Report on an inspection visit to court custody facilities in

Cleveland, Durham & Northumbria

by HM Chief Inspector of Prisons

31 March – 14 April 2021

Contents

Introduction

This report presents the findings from our second inspection of custody provision in the court cluster of Cleveland, Durham and Northumbria. The custody estate in the cluster had reduced since our last visit in 2012 and now comprised facilities in three crown courts, one combined court and six magistrates' courts. There had been some reasonable progress since the last inspection, with over two-thirds of recommendations made previously either fully or partially achieved.

Following the substantial curtailment of court business at the onset of COVID-19, activity in court custody had broadly returned to pre-pandemic levels by the time of the inspection. The three main agencies responsible for the provision of court custody had worked well together to amend working practices aimed at minimising the transmission of the virus, most of which were well embedded.

A few areas gave cause for serious concern. The multi-agency relationships and communication that are so important in delivering good outcomes for detainees were not always effective. The collation and analysis of data on key areas affecting detainees were poor and were not used to drive necessary improvements. It was disappointing that women, and some children, often shared transportation with men and were not always adequately protected from verbal abuse. The conditions across the custody facilities varied greatly, and many afforded a poor environment for detainees.

Notwithstanding these areas of concern, this was a reasonably good inspection, overall, and we found a number of positive features. Detainees were consistently treated with respect and spoke positively about their experience in court custody. The health care provision had improved considerably, was responsive and was appreciated both by detainees and staff. The more focused arrangements for dealing with the relatively few children held in court custody delivered good care. We were also pleased that the previously routine handcuffing and excessive searching were now not commonplace and only happened when supported by an individual risk assessment.

We have made 18 recommendations that we hope will help HMCTS, PECS and GEOAmey to improve the treatment of, and conditions for, detainees.

Charlie Taylor
HM Chief Inspector of Prisons
April 2021

About court custody in Cleveland, Durham & Northumbria

Data supplied by the HMCTS Cluster, PECS, and custody and escort Provider.

HMCTS cluster	Cleveland, Durham & Northumbria
Cluster manager	Lisa Shotton
Geographical area	North East of England

Court custody suites and cell capacity

Durham Crown Court	8 cells
Newcastle Moot Hall Crown Court	6 cells
Teesside Crown Court	17 cells
Newcastle-upon-Tyne Combined Court	17 cells
County Durham & Darlington Magistrates' Court (Newton Aycliffe)	12 cells
Mid & South East Northumberland Magistrates' Court (Bedlington)	10 cells
North Tyneside Magistrates' Court (North Shields)	7 cells
Peterlee Magistrates' Court	8 cells
South Tyneside Magistrates' Court (South Shields)	11 cells
Teesside Magistrates' Court (Middlesbrough)	22 cells

Annual custody throughput

1 February 2020 to 31 January 2021	8,457 detainees

Custody and escort provider	GEOAmey
Custody staffing	2 senior court custody managers 6 court custody managers 58 prisoner custody officers, including 3 deputy court custody managers

Summary of key findings

S1 We last inspected court custody in Cleveland, Durham and Northumbria in 2012 and made 36 recommendations overall, eight of which were about areas of key concern (see Section 7 for a full list).

S2 At this inspection, we found that 14 of the 36 recommendations had been achieved, including one of the recommendations about key areas of concern. Nine recommendations had not been achieved.

S3 There had been reasonably good progress since our last inspection. Over two-thirds of the recommendations we made were fully or partially achieved.

Leadership and multi-agency relationships

S4 Each of the main agencies had a clear management structure to oversee the provision of court custody, but the multi-agency arrangements to make sure that outcomes for detainees were consistently good were not always effective: meetings had lapsed, audit regimes were almost non-existent, communication was sometimes too limited and escalation processes were not widely known about or used.

S5 The overall approach to managing COVID-19 had been thoroughly risk assessed and most practices to reduce the transmission of the virus were well embedded.

S6 There were sufficient court custody staff. There was a programme of initial and ongoing training and development activity, but this was not always comprehensive, and staff understanding, and implementation, of learning was not always checked.

S7 We did not have confidence in the integrity of the data provided. We experienced serious issues with obtaining accurate information. The collation and analysis of data were not sufficiently robust and were not used to drive the required improvements for detainees.

Transfer to court custody

S8 Information contained within person escort records (see Glossary of terms) was often too vague to be useful. Many escort vehicles were new but we were not confident that cellular compartments were cleaned between uses. Women, and some children, travelled in the same vehicles as men too often and were not always adequately protected from verbal abuse. Detainees were disembarked in reasonable privacy and generally without undue delays.

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

S9 Custody staff were generally respectful, calm and positive in their dealings with detainees. They had an all-round awareness of equality and diversity issues, and mostly responded well to the differing needs of individuals. The needs of women, those observing a faith and transgender detainees were generally well met. The provision was more inconsistent for those with disabilities or who spoke little or no English.

S10 There was a reasonably good approach to the identification and management of risk. Staff were alert to signs of vulnerability; appropriate levels of observation were set and checks were mostly completed at the required frequency. As we found at the last inspection, comprehensive staff briefings did not always take place, but all staff now carried anti-ligature knives.

S11 Detainees were provided with printed copies of their rights in court custody, but were not always asked if they could read or understand them. Access to legal consultation rooms was mostly adequate. Despite the listings protocol allowing for the prioritisation of custody cases, this did not happen routinely. A range of factors clearly contributed to some unnecessarily long stays in custody, but not enough was done fully to understand or address this. Few complaints were submitted.

In the custody cell, safeguarding and health care

S12 Conditions in cells varied considerably and, overall, we considered that they remained inadequate. Too many were shabby and grubby, and some had ingrained dirt, graffiti and potential ligature points. We provided a separate report illustrating our findings, and this was responded to comprehensively. Staff were familiar with fire evacuation procedures, but did not practise them regularly enough with detainees.

S13 Staff were calm and patient, and skilfully defused tense situations. Force was used relatively infrequently against detainees and we were confident that it was used only as a last resort. Documentation showed that all uses had been necessary and proportionate. The approach to handcuffing and searching was much improved. There was some oversight of the use of force in court custody, and quality assurance processes were developing.

S14 Detainees consistently told us that they were content with the way they had been looked after in custody. The provision of food and drinks was adequate. Most suites provided a range of limited activities to help detainees pass their time until their cases were dealt with. Toilet and handwash facilities were reasonable, although in most there was limited privacy.

S15 GEOAmey now had reasonably comprehensive safeguarding policies both for adults and children. Although most staff had a limited understanding of the meaning of safeguarding and the referral process, managers were generally better informed. Relatively few children were held in court custody, and generally stayed for short periods. They now received an enhanced level of care and were generally well supported by specially trained staff.

S16 The provision of physical health care support for detainees had improved considerably. Specialist mental health support was less consistent across the cluster. All custody staff had undertaken the Custody Early Warning Score (see Glossary of terms) training, and most were up to date with their first-aid training and knew what to do in an emergency. First-aid equipment was rudimentary. The in-house paramedic offered a limited range of risk-based symptomatic relief for those experiencing opiate or alcohol withdrawal, which was a positive development.

Release and transfer from court custody

S17 Once cases were concluded, only a minority of detainees experienced long waits to be transferred to prison. For those who had originated from a prison and were subsequently released by the court, many were deprived of their liberty for too long while waiting for a formal governor's authority to release them (see Glossary of terms). Custody staff made

sure that detainees had the means to travel home safely on release but few facilities had access to information about local support services to offer them.

