Some courts used telephone interpreting services to ensure they understood the needs of non-English-speaking detainees, but this was not the case everywhere. In some courts, menstrual care products were not always freely available. Every court had a religious artefacts box and a log of items issued, but some courts had decided not to issue religious artefacts during the pandemic. Most court custody staff were not confident when it came to explaining GEOAmey's policies, particularly on the treatment of transgender detainees or those with non-physical disabilities.

S14 There was no consistent assessment of detainees' risks on arrival. Interactions with detainees were generally brief and often conducted without consulting person escort records (PERs). The information on risk factors in PERs was frequently not precise enough to be of any use and contained acronyms that court custody staff were often unaware of. Staff were, however, aware of and able to explain the signs of vulnerability, instability or low mood, which they looked for in detainees. The assessment for detainees who arrived off-bail (see Glossary of terms) directly from court was more thorough.

S15 Comprehensive staff briefings did not always take place. There was confusion among staff about the designated frequency of observations, but we saw checks being conducted when they were meant to be. Cell call bells were answered promptly. All staff carried anti-ligature knives. There were enough affray alarms along the routes to the courts.

S16 Working with the responsible HMCTS staff, custody staff attempted to prioritise custody cases, particularly those involving women, children and vulnerable detainees. However, for a variety of reasons this was not always achieved, and some detainees were not held for the

minimum possible time. Delays happened for a variety of reasons and were sometimes due to the non-attendance or late arrival of court-appointed interpreters and legal representatives. We saw evidence showing that many detainees remanded or sentenced in the morning were moved to prison at lunchtime or in the early afternoon, which was positive. Once the court requested a detainee's attendance, they were presented without delay.

S17 Information about detainees' rights was placed in each cell prior to a detainee's arrival, but staff did not always check if detainees could read or understand the documentation. Consultation rooms were available in all custody facilities but were not always sufficiently soundproofed.

S18 Notices detailing the complaints process were placed in each cell, but they were not always explained to detainees. Staff demonstrated a reasonable awareness of complaints procedures. Only a small number of complaints was received.

In the custody cell, safeguarding and health care

S19 The condition of cells across the custody estate varied. Those in the two private finance initiative sites at Chesterfield and Derby magistrates' courts were generally good, but others were less well maintained and grubby in places. There was graffiti in all custody suites, some of which was extensive and offensive and which staff had become inured to. Few cells had natural light and some were cold. There were potential ligature points in most of the suites: we provided an illustrative report detailing them during the inspection, which HMCTS responded positively to. Communal toilets were mostly clean but not always sufficiently private. There was no hot water at any of the handwashing facilities at Nottingham Crown Court, which was unacceptable. Maintenance arrangements were generally effective, but we were informed of some delays. Fire evacuation plans were not prominently displayed in all the suites and emergency evacuation drills were not carried out regularly enough, which potentially posed a significant risk.

S20 Force was not used frequently against detainees and we were confident that all incidents were recorded. Staff we spoke to focused on de-escalating incidents and using force only as a last resort. Overall, force used on detainees, described in the incident reports we viewed, appeared to be necessary and proportionate in the circumstances. Notwithstanding some missing statements, staff generally submitted individual reports to justify why they had used force, but these written accounts were not always sufficiently detailed and quality assurance was inconsistent. The response to COVID-19 and changes brought about by the new contract had led to a more proportionate approach to handcuffing and searching.

S21 Detainees we spoke to said they had been treated well during their time in court custody. Food preparation areas were clean at all courts except Nottingham Crown Court. Detainees were routinely offered a drink, but not food, on arrival. There was a reasonable choice of microwave meals and snacks. Distraction activities were available, but at most sites the range of reading material was too limited. The available resources were not always promoted.

S22 There was no overarching HMCTS safeguarding protocol. The GEOAmey standard operating procedure was not well promoted and court custody staff did not understand it well enough. Most staff were not aware of the safeguarding team or referral mechanisms and no safeguarding referrals had been made in the year before the inspection.

S23 Relatively few children experienced court custody. When accompanied by specialist trained staff, children were generally held in interview rooms rather than cells and had access to distraction activities. Otherwise, they were treated the same as adults. Staff had a limited

awareness and understanding of the GEOAmey children's safeguarding and child protection policies. Few court custody staff had yet been trained in minimising and managing physical restraint (MMPR) (see Glossary of terms) techniques for use with children. Instead they relied on control and restraint techniques designed for adults, and had used them on children four times in the previous year. However, all use of force against children was scrutinised and referrals were made to the local authority if necessary.

S24 Detainees' health risks were reviewed nationally and a new health contract suggested a more responsive and timely level of health care provision was now available. However, as these changes were so recent, and activity in courts was more limited due to COVID-19, it was too early to assess the outcomes for detainees. Revised governance arrangements were in the process of being implemented. The framework for medical and paramedic registration, training and supervision appeared comprehensive.

S25 All custody staff we spoke with knew what do in a health emergency and every three years undertook First Aid at Work training, but there were no arrangements to make sure such skills were retained and first aid equipment on site was limited. Specialist mental health input into court and custody areas was good, and clinical governance processes were comprehensive. Detainees had access to clearly labelled and authorised personal medication, which was held with their property.

Release and transfer from court custody

S26 Staff did not prepare pre-release risk assessments with detainees to identify their needs on release, but could explain how they would safeguard detainees at risk of self-harm. Some detainees who arrived from prison experienced lengthy waits for the prison to complete release checks, which was unacceptable. Each court had a list of community support organisations, but it was not routinely handed out to released detainees. Managers made telephone calls on behalf of detainees and provided face coverings and travel expenses. Detainees who were remanded or sentenced were not given up-to-date information concerning COVID-19 or what might happen as a result in their onward custodial destinations.

