Report on an inspection visit
to court custody facilities in

Humber and South Yorkshire

by HM Chief Inspector of Prisons

27 November – 9 December 2023

Contents

Introduction

This report details findings from an inspection of court custody facilities in Humber and South Yorkshire. It covers four Crown courts and five 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.

Overall, this was a positive inspection with many features to applaud. We were very pleased to find that detainees felt well cared for, with good attention to meeting their individual needs. Interactions between custody staff and detainees were generally very good and undoubtedly contributed to the low levels of force used. The introduction of bespoke rooms to hold children in Sheffield magistrates' court was an excellent initiative and we hoped this would be replicated in other court custody facilities across England and Wales.

The access to medical support services had been transformed and was providing much improved care to detainees. Following a major financial commitment from HMCTS, this was the first area where automated external defibrillators were readily available in all of the custody suites we visited.

The strong multi-agency relationships were focused on making sure detainees were dealt with promptly. While this was not always achieved, there was useful monitoring and oversight to try to prevent or address issues as they occurred. The staffing challenges faced by GEOAmey were managed proactively but, despite this, some detainees were still delivered late to court and remained in custody for too long at the conclusion of their hearings before they were moved to prison.

There was one area that caused us greatest concern, which we encouraged leaders to address as a matter of urgency. That was the frequent and arguably disproportionate searching of detainees without an individual risk assessment. Moving forward, other areas that required more attention included the management of detainees' risks, improved provision of distraction activities, sustained efforts to make sure that conditions in all custody facilities were clean and well maintained, and the unsatisfactory arrangements for many people released from court custody.

The report lists one priority concern 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
January 2024

What needs to improve in Humber and South Yorkshire court custody

We last inspected court custody in Humber and South Yorkshire in 2015 and made 40 recommendations overall, eight of which we considered key concerns, (see Section 7 for a full list).

At this inspection we found that there had been good progress and 28 of the 40 recommendations had been achieved or partially achieved, including six of the recommendations of greatest concern. Eleven recommendations had not been achieved.

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

Priority concerns

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

1. **Excessive routine searching of detainees without any individual risk assessment was often disproportionate.**

Key concerns

We identified a further eight key concerns.

2. **GEOAmey staff shortfalls were causing delays to the transfer of detainees to and from court.**

3. **Some reception interviews were rushed and not conducted in private.**

4. **Staff were not always briefed about detainee risks, and observation checks were often cursory and not always carried out at the required frequency.**

5. **A range of factors led to some detainees being held in court custody for longer than needed.**

6. **There was too little reading material or other distractions for detainees at most courts.**

7. **Some cells were not clean enough and not sufficiently well maintained.**

8. **Staff training in resuscitation skills did not take place with sufficient frequency.**

9. **Detainee release arrangements were weak.** Some risk assessments were cursory and did not adequately identify welfare needs, some detainees were locked into cells pending their release, and serving prisoners often waited too long for their release to be authorised.

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 five examples of notable positive practice during this inspection.

- Artwork displayed in the Sheffield court custody facilities softened what were otherwise austere environments. (See paragraph 4.1)
- Doncaster Crown court displayed a selection of reading and distraction materials, including some games, so detainees could choose what they wanted, with a better take-up than we see elsewhere. (See paragraph 4.11)
- The two private child-friendly rooms in Sheffield magistrates' court custody facility were a much-needed improvement from the conditions we normally see. They were painted in warm colours, had fitted carpets, pictures on the walls, comfortable seating and a TV, as well as a range of distraction activities. (See paragraph 4.15)
- This is the first inspection where we have seen systematic provision of automated external defibrillators (AEDs) in all court custody suites to allow swift treatment of detainees following a cardiac event. (See paragraph 4.17)
- The health needs of detainees were met promptly by informed custody staff, due to the reliable and rapid availability of medical consultation and visiting paramedics to assess and treat as necessary. (See paragraph 4.18)

About court custody in Humber and South Yorkshire

Data supplied by HMCTS cluster and custody and escort provider.