Key concerns and recommendations

S18 Key concerns and recommendations identify the issues of most importance to improving outcomes for detainees and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

S19 During this visit, we identified some areas of key concern and have made a small number of recommendations for HMCTS, Prisoner Escort and Custody Service (PECS) and the escort provider to address those concerns.

S20 Key concern: Multi-agency meetings had lapsed and there was no consistent or reliable forum in which the detainee experience was discussed. Regular audit regimes that considered the treatment of, and conditions for, detainees were almost non-existent. There was a lack of mutual understanding of the responsibilities, pressures and challenges faced by each of the main agencies and how they needed to coordinate better. Communication between relevant staff was not always sufficiently effective. Escalation procedures were not widely understood, or used to highlight concerns or take necessary action to improve the outcomes for detainees.

Recommendation: Relationships and communication between the three main agencies responsible for custody should be improved and prioritise the delivery of good outcomes for detainees.

S21 Key concern: We experienced serious issues in obtaining the data we requested in advance of the inspection. We were not confident of the integrity of much of the data provided, as there were gaps and some data were inaccurate. The routine data that were collated and analysed were too limited and did not cover a sufficient range of issues that directly affected detainees. There was no action to identify and address shortfalls in concerns identified, such as delays in obtaining authority to release from prison or the poor use of telephone interpreting services.

Recommendation: Comprehensive data covering activity affecting detainees in court custody should be collated and analysed, so that action can be identified and taken to drive improvement.

S22 Key concern: Data showed that women had travelled in the same vehicles as men on 59 occasions between 1 November 2020 and 30 January 2021. We found no evidence that these were exceptional events and we witnessed this practice during the inspection. We saw that the partition available in the vehicle to afford a degree of separation was not always used on these occasions, which placed the women at risk of verbal abuse. We also found evidence that children sometimes shared transportation with adults.

Recommendation: Female detainees and children should be transported separately from adult men.

S23 Key concern: Conditions in cells varied; too many were not sufficiently clean, and some had ingrained dirt. This appeared to be the result of inadequate cleaning arrangements and ineffective daily checks. All cells lacked natural light. Some also had extensive graffiti and/or potential ligature points, and were cold, small and needed better maintenance to make sure that they were both decent and safe.

Recommendation: Conditions across custody facilities should be improved. In particular, cells should be properly cleaned, of an appropriate temperature, have access to natural light and be free from potential ligature points.

Notable positive practice

S24 We define notable positive practice as innovative practice or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

S25 Inspectors found no examples of notable positive practice during this visit.

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 Cleveland, Durham and Northumbria operated as a single cluster. Three main 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), which commissioned and managed the contract provision; and GEOAmey, the contracted service provider. This was our second inspection of custody facilities in this cluster. There was a solid commitment to implementing the recommendations we made previously, and over two-thirds had been achieved or partially achieved.

1.2 Court business and the use of custody facilities had been substantially curtailed at the beginning of the COVID-19 pandemic, but both were operating broadly at pre-pandemic levels at the time of the inspection. The three agencies had worked well together to risk assess and amend working practices aimed at making the custody facilities COVID-19 safe for detainees and the staff who worked there. Most of these practices were well embedded: there was generally good attention to social distancing, custody staff wore face masks routinely and encouraged detainees to do likewise, and no detainees were required to share a cell. We were, however, concerned about the standards of cleaning (see paragraphs 4.3–4.5, and key concern and recommendation S23) – particularly that cells were sometimes not cleaned sufficiently between uses and that detainees were rarely offered hand sanitiser.

1.3 Each of the main agencies had a management structure with clear responsibility for the provision of court custody, but joint working arrangements and communication to make sure that outcomes for detainees were consistently good were not always effective. Multi-agency meetings and face-to-face contact had lapsed and there was no regular or reliable forum in which the outcomes for detainees were discussed or shortfalls in provision were identified and addressed systematically. The regular audit regimes that had been in place to review the treatment of, and conditions for, detainees had also lapsed and now took place infrequently, if at all. Mutual understanding of the pressures and challenges faced by each of the main agencies and the need for better coordination was sometimes weak. The communication between custody staff and their counterparts in HMCTS was sometimes too limited; escalation procedures were not widely known about or used when necessary, to alert managers in HMCTS, GEOAmey or PECS of any issues arising; and there was not always a proper focus on improving the detainee experience (see key concern and recommendation S20).

1.4 The GEOAmey staffing levels in court custody were sufficient and there was an appropriate culture of care among staff. Staff were properly vetted and were all required to complete a reasonably comprehensive initial training course before working in custody. There was an ongoing programme of training and development activity, but much of this only required staff to read the broad range of policies or briefings, and their understanding from this was not systematically checked to make sure that they implemented what was expected of them. Of concern, we found that many staff had limited awareness and understanding of safeguarding (see paragraph 4.22).

1.5 At the time of the inspection, there had been no external scrutiny of court custody since before the start of the COVID-19 pandemic.

1.6 We experienced serious issues with obtaining the information we requested in advance of the inspection and we did not have confidence in the integrity of much of the data provided. The range of data that was collated was too limited and analysis was poor (see key concern and recommendation S21). Different agencies were responsible for each aspect of the work, and no single organisation collated or analysed the whole range of data, to inform action to address any shortfalls affecting detainees. There was little demographic breakdown or analysis of data concerning detainees. There were gaps in the data we were provided with, and some were inaccurate. For example, the initial figure provided for the throughput of detainees was almost double the accurate figure which we later obtained after questioning the information we had been given. There were also insufficient data on the use of telephone interpreting services (see paragraph 3.9 and recommendation 3.11) and the delays experienced by some detainees released from court custody when they had formerly been located in prison (see paragraph 5.2 and recommendation 5.6).

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 Escort staff were familiar with the information in the person escort record (PER; see Glossary of terms), but this was often too vague to be useful. Records of events in police custody were often absent and there were examples where escort staff had recorded information passed to them by the police during verbal briefings (see paragraphs 3.14 and 4.39). Confidential medical information was appropriately sealed.

2.2 Many escort vehicles were new, clean and well equipped. Most escort staff were positive about the new fleet, especially the glass-fronted cells which were used to support the most vulnerable. Detainees were pleased with the additional comfort and the seatbelts. From our observations and conversations with escort staff, we were not confident that cellular compartments on vehicles were always cleaned between uses.

2.3 Data showed that women had travelled in the same vehicles as men on 59 occasions between 1 November 2020 and 30 January 2021. We found no evidence to suggest that these were exceptional events, and we witnessed this practice during the inspection. One woman told us that she had been verbally abused by male detainees during a number of journeys on a cellular vehicle shared with men. We saw that the partition in the vehicle to afford a degree of separation was not always used, even during boarding and disembarking. We also found evidence that children sometimes shared vehicles with adults (see paragraph 4.28, and key concern and recommendation S22).

2.4 Detainees generally had short waits to disembark, while the escort staff briefed the custody staff and submitted paperwork for checking.

2.5 Most courts had secure vehicle docks that allowed detainees to disembark in privacy. However, at North Tyneside Magistrates' Court there was no van dock, and the disembarkation area was not secure and was overlooked. At this court, and also at Peterlee Magistrates' Court, and Durham and Newcastle Moot Hall Crown Courts, escort chains (see Glossary of terms) were used for disembarkation. Generally, these were removed as soon as the detainee was in a secure area, but at North Tyneside Magistrate's Court and Peterlee Magistrates' Court they remained in use within secure areas (see paragraph 4.14 and recommendation 4.16).