Key concerns and recommendations

S27 Key concern: We were concerned that the daily operational response to managing and mitigating the risks associated with COVID-19 was not consistently good enough across all custody facilities. Insufficient attention was paid to social distancing. Cleaning regimes were not as effective as they should have been and touchpoints and vehicles were not wiped down regularly or between use. Detainees were not routinely or comprehensively briefed about the impact of COVID-19 during their time in court custody and were not encouraged to wear or provided with face coverings. They were not able to wash or sanitise their hands regularly enough. Some staff were unaware of new arrangements, which meant detainees should only be searched following a risk assessment and they did not always wear PPE when interacting with or searching detainees in close proximity.

Key recommendation: The three key agencies should collectively make sure that working practices consistently focus on managing and mitigating the risk of COVID-19 transmission, in particular by paying attention to social distancing, cleaning and hygiene and by wearing PPE when interacting with or searching detainees.

S28 Key concern: Detainees' cases were not always prioritised, which meant some were held in court custody for longer than necessary. Delays occurred:

- when courts did not start promptly in the morning
- due to the late attendance of legal representatives
- due to the late or non-attendance of court-appointed interpreters
- for some detainees who arrived at the court in the morning but who did not appear in court until after lunchtime
- when waiting for a governor to formally authorise a detainee's release from prison
- for some children while awaiting receipt of a placement order so they could be moved to their place of detention.

Key recommendation: Detainees in court custody should have their cases prioritised and heard promptly. They should be held in custody for the minimum possible time and the reasons for delays should be explored and addressed.

S29 Key concern: Training and development activities were not always sufficient. Custody staff often lacked sufficient understanding of key policies and procedures, particularly in equality and diversity, safeguarding, working with children and mental health and substance misuse awareness, and often failed to implement them satisfactorily. This meant we were not convinced that detainees would be treated in line with policies or that concerns would be identified and appropriate referrals made if required.

Key recommendation: The approach to delivering training and development to custody staff should be improved to ensure they understand what is required of them and can implement what they have learned in safeguarding, equality and diversity, working with children and mental health and substance misuse awareness.

Section 1. Leadership and multi-agency relationships

Expected outcomes:
There is a shared strategic focus on custody, including the care and treatment of all those detained, during escort and at the court, to ensure the well-being of detainees.

1.1 HM Courts & Tribunal Service (HMCTS) in Derbyshire and Nottinghamshire 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, which commissioned and managed the contract provision; and GEOAmey, the contracted service provider. GEOAmey had retained responsibility for the new contract awarded in August 2020. This was the second inspection of court custody in this cluster. There had not been enough focus on implementing recommendations made at the last inspection in July 2013 and only eight out of twenty-nine had been achieved (see paragraph S4).

1.2 Efforts to manage and mitigate the risk and impact of the COVID-19 crisis meant courts had stopped operating for a time, and the requirement for court custody ceased almost entirely in April and May 2020. Hearings for those remanded in custody by the police were generally conducted via video technology in police stations and crown court trials were significantly curtailed. Recovery plans led to an increase in the number being held in court custody from June, but even during our inspection, the numbers were still much lower than usual.

1.3 The three agencies had worked well together to implement risk assessments aiming to make court custody safe for detainees and staff during the COVID-19 pandemic. Action included limiting the number of detainees, custody staff and visitors who could be present in custody suites at any given time, as well as changing some working practices, such as searching and handcuffing, all of which helped limit the spread of the virus. We did, however, have some significant concerns about how staff responsible for the daily operation of custody and escorts were managing the response to COVID-19. Staff frequently failed to socially distance from each other and detainees, and when searches were undertaken, staff did not always wear personal protective equipment (PPE) (see paragraph 4.10). We were told that cleaning regimes had been reviewed and improved, but we found some dirty cells and did not see extensive evidence of effective 'touchpoint' cleaning throughout the working day. Escort staff advised us that cellular compartments in vehicles were not sanitised between use. Detainees were not briefed or consistently provided with information about the impact of COVID-19 on their stay in court custody. Staff did not routinely wear face coverings and detainees were not encouraged to wear or provided with face coverings during interactions in the custody suite. Nor were they encouraged to or provided with adequate facilities to wash and/or sanitise their hands regularly enough. (See key concern and recommendation S27.)

1.4 HMCTS had a clear line management structure for the cluster, where four magistrates' and two crown courts operated. In normal circumstances, HMCTS managers visited custody suites regularly to conduct audits, but despite many not being on site in recent months, the audits were still recorded as having been completed. In some instances, no action was taken when issues were raised consistently. For example, no one seemed to understand whose responsibility it was to address the lack of hearing loops or information in Braille, which meant these and other shortfalls continued month on month.

1.5 HMCTS was responsible for the upkeep of court buildings, including custody facilities. It contracted a private provider to undertake the cleaning and maintenance in four courts,

while a separate contractor was responsible for the two private finance initiative facilities. HMCTS was frequently the conduit between custody staff and cleaning and maintenance contractors, which worked reasonably well. Oversight of the cleaning and maintenance arrangements was generally good and included escalating issues where necessary. However, contractual complexities and budgetary constraints made some maintenance work difficult to progress, particularly costly work. (See paragraphs 4.1 and 4.5.)

1.6 When interviewed, managers from each of the key agencies described their shared aim as being to ensure detainees were held in good conditions and were treated well. They all maintained that relationships between them to achieve this were good and that communication was effective. Some formal meetings and face-to-face interactions had lapsed or ceased since the start of the pandemic, and the focus on detainee care and welfare was not clearly evident from the meeting minutes we were provided with. Much ongoing communication was informal and was generally sufficient to maintain reasonable working relationships.

1.7 The listing of court cases was a judicial responsibility and process, but an HMCTS listings protocol allowed for custody cases to be prioritised. There was a broad commitment to do this, but it was not always achieved. Some custody staff did not feel relationships were as positive as they should have been in this area. They repeatedly shared their frustrations – they believed detainees were not always prioritised for court and frequently spent too long in custody unnecessarily, while their representations to expedite cases were often not taken into account. From a strategic perspective, more needed to be done to determine and address the range of issues, which were potentially adversely affecting detainees. (See key concern and recommendation S28 and paragraphs 3.23 to 3.24.)