HMCTS cluster	Humber and South Yorkshire
Cluster manager	Tracy McCrea
Geographical area	Counties of Humberside and South Yorkshire

Court custody suites	**Cell capacity**
Barnsley Magistrates' Court	9 cells
Beverley Magistrates' Court	7 cells
Doncaster Crown Court	6 cells
Doncaster Magistrates' Court*	10 cells
Grimsby Combined Court Centre	6 cells
Grimsby Magistrates' Court	9 cells
Hull Combined Court Centre	8 cells
Hull Magistrates' Court	19 cells
Sheffield Combined Court Centre	16 cells
Sheffield Magistrates' Court	17 cells

*Closed at time of inspection with magistrates' work moved to Doncaster Crown Court

Annual custody throughput	15,686 detainees (October 2022 to September 2023)
Custody and escort provider	GEOAmey
Custody staffing	2 senior court custody managers 6 court custody managers 5 deputy court custody managers 45 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 relationships between the main agencies involved in the provision of court custody were strong and cohesive. Leaders from the respective agencies were properly focused on detainee welfare and well sighted on most areas that fell below the required standards. They met regularly to understand and address issues, including the conditions detainees were held in as well as shared concerns that they spent longer in custody than expected.

1.2 There were ongoing challenges with shortages of GEOAmey staffing which sometimes had an adverse impact on outcomes for detainees. This was most acute in the promptness of their delivery to court (and often worse when detainees had been displaced to out-of-area prisons), which sometimes affected the timeliness of their hearings and the subsequent onward movement to prison if required. The respective agencies were sighted on and closely monitored issues around late delivery to court. They reallocated work where possible but efforts to minimise disruption to both detainees and court business were not always successful.

1.3 A range of data on outcomes for detainees was monitored and used to influence improvements. Weekly meetings considered the detainee journey through custody and any identified shortfalls were acknowledged and tackled robustly, where possible.

1.4 Leaders and managers responsible for custody valued the 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 Most detainees had relatively short journeys to the courts and travelled in clean, well-equipped vehicles. They generally alighted quickly, especially when staff appropriately prioritised detainee welfare over property checks. Most vehicle docks were secure, except at Grimsby and Sheffield magistrates' courts, where staff routinely handcuffed detainees. However, handcuffs were not always removed promptly once the detainee was in a secure location. Detainee privacy while disembarking vehicles was well managed. Women and children still shared vehicles with adult males, but the use of partitions helped to mitigate risks.

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 Most custody staff treated detainees with respect, and we observed some caring, patient and reassuring interactions. However, some reception interviews lacked privacy and were rushed, and did not always consider decency for detainees. We saw some interviews conducted while detainees were still handcuffed, and on one occasion inappropriately with someone while they were using the toilet.

3.2 In several facilities, noticeboards displaying information about individuals in court custody could be seen by other detainees, which was poor practice.

Meeting individual and diverse needs

3.3 Custody staff were well intentioned and described how they would meet a range of individual and diverse needs. Women received reasonable care. Staff knew the correct arrangements for meeting the needs of transgender detainees, but some lacked confidence about the appropriate terminology.

3.4 The needs of detainees wishing to observe their religion were generally well met. Arrangements for detainees who spoke little or no English had improved and custody staff now used professional telephone interpreting more confidently. Important documentation was available in a range of foreign languages, but not in Braille.

3.5 Only two courts had basic adaptations for detainees with mobility difficulties, and hearing loops were not available in custody suites. Most custody staff had insufficient knowledge about how to support detainees with neurodivergent conditions.

Risk assessments

3.6 There were some gaps in the identification and management of risk. While escort staff shared relevant risk information about detainees, custody staff were not consistently briefed about those in their care, and some were unsure of presenting risks. Staff were alert to detainee vulnerabilities and how these might fluctuate throughout their stay in

custody. Some observation checks were, however, cursory and not always carried out at the required frequency.

3.7 All staff now carried anti-ligature knives, and routes to the court were safe. Cell call bells were generally answered promptly.