Section 3. In the custody suite: reception processes, individual needs and 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 In most of the custody suites, staff were respectful, calm and positive in their dealings with detainees. There was generally little opportunity for detainees to have a private conversation with a staff member when they arrived (see also paragraph 3.13), but staff generally took time to explain processes and provide reassurance, particularly to more vulnerable individuals. A small minority of staff were abrupt with detainees, but, overall, staff were professional and effective in defusing tension and promoting well-being.

3.2 In some suites, whiteboards were visible to those passing through open areas, including other detainees. The information displayed on them was limited but potentially identified detainees.

3.3 At Durham Crown Court, a few detainees still had to pass through public areas wearing an escort chain (see paragraph 4.14 and recommendation 4.16) to access one of the courts. This was unavoidable, given the location of the cells, but fundamentally undermined detainees' privacy and dignity.

Recommendation

3.4 Detainees' personal data, including their names, should only be displayed on whiteboards which are out of general view.

Meeting individual and diverse needs

3.5 Staff had a reasonable all-round awareness of equality and diversity issues, although not many were able to describe any training which they had been given. In practice, we saw many instances of staff responding well to the differing needs of individuals.

3.6 A generic information sheet was made available to women. Menstrual care products were freely available in almost all of the cell corridors where women were normally located but were not always stored hygienically. In the custody suites, women were generally placed in a separate area to men; in one suite, however, because of building work, female detainees temporarily had to use the toilet in the male corridor, and the women were subject to unwanted attention from the men. Courts generally had sufficient female staff.

3.7 There was a comprehensive policy concerning the treatment of transgender detainees. Staff were accustomed to having such individuals in custody and generally described supporting them with a mature and well-informed approach.

3.8 The provision for detainees with disabilities or mobility difficulties was inconsistent. They were generally dealt with at Teesside Magistrates' Court or Newcastle Combined Court. There were no adaptations such as grab rails or lowered call bells at either court and at Teesside Magistrates' Court, despite the presence of an adapted toilet, a wheelchair user was directed to a non-accessible facility. A van with suitable adaptations was available for transferring those using a wheelchair. Hearing loops were available from the courts, but not all staff knew how to access them, and at one court staff said that they would 'get by' with gestures if someone could not hear. By contrast, during the inspection a custody officer, on their own initiative, gained the judge's permission to enable a hearing-impaired man, who had just received a substantial prison sentence, to have a private visit from his partner because he had difficulty in communicating with her from prison by telephone.

3.9 Information about individual rights was available in 29 languages, with posters enabling detainees to point to their native language. Braille or Easy Read versions were not available but there was a rarely used 'emoji' version, designed to be suitable for younger people. There was access to a cordless or mobile telephone, or a speakerphone in each suite to facilitate use of professional telephone interpreting. Although there was little evidence of its regular use, a few staff could describe occasions when they had used the service, and at one suite staff spoke enthusiastically about having made more use of it recently, and of the benefits this brought. Some staff resorted to unsatisfactory responses such as: 'most can speak pidgin English', or 'they understand when you ask if they want tea'.

3.10 All those arriving in custody were asked if they had any religious requirements, and faith resources were available and appropriately stored in all sites. The direction of Mecca was discreetly indicated in the suites, and staff in most facilities could advise Muslim detainees of the direction for prayer.

Recommendation

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

Risk assessments

3.12 There continued to be no formal, consistent risk assessment of detainees on arrival in court custody suites. Despite this, the overall identification and management of risk were reasonably good. Escorting staff shared relevant risk information with custody staff about the detainees they transported to court. Staff checked the information provided by the police and prison staff, recorded in the detainee's PER, so were aware of any potential risks before individuals were located in cells.

3.13 Staff completed a basic checklist for new receptions, but this had little focus on identifying risks. Initial engagement was generally positive, although brief for most detainees. Most of these interactions were not conducted in private, which potentially inhibited the disclosure of information relating to risks and/or vulnerabilities. However, staff were alert to signs of instability, vulnerability or low mood and would usually visit detainees in their cells to ask more probing questions if they had concerns.

3.14 The information in PERs, warning markers and disclosures from detainees were used to set the level of observation for each detainee. Many of the PERs we reviewed did not provide sufficient accurate or up-to-date information to support the effective assessment of risk (see paragraphs 2.1 and 4.39). Detainees at risk of self-harm were subject to an enhanced level of

checks or placed under constant supervision if necessary. Overall, we considered that appropriate levels of observations were set and those we observed were mostly carried out as required.

3.15 As we found at the last inspection, most briefings to inform custody staff of detainee risks were written; oral briefings were rare and the standard of both varied. They did not always impart information about the risks posed by or to detainees, or the level of checks required.

3.16 Cell call bells were tested daily and were clearly audible. Detainees who were new to court custody were told how to use the bell when they were located in a cell. When activated, the bells were answered promptly. Routes to court were safe and there were adequate affray alarms available to staff; most routes did not pass through any public areas, but, when they did, there were arrangements to do this safely.

3.17 All court custody and escort staff now carried personal anti-ligature knives, which was an improvement since the last inspection.

Recommendations

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

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

Individual legal rights

3.20 Detainees had access to printed copies of their rights in court custody, although some were in a poor condition. Detainees were not routinely asked if they could read or understand the document, but we saw staff explaining it to a few who indicated that they needed support.

3.21 On arrival, all detainees were asked for the name of their legal representative, who was duly notified that their client was in custody. There were sufficient consultation rooms to allow legal visits to take place either socially distanced or via telephone, but some were not sufficiently soundproofed.

3.22 Detainees could keep legal documents pertaining to their case, and pencils and paper were available if they wished to prepare notes.

3.23 Custody staff rarely made telephone calls to detainees' family or friends, but would generally refer such requests to the legal representative. They were aware that foreign national detainees had the right to contact their relevant consulate, embassy or high commission if they wished, but none we spoke to had experienced such a request.

3.24 The listing of court cases was a judicial responsibility and an often complex process, but an HMCTS listings protocol (see Glossary of terms) allowed for custody cases to be prioritised, particularly in Magistrates' courts. There was a broad strategic commitment to do this and to making sure that detainees spent the minimum possible time in custody, but for a variety of reasons this was not always achieved.

3.25 We encountered a number of reasons why custody cases were not heard promptly and which contributed to detainees potentially spending longer in custody than necessary. For

example, courts did not always start promptly in the morning; detainees who arrived in the morning often did not appear until the afternoon sitting; solicitors who represented multiple clients often chose to deal with their off-bail clients first, when those in custody should have been prioritised; and some detainees released by the court who had previously been located in a prison experienced excessive waits for their release to be authorised (see paragraphs 1.6 and 5.2). Delays with hearings were also sometimes attributed to the police experiencing difficulties in transferring case files to the court and Crown Prosecution Service (CPS), and the CPS sometimes had difficulties with their system for transferring case papers to defence solicitors. When either of these two scenarios arose, strategic meetings between the key stakeholders were arranged in an attempt to rectify them.

3.26 Once the court had asked for the detainee to attend, they were presented without delay. When detainees appeared in court in the morning and were remanded or sentenced before lunchtime, in many cases they were moved to prison reasonably quickly. However, some detainees experienced much longer waits before being moved. The longest delay we came across was just over six hours.

3.27 Some detainees appeared to spend unnecessarily long periods in custody because of a combination of the factors explained above. While the main agencies were aware of some of these issues, not enough was being done fully to understand or address the reasons for the lack of proactive prioritisation, the delays and the unnecessarily extended periods in custody.

3.28 Detainees held in police custody should be able to appear before a court if the court is sitting and there is capacity to hear their cases. We found that detainees were routinely accepted throughout the day from police custody. This was a better position than we usually encounter and assured us that detainees were enabled to appear before the first available court, where possible, appropriately minimising the time they spent in police, and other, custody.

