Report on an inspection visit
to court custody facilities in

Lancashire and Cumbria

by HM Chief Inspector of Prisons

28 July – 10 August 2022

Contents

Introduction

This report presents the findings from an inspection of court custody facilities in Lancashire and Cumbria. It covers three combined courts, one Crown court and seven 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. Generally, we found that these agencies worked well together to improve outcomes, although a renewed focus on improvement was required.

On this visit we found some good progress since our last inspection in 2013, with about three-quarters of the recommendations we made previously, and which remained relevant, having been achieved or partially achieved. While some findings during the present inspection still required improvement, on the whole, detainees were treated with kindness and compassion, many being very positive when telling us about how staff had looked after them during their time in court custody.

The main areas of concern included the great variability in conditions across the custody estate. Some, particularly in Lancashire, were barely fit for purpose. There was also only one custody suite across the whole cluster that was suitable for detainees with impaired mobility. In several facilities detainees routinely alighted vehicles in full view of the public which was undignified and caused embarrassment. Many detainees who originated from a prison and who were freed by the court continued to be held in cells for too long awaiting formal authority for release by a prison governor.

The report lists three priority concerns and 12 key concerns and hopes they will assist HMCTS, PECS and GEOAmey to deliver further improvement.

Charlie Taylor
HM Chief Inspector of Prisons
August 2022

What needs to improve in Lancashire and Cumbria court custody

We last inspected court custody in Lancashire and Cumbria in 2013 and made 36 recommendations overall, five of which were about areas of key concern (see Section 7 for a full list).

At this inspection, we found that there had been good progress and 17 of the 36 recommendations had been achieved, including one 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 and Tribunals Service (HMCTS), the Prisoner Escort and Custody Services (PECS) and the escort provider. All concerns identified here 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 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. **Where custody facilities did not have secure vehicle bays, detainees alighted in public areas or areas that could be overlooked, a practice that was both undignified and embarrassing.**

2. **Some custody facilities, particularly in Lancashire, were not sufficiently clean, safe, or well-maintained.** Identified potential ligature points could have posed a risk to some detainees.

3. **Serving prisoners who had been released by the court, and who were additionally subject to a prison governor's authority (see Glossary) to release, often had long waits in cells before they were allowed to leave custody.**

Key concerns

We identified a further 12 key concerns.

4. **There was not always an effective shared strategic focus on the provision of court custody. HMCTS, PECS and GEOAmey were not always properly sighted on areas where treatment of and conditions for detainees needed to be better.**

5. **Accurate data concerning the treatment of detainees was not collated or used to inform organisational learning or to improve outcomes.**

6. **Women and children continued to be transported in the same vehicles as men, particularly when collected from police stations.** This did not adequately safeguard these detainees.

7. **Training and ongoing development activity to help custody staff to identify and meet diverse needs was weak.**

8. **Preston Crown Court housed the only designated court custody facility across Lancashire and Cumbria for detainees with impaired mobility.** Some detainees therefore had very long journeys to and from court, and often experienced delays in their cases being heard.

9. **Telephone interpretation services were not always used when necessary and some custody facilities had no access to the service.** As a result, staff missed valuable opportunities to identify risks and needs, promote welfare and make sure that the detainee understood what was happening.

10. **Custody staff did not always complete an initial assessment with detainees to explore risks or welfare issues.** Detainee checks were not always conducted at the required frequency and were not always recorded accurately.

11. **A range of factors led to some detainees being held in court custody for longer than necessary.** Not enough was being done to understand or address the extent of the problem.

12. **Only a very limited supply of reading materials and other distraction activities, such as puzzles and word searches, were readily available.** These were not offered or provided routinely to detainees who otherwise had little or nothing to help them pass the time in court custody.

13. **Care for children was not always good enough.**

14. **Custody staff completed first-aid training only every three years, which was not sufficient to maintain a level of confidence and competence.**

15. **Automated external defibrillators were not readily available in custody in the event of a cardiac arrest.**

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 Lancashire and Cumbria

Data supplied by HM Courts & Tribunals (HMCTS) cluster, Prisoner Escort and Custody Services (PECS), and court and escort provider