1.8 GEOAmey staffing levels in court custody were now sufficient and officers were properly vetted. Initial training for custody staff was generally adequate and there were opportunities for ongoing development. GEOAmey had a comprehensive range of policies and procedures that staff could refer to, but they repeatedly told us that they were not aware of the policies or their content and did not understand what was required of them in a number of important areas. With the exception of control and restraint, many staff struggled to articulate the content of policies, training or awareness sessions they had participated in or describe how they used them in their dealings with detainees. This was particularly acute in safeguarding, equality and diversity, dealing with children and mental health awareness and was a concern during our last inspection. (See key concern and recommendation S29.)

1.9 At the time of the inspection, there had been no external scrutiny of court custody since the beginning of the COVID-19 crisis. Prior to that independent lay observers visited court custody suites regularly to observe the conditions in which detainees were held and their treatment.

1.10 There were gaps in the data we received. Different agencies were responsible for different aspects of the work and no single organisation collated or analysed the whole range of data to inform action to address any shortfalls affecting detainees. For example, we received several varying figures for the staffing complement, throughput of detainees and use of health provision. There was very little demographic breakdown or analysis of data on detainees. Data on the use of telephone interpreting showed that it was used less frequently than expected. Very limited action was taken to determine what issues the data revealed or to address them.

Recommendations

1.11 Relationships and communication between the three key agencies should be reinforced to ensure a consistent focus on delivering good outcomes for detainees.

1.12 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.

1.13 Comprehensive data covering all activity in court custody should be collated and analysed so that action can be identified and taken to address any shortfalls.

Section 2. Transfer to court custody

Expected outcomes:
Escort staff are aware of detainees' individual needs, and these needs are met during escort.

2.1 Detainees had reasonably short journeys from local prisons. Records showed that escort staff regularly checked detainees' welfare during transit. Some vehicles contained small amounts of graffiti, but they were generally clean. Cellular compartments were, however, not wiped down between use (see key concern and recommendation S27 and paragraph 1.3). Vehicles were generally well equipped with amenities such as water, disposable urinal bags, menstrual products and first aid kits. We did not see any women, children or adult men in the same vehicle, but staff told us that when they did share vehicles, a partition screen was used to separate them.

2.2 All courts had secure vehicles docks, preventing detainees from being seen by the public and adequately maintaining their privacy and dignity. Detainees were disembarked promptly from vehicles. They were adequately dressed, but some advised us they had been unable to access smart clothes because of restrictions imposed by the prison they had come from.

2.3 All detainees were accompanied by person escort records, which were handed to custody staff on arrival. Escorting staff also provided a verbal briefing to highlight any known risks, incidents or exchanges that had taken place while detainees were in their care.

Recommendations

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

2.5 Detainees should be able to wear clothing of their own choice when appearing at court.

Section 3. In the custody suite: reception processes, individual needs and legal rights

Expected outcomes:
Detainees receive respectful treatment in the custody suite and their individual needs are met. Detainees are held in court custody for no longer than necessary, are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

3.1 Staff interacted respectfully with detainees. They were friendly and often used first names, especially with detainees they knew well. Most staff showed kindness and empathy and spoke about detainees professionally, explaining how they listened and talked to detainees to help them manage stressful situations. In some courts, regular observations could have been used more proactively to build relationships with detainees (see paragraph 3.13), but the detainees we met were content with their treatment.

3.2 Detainees were sometimes asked personal questions while standing in an open reception area, where several staff could see and hear them. This lack of privacy had the potential to deter them from providing full and honest answers and to compromise efforts to identify detainees' risks and needs (see paragraph 3.12). However, we also saw a newly sentenced woman being interviewed in suitably private conditions.

3.3 In several courts, detainees' full names were displayed on a white board where they could be seen by other detainees, which undermined confidentiality.

Recommendation

3.4 Personal information about detainees, including names, should be kept confidential, especially from other detainees.

Meeting individual and diverse needs

3.5 Most staff understood the importance of meeting detainees' individual needs and could describe occasions where they felt they had managed their specific needs well. However, staff of all grades had little formal training in equality and diversity and what was delivered was not always effective. There was often an over-reliance on informal briefings and on staff reading standard operating procedures without any mechanisms to check their understanding or how they would implement their learning to make sure the diverse needs of detainees were consistently met. Staff we spoke to often lacked confidence when asked to explain GEOAmey's policy, particularly on transgender detainees. Many staff said that they would have welcomed additional training to help them understand and manage detainees with mental health issues. (See key concern and recommendation S29.)

3.6 Nottingham Magistrates' Court was the only facility that complied with the Equality Act. It was accessible for wheelchair users, but we were told that the lifts to courts were unreliable. The accessible cell had a wide door and low cell call bell so that it was suitable for a wheelchair user, and there was an adapted toilet. Most of the courts did not have a hearing

loop in their custody suites. No documentation was available in Braille, but information on detainees' rights, including female detainees' rights, and complaints was available in 26 languages. Custody staff had a limited awareness of how detainees with non-physical disabilities would be identified and supported. Staff described the transport options available for detainees with specific needs and we saw staff ordering a non-cellular vehicle for a detainee with claustrophobia. There were no specific services for elderly or young adult detainees.

3.7 Staff in some courts spoke confidently about using the telephone interpreting service to make sure they understood and met detainees' needs. This was most notable in Derbyshire crown court and Chesterfield magistrates' court. However, in other courts staff relied on hand signals or court appointed interpreters, who generally did not arrive until hours after the detainee. Neither the use of hand gestures nor awaiting the arrival of interpreters were satisfactory solutions, particularly when all suites now had facilities to access telephone interpreting services. The under-use of telephone interpreting was a concern during our last inspection. Some teams felt that they needed a manager's permission to use telephone interpretation or did not have ready access to the relevant telephone number and codes. Despite the existence of a suitable portable phone in each location, some staff still did not understand that the prompt identification of detainees' risks and needs was of paramount importance for their safety and welfare. Some staff seemed unaware that this required a conversation in which the detainee could express their thoughts and feelings and ask questions. This failing was related to weaknesses in risk assessments on arrival (see paragraph 3.12.) We were not confident that foreign national detainees would be allowed to contact their embassy or consulate.