Recommendations

3.29 Interview rooms should be sufficiently soundproofed to make sure that legal consultations can take place confidentially.

3.30 Detainees should spend the minimum possible time in court custody; they should have their cases prioritised and heard promptly, and the reasons for delays should be explored and addressed.

Complaints

3.31 The overall approach to complaints had improved. Notices about the complaints procedure and the right to appeal to an independent body were accessible to detainees, but staff offered no further explanation about the process. Court custody staff had a reasonable understanding of the procedure.

3.32 Few complaints were received. Data supplied by GEOAmey showed that only four complaints had been received between February 2020 and January 2021. When complaints related to matters outside GEOAmey's control, there was poor sharing of information with other relevant agencies, and responses did always adequately acknowledge or address the issues raised.

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

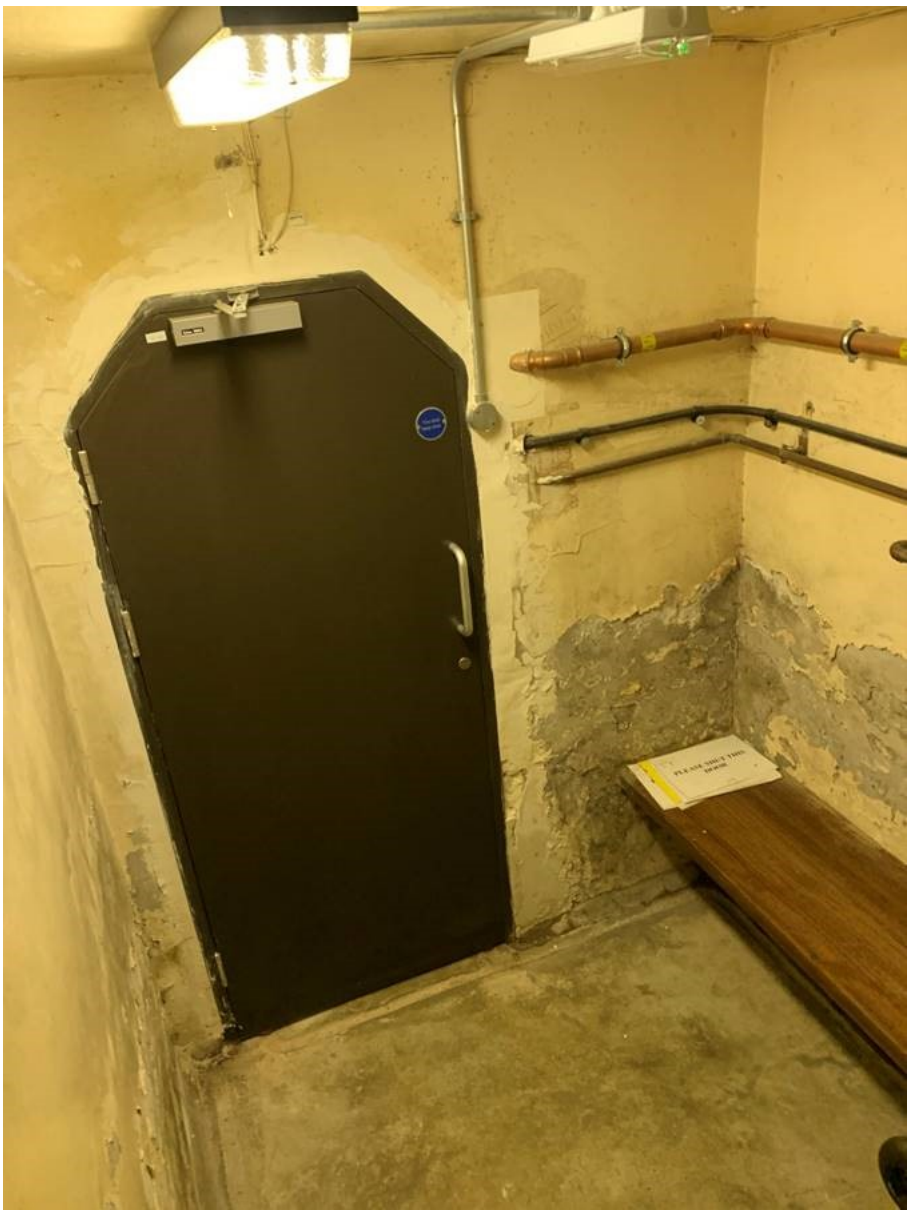
Expected outcomes:
Detainees receive respectful treatment in the custody suite and their individual needs are met. Detainees are held in court custody for no longer than necessary, are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the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

Physical environment

4.1 Since the last inspection, the custody estate had reduced from 16 to 10 facilities. HMCTS was responsible for the upkeep of court buildings, including custody facilities. A private provider was contracted to undertake the cleaning and maintenance, and HMCTS was the conduit between them and custody staff. Contractual complexities and budgetary constraints made some maintenance work difficult to progress, particularly costly work.

4.2 Conditions in cells varied considerably, from very good at Teesside Crown Court to unacceptably poor at South Tyneside Magistrates' Court (see key concern and recommendation S23). Records showed that staff at all custody suites conducted daily cell checks but we observed that these mainly involved checking the operation of the cell call bell and removing litter; too often, staff did not pay attention to the physical condition of the cell, in terms of cleanliness, safety and decoration.

4.3 Overall, we considered that conditions remained inadequate. Some facilities were old and had not been well maintained. Too many cells were shabby and grubby, and some had ingrained dirt, splash marks and extensive graffiti. Routine cleaning was not good enough to make sure that dirt did not build up to unacceptable levels over time. In most facilities, staff struggled to recall the last time that cells had been deep cleaned. In some courts, staff explained how they would wipe up food spills and remove or paint over graffiti, but in others staff preferred to rely exclusively on the cleaning contract. The contract for specialist cleaning of body fluids was responsive and effective.



