Report on an inspection visit to court custody facilities in

Cheshire and Merseyside

by HM Chief Inspector of Prisons

30 November – 10 December 2022

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Introduction

This report presents the findings from an inspection of court custody facilities in Cheshire and Merseyside. It covers two combined courts, one crown court and four magistrates' courts.

The prisoner escort and custody services (PECS) arm of HM Prison and Probation Service (HMPPS) had contracted GEOAmey on behalf of HM Courts & Tribunals Service (HMCTS) to provide escort and court custody services in the region.

Multi-agency relationships worked well and were properly focused on the treatment of detainees. A key strength lay in the way staff dealt with detainees. We observed kindness and compassion, and detainees repeatedly told us they were treated well.

However, our most significant concern centred around the lack of GEOAmey staff to carry out tasks in a timely way. This shortage adversely affected detainees because they were not always dealt with promptly and frequently spent too long in court custody.

The inspection found several other areas that also required attention. Risk management was not always good enough. Continuing staff development was weak, particularly in the areas of safeguarding and diversity. Although detainees received a train or bus ticket or money for a taxi so they could get home, release planning was otherwise limited and some who came from prison waited far too long for checks to be undertaken to authorise their release from custody.

The report lists three priority concerns and nine key concerns. We hope they will assist HMCTS, PECS and GEOAmey to deliver the required improvements.

Charlie Taylor
HM Chief Inspector of Prisons
December 2022

What needs to improve in Cheshire and Merseyside court custody

We last inspected court custody in Cheshire and Merseyside in 2012 and made 28 recommendations overall, six of which were about areas of key concern (see Section 7 for a full list).

At this inspection we found that there had been reasonably good progress and 17 of the 28 recommendations had been achieved or partially achieved, including five of the recommendations about key areas of concern. Nine recommendations had not been achieved.

During this inspection we identified areas of concern to be addressed by HM Courts & Tribunals Service, the prisoner escort and custody service and the escort provider. All concerns identified here should be addressed and progress tracked through a plan which sets out how and when they will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

During this inspection we identified three priority concerns. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

1. **The lack of GEOAmey staff adversely affected detainees in a number of ways – including delays in being transferred to and from court and some legal consultations.**

2. **There were weaknesses in the approach to identifying and managing detainees' risks.**

3. **Most detainees who required a governor's authority to be released waited too long, locked in a cell.**

Key concerns

We identified a further nine key concerns.

4. **Continuing development for custody staff was weak, particularly in the areas of safeguarding and diversity.**

5. **Custody staff did not always make sure detainees were aware of their rights while in court custody.**

6. **Some detainee toilet facilities were in poor condition.**

7. **In some facilities, the searching of detainees on arrival was disproportionate.**

8. **Staff did not always offer detainees any of the limited range of distraction activities available.**

9. **Placement orders for children often took too long to obtain, which unnecessarily prolonged their stay in court custody.**

10. **Automated external defibrillators were not always readily available in custody suites, and training in resuscitation skills did not take place frequently enough.**

11. **The provision offered by liaison and diversion services was not consistent. Practitioners were not visible in all custody facilities to assist detainees.**

12. **Release planning was weak, and detainees were not informed of relevant support services.**

Notable positive practice

We define notable positive practice as innovative work 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 prisoners; 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.

Inspectors found no examples of notable positive practice during this inspection.

About court custody in Cheshire and Merseyside

Data supplied by the HM Courts & Tribunals Service cluster, prisoner escort and custody services, and court and escort provider.