3.8 Women were held separately from men and in each court the staff team included women officers. All courts had a stock of menstrual care products, but they were not always freely available. In some courts, the products were not always hygienically stored. Sanitary disposal bins were available in all courts.

3.9 Every court had a religious artefacts box and a log of items issued. We found that some smaller items, such as a compass, were missing from the boxes, but staff could generally tell Muslim detainees the appropriate direction to face during prayer. Some courts had decided not to issue religious artefacts during the pandemic because of concerns about infection. We considered that this was disproportionate and that hygiene concerns could have been managed by enabling detainees to wash their hands after use (see key concern and recommendation S27 and recommendation 4.14).

Recommendations

3.10 Staff should use telephone interpreting services whenever necessary to check on the welfare, risks and understanding of non-English speaking detainees.

3.11 Women detainees should have access to menstrual care products without having to ask for them.

Risk assessments

3.12 As we found at the last inspection, there was still no systematic assessment of detainees' risks on arrival. Staff's initial interactions with a detainee were often brief and most conversations were not conducted in private, with the potential to inhibit the disclosure of any information relating to a detainee's risks and vulnerabilities (see paragraph 3.2). Although detainees arrived from prisons, and pre-COVID-19 from police stations, with a person

escort record (PER), staff often only referred to them once the individuals had been located in cells. Many of the PERs we checked were poorly completed, containing vague risk information, for example, 'under mental health' or 'self-harm', which did not assist custody staff in adequately assessing risks or in looking after detainees (see also paragraph 4.28). They also frequently contained acronyms that staff did not always understand and therefore would not have been able to respond appropriately. Staff had a basic checklist as a guide for all new receptions, but they did not use it consistently, and it placed too much emphasis on how to process detainees, without focusing sufficiently on identifying and managing risks. The reception and risk assessment for detainees received off-bail directly from the court was more thorough.

3.13 Staff, however, explained how they would ask detainees relevant general questions sensitively to identify any signs of vulnerability, instability or low mood so they could manage their individual risks. Staff told us that if a detainee was identified as presenting a risk of self-harm, pre-COVID-19 they would have considered allowing them to share a cell with another detainee subject to a cell-sharing risk assessment (see Glossary of terms). However, this was not now possible due to social distancing measures. Staff stated the detainee would instead be subject to an enhanced level of checks or perhaps placed under constant supervision if necessary. Despite the confusion about the frequency of these enhanced checks (see paragraph S15), those we observed were carried out at appropriate times. However, staff interactions with detainees were often limited, which meant they missed the opportunity to monitor them for any changes in mood or behaviour (see paragraph 3.1). Checks were clearly communicated to the staff member responsible for recording them on the electronic custody recording system. Not all staff conducting checks wore face coverings when doing so. (See key concern and recommendation S27 and paragraph 1.3.)

3.14 All custody staff should have received a comprehensive briefing to inform them of the risks relating to the detainees in their care. However, briefings did not always take place, the standard of them varied and they did not always impart relevant information about detainees, such as the risks they posed or the level of checks required.

3.15 Cell call bells were tested every morning and were clearly audible. Detainees who were new to court custody were advised how to use them when they were located in cells. The bells were answered promptly. Access to affray alarms along the routes to court, which did not pass through public areas, was adequate. All court custody staff carried anti-ligature knives which was an improvement since the last inspection.

Recommendations

3.16 A PER that includes comprehensive, clear and accurate information about a person's risks to themselves or others should accompany all detainees.

3.17 The assessment of each detainee's risks on arrival in custody should be carried out consistently and should take account of all relevant information.

3.18 All staff should receive a thorough briefing covering the risks presented by detainees while held in court custody.

Individual legal rights

3.19 The data we analysed, showed a reasonable proportion of cases was dealt with before the court broke for lunch. Custody staff were committed to prioritising cases involving women, children and vulnerable detainees. However, for a variety of reasons custody cases were not

always prioritised, which meant some detainees potentially spent too long in court cells unnecessarily. (See key concern and recommendation S28 and paragraph 1.7.)

3.20 Courts did not always start promptly in the morning. There were some significant delays before detainees were presented at court, for example, in one court, the only detainee in custody did not appear in court until 12.33pm and the reason for this was unclear. We were told the courts did not always progress custody staff's requests to prioritise cases, such as those of vulnerable detainees, but the reasons for this were also unclear. At one court, we were advised there was no mechanism for requesting cases to be prioritised because the relevant team meetings had been suspended. (See paragraph 1.7.)

3.21 We were told that legal representatives often chose to deal with other matters before attending custody to deal with their clients, which delayed their consultations and potentially prevented cases from being heard promptly. Legal representatives sometimes claimed they were held up because of delays in transferring electronic case papers, which ensured they were fully informed of their clients' case before meeting with them. (See key concern and recommendation S28.)

3.22 Non-English speaking detainees were sometimes held in court custody for longer than necessary because court-appointed interpreters were delayed or did not attend court. We were told this could, on occasion, result in detainees being remanded to prison for an additional night. We identified one case where a detainee did not appear in court until 3pm because an interpreter failed to attend in the morning. (See key concern and recommendation S28.)

3.23 We observed delays in detainees appearing in court promptly after their arrival – one detainee who arrived in the early morning was not dealt with until after 3.30pm. There were gaps in the data supplied to us, but we found that, in the four weeks from 3 August 2020, at least 25% of detainees appearing at the crown courts were not dealt with until after 2pm. It was likely that this was because cases were not being listed until the afternoon, but it still unnecessarily extended the detainees' length of stay in court custody. (See key concern and recommendation S28.)

3.24 Once the court had asked for the detainee to attend, they were presented without delay. When detainees did appear in court in the morning and were remanded or sentenced before lunchtime, in most cases they were moved to prison at midday or in the early afternoon. This was an improvement and was now a key benefit of the new escort contract.