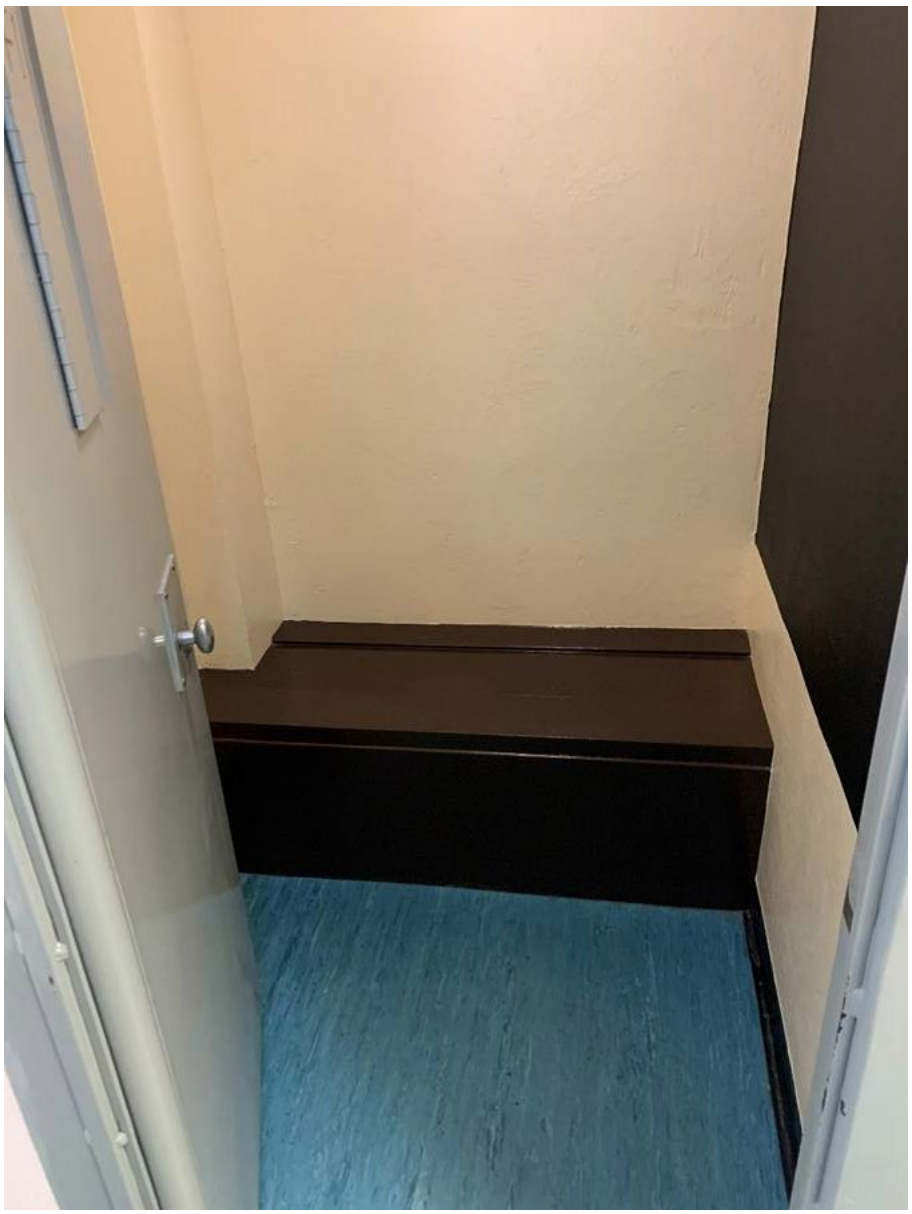
General conditions in the custody suite at Durham Crown Court

Ingrained dirt in a cell in North Tyneside Magistrate's Court

4.4 We found that some cells were not cleaned between uses, which was particularly unacceptable during a pandemic. Staff told us that this was more acute over weekends and public holidays, when cells could go uncleaned for a number of days.

4.5 As an additional COVID-19 measure, a separate contractor was responsible for visiting custody suites twice a day to provide 'touchpoint cleaning'. The standard of this varied and it often involved no attendance in areas where detainees were held.

4.6 We identified potential ligature points in some cells. Some could have been avoided with better maintenance, but others (for example, around cell doors or in ventilation grilles) were inherent in the design of the cell. All cells lacked natural light, some were very small and some were cold. We provided a separate report illustrating our general findings on the physical conditions in the custody suites, and this was responded to comprehensively.



Small cell in Durham Crown Court

4.7 Staff were familiar with fire evacuation procedures, but did not practise them regularly enough with detainees.

Recommendation

4.8 Emergency evacuations should be practised at least annually in all custody suites and should involve detainees.

Use of force

4.9 More than half of custody staff were not up to date with their control and restraint training because of COVID-19 restrictions, but there was a comprehensive training plan to rectify this. At the time of the inspection, six custody staff were trained in minimising and managing physical restraint (MMPR; see Glossary of terms), which was designed for use with children.

4.10 Force was used reasonably infrequently against detainees, with 47 recorded uses in the 12 months to the end of January 2021. This included three incidents involving children. Records we reviewed suggested that in some cases individual detainees had been involved in multiple incidents, which had not been recorded separately; however, the overall number of incidents was still relatively small. Custody staff were calm and patient in their dealings with detainees, and skilfully defused tense situations that might otherwise have resulted in the use of force. From conversations with custody staff and the review of documentation, we were confident that force was used only as a last resort.

4.11 We reviewed paperwork relating to 32 incidents in which force had been used against detainees. Staff routinely completed individual statements to justify their involvement in the incident. While a few of these lacked detail, we were able to establish clearly what had happened, and, overall, the documentation reflected that all uses of force had been necessary and proportionate. Protracted or sustained use of force was rare. Much of the force used was at a low level – for example, to remove reluctant detainees from the dock on conclusion of their hearing or to prevent detainees from hurting themselves.

4.12 There was some oversight of incidents involving the use of force, and quality assurance processes were developing and improving. The completed documentation was generally checked by a GEOAmey manager, but this was not always properly focused and had not consistently identified the shortfalls that we found. There was also some additional oversight of documentation by PECS. All incidents involving children were scrutinised.

4.13 There was now a much-improved picture concerning the handcuffing of detainees in court custody. Where the use of handcuffs had previously been routine, they were now used only when supported by an individual risk assessment, which reflected a far more proportionate approach. A similar perspective had been adopted towards searching. When we observed detainees being handcuffed or searched there was appropriate justification.

4.14 We encountered more use of the escort chain, particularly when detainees were disembarked from vehicles in insecure areas or when routes to court involved movement through public areas. As an example of the latter, we observed an escort chain being used on a frail 79-year-old man, which appeared excessive. The application of the escort chain was not always subject to an individual risk assessment and it sometimes remained in place for too long after detainees were in a secure environment (see also paragraphs 2.5 and 3.3).

Recommendations

4.15 Each incident involving the use of force against detainees should be recorded separately, and the paperwork justifying any use of force should be sufficiently detailed.

4.16 Escort chains should only be used on detainees subject to an individual risk assessment, and should remain in place for the shortest time possible.

Detainee care

4.17 Detainees in all suites spoke highly of the way they had been looked after in custody, with one typical description being '10 out of 10'.

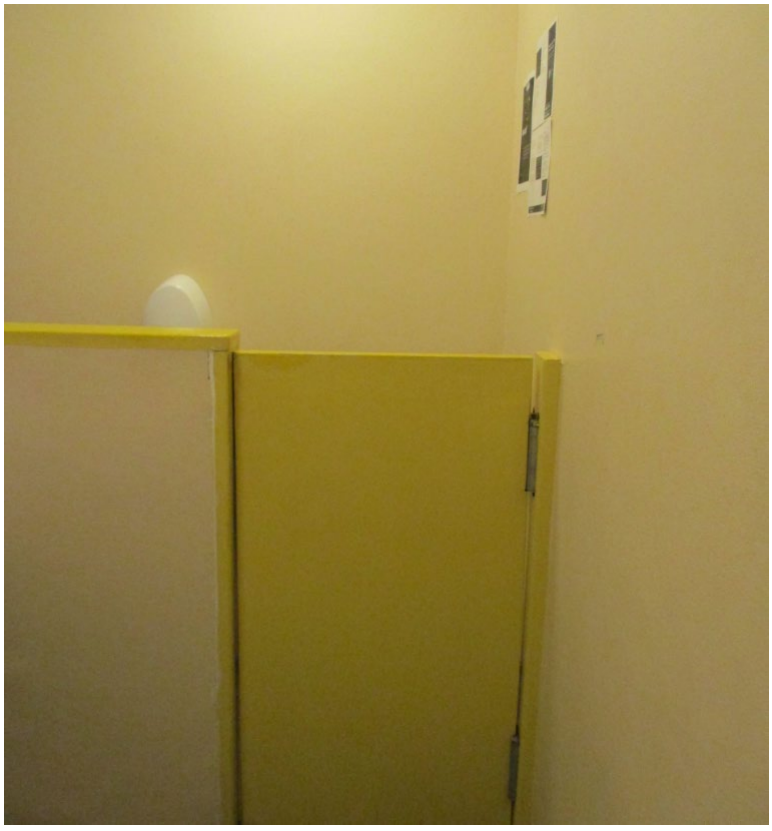
4.18 All detainees were offered a drink soon after arrival and thereafter at frequent intervals. A range of food and snacks was available at all suites, but in some was only offered at recognised mealtimes, even if detainees indicated that they were hungry at other times. Food

preparation areas were generally adequate, but in one or two smaller suites they fell short of ideal standards of hygiene. Staff were ready to use petty cash to buy alternative foods if there was a genuine dietary need.