Individual legal rights

3.8 Staff rarely explained to detainees' their rights and did not always make sure that they were able to read and/or understand documentation. Information detailing rights was available in cells but was sometimes in a poor condition.

3.9 Some custody facilities lacked sufficient interview rooms to facilitate legal consultations, which resulted in queues. While some rooms were not sufficiently private, staff supervised them discreetly.

3.10 Despite some good oversight, a range of factors contributed to some detainees spending longer in custody than necessary. They included: detainees arriving late at court, which potentially delayed their hearings (see paragraph 1.2); cell capacity not always meeting demand; custody court sessions starting late and long waiting times to see legal representatives, sometimes linked to delays in receiving electronic case papers; the non-attendance of court-appointed interpreters; detainees arriving in the morning for afternoon listings; and some long waits to move detainees to prison once their hearings had concluded.

Complaints

3.11 Custody staff did not explain the complaints procedures well enough to detainees. Complaints were rare but were dealt with appropriately.

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 Most communal areas were presentable, decent and safe. Artwork was displayed throughout the Sheffield custody facilities, which softened the otherwise austere environments.

4.2 Some cells were, however, not clean enough. Others had considerable graffiti (although none that we saw was overtly offensive) etched into chalk boards or the reverse of cell doors. Few cells had natural light. We found potential ligature points in most facilities. We provided a comprehensive report of our findings to HMCTS which was responded to appropriately.

4.3 Most toilets lacked a seat and sufficient privacy but were clean and supervised discreetly. Generally, there were sufficient supplies of toilet paper and paper towels in dispensers, and handwashing facilities were good.

4.4 Emergency evacuation routes were mostly known to staff, but care was needed to make sure visiting staff were also made aware. Evacuation drills took place but needed to include an opportunity for staff to practise the evacuation procedures practically.

Dirty cell wall at Doncaster Crown court

Use of force

4.5 The use of force against detainees was infrequent. Our review of the associated paperwork and conversations with staff and managers provided reasonable assurance that force was used only as a last resort, was proportionate to the risk posed and was deescalated quickly.

4.6 Handcuffs were no longer used routinely in custody facilities, which was positive. However, more attention was required to make sure they were only applied for the shortest time when detainees boarded and alighted escort vehicles in unsecure areas (see paragraph 2.1).

4.7 The excessive and disproportionate searching of detainees was a major concern. All detainees were searched multiple times during their stay in court custody without a good reason.

Detainee care

4.8 The detainees we spoke to told us that they were content with the care they received in court custody, which was consistent with our observations.

4.9 The range of meals and snacks provided met most cultural and dietary needs, and staff could use petty cash to buy alternatives if required. It was, however, disappointing that some detainees who arrived hungry were refused food until a standard mealtime.

4.10 Detainees generally had too little to do to occupy themselves while waiting in their cells. Distraction packs and a limited selection of books,

old newspapers and magazines were generally available, but were provided relatively infrequently. There were chalk boards in most cells, which were well used by some detainees for drawing.

4.11 The situation at Doncaster Crown court was much better. Reading and distraction materials, including some games, were laid out so that detainees could see what was available and select what they wanted. They were also encouraged to choose something, which increased take-up and was appreciated.

Safeguarding

4.12 Oversight of safeguarding procedures was good. The few safeguarding referrals that had been submitted (three in the last year) were recorded and referred to the relevant authorities swiftly, and appropriate support was offered to the detainees concerned.

4.13 Staff were aware of both child and adult safeguarding procedures and knew how to contact the safeguarding team, whose names and contact details were prominently displayed.

Children

4.14 Relatively few children were held in the custody facilities. Specially trained staff were generally available and tried to find the most suitable place for children to be held away from adult detainees.

4.15 At Sheffield magistrates' custody suite, the holding areas were much more child-friendly. Two rooms, the first of their kind that we have seen, had been refurbished and equipped specifically for children, with warmer colours, fitted carpets, comfortable seating, pictures and a TV. Each room was equipped with its own box of games and distraction materials.