3.25 Printed information outlining detainees' rights were placed in cells during the daily checking process for each custody suite. On arrival at court, not all detainees were asked if they could read or understand the document. Staff told us if a detainee said they could not read, their rights would be read to them (see also paragraph 3.6).

3.26 Custody staff at all courts asked detainees when they arrived for the name of their legal representative and processes were in place to ensure they were informed that their clients were in custody. The number of useable consultation rooms had been reduced to allow for social distancing, and there were enough to meet the demand, but they were not always sufficiently soundproofed. Detainees could keep legal documents relating to their case with them, and pencils and paper were available so they could prepare notes.

3.27 Court custody staff told us that if a detainee wanted to tell somebody where they were, they would either make the call on their behalf or would refer the matter to the detainee's legal representative. We saw staff checking with detainees that a relative or friend knew they were in court custody.

Recommendation

3.28 HM Courts & Tribunals Service should ensure that consultation rooms are soundproofed to ensure confidentiality.

Complaints

3.29 The overall approach to complaints had improved since the last inspection. Notices about the complaints procedure and the right to appeal to an independent body were placed in each cell before a detainee's arrival. They were pointed out to some detainees, but staff offered no further explanation about the purpose of them. Court custody staff had a reasonable awareness of the complaints procedure. We were told that all detainees were asked on their release if they had any issues with their time in custody and if they did, they were handed a complaint form, but there was no similar process for detainees being transferred to another custodial establishment. Data supplied by GEOAmey showed that nine complaints had been received during the 13-month period from 1 July 2019, of which only one was upheld.

Section 4. In the custody cell, safeguarding and health care

Expected outcomes:
Detainees receive respectful treatment in the custody suite and their individual needs are met. Detainees are held in court custody for no longer than necessary, are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Physical environment

4.1 The condition of cells across the custody estate varied and some of the issues raised in our last report remained a concern. Those in the two private finance initiative suites at Derby and Chesterfield magistrates' courts, were clean and in a good state of repair. Others were less well maintained and were grubby in places, which was unacceptable during a pandemic and when use was so low. Most cells lacked natural light and some were cold. Staff could not control the heating but, where possible, managed by moving detainees to warmer cells. We carried out checks on a random sample of cells in each suite, including at Mansfield Magistrates' Court, which was not in use during the inspection, and found potential ligature points in most suites, some due to poor maintenance. An illustrative report was provided to HM Courts & Tribunals Service (HMCTS) at the end of the inspection, which was responded to positively.

4.2 Staff conducted daily 'opening checks' in the custody suites. While some cell checks were thorough, others simply involved finding out if the cell call bell was functioning and if the rights and complaints documentation was present. Checks did not focus on graffiti or damage, to which some staff had become inured. This could have explained why we found so much graffiti in cells, some of which was extensive and offensive, which staff were either not aware of or which had not been reported.

4.3 Communal toilets were generally clean but not all were sufficiently private. For example, at Nottingham Magistrates' Court, one was overlooked by glass fronted cells nearby and at Mansfield Magistrates' Court, there was a urinal in a glass fronted observation cell, which anyone standing in the main reception area could see. There was no hot water in any of the handwashing facilities at Nottingham Crown Court, which was unacceptable, particularly with the need for extra vigilance regarding cleanliness. Toilet paper, paper towels and liquid soap were mostly readily available. However, at Nottingham Crown Court, the lack of dispensers meant paper towels were not stored hygienically, and cardboard boxes were used for waste disposal purposes. At Nottingham Magistrates' Court, there was no liquid soap, but bars of soap could be issued to detainees, although this did not always happen in practice.

4.4 Regular cleaning arrangements were mostly reasonable, although we did find some cells that were dirty. Additional 'touchpoint' cleaning had been introduced in all the courts and cleaners attended the custody suites at 11am and 2pm to wipe down door handles and communal work surfaces. However, touchpoint cleaning was often cursory and rarely included the cells or communal toilet areas. (See key concern and recommendation S27 and paragraph 1.3.)

4.5 There was a system at all courts for reporting maintenance defects and they were generally dealt with promptly. The length of the delay in repairing defects was influenced by the cost

and nature of the repair. For example, a fire door damaged by a detainee in February 2019 at Mansfield Magistrates' Court had not been replaced. At Nottingham Crown Court three cells were out of use, but we could not find a record in the suite of when they had been withdrawn from service or what faults had been reported.

4.6 Fire evacuation plans were not always prominently displayed. Those that were, did not always identify the primary or secondary evacuation route. Most suites did not have fire exit signs. Very few custody staff we spoke to had been involved in a fire evacuation drill and emergency procedures were not practised frequently, which did not meet health and safety requirements. None of the custody suites held records to confirm when staff had previously taken part in an evacuation drill.

Recommendation

4.7 Fire drills to practise emergency evacuations should be carried out at least annually in all court custody suites.

Use of force

4.8 The number of incidents involving the use of force was low. Most custody staff were up to date with their control and restraint training. They were focused on defusing anxieties and communicating with detainees to de-escalate situations with the potential to avoid using force. From our review of records and after speaking to staff, we were confident that all incidents were recorded and that force was only used as a last resort.

4.9 We examined 28 records where force had been used. Much of it was low level, for example to prevent self-harm or to remove reluctant detainees from the dock when their case had been completed. The standard of written records generally demonstrated that the use of force was necessary and proportionate to the risk or threat posed. However, a number of individual statements were missing and some lacked sufficient detail. Quality assurance processes were inconsistent, although some robust action had been taken to address one case where force was considered to have been excessive.

4.10 At the outset of the COVID-19 crisis, working practices in court custody had been reviewed and the decision taken that the close proximity required for handcuffing and searching, meant they should only take place following a risk assessment. This was further reinforced by changes to the new contract implemented in August 2020. We welcomed these changes which represented an improvement since our last inspection. During the inspection, we saw very little searching or handcuffing and welcomed this proportionate and individual approach. Some staff were, however, unaware of the new arrangements or of the requirement to wear personal protective equipment (PPE) when carrying out searches. (See key concern and recommendation S27.)