4.19 Reading materials and other activities were generally offered routinely to help detainees pass the time until their cases were dealt with. At all suites, there was a pile of old newspapers which staff had brought in, and these were offered to detainees. Books were generally not made available. Distraction packs, including puzzles and quizzes, were offered in most suites. Boxes of activity materials, including games, were present in all suites but were rarely offered. In most suites, a large square had been painted in the cells with 'blackboard paint' and chalks provided – this was very new but was being used and was appreciated by some detainees.

4.20 Conditions in cells afforded little comfort. None of the custody suites had any clothing to issue to detainees if they were cold or in unsuitable attire. No blankets or mattresses were available and detainees had to sit on uncomfortable hard benches, often for long periods.

4.21 Toilet and handwash facilities were reasonable in most places, although in most suites there was limited privacy, with many toilets having low swing doors. These areas were supervised discreetly, but a detainee told us that the lack of privacy inhibited his use of the toilet. Most toilet facilities had toilet paper, soap and paper towel dispensers, but several had no waste bins for used towels.



Stable-type door to toilet in Bedlington Magistrates' Court

Safeguarding

4.22 There was still no overarching HMCTS safeguarding policy on protecting detainees, including children, from harm, abuse or mistreatment. GEOAmey now had reasonably comprehensive and well-promoted safeguarding policies both for adults and children, although none contained details of the National Referral Mechanism (see Glossary of terms). However, there had been no formal training in this area for most staff and few could speak about it confidently. Most had only a limited understanding of the meaning of safeguarding and the referral process – particularly in relation to adults. However, when given example scenarios, many staff could describe an appropriate response. Most staff knew the names of the safeguarding officers and valued their expertise, and some could give examples of situations when they had sought advice from them.

4.23 Managers were generally better informed and we observed situations where vulnerable detainees received support. For example, a woman was signposted to domestic violence support in prison after contact with her social worker; and an elderly man had his case adjourned for a medical assessment after staff identified that he had little understanding of what was happening to him.

4.24 Staff knew about support services for victims of modern-day slavery, and these were also advertised to detainees. At Newton Aycliffe Magistrates' Court, flyers advertising support were displayed inside toilet cubicles.

4.25 The ability of staff to identify safeguarding risks had improved but needed reinforcement to make sure that they were all sufficiently confident.

Recommendation

4.26 HMCTS should develop an overarching safeguarding policy. All staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable adults at risk.

Children

4.27 Most courts had stopped holding children in cells by December 2020 and now held them in an interview room whenever possible. However, at South Tyneside Magistrates' Court, the last five child detainees had been held in a cell, and we were not confident that there had been sufficient justification for this, although it had been slightly mitigated by the cell door remaining open and consistent staff presence. At Peterlee Magistrates' Court, there was no suitable non-cellular location, so children were held in the cell designated for women, with the door unlocked, giving access to a small lobby area. This area was appropriately separate and large enough to accommodate accompanying officers.

4.28 Children usually travelled to the courts separately from adults, in a car rather than a cellular vehicle. However, in a sample of data from February 2021, we identified that a child had travelled with an adult on at least two occasions (see paragraph 2.3, and key concern and recommendation S22). Most journeys to court were short, but a child from Rainsbrook Secure Training Centre had experienced very long journeys; a judge had recognised this and arranged video proceedings, to minimise the requirement for them to travel every day.

4.29 Children were supported well by dual-badged officers (see Glossary of terms) and enhanced care officers (see Glossary of terms), all of whom were specifically trained to work with

children and had received training in MMPR techniques (see also paragraph 4.9). Children had access to a range of suitable distraction activities. Some courts did not have a dual-badged officer, which meant that there could be a delay before specialists arrived. Staff without MMPR training were aware that pain compliance should not be used when restraining children.

4.30 In February 2021, 12 children were held on 16 occasions. Most were held in court custody for short periods, often less than two hours. Youth offending services staff generally visited any child in custody, but we found occasional examples where this had not happened.

Recommendation

4.31 Children should only be held in cells when this is justified by an individual risk assessment.

Health

4.32 The health needs of detainees had been reviewed as part of the new PECS contract, introduced in August 2020, and we found that the provision of physical health care support for detainees had improved considerably. Stadn Limited was responsible for the 'Health Finder Pro' advice line, which enabled custody staff to receive immediate medical advice and support. In addition, if an on-site clinical assessment was deemed necessary, the service enabled an in-house paramedic to be despatched to the courts. Since February 2020, the advice line had been used 179 times, triggering 101 requests for attendance.

4.33 All court staff expressed appreciation of this responsive paramedic support, which we also saw first-hand during the inspection. This service gave custody staff confidence that detainees' health risks could be professionally determined in a timely manner.

4.34 Governance and monitoring arrangements were still being developed, and recorded response time data were not made available to us as part of the inspection. Operational policies and procedures, which included a range of patient group directions (which authorise appropriate health care professionals to supply and administer prescription-only medicine) for use by the paramedics, were clear and facilitated good care. In addition, the processes shared with us which detailed medical and paramedic registration, training and supervision appeared robust.

4.35 The delivery of mental health liaison and diversion services (L&D) was less consistent, partially due to the pandemic controls established in most settings. L&D input was delivered by Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust at North Shields, South Shields and Bedlington Magistrates' Courts, and Newcastle Combined Court. Tees, Esk and Wear NHS Foundation Trust delivered support to Newton Aycliffe and Teesside Magistrates' Courts, as well as Durham and Teesside Crown Courts. Both providers embraced an all-vulnerabilities model to support detainees and enable appropriate diversion from custody.

4.36 Custody staff told us that the L&D footprint had reduced in some settings before the pandemic. At the time of the inspection, practitioners in the Newcastle and Bedlington suites provided telephone advice and only attended on request. We were told that detainees leaving police custody to attend these courts would be screened to assess potential need, but this often involved reviewing the clinical records rather than a direct assessment. Newcastle Combined Court had a dedicated health professional to help the court, but this individual was not routinely accessible to detainees. By contrast, in the Teesside Magistrates'

and Crown Courts, a permanent practitioner presence enabled a more flexible, timely and engaged approach to be delivered. Newton Aycliffe Magistrates' Court operated on a needs-led basis, but was expecting to return to a more regular input post-pandemic.

4.37 Overall, we found that detainees with mental health needs would generally be seen in all court locations on request, provided that the practitioners could arrive before release or transfer. Links to community pathways had been established and there were systems to support detainees on release, but at the time of the inspection there were some missed opportunities to provide support both within and post-custody. Governance processes to scrutinise L&D service provision were well established, enabling regular review of performance data to drive improvement.

4.38 All custody staff we spoke to had undertaken the Custody Early Warning Score (see Glossary of terms) training, and these initial health checks were routinely offered to detainees, with good uptake. Most staff were up to date with the first-aid at work course and told us that they knew what to do in an emergency, although these situations rarely arose. However, there was no ongoing provision to make sure that such skills were retained, which was a potential risk as without these, staff were reliant purely on basic life support skills. There was no basic resuscitation equipment and the contents of first-aid boxes were rudimentary. Automated external defibrillators were all located in the main court buildings and although no one suggested that this had been a problem, custody staff had no direct control of this equipment. Most sites had a mental health champion identified, who had undertaken an additional two-day training programme, although some champions covered up to three suites. Teesside Crown Court had an impressive portfolio containing mental health information developed by the local champion in liaison with the charity Mind, but this was not replicated in other facilities.