HMCTS cluster	Cheshire and Merseyside
Cluster manager	Jayne Jones
Geographical area	Counties of Cheshire and Merseyside

Court custody suites	**Cell capacity**
Chester Crown Court	7 cells
Chester Magistrates' Court	13 cells
Crewe Magistrates' Court	7 cells
Liverpool QEII Law Courts	28 cells
Sefton Magistrates' Court	12 cells
Warrington Law Courts	7 cells
Wirral Magistrates' Court	9 cells

Annual custody throughput	
1 October 2021 – 30 September 2022	15,836 detainees
Custody and escort provider	GEOAmey
Custody staffing	2 senior court custody managers 6 court custody managers 2 deputy court custody managers 69 prisoner custody officers

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 The main agencies involved in the provision of court custody worked well together. Effective communication made sure there was an appropriate balance between delivering the requirements of custody and court business.

1.2 Data were used well to identify areas where improvements were needed. While there was a shared aim to deliver the best possible outcomes for detainees, it was not achieved consistently.

1.3 The lack of GEOAmey staff adversely affected detainees (see paragraphs 2.2 and 3.8). Initial training for custody staff was good and learning was reasonably well embedded. Continuing development for staff was weak and they were not always familiar with policies or procedures. There was, however, a good culture and staff generally dealt with detainees in a kind and compassionate way.

1.4 Managers responsible for custody valued external scrutiny from lay observers and carefully considered the findings from their reports.

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 Vehicles used to transport detainees to and from court custody were clean and well equipped, but women and children still sometimes shared vehicles with adult men. Partitions to safeguard those who shared transport were used more often than previously, but they were still employed inconsistently.

2.2 GEOAmey staff shortages frequently meant vehicles took circuitous routes to collect detainees from multiple locations before taking them to court. This often meant detainees arrived late (See paragraph 1.3 and 3.8).

2.3 Most custody facilities had a secure vehicle bay that was not overlooked. Where there was no private area, not enough attention was paid to maintaining the dignity or privacy of all detainees.

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 Custody staff treated detainees with respect. They communicated with detainees well, which helped to reduce tension and anxieties.

3.2 In several custody suites the names of detainees were displayed on whiteboards in areas where other detainees could see them, which was poor practice.

Meeting individual and diverse needs

3.3 Diversity awareness was now included in the initial training course and new staff had a reasonable understanding. Some established officers did not fully understand how to meet detainees' diverse needs. For example, telephone interpretation services for detainees who spoke little or no English were underused, there was a lack of facilities for those with disabilities or neurodivergent conditions, menstrual care products and disposal units were not always readily available and religious observance material was rarely offered to detainees.

Risk assessments

3.4 There were weaknesses in custody staff's approach to identifying and managing detainees' risks. There was no thorough assessment of their risks on arrival, and staff were rarely adequately briefed about those in their care. While staff were aware of dynamic factors that might affect presenting risks, they did not always conduct observation checks at the required frequency.

3.5 Cell call bells were answered promptly. All court custody and escort staff now carried anti-ligature knives.

Individual legal rights

3.6 Custody staff did not always make sure detainees were aware of their rights while in court custody.

3.7 Legal representatives were routinely advised when their clients had arrived in custody. There were generally sufficient consultation rooms to meet the demand.

3.8 A range of factors contributed to some detainees spending longer in custody than necessary. They included: detainees arriving late at court and long waiting times to see legal representatives, which delayed cases being heard; detainees being taken to court in the morning for afternoon listings (see Glossary) and some unacceptable waits for a transfer to prison once cases had been concluded. (See paragraphs 1.3 and 2.2 and 5.1.)

3.9 On occasion, legal consultations at Liverpool were suspended due to custody staff shortages, which affected the running of court business (see paragraph 1.3).

Complaints

3.10 Custody staff did not promote the complaints procedure well enough or explain it to detainees. Few complaints were received, but responses to the four made in the 12 months to September 2022 were appropriate.

Section 4 In the custody cell, safeguarding and health care

Expected outcomes: Detainees are held in a safe and clean environment in which their safety is protected at all points during custody.

Physical environment

4.1 Conditions were mostly decent and communal areas were presentable. Most cells were in reasonable condition and had less offensive graffiti and fewer serious potential ligature points than we often see. However, cells at Sefton Magistrates' Court were dirty. Some toilet facilities were poor – they were stained, had no seats and lacked dispensers for toilet paper and soap.