Recommendation

4.11 The standard of individual statements accounting for the use of force against detainees and related quality assurance processes should be improved.

Detainee care

4.12 There had been some important improvements to the approach to looking after detainees since our last inspection. Detainees we spoke to said they had been treated well in court custody. All were offered a drink on arrival and at lunchtime, and we saw further drinks being provided on request. Detainees could choose from a range of microwave meals at lunchtime, and most dietary requirements were catered for. Biscuits and crisps were also available. At Nottingham Crown Court, the stock of meals was too limited and we found that the microwaves and fridge were not clean enough. Staff there also told us food would only be offered at lunchtime even if the detainee was hungry at other times. Elsewhere, the choice and provision were reasonable and food preparation areas were sufficiently clean.

4.13 Each court had a range of distraction activities. Copies of a free newspaper were brought in by staff at some courts and were popular with detainees. Some courts routinely offered detainees activities, such as word searches and crosswords, but this did not happen everywhere, even though all sites had access to the material. Each site had some books, but the stock did not cater for detainees' diverse needs and at some courts staff told us that the books could not be issued because of COVID-19 (see paragraph 3.9). Boxes of games were available at each site but had not yet been used and some staff believed they were only for children.

Recommendation

4.14 Managers should implement a COVID-19-secure method for issuing distraction activities and religious artefacts.

Safeguarding

4.15 There was still no overarching HMCTS safeguarding policy on protecting detainees, including children, from harm, abuse or maltreatment. GEOAmey had its own standard operating procedures, but they were not as comprehensive as we would expect. For example, they did not include details of the National Referral Mechanism (see Glossary of terms). Policies were not well promoted and many staff told us they were not aware of the safeguarding team or manager. Most custody staff we spoke to had an extremely limited understanding of adult safeguarding and referral mechanisms. (See key concern and recommendation S29.) We were not satisfied that concerns would be identified or addressed consistently and no referrals had been made in the year preceding the inspection (see recommendation 1.12).

Children

4.16 Only a small number of children were held in court custody. GEOAmey had its own child protection and safeguarding policies, but they were not widely promoted or understood. Most custody staff we spoke to had received little or no training on dealing with children and few staff understood their distinct needs. (See key concern and recommendation S29.) However, the new contract had a greater focus on working with children and specific training had begun to be rolled out.

4.17 The relatively few children escorted to and from local authority accommodation or secure training centres were accompanied in non-cellular vehicles by trained staff. We were told that these children would often be held in interview rooms rather than cells and that the escorting staff would remain with them and could provide them with activities to keep them

occupied. The experience for other children, generally those received directly from police custody, was described to us as being less positive – they were not accompanied by specialist staff and would generally have a similar experience to an adult. They were separated from adults, but they were generally accommodated in cells, travelled in cellular vehicles (often with adults) and their vulnerability was not specifically considered.

4.18 Although plans were in place to increase the number of trained custody staff, very few had currently received trained in minimising and managing physical restraint techniques (MMPR). Instead they used control and restraint, which was not suitable for children but had been used on four of them in the previous year. The safeguarding team reviewed all incidents involving force against children and liaised with the relevant local authority to make safeguarding referrals if necessary. No referrals had been made in the year before the inspection.

4.19 Children who were remanded in custody or who received a custodial sentence required a placement order specifying where they would be detained. Documentation detailing the times placement orders were received were not always readily available, but we found evidence of some delays, including nearly six hours at Chesterfield Magistrates' Court. Once the placement order had been received, children were generally moved to their onward place of detention reasonably quickly but delays meant they could arrive there late in the evening.

Recommendation

4.20 Children should be moved promptly to places of detention when remanded in custody or receiving a custodial sentence.

Health

4.21 Health risks during court custody had been subject to a national review. It had helped to steer the health contract, which had been revised in August 2020. As a result, a more responsive and timely level of provision was now available. However, as these changes were so new, and activity in courts was more limited due to COVID-19, it was too early to assess the outcomes for detainees.

4.22 The revised governance framework for health care incorporated scrutiny of clinical activities and operational performance and took into account service developments. Initial meetings had rightly focused on implementation, but it was too early to review any tangible clinical activities.

4.23 Custody staff had access to a telephone helpline that provided clinical advice on detainee health issues. The helpline could now also give detainees access to medical consultations via a web-enabled tablet device and paramedics could be sent to the suites to undertake assessment, provide treatment and offer essential medication if necessary. The paramedics were expected to reach 70% of custody facilities within one hour, which was a significant improvement on previous arrangements. The profile for medical and paramedic training, as well as proposed supervision arrangements, appeared comprehensive.

4.24 In the previous 12 months, the helpline had been used 27 times, mostly for advice and medicine authorisation. The helpline was well advertised and court custody staff knew how to access health advice and make referrals for a medical opinion, including when they had concerns about a detainee being physically and/or mentally well enough to attend court.

4.25 All court areas we visited had retained specialist mental health input, despite COVID-19 restrictions. The input was provided by Derbyshire Healthcare NHS Foundation Trust and Nottinghamshire Healthcare NHS Foundation Trust. An 'all-age, all-vulnerabilities' model had been developed by both the specialist health providers. This enabled effective court decisions to be made and detainees to be diverted from custody, as well as direct care to be provided to detainees. Clearly identified pathways involving community link workers covered the spectrum of vulnerabilities, including substance and alcohol misuse. Although some community support had been reduced, most of the provision had been retained. During the inspection, mental health practitioners were still supporting detainees in custody, providing a level of timely and responsive input, which custody staff valued. Mental health commissioning, oversight and clinical governance processes were all comprehensive.

4.26 All custody staff we spoke with were confident about dealing with a health emergency and were familiar with the revised post-COVID-19 resuscitation guidelines. Every three years custody staff undertook First Aid at Work training. This was not sufficient to maintain competence or to make sure their skills were retained. Onsite first aid equipment was limited, with no access to oxygen or resuscitation devices. Automated external defibrillators (AEDs) were located elsewhere in the court buildings, but systems for retrieving them were ad hoc, which was a concern raised during our last inspection.