4.39 PERs were used to capture health interventions and clinical risks, but any prevailing clinical risks were not always described adequately, particularly for detainees arriving from police custody. In one example we saw, a detainee arriving at Teesside Magistrates' Court had been on constant watch in police custody, but the escorting police had not, at that point, recorded this in the PER (see also paragraphs 2.1 and 3.14).

4.40 Custody staff could now offer some simple health remedies after consulting the medical advice line. The range was fairly limited and there was scope to develop this. Detainees arriving from police custody often told us that they had not received adequate medication during their stay, particularly for drug and/or alcohol withdrawal. The paramedic could offer risk-based symptomatic relief for those experiencing opiate or alcohol withdrawal, which was a positive development, although there was no access to nicotine replacement products. Medicine storage was managed safely. The enhanced medical support also enabled detainees to access clearly labelled personal medication. Custody staff would facilitate access to such medicines at the authorised intervals documented on PER forms.

Recommendation

4.41 All custody staff should receive annual first-aid refresher training to maintain their skills, and have immediate access to regularly checked basic life support equipment, including an automated external defibrillator.

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 Although many detainees were moved to prison quickly after a court hearing, records showed that there had been some long waits (see paragraph 3.26). Assessments of risk and need were generally done thoroughly for those going to prison who had been received directly from the court off-bail (see Glossary of terms). While not offered routinely, there were a few, mainly out-of-date, leaflets about the particular prisons to which people were normally transferred.

5.2 Data we were provided with for the period September 2020 to March 2021 were incomplete but showed that, across most custody suites, at least 57 detainees released by the court needed a formal governor's authority to release (see Glossary of terms). We expect the process of release for those originating from prison to take no longer than an hour, but acknowledge that in a minority of cases there may be complexities which extend this. In the data we reviewed, over a third waited more than two hours for the authorisation to be given by the sending prison, with the longest wait being five hours and 17 minutes. These delays deprived people of their liberty for too long. Escalation procedures were not known about or used (see paragraphs 1.3 and 3.25, and key concern and recommendation S20).

5.3 Beyond helping with onward travel, staff did not routinely ask people how they were feeling about what would happen after release, or open up wider conversations to explore any broader risks or needs. In all courts, detainees were given the means to get home safely, including bus tickets, or rail warrants, or the exact amount of cash if they had to use other transport, such as the Metro or a taxi. Staff were helpful in giving directions to bus stops, for example, but no local maps were available. GEOAmey leaflets with contact details for national support organisations were available in all suites, but few had a list of local services to which those leaving courts might be able to turn for help. Detainees were given face masks on leaving, if they did not have one.

5.4 In many of the custody facilities, people were able to change their clothes, or put on additional clothing from their property, before leaving the suite. At others, they were not allowed to do this but were told to change elsewhere. A detainee in a wheelchair was told that, after release, he would have to go into the public toilets if he wished to change his clothing. At some courts, staff brought in carrier bags for use by detainees being released who would otherwise have to use a conspicuous plastic sack for their property.

Recommendations

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

5.6 HMCTS should work with PECS/HMPPS to make sure that the governor's authority to release is issued as promptly as possible to the custody staff.

Section 6. Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

6.1 Key concern (S20): Multi-agency meetings had lapsed and there was no consistent or reliable forum in which the detainee experience was discussed. Regular audit regimes that considered the treatment of, and conditions for, detainees were almost non-existent. There was a lack of mutual understanding of the responsibilities, pressures and challenges faced by each of the main agencies and how they needed to coordinate better. Communication between relevant staff was not always sufficiently effective. Escalation procedures were not widely understood, or used to highlight concerns or take necessary action to improve the outcomes for detainees.

Recommendation: Relationships and communication between the three main agencies responsible for custody should be improved and prioritise the delivery of good outcomes for detainees. (Directed to: HMCTS, PECS and GEOAmey)

6.2 Key concern (S21): We experienced serious issues in obtaining the data we requested in advance of the inspection. We were not confident of the integrity of much of the data provided, as there were gaps and some data were inaccurate. The routine data that were collated and analysed were too limited and did not cover a sufficient range of issues that directly affected detainees. There was no action to identify and address shortfalls in concerns identified, such as delays in obtaining authority to release from prison or the poor use of telephone interpreting services.

Recommendation: Comprehensive data covering activity affecting detainees in court custody should be collated and analysed, so that action can be identified and taken to drive improvement. (Directed to: HMCTS, PECS and GEOAmey)

6.3 Key concern (S22): Data showed that women had travelled in the same vehicles as men on 59 occasions between 1 November 2020 and 30 January 2021. We found no evidence that these were exceptional events and we witnessed this practice during the inspection. We saw that the partition available in the vehicle to afford a degree of separation was not always used on these occasions, which placed the women at risk of verbal abuse. We also found evidence that children sometimes shared transportation with adults.

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

6.4 Key concern (S23): Conditions in cells varied; too many were not sufficiently clean, and some had ingrained dirt. This appeared to be the result of inadequate cleaning arrangements and ineffective daily checks. All cells lacked natural light. Some also had extensive graffiti and/or potential ligature points, and were cold, small and needed better maintenance to make sure that they were both decent and safe.

Recommendation: Conditions across custody facilities should be improved. In particular, cells should be properly cleaned, of an appropriate temperature, have access to natural light and be free from potential ligature points. (Directed to: HMCTS, PECS and GEOAmey)

Recommendations

6.5 Recommendation (3.4): Detainees' personal data, including their names, should only be displayed on whiteboards which are out of general view. (Directed to: HMCTS, PECS and GEOAmey)

6.6 Recommendation (3.11): Staff should use professional telephone interpreting services, to check on the welfare, risks and understanding of detainees who speak little or no English, on arrival and throughout their stay in court custody. (Directed to: HMCTS, PECS and GEOAmey)

6.7 Recommendation (3.18): A person escort record 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)

6.8 Recommendation (3.19): All staff should receive a thorough briefing, covering the current risks presented by detainees while held in court custody. (Directed to: HMCTS, PECS and GEOAmey)

6.9 Recommendation (3.29): Interview rooms should be sufficiently soundproofed to make sure that legal consultations can take place confidentially. (Directed to: HMCTS, PECS and GEOAmey)

6.10 Recommendation (3.30): Detainees should spend the minimum possible time in court custody; they should have their cases prioritised and heard promptly, and the reasons for delays should be explored and addressed. (Directed to: HMCTS, PECS and GEOAmey)

6.11 Recommendation (4.8): Emergency evacuations should be practised at least annually in all custody suites and should involve detainees. (Directed to: HMCTS, PECS and GEOAmey)

6.12 Recommendation (4.15): Each incident involving the use of force against detainees should be recorded separately, and the paperwork justifying any use of force should be sufficiently detailed. (Directed to: HMCTS, PECS and GEOAmey)

6.13 Recommendation (4.16): Escort chains should only be used on detainees subject to an individual risk assessment, and should remain in place for the shortest time possible. (Directed to: HMCTS, PECS and GEOAmey)

6.14 Recommendation (4.26): HMCTS should develop an overarching safeguarding policy. All staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable adults at risk. (Directed to: HMCTS, PECS and GEOAmey)