Children's room at Sheffield magistrates' custody suite

Health

4.16 Health Finder Pro (HFPro), a private health services provider, was contracted to provide medical services to detainees, and did so effectively. Custody staff told us that the medical support available to them had been transformed in 2023, resulting in greater confidence in assisting detainees with health risks. They also generally used Custody Early Warning Scores (CEWS, see Glossary) appropriately to screen detainees who presented health risks on arrival.

4.17 Staff had ready access to first aid supplies and, notably, this was the first region we have visited where automated external defibrillators (AEDs) were available in every custody facility to allow swift treatment of detainees following a cardiac event. Custody staff were up to date with first aid training, but refreshers for resuscitation skills did not take place with sufficient frequency.

4.18 Custody staff were confident in using the available HFPro services to meet the health needs of detainees. The medical consultation response was reliable and rapid, and often involved the attendance of HFPro paramedics to assess and treat detainees.

4.19 The liaison and diversion services in both Humberside and South Yorkshire provided a range of interventions for vulnerable individuals in custody, such as assistance with finding housing and mental health assessment.

4.20 Substance misuse workers from local community providers were also embedded in the busiest courts and offered detainees community treatment options for addictions.

4.21 Detainees had suitable access to prescribed medicines, which were securely stored and administered appropriately. Subject to a risk assessment, detainees could now retain in their possession urgent response medicines, such as inhalers and EpiPens. It was detrimental to detainees that treatment to minimise withdrawal symptoms was no longer available.

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 In their desire to release detainees quickly, custody staff tended to rush release risk assessments. This meant they often failed to make sufficient inquiry about detainee welfare. For example, some risk assessments were cursory and did not adequately identify welfare needs. Some detainees received good support, but others were released with unmet needs, such as no accommodation or assistance to address this. Detainees were, however, routinely offered travel warrants and money for bus or taxi fares, if needed. At Sheffield magistrates' court, custody staff locked detainees ready for release in a cell while they prepared the relevant paperwork, which was inappropriate.

5.2 Although courts had some printed information about support services, it was not tailored to specific localities. Leaflets about local prisons, intended to support detainees remanded to custody, were out of date. Neither the release nor the prison information was routinely offered to relevant individuals. Some detainees waited in court custody for too long before their onward transfer to prison (see paragraphs 1.2 and 3.10).

5.3 The process of securing authority to release serving prisoners took too long, at six hours in one case during the inspection. We were also told of many individuals who were returned to prison for this process to be completed, which further delayed release and was not a good outcome for them.

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 excessive routine searching of detainees without an individual risk assessment was disproportionate.**

Key concerns

2. **The lack of GEOAmey staff had an adverse effect on detainees in several ways, including delays in their transfer to and from court.**

3. **Some reception interviews were rushed and not conducted in private.**

4. **Staff were not consistently briefed about detainee risks, and observation checks were often cursory and not always at the required frequency.**

5. **Some detainees were held in court custody for longer than necessary because of a range of factors.**

6. **There was too little reading and distraction material for detainees at most courts.**

7. **Some cells were not clean enough and not sufficiently well maintained.**

8. **Staff training in resuscitation skills did not take place frequently enough.**

9. **There were weaknesses in detainees' release arrangements.** Some risk assessments were cursory and did not adequately identify welfare needs, some detainees were locked into cells pending their release, and serving prisoners often waited too long for their release to be authorised.

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

Court custody staff should be trained to identify and refer detainees about whom they have child protection or safeguarding concerns.
Achieved

A professional telephone interpreting service should be available in each custody suite and used as necessary.
Partially achieved

Person escort record should contain sufficient accurate, legible risk information and health care advice to inform risk assessment and facilitate the care of detainees.
Not achieved

Staff should complete a standard risk assessment form for each detainee, and be trained to do this.
Not achieved

Handcuffs should only be used if necessary, justified and proportionate.
Partially achieved

National issues

Her Majesty's Courts and Tribunal Services (HMCTS) and Prison Escort and Custody Services (PECS) should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody.
Achieved