4.27 The prisoner escort and custody services contractor had an operating policy that included escalation processes. Additional health awareness training sessions had been developed to make sure these aspects were brought to the attention of all custody staff, but few of them had participated. Some custody staff had been identified as mental health champions and had received mental health awareness training, but the approach appeared to be voluntary rather than part of a systematic training programme to improve care for detainees. (See key concern and recommendation S29.) Most custody staff had a common sense understanding of drugs and alcohol issues, but they did not receive any training on drug- and/or alcohol-related risks. (See key concern and recommendation S29.)

4.28 Some of the person escort records (PER) scrutinised during the inspection did not capture sufficient critical health interventions information (see also paragraph 3.12). Inspectors were unable to review any real-time clinical health records, but both mental health trusts held separate records that were secure and we were informed that they routinely shared risk-based information with relevant agencies when required.

4.29 Arrangements were in place to improve detainees' access to simple over-the-counter medicines and facilitate a limited range of risk-based prescribing for alcohol withdrawal, opiate overdose and symptomatic relief for opiate withdrawal. They included being able to maintain prescriptions originating from police custody. However, the arrangements had not been tested. Onsite, secure medicine storage facilities were still being installed, but detainees had access to clearly labelled and authorised personal medication, which was held with their property and documented in the respective PER.

Recommendations

4.30 All custody staff should receive annual first aid refresher training to maintain their skills.

4.31 All custody staff should have ready access to regularly checked basic life support equipment, including an AED.

Section 5. Release and transfer from court custody

Expected outcomes:
Detainees are released or transferred from court custody promptly and safely.

Release and transfer arrangements

5.1 Staff did not prepare pre-release risk assessments with detainees to identify their needs on release, but they did provide them with money for bus or taxi fares, travel warrants for trains and a face-covering. If asked, managers would make telephone calls on behalf of detainees to help make travel arrangements. Staff explained that they would safeguard detainees at risk of self-harm by ensuring that someone who cared for them knew of their discharge. Each court had a generic list of community support organisations, but it was not routinely handed out to detainees.

5.2 Some detainees who arrived from prison experienced lengthy waits for the prison to complete release checks. We found examples of three-hour waits and witnessed a wait of over an hour. Managers rarely escalated these matters appropriately to make sure detainees were not held any longer than necessary. (See key concern and recommendation S28.)

5.3 Most courts held information about onward custodial destinations, but it was out of date, having been written before the COVID-19 pandemic. Detainees going to prison for the first time therefore had no accurate information about what would happen to them next.

Section 6. Summary of key concerns and recommendations

The following is a listing of repeated and new key concerns and recommendations included in this report.

Key concerns and key recommendations

6.1 Key concern (S27): We were concerned that the daily operational response to managing and mitigating the risks associated with COVID-19 was not consistently good enough across all custody facilities. Insufficient attention was paid to social distancing. Cleaning regimes were not as effective as they should have been and touchpoints and vehicles were not wiped down regularly or between use. Detainees were not routinely or comprehensively briefed about the impact of COVID-19 during their time in court custody and were not encouraged to wear or provided with face coverings. They were not able to wash or sanitise their hands regularly enough. Some staff were unaware of new arrangements, which meant detainees should only be searched following a risk assessment and they did not always wear PPE when interacting with or searching detainees in close proximity.

Key recommendation: The three key agencies should collectively make sure that working practices consistently focus on managing and mitigating the risk of COVID-19 transmission, in particular by paying attention to social distancing, cleaning and hygiene and by wearing PPE when interacting with or searching detainees. (Directed to: HMCTS, PECS and GEOAmey)

6.2 Key concern (S28): Detainees' cases were not always prioritised, which meant some were held in court custody for longer than necessary. Delays occurred:

- when courts did not start promptly in the morning
- due to the late attendance of legal representatives
- due to the late or non-attendance of court-appointed interpreters
- for some detainees who arrived at the court in the morning but who did not appear in court until after lunchtime
- when waiting for a governor to formally authorise a detainee's release from prison
- for some children while awaiting receipt of a placement order so they could be moved to their place of detention.

Key recommendation: Detainees in court custody should have their cases prioritised and heard promptly. They should be held in custody for the minimum possible time and the reasons for delays should be explored and addressed. (Directed to: HMCTS)

6.3 Key concern (S29): Training and development activities were not always sufficient. Custody staff often lacked sufficient understanding of key policies and procedures, particularly in equality and diversity, safeguarding, working with children and mental health and substance misuse awareness, and often failed to implement them satisfactorily. This meant we were not convinced that detainees would be treated in line with policies or that concerns would be identified and appropriate referrals made if required.

Key recommendation: The approach to delivering training and development to custody staff should be improved to ensure they understand what is required of them and can implement what they have learned in safeguarding, equality and

diversity, working with children and mental health and substance misuse awareness. (Directed to: HMCTS, PECS and GEOAmey)

Recommendations

Leadership and multi-agency arrangements

6.4 Recommendation (1.11): Relationships and communication between the three key agencies should be reinforced to ensure a consistent focus on delivering good outcomes for detainees. (Directed to: HMCTS, PECS and GEOAmey)

6.5 Recommendation (1.12): 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. (Directed to: HMCTS)

6.6 Recommendation (1.13): Comprehensive data covering all activity in court custody should be collated and analysed so that action can be identified and taken to address any shortfalls. (Directed to: HMCTS, PECS and GEOAmey)

Transfer to court custody

6.7 Recommendation (2.4): Women and children should be transported separately from adult men. (Directed to: HMCTS, PECS and GEOAmey)

6.8 Recommendation (2.5): Detainees should be able to wear clothing of their own choice when appearing at court. (Directed to: HMCTS, PECS and GEOAmey)

In the custody suite: reception processes, individual needs and legal rights

6.9 Recommendation (3.4): Personal information about detainees, including names, should be kept confidential, especially from other detainees. (Directed to: HMCTS, PECS and GEOAmey)