4.2 Emergency evacuation procedures had not been practised often enough.

Use of force

4.3 Force was used relatively infrequently and only as a last resort. There was a strong focus on defusing tension and de-escalating situations before force was considered or used.

4.4 Paperwork we reviewed reflected that most of the force used was low level and de-escalated promptly. Although some individual accounts lacked sufficient detail, the overall standard of documentation was adequate. Quality assurance, which GEOAmey managers undertook, had improved and was appropriately focused.

4.5 Handcuffs were now rarely used. The approach to searching was generally appropriate but had become routine in some facilities, which was disproportionate.

Detainee care

4.6 The approach to looking after detainees was good and those we spoke to felt well cared for. Staff offered them drinks and snacks regularly. A range of meals met most detainees' dietary needs, and alternatives could be purchased if necessary.

4.7 The provision of activities to keep detainees occupied was poor. Staff did not recognise how helpful distraction activities could be in improving detainees' well-being and did not offer them to detainees consistently.

Safeguarding

4.8 Too few staff, including some managers, understood the safeguarding policy (see paragraph 1.3). Most staff could identify areas of risk when

given scenarios, but too few were aware of their responsibility to act if needed. This was at least partly because they did not know the contact details of the safeguarding managers either at GEOAmey or HM Courts & Tribunals Service.

Children

4.9 Children held in secure residential facilities usually travelled to court in non-cellular vehicles and received enhanced care from specialist officers (see Glossary). However, children arriving from police stations often shared vehicles with adults (see paragraph 2.1) and did not always benefit from specialist support once they arrived at court.

4.10 On arrival in court custody, children were not always provided with a non-cellular or 'open-door' location, either because of a shortage of staff or because of competing demands on available space.

4.11 There were often lengthy waiting times for a placement order so children could be returned or moved to secure residential facilities. This unnecessarily delayed their departure from court.

Health

4.12 Health Finder Pro (a provider of medical services) offered an effective telephone advice and visiting service. Custody staff gave detainees a limited health screening on arrival using the custody early warning score system (see Glossary) to good effect.

4.13 First aid kits were stocked, but automated external defibrillators were not always readily available, which meant there could be delays in administering life-saving treatment. Resuscitation skills training did not take place frequently enough.

4.14 Staff could administer personal medicines with Health Finder Pro approval, and a small range of stock medicines was held securely. Oversight of administration was appropriate.

4.15 Liaison and diversion services had been affected by staff shortages. Cheshire courts had embedded practitioners who could be contacted easily and were visible in custody suites. However, this was not the case in Merseyside, despite holding detainees with some high levels of need. Detainees were not informed of relevant support services, and there was no specific support for those with drug or alcohol issues.

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 The approach to release planning was weak. While detainees were released promptly and provided with appropriate assistance with transport, such as bus or train tickets or money for taxi fares for their onward journey, staff did not ask about their welfare and did not routinely offer any information about support services. Those remanded or sentenced to prison often experienced lengthy delays owing to a lack of GEOAmey staff before being transferred and did not receive information about the prison (see paragraphs 1.3 and 3.8).

5.2 Most detainees requiring a governor's authority to release them from prison (see Glossary) waited too long, locked in a cell. Court custody managers were not aware of how to escalate concerns about this process.