HMCTS cluster	Lancashire
Cluster manager	Laura Connor
Geographical area	Counties of Lancashire and Cumbria
Court custody suites	**Cell capacity**
Crown Courts	
Burnley Combined Court	6 cells
Carlisle Combined Court	8 cells
Preston Combined Court	17 cells
Preston Crown Court (Sessions House)	7 cells
Magistrates' courts	
Barrow-in-Furness Magistrates' Court	6 cells
Blackburn Magistrates' Court	12 cells
Blackpool Magistrates' Court	10 cells
Burnley Magistrates' Court	4 cells
Carlisle Magistrates' Court	5 cells
Preston Magistrates' Court	6 cells
Workington Magistrates' Court	6 cells
Annual custody throughput (1 June 2021 to 31 May 2022)	14,389 detainees
Custody and escort provider	GEOAmey
Custody staffing	2 senior court custody managers 8 court custody managers 2 deputy court custody managers 54 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 HMCTS, PECS and GEOAmey each had a separate but clear leadership structure for custody. Good progress had been made against recommendations made at the last inspection in 2013.

1.2 Despite this, we found evidence to suggest coordination between the main agencies could be better. For example, communication between custody staff and their counterparts in HMCTS was sometimes too limited and escalation arrangements were unclear, often delaying needed interventions from managers in HMCTS, GEOAmey or PECS when problems emerged. Similarly we also found that the leadership focus on improving outcomes for detainees was often lacking, although this was slightly better after the announcement of the inspection.

1.3 There were ongoing challenges with the recruitment and retention of staff. Sufficient custody staff were not always readily available at facilities, although we saw no evidence that this adversely impacted how detainees were looked after.

1.4 The commitment to training and ongoing development of custody staff was now appropriate and a comprehensive range of policies concerning how detainees were to be treated was available. However, understanding concerning what was expected was not always well embedded amongst staff, particularly in relation to identifying and meeting diverse needs.

1.5 We had difficulties obtaining accurate data from the main management stakeholders concerning detainee experiences. Collation was limited, gaps were evident, and some material was inaccurate. It became clear to us that data was hardly used to inform organisational learning or to improve outcomes for detainees.

1.6 External scrutiny by independent lay observers had resumed in most courts. Their reports were taken account of and often acted on, particularly in relation to low-level issues concerning the custody estate.

Section 2 Transfer to court custody

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

2.1 Detainees were transferred to court in safe and well-equipped vehicles, but they were not clean. Women and children still shared transportation with men too often, especially from police stations. This was mitigated slightly by the use of partitions between the cellular compartments, which afforded a degree of separation. However, we saw men being held in the same separated compartment, which negated the use of the partition.

2.2 There were not always sufficient vehicles available, which meant either multiple collections or long journeys to collect detainees from numerous locations before delivering them to court. The latter and the geography of the region resulted in some long journeys and delays in delivering detainees to court (see also paragraph 3.22).

2.3 Most courts had a secure vehicle bay which was not overlooked. However, several in the region had no secure area for detainees to alight and not enough was done to protect them from public view. We saw detainees' privacy and dignity being compromised on several occasions. Those who had been handcuffed and escorted through a public thoroughfare described being embarrassed by the experience and we saw some being subject to abuse and comments from members of the public. A minority of detainees who arrived from a police station were not dressed appropriately for court.

2.4 With a few exceptions, digital person escort records (see Glossary) contained sufficient information about detainee risks, medication and property.

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 were welcoming to new arrivals and interactions with detainees were respectful and calm. Even when detainees were agitated, staff remained polite and patient, showing kindness and compassion.

3.2 At the previous inspection, we highlighted the risk to confidentiality of allowing detainees to see whiteboards displaying the names of others held. It was therefore disappointing to find that, in five courts, this was still the case.

Meeting individual and diverse needs

3.3 New custody staff received minimal training around the promotion of equality and meeting individual and diverse needs. More established staff told us they had completed little or no training/development activity in this area. Many, as a consequence, lacked confidence meeting the diverse range of needs for detainees with whom they came in to contact.

3.4 Staff now knew about the telephone interpretation service, but they did not always use it when needed, particularly when detainees first arrived. They therefore missed opportunities to identify risks or needs, explain processes and answer detainee questions. Preston and Workington Magistrates' Courts did not have a telephone suitable for use with a detainee, and at Burnley Magistrates' Court the service was used with detainees while they were handcuffed in the main office, where confidential information was displayed.

3.5 All courts had a box of religious items, appropriately stored. These were not always offered on arrival. Records showed that religious items were issued rarely in most locations.