6.10 Recommendation (3.10): Staff should use telephone interpreting services whenever necessary to check on the welfare, risks and understanding of non-English speaking detainees. (Directed to: HMCTS, PECS and GEOAmey)

6.11 Recommendation (3.11): Women detainees should have access to menstrual care products without having to ask for them. (Directed to: HMCTS, PECS and GEOAmey)

6.12 Recommendation (3.16): A PER that includes comprehensive, clear and accurate information about a person's risks to themselves or others should accompany all detainees. (Directed to: HMCTS, PECS and GEOAmey)

6.13 Recommendation (3.17): The assessment of each detainee's risks on arrival in custody should be carried out consistently and should take account of all relevant information. (Directed to: HMCTS, PECS and GEOAmey)

6.14 Recommendation (3.18): All staff should receive a thorough briefing covering the risks presented by detainees while held in court custody. (Directed to: HMCTS, PECS and GEOAmey)

6.15 Recommendation (3.28): HM Courts & Tribunals Service should ensure that consultation rooms are soundproofed to ensure confidentiality. (Directed to: HMCTS)

In the custody cell, safeguarding and health care

6.16 Recommendation (4.7): Fire drills to practise emergency evacuations should be carried out at least annually in all court custody suites. (Directed to: HMCTS, PECS and GEOAmey)

6.17 Recommendation (4.11): The standard of individual statements accounting for the use of force against detainees and related quality assurance processes should be improved. (Directed to: HMCTS, PECS and GEOAmey)

6.18 Recommendation (4.14): Managers should implement a COVID-19-secure method for issuing distraction activities and religious artefacts. (Directed to: HMCTS, PECS and GEOAmey)

6.19 Recommendation (4.20): Children should be moved promptly to places of detention when remanded in custody or receiving a custodial sentence. (Directed to: HMCTS)

6.20 Recommendation (4.30): All custody staff should receive annual first aid refresher training to maintain their skills. (Directed to: HMCTS, PECS and GEOAmey)

6.21 Recommendation (4.31): All custody staff should have ready access to regularly checked basic life support equipment, including an AED. (Directed to: HMCTS, PECS and GEOAmey)

Section 7. Progress on recommendations from the last report

Main recommendations

Staffing levels should be sufficient to ensure the safety and wellbeing of detainees, staff and visitors. (2.17)
Achieved

HMCTS should ensure a local safeguarding policy is established and that custody staff are briefed about how to implement it. (2.18)
Not achieved

Custody staff should undertake a risk assessment with each detainee on arrival in court custody. (2.19)
Not achieved

GEOAmey should ensure custody staff understand, and can manage, the risks associated with intoxication and self-harm. (2.20)
Not achieved

National issue

HMCTS should establish agreed standards in staff training, treatment and conditions, which should cover areas such as risk assessments and monitoring of complaints in court custody; these should be included in the measurement of performance. (2.21)
Partially achieved

Recommendations

Leadership, strategy and planning

There should be greater liaison between HMCTS and GEOAmey managers so that court custody operations are reviewed and problems resolved. (3.8)
Partially achieved

Court custody should have a higher profile in inter-agency forums, such as court user groups, so that difficulties can be resolved. (3.9)
Partially achieved

GEOAmey should review its current custody workforce and consider updating the training staff receive in relation to mental health, diversity and health care. (3.10)
Partially achieved

Individual rights

There should be an independent body to which detainees who are unsatisfied with the outcome of a complaint about court custody can appeal. (4.11)
Achieved

Custody staff should be told how to use the telephone interpreting service, and telephones should be provided in suitable locations. (4.12)
Partially achieved

Detainees should be told on arrival at every court about their rights and entitlements, including the process for making a complaint, and staff should offer to read or explain the information if necessary. (4.13)
Partially achieved

Treatment and conditions

Cellular vehicles should be clean inside. (5.15)
Achieved

Female and male detainees should not be transferred together in the same cellular vehicle (5.16)
Partially achieved

Detainees should have access to hearing loops and Braille versions of key information. (5.17)
Not achieved

All custody staff should receive diversity and equalities training that includes how to care for young people. (5.18)
Partially achieved

Every court custody area should have a copy of each of the holy books of the main religions, a suitable prayer mat, which is respectfully stored, and a reliable means of determining the direction of Mecca. (5.19)
Achieved

A reasonable range of amenities, including hot meals, when necessary, and reading materials, should be offered in response to detainees' needs. (5.20)
Achieved

GEOAmey should allow vulnerable detainees to have social visits if the circumstances are exceptional. (5.31)
Not achieved

Staff undertaking observations and cell visits should carry anti-ligature knives always. (5.32)
Achieved

Custody staff should be briefed about how to make referrals under the local authority's safeguarding procedures if they have concerns about a vulnerable detainee being released. (5.33)
Not achieved

Young people in court custody should be supported by a named staff member trained to work with young people. (5.34)
Partially achieved

Handcuffs should only be used if justified and proportionate. (5.35)
Achieved

Every court should have information leaflets about local support organisations as well as accurate information about local custodial establishments, which should be available in a range of languages. (5.36)
Partially achieved

A programme of regular deep cleaning should be put in place and graffiti should be removed. (5.41)
Not achieved

Mattresses and blankets or warm clothing should be made available. (5.42)
Not achieved

A suitable temperature should be maintained in all cells. (5.43)
Partially achieved

An automated external defibrillator should be available in each of the court custody areas and staff should be trained to use it. (5.54)
Not achieved

All detainees who need prescribed medication should have access to it while in court custody and all medications for personal emergency use should be kept in the possession of the detainee unless a risk assessment demonstrates otherwise. (5.55)
Achieved

Court custody staff should be trained to identify and refer detainees who may be experiencing mental health or substance misuse problems. (5.56)
Not achieved

Section 8. Appendices

Appendix I: Inspection team

Kellie Reeve	Team leader
Jeanette Hall	Inspector
Fiona Shearlaw	Inspector
Stephen Eley	Health care inspector