HMCTS and PECS should clarify the responsibilities of each organisation for resolving problems.
Achieved

Complaints in court custody should be monitored and complaints should be included in the measurement of performance.
Achieved

Recommendations

There should be regular inter-agency forums covering all courts in the cluster, and their remit should include improvements in the care of detainees in court custody.
Achieved

Quality assurance processes should be more effective in encompassing key elements of detainee care and rights during escorts and court custody.
Achieved

There should be a designated officer in charge, responsible for the safe, respectful and decent delivery of court custody.
Achieved

HMCTS should ensure that custody cases are prioritised where possible, and this should be monitored.
Partially achieved

Detainees who have attended court voluntarily, and who can be dealt with at court on the same day, should not be detained in cells unless there is good reason to do so.
Achieved

HMCTS and PECS should liaise with the Youth Justice Board to reduce delays in transferring children to secure training centres.
Achieved

All courts should offer detainees information about their rights, including the process for making a complaint, and staff should offer to read or explain the information if necessary.
Partially achieved

There should be sufficient comfortable, private consultation rooms at all courts.
Partially achieved

Cellular vehicles should be clean and free of graffiti.
Achieved

Men, women and children should not be carried in the same escort vehicle, and detainees should be transferred from cellular vehicles to the court cells out of public view. Detainees should not be embarked or disembarked from escort vehicles in public view.
Partially achieved

Children in court custody should be supported by a specifically trained named staff member.
Achieved

Custody officers should receive sufficient training to meet the diverse needs of detainees held in court custody.
Achieved

GEOAmey should produce a policy, in line with police and Prison service guidance, setting out the correct approach to caring for transgender detainees, and ensure that staff implement it.
Achieved

There should be a small stock of mattresses and blankets or warm clothing for detainees who are pregnant, older or have disabilities.
Not achieved

All court custody suites should have materials for observance of the main religions. Materials should be suitable and be respectfully stored. There should be a means for determining points of the compass.
Achieved

All court custody suites should have hearing loops as well as Braille versions of key information.
Not achieved

All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers, and this should be offered to detainees routinely.
Not achieved

Information about detainees should not be displayed in public view.
Not achieved

All custody staff should receive a briefing focused on risk management and the care of vulnerable detainees at the start of duty.
Partially achieved

Cell sharing risk assessments should be completed for all detainees before they share a cell.
Partially achieved

Staff should record the outcome of all cell visits accurately in the detention log.
Partially achieved

Staff undertaking observations and cell visits should carry anti-ligature knives at all times.
Achieved

Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave custody.
Not achieved

Each court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages for detainees leaving custody.
Not achieved

The searching of detainees should be proportionate to the risks posed.
Not achieved

A programme of regular deep-cleaning, graffiti removal and cell repairs should be implemented immediately.
Not achieved

All detainees should be able to use the toilet in privacy.
Not achieved

Custody staff should understand how and when to call Taylor Made, including its role in providing advice and medical triage.
Achieved

Custody staff should be appropriately trained in: emergency response skills, including the use of automated external defibrillators, with annual refresher training; mental health awareness; and drug and alcohol awareness.
Partially achieved

First-aid equipment should include sufficient in-date kit to manage all predictable incidents, including automated external defibrillators and equipment to maintain an airway.
Achieved

All detainees should be able to have asthma inhalers and glucose blood testing equipment with them at all times, unless a formal risk assessment indicates otherwise.
Achieved

Where sending establishments have omitted vital information from the person escort record (PER) pertaining to the health and welfare of a detainee, there should be formal escalation process to ensure lessons are learnt and mistakes are not repeated.
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
David Foot	Inspector
Jeanette Hall	Inspector
Fiona Shearlaw	Inspector
Paul Tarbuck	Health and social care 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 (CEWS)
An adapted version of a health care physiological scoring system for use in custody aimed at identifying detainee health need and reducing morbidity.

HMCTS
His Majesty's Courts & Tribunals Service.

PECS
Prisoner escort and custody services.

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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