Section 6 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

Priority concerns

1. **The lack of GEOAmey staff adversely affected detainees in a number of ways – including delays in being transferred to and from court and some legal consultations.**

2. **There were weaknesses in the approach to identifying and managing detainees' risks.**

3. **Most detainees who required a governor's authority to be released waited too long, locked in a cell.**

Key concerns

4. **Continuing development for custody staff was weak, particularly in the areas of safeguarding and diversity.**

5. **Custody staff did not always make sure detainees were aware of their rights while in court custody.**

6. **Some detainee toilet facilities were in a poor condition.**

7. **In some facilities, the searching of detainees on arrival was disproportionate.**

8. **Staff did not always offer detainees any of the limited range of distraction activities available.**

9. **Placement orders for children often took too long to obtain, which unnecessarily prolonged their stay in court custody.**

10. **Automated external defibrillators were not always readily available in custody suites, and training in resuscitation skills did not take place frequently enough.**

11. **The provision offered by liaison and diversion services was not consistent. Practitioners were not visible in all custody facilities to assist detainees.**

12. **Release planning was weak, and detainees were not informed of relevant support services.**

Section 7 Progress on recommendations from the last report

The following is a list of all the recommendations made in the last report.

Main recommendations

HMCTS managers should visit court custody suites regularly, to monitor standards and to resolve or escalate any issues as appropriate.
Achieved

A standard risk assessment proforma should be completed for each detainee, and staff should be trained in completing it.
Not achieved

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, provision of interview rooms and improvements to health and hygiene, should be put in place as soon as possible.
Achieved

There should be a clear policy on the use of the partition in cellular vehicles and escort staff should implement it.
Partially achieved

National issues

There should be a national body to which detainees who have complained about court custody can appeal if they are dissatisfied with the outcome of their complaint.
Achieved

HMCTS should establish agreed standards for treatment and conditions in court custody and include these in the measurement of performance.
Achieved

Recommendations

Court user groups should meet at regular intervals to support communication and good working relationships between key stakeholders in the custody function.
No longer relevant

Defendants brought to court by court enforcement officers, or who attend voluntarily, and who can be dealt with at court on the same day should not be placed in a cell unless there is a good reason to detain them.
No longer relevant

Courts should liaise with HMP Liverpool to resolve the delays experienced in confirming that detainees can be released.
Not achieved

Sufficient comfortable, private and sound-proofed interview rooms should be made available at all courts for legal consultations and the provision of welfare advice.
Achieved

Staff should be told how to use the telephone interpreting service, and telephones should be provided in suitable locations.
Not achieved

At every court, detainees should be told on their arrival about their rights and entitlements, and staff should offer to read or explain them.
Not achieved

Detainees should be transferred from cellular vehicles to the cells in privacy.
Not achieved

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.
Achieved

Hearing loops, and Braille versions of key information for detainees, should be available.
Not achieved

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

Standards of searching should be made consistent and rub-down searches within secure areas should not be routine.
Not achieved

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

Handcuffs should only be used if it is necessary, justified and proportionate.
Achieved

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.
Not achieved

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

A programme of regular deep cleaning should be implemented, and standards of daily cleaning should be improved.
Partially achieved

The toilets adjacent to the staff working area in Liverpool Crown Court should be moved.
Achieved

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

First-aid kits should contain the necessary equipment to deal with incidents that are likely to occur in the environment, such as serious self-harm; they should all be in-date and subject to documented checks.
Achieved

Each court custody suite should hold an automated external defibrillator and equipment to maintain an airway, and staff should be trained to use them.
Partially achieved

All detainees who have the need for prescribed medications should have access to it while in court custody.
Achieved

Court custody staff should be trained to identify and appropriately refer detainees who may be experiencing mental health or substance use-related problems.
Partially achieved

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.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for detainees. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which HMCTS, the prisoner escort and custody service (PECS) should attend to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work 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 prisoners; 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.

Inspection team

This inspection was carried out by:

Kellie Reeve	Team leader
Jeanette Hall	Inspector
Steve Oliver-Watts	Inspector
Fiona Shearlaw	Inspector
Paul Tarbuck	Health and social care inspector
Dayni Johnson	Care Quality Commission inspector

Appendix II Glossary

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
An adapted version of a health care physiological scoring system for use in custody aimed at identifying detainee health need and reducing morbidity.

Enhanced care officers
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.

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.

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

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