3.6 Preston Crown Court was the only accessible court for detainees unable to use stairs. These detainees often had extended waits for transfer to Preston and many experienced long journeys to get there. Once there, they often waited until the end of the day to be seen. On release, these detainees could have long journeys home, often on public transport. Aside from a lift to the courtrooms, the only other

adaptations were a rail and back rest in a toilet and a wheelchair accessible cell.

3.7 Women in custody were held in cells apart from the men. A suitable range of menstrual care products was freely available in all courts and most had a sanitary waste disposal bin. However, at Burnley Magistrates' Court (where most toilets were in-cell), women had to ask staff to dispose of used menstrual care products, which was humiliating and unsatisfactory.

3.8 Staff were alert to signs of mental ill-health and were aware that people with neurodiverse conditions such as autism might need extra support. However, they did not readily use the distraction resources available in suites to help detainees cope with detention (see also paragraph 4.15).

3.9 Most staff could explain how they would care for transgender detainees and recognised the importance of listening to their preferences. However, a few staff used some insensitive language when talking about such detainees and needed more familiarity and confidence with appropriate terminology.

Risk assessments

3.10 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. Escort staff shared relevant information about detainees with custody staff, who checked the risk information and warning markers recorded in the detainee's digital person escort record (dPER; see Glossary). A few of the dPERs we reviewed did not provide sufficient accurate or up-to-date information to support the effective assessment of risk.

3.11 Initial interactions with detainees were positive, but frequently lacked privacy and were often too brief. A basic reception checklist was not used consistently and detainees were not always asked about their current state of health, risks or welfare issues.

3.12 Staff were alert to dynamic risk factors concerning detainees' vulnerability, instability or low mood. Detainees at risk of self-harm or suicide were observed more frequently, or constantly.

3.13 Most staff understood the level of checks needed to maintain the safety and welfare of detainees. The checks we observed were mostly completed at the required frequency, but they were not always recorded accurately.

3.14 The sharing of information to make sure that all staff knew about the risks relating to detainees in their care varied considerably. There were thorough verbal briefings at some courts, but at others no briefing took place, or a written briefing was completed which was not always sufficiently informative.

3.15 Some limited cell sharing had been reintroduced since the lifting of pandemic restrictions, but cell sharing risk assessments were not always completed when needed. Detainees who were new to court custody were told how to use the cell call bells, which were answered promptly. All court custody and escort staff now carried personal-issue anti-ligature knives.

3.16 The few risk assessments we saw for detainees received off-bail (see Glossary) were rushed, did not take place in private and did not put detainees at ease.

Individual legal rights

3.17 Information detailing detainees' rights while in custody was present in all cells, but not all detainees were advised of this. Staff told us that they would explain the rights document to detainees who needed help with reading. However, they did not always check if such help was needed.

3.18 Legal representatives were routinely advised when their clients had arrived in custody. There were enough private and soundproof consultation rooms to meet demand.

3.19 In Cumbria, staff would advise the detainee's family or friends of their whereabouts. This did not happen in Lancashire, where such requests were routinely referred to the detainee's legal representative.

3.20 There was a strategic commitment to prioritising custody cases through the HM Courts & Tribunals Listings Protocol (see Glossary), but this was not always achieved. A range of complex factors contributed to detainees spending longer in custody than strictly necessary, some of which had a cumulative impact. Not enough was being done to understand and address this.

3.21 Not all custody staff made efforts to have custody cases involving children and vulnerable detainees prioritised. When custody staff made requests for cases to be prioritised, communication from court staff was limited or non-existent and it was generally unclear why this did not happen. However, we acknowledged that some cases were delayed in the best interest of the detainee – for example, while attempts were made to source alternative accommodation or secure bail applications.

3.22 Some detainees' arrival at court was delayed because there were no vehicles to transport them or vehicles were diverted to collect from multiple locations (see also paragraph 2.2).

3.23 Courts responsible for hearing cases for detainees held in custody did not always start promptly and some detainees arrived in the morning, even if their case was listed for the afternoon. At the conclusion of their cases, some detainees experienced long waits to transfer to prison; the longest that we identified was around five

hours. Delays were, again, usually caused by the lack of available vehicles.

3.24 Legal representatives did not always receive case files from the Crown Prosecution Service in good time, which delayed consultations with their clients. Some detainees also had their consultations delayed if their legal representative had poor availability because of dealing with multiple clients. A national barristers strike was in place during the inspection and this was having an impact on their availability.

3.25 Non-English-speaking detainees were sometimes affected by poor availability of court-appointed interpreters to help with their cases.

Complaints

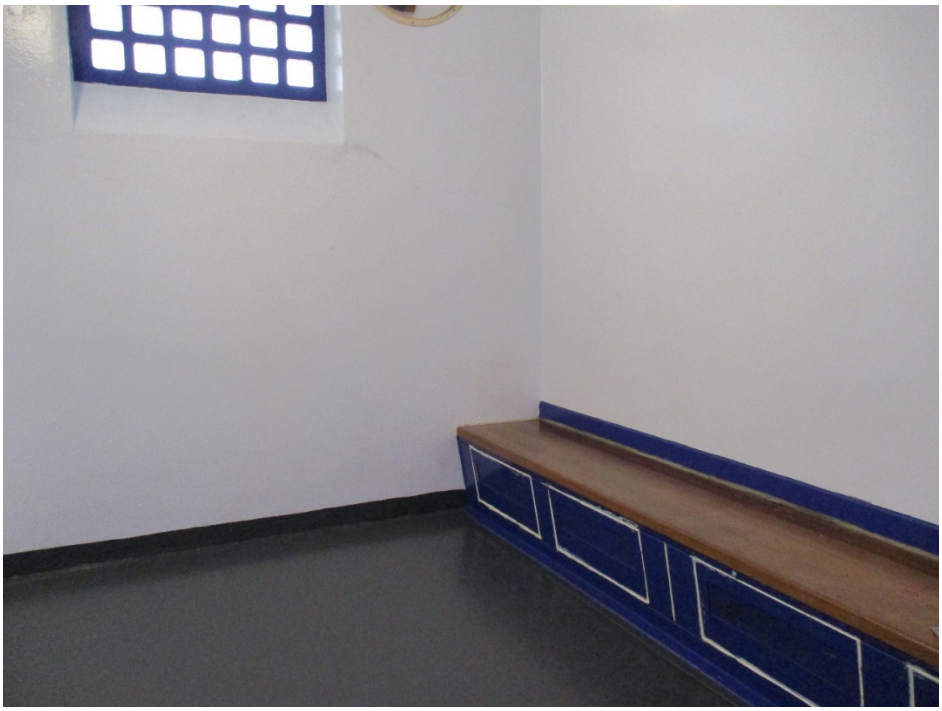
3.26 Custody staff had a reasonable awareness of the complaints procedure. Detainees were given information about complaints on arrival. Few complaints were received. The five dealt with in the 12 months to June 2022 were responded to appropriately.

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.

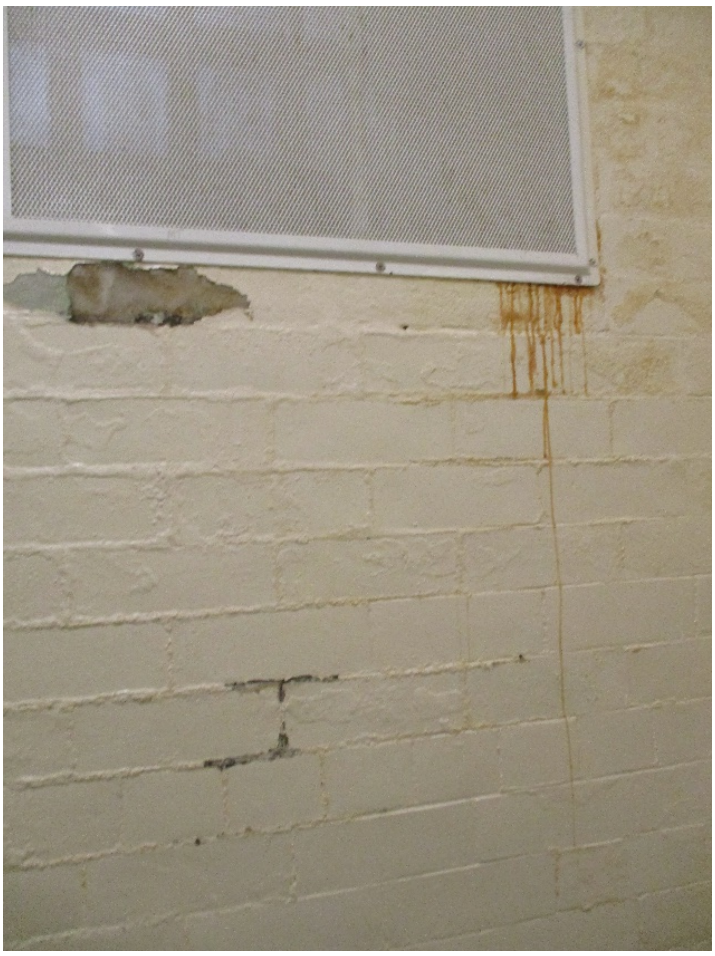
Physical environment

4.1 Conditions across the estate varied considerably, from very good to poor. In Cumbria, the cells were clean and mostly well maintained, but some of the facilities in Lancashire were barely fit for purpose.



Clean and well-maintained cell in Carlisle Magistrates' Court

4.2 Too many cells were either superficially clean or grubby with built-up dirt in corners, and some had extensive graffiti (some of which was offensive) on the rear of doors and benches. Many cells at Blackburn Magistrates' Court were out of action, and had been for a long period, because of issues with the toilets. These cells smelled rancid. Preston Crown Court Sessions House was an old building and some of the cells there were damaged due to damp, but remained in use. At Blackpool Magistrates' Court, the walkway from the vehicle bay to the custody suite was messy with bird guano and other hazards, despite recent attempts being made to improve it. We found a small number of potential ligature points in most facilities, generally caused by gaps around doors or the lack of sealant under or around benches. We provided a separate, illustrative report of our findings.



Cell at Preston Crown Court Sessions House

4.3 Minor repairs were carried out quickly, but painting and expensive repairs were more difficult to arrange because of budgetary constraints and complex contractual arrangements.

4.4 Routine cleaning took place outside operating hours, but not after the Saturday sittings at Carlisle and Barrow Magistrates' Courts, which was unacceptable. The contractor for specialist cleaning of body fluids was responsive and effective.

4.5 The heating was not controlled directly in any of the suites. Although temperatures were taken each day, some detainees told us that they were cold.

4.6 Routes to court were safe and did not pass through public areas. Enough fixed or personal alarms were available.

4.7 Staff knew the emergency evacuation plans, but did not practise them with detainees regularly enough.

Use of force

4.8 Force was used relatively infrequently. We were told of 23 incidents since 1 June 2021, although documentation relating to three of these reflected multiple incidents which should have been recorded

separately. No incidents involved the use of minimising and managing physical restraint (see Glossary) against children.

4.9 Most staff were up to date with their control and restraint training. They were focused on using force only as a last resort and knew of the requirement to report incidents.

4.10 Staff communicated well with detainees and skilfully de-escalated situations, particularly when detainees exhibited challenging behaviour. This potentially avoided force being used.

4.11 We reviewed the records for all of the incidents since June 2021. They reflected efforts to de-escalate situations and most involved only low-level force or restraint to prevent self-harm or when detainees refused to leave the dock or board vehicles. Although some individual statements lacked sufficient detail about the techniques used, most were of an adequate standard. Records showed that, on a couple of occasions, detainees had been left handcuffed and alone in a cell, which was inappropriate.

4.12 Quality assurance of documentation was developing. A GEOAmey manager had recently taken responsibility for oversight and a sample of incidents was reviewed at a quarterly meeting attended by the Prisoner Escort and Custody Services (PECS) contract delivery manager.

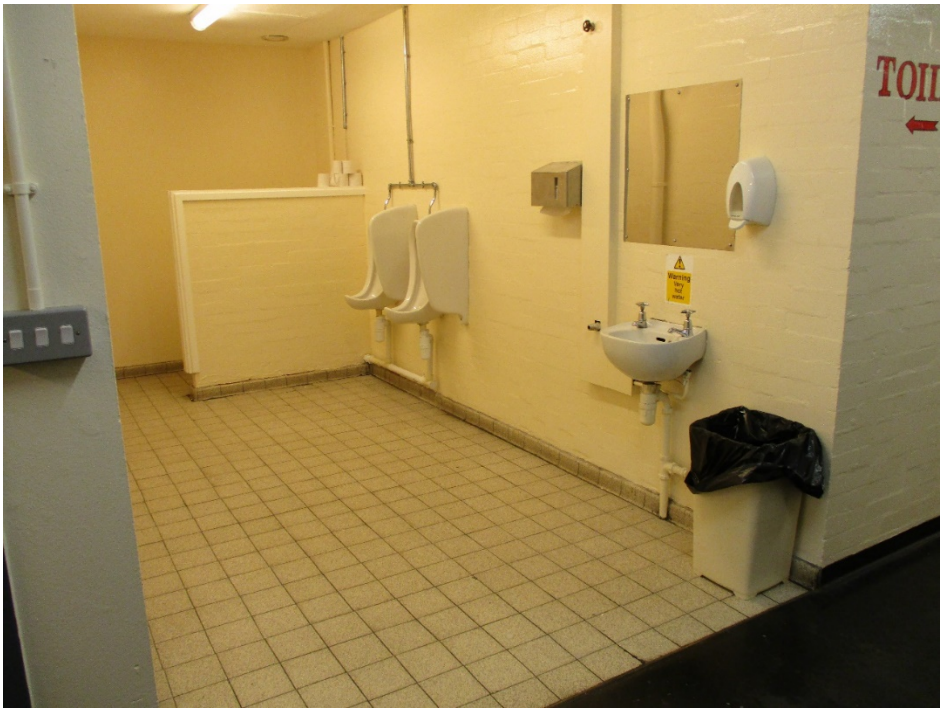
4.13 Handcuffs were used infrequently, and in custody only following a risk assessment. In courts where detainees alighted vehicles in an insecure area, handcuffs were used routinely and remained on until the detainee was outside their cell. This was unnecessary once they had entered the secure custody environment.

Detainee care

4.14 Detainees spoke favourably about their treatment in custody. Drinks were offered on arrival and regularly thereafter. Meals or snacks were provided whenever detainees were hungry. In most locations, they were offered sandwiches, crisps and biscuits for lunch. Hot microwave meals and rice were alternatives, and were generally the only options available in Cumbrian facilities.

4.15 All courts had a box of distraction activities, but some were less well stocked than others. Most staff considered that these items were primarily for children and did not offer them routinely. Courts also had printed puzzles (such as wordsearch or Sudoku) and, occasionally, colouring pencils. Some custody suites had chalkboards painted on cell walls, but chalk was rarely offered. Some of the reading material was tatty and there was nothing aimed at children, those with limited literacy or those who did not speak English. Distraction activities were not offered routinely to detainees who otherwise had little or nothing to help them pass the time in court custody.

4.16 Toilet facilities were clean and, except at Preston and Carlisle Crown Courts and Blackpool Magistrates' Court, sufficiently private. In Cumbrian courts, there were no bins for used paper towels, apparently because a bin could be used as a weapon. We considered this restriction to be disproportionate to any potential risk. At some courts, there were no dispensers for toilet paper, soap or paper towels, and at Preston and Blackburn Magistrates' Courts detainees relied on staff to flush the toilet, which was degrading.



Men's toilets accessed directly from the cell corridor at Blackpool Magistrates' Court

Safeguarding

4.17 HM Courts & Tribunals had now published a safeguarding policy, but it lacked clarity about who was responsible for what in the event of a concern being identified. GEOAmey had several overlapping policy documents, which would have benefited from consolidation.

4.18 Staff understood their responsibility to promote detainee welfare and knew how to contact the safeguarding managers. However, we were told about a couple of occasions when the managers had not been contactable to provide the immediate help needed by staff.

4.19 Only a minority of staff explained safeguarding as a specific process designed to protect detainees from harm and neglect; most believed that a 'safeguarding referral' meant discussing a detainee with a GEOAmey safeguarding manager. However, over the course of the inspection, we heard several examples of how staff had supported vulnerable detainees. We were therefore broadly confident that if an issue was identified, some action would be taken.

Children

4.20 The number of children held in court custody in Lancashire and Cumbria was relatively low. Those travelling to or from young offender institutions and secure children's homes often had long journeys to court.

4.21 When moves to court were predictable, GEOAmey safeguarding managers used individual risk assessments to plan children's journeys. Most travelled in non-cellular vehicles, accompanied by a team of specially trained staff (enhanced care officers and dual-badged officers; see Glossary). In court custody, these children were usually held in unlocked consultation rooms and could interact constantly with staff. In these cases, we saw excellent care, with good use of distraction activities. The tablet computers that should have been available were temporarily not in use because of a technical issue.

4.22 Children arriving from police stations generally received less good care because these journeys could not be pre-planned. They often travelled to court in cellular vehicles (See para 2.1) with adults and were usually locked in a cell, at least initially. A specialist team sometimes arrived later to deliver enhanced care, but this was not always the case.

4.23 With some exceptions, youth offending teams responded appropriately when notified of a child in custody, seeing them both before and after their court appearance.

Health

4.24 Access to physical health care support had improved and all staff knew how to access this. Health Finder Pro provided a medical advice helpline and paramedic attendance if necessary. The advice line had been used 162 times in the previous 12 months. Most calls were for authority to administer paracetamol for pain relief.

4.25 There was good monitoring of clinical activity with all detainee contacts, and response times were recorded individually and compiled as part of a reported data set. The current governance arrangements included no imperative to gather detainees' views on health care.

4.26 NHS England and NHS Improvement commissioned liaison and diversion (L&D) services directly and there was good oversight of the contract, with commissioners conducting quarterly contract review meetings and regular site quality visits.

4.27 Custody staff completed a Custody Early Warning Score (CEWS; see Glossary) assessment for new arrivals. However, we witnessed poor explanation to detainees of the purpose of the assessment and the associated pulse oximetry measuring.

4.28 Custody staff we spoke to were confident in accessing the medical advice helpline if they had concerns about a detainee's physical health and said that it was a responsive service. Paramedics could be dispatched if necessary, although the data supplied showed that this was infrequent. In Barrow-in-Furness, detainees could access a tablet computer to receive a video call from a medical professional, which was impressive.

4.29 Mental health L&D services were delivered by Lancashire and South Cumbria NHS Foundation Trust in all courts, apart from Burnley and Carlisle Crown Courts. The service delivered an all-age, all-vulnerabilities model of care. Courts in Lancashire had regular embedded practitioners, which custody staff valued, but in Cumbria practitioner input was irregular, particularly in the more remote courts. While practitioners could be contacted by telephone in these courts, this was inequitable with the services in Lancashire. Information sharing between L&D staff in court and police custody, and custody staff was good in Lancashire.

4.30 Well-established governance processes scrutinised the L&D service provision, enabling regular review of performance data to drive improvement. Practitioners we spoke to felt valued and were participating in regular training and supervision. The service had recently recruited lived experience workers.

4.31 Court custody staff completed first-aid training every three years, which was insufficient and not in line with national guidance. Despite this, staff we spoke to knew what to do in a medical emergency. GEOAmey had developed a standard operating procedure for summoning medical assistance in an emergency. Automated external defibrillators were located in some custody areas, but in others these were located in the main court building. This had the potential to create unnecessary delays for responding to medical emergencies.

4.32 Medicines were stored securely at all custody suites. Only paracetamol could be administered by custody staff, following authorisation from the medical advice helpline, which was unnecessarily restrictive and delayed treatment. Detainees had no access to other over-the-counter medicines.

4.33 All suites stored naloxone (a medicine to counteract an opioid overdose) and staff were trained in its use. There was no provision of any symptomatic relief for alcohol or drug withdrawal, nor access to nicotine replacement products, which created a potential risk in some circumstances and could have had an adverse impact on a detainee's ability to represent themselves in court.

4.34 Detainee medication was stored as part of their individual property. Custody staff could facilitate access for detainees to take their own clearly labelled medicines, following agreement with the medical advice helpline.

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 There was a reasonable focus on making sure that detainees were released safely and quickly when they had finished in court. A conversation generally took place before release, the main purpose of which was to establish whether the detainee had the means to get to their onward destination. Some courts were more focused on other welfare issues and communicated with agencies such as liaison and diversion services or the police if they had concerns.

5.2 Travel warrants for use on trains, and petty cash for bus tickets and other sundries were available in all facilities. These were readily given out to detainees who needed support to get to their onward destination. Particular attention was given to those affected by rail strikes and arrangements were made for more vulnerable detainees to use taxis if needed.

5.3 Most facilities had a range of support leaflets containing local information, but these were not routinely given to detainees on release.

5.4 It remained a concern that serving prisoners who had been released by the court and who were subject to governor's authority to release (see Glossary) often had long waits in cells before they were allowed to leave custody. Data provided indicated that 85 of the 102 detainees released from prison during the previous four months had waited more than an hour, with the longest wait being five hours and 59 minutes. The escalation process was not used consistently. Such delays were a concern in our last inspection and still unnecessarily denied people their liberty for too long and were unacceptable.

5.5 Most detainees in Lancashire were transferred to prison within reasonable timescales on conclusion of their hearings. The availability of vehicles and staff in Cumbria often led