6.15 Recommendation (4.31): Children should only be held in cells when this is justified by an individual risk assessment. (Directed to: HMCTS, PECS and GEOAmey)

6.16 Recommendation (4.41): All custody staff should receive annual first-aid refresher training to maintain their skills, and have immediate access to regularly checked basic life support equipment, including an automated external defibrillator. (Directed to: HMCTS, PECS and GEOAmey)

6.17 Recommendation (5.5): All detainees should be helped to prepare for leaving custody with practical consideration of any imminent risks and needs, the provision of relevant support leaflets and the opportunity to wear their own clothes as they leave. (Directed to: HMCTS, PECS and GEOAmey)

6.18 Recommendation (5.6): HMCTS should work with PECS/HMPPS to make sure that the governor's authority to release is issued as promptly as possible to the custody staff. (Directed to: HMCTS, PECS and GEOAmey)

Section 7. Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Main recommendations

7.1 HMCTS should establish agreed standards for treatment and conditions in court custody. (2.31)
Achieved

7.2 HMCTS local managers should visit court custody suites regularly, to monitor standards and to resolve or escalate any issues as appropriate. (2.32)
Partially achieved

7.3 Comprehensive risk assessments should be consistently carried out by appropriately trained staff on all detainees. (2.33)
Not achieved

7.4 Detainees should not routinely be taken in handcuffs through areas of the court to which the public have access. (2.34)
Partially achieved

7.5 A programme of regular deep cleaning should be implemented, and standards of daily cleaning should be improved. (2.35)
Not achieved

7.6 A survey should be undertaken of all the court cells and a programme of remedial works, to include decoration, heating, ventilation, provision of natural light, enlargement of the smallest cells, provision of interview rooms and improvements to health and hygiene, should be put in place as soon as possible. (2.36)
Partially achieved

7.7 The cells at Newcastle Magistrates' Court should be completely refurbished, with interview rooms created, or they should be closed. (2.37)
No longer relevant

National issues

7.8 Detainees should have an avenue of appeal if they are dissatisfied with the outcome of their complaint about court custody. (2.38)
Achieved

Recommendations

Leadership, strategy and planning

7.9 Court user-groups should meet at regular intervals to support communication and good working relationships between key stakeholders. (3.9)

Not achieved

Individual rights

7.10 Detainees who have attended voluntarily and who can be dealt with at court on the same day should not be arrested unless there is a good reason to detain them. (4.7)
No longer relevant

7.11 Courts should liaise with HMP Durham to resolve the delays experienced in confirming that detainees can be released. (4.8)
Not achieved

7.12 Detainees should be told on their arrival about their rights and entitlements. They should be given written information about these, and staff should offer to read them to detainees. (4.16)
Partially achieved

7.13 Sufficient comfortable, private and sound-proofed interview rooms should be made available at all courts for legal consultations and the provision of welfare advice. (4.17)
Partially achieved

7.14 Staff should be told how to use the telephone interpreting service, and telephones should be provided in suitable locations. (4.18)
Achieved

7.15 Detainees should be told how to make a complaint and not be discouraged from doing so. (4.19)
Partially achieved

Treatment and conditions

7.16 The policy on the use of the partition in cellular vehicles should be clarified and escort staff should implement it. (5.7)
Not achieved

7.17 Adequate provision should be made for detainees to be transferred from cellular vehicles to the cells in privacy. (5.8)
Achieved

7.18 Confidential information on whiteboards and in documents should be placed out of general view. (5.9)
Partially achieved

7.19 Every court cell 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. (5.23)
Achieved

7.20 A reasonable range of amenities, including hot meals when necessary and reading materials, should be offered in response to detainees' needs. (5.24)
Partially achieved

7.21 There should be suitable provision in the region to enable detainees with disabilities to appear at court within a reasonable distance of their home. (5.25)
Partially achieved

7.22 At each court, the senior custody officer should hold a staff briefing each morning, where information about all detainees, particularly regarding self-harm, vulnerability and needs, is shared. (5.46)
Partially achieved

7.23 All uses of force and adverse incidents should be documented and the data analysed for trends. (5.47)
Partially achieved

7.24 Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits. (5.48)
Achieved

7.25 GEOAmey should direct senior custody officers to allow social visits for vulnerable detainees if the circumstances are exceptional or if a visit is ordered by the court. (5.49)
Achieved

7.26 Staff should be briefed about how to make referrals under the local authority's safeguarding procedures if they have concerns about a vulnerable detainee who is being released. (5.50)
Achieved

7.27 Standards of searching should be made consistent and rub-down searches within secure areas should not be routine. (5.51)
Achieved

7.28 Handcuffing policy should be defined for each court in accordance with local conditions, and should take into account the needs of those with mobility problems. Detainees should not be double-cuffed on narrow staircases. (5.52)
Achieved

7.29 Each court should have information leaflets about local support organisations and an adequate supply of up-to-date and accurate leaflets about prisons. (5.53)
Not achieved

7.30 Young people in court custody should be supported by a named staff member who is trained to work with young people. (5.54)
Achieved

7.31 Defects in cell call bell systems should be rectified promptly. (5.71)
Achieved

7.32 Mattresses, and blankets or warm clothing should be made available at all courts. (5.72)
Not achieved

7.33 The first-aid kits in court custody should be customised to ensure that they contain the necessary equipment to deal with incidents that are likely to occur in the environment, such as serious self-harm. (5.80)
Not achieved

7.34 There should be equipment to maintain an airway and an automated external defibrillator available in each of the court custody suites, and staff should be trained to use them. (5.81)
Not achieved

7.35 All detainees who have the need for prescribed medications should have access to them while in court custody. (5.82)
Achieved

7.36 Mental health liaison and diversion schemes should be available to detainees at all times that the courts are open. (5.83)
Achieved

Section 8. Appendices

Appendix I: About our inspections and reports

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.

The inspections of court custody look at leadership and multi-agency relationships; transfer to court custody; reception processes, individuals 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.

Four key sources of evidence are used by inspectors: observation; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Inspection team

This inspection was carried out by:

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

Appendix II: 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/

Custody Early Warning Score (CEWS)
An adapted version of a health care physiological scoring system for use in custody aimed at identifying detainee health need and reducing morbidity.

Dual-badged officers (DBOs)
Officers who work in custody and who additionally undertake specific training, including MMPR, to work with children.

Enhanced care officers (ECOs)
Officers who only work with and escort children. They undertake specific training, including MMPR, to provide an enhanced level of care and support. They are deployed from a central resource and remain with children throughout their stay in custody.

Escort chain
A mechanical restraint comprising a chain with handcuffs at either end. Normally used when handcuffs would be inappropriate, for example if a detainee was under escort outside of a secure custody environment and needed to use the toilet. During the pandemic, the escort chain has been used to provide social distancing between escorting/custody staff and detainees.

Governor's authority to release
The formal authorisation required to release detainees from court custody if directed by the court if they have originated from a prison. The process involves checking to ensure there are no other reasons that the detainees should be returned to prison and providing any licence conditions that are applicable to the person on release.

HMCTS Listings Protocol
The listing of cases to be heard in courts is a judicial function. There is a protocol between the judiciary and HMCTS which sets out the priorities for the listing of cases. The first priority refers to all custody cases including: overnight custody cases from police stations (including arrest warrants and breach of bail cases), productions from prisons and sentencing cases.

Minimising and managing physical restraint (MMPR)
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.

Person escort record (PER)
The PER is the key document for ensuring that information about the risked posed by detainees on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody. It is a standard form agreed with and used by all agencies involved in the movement of detained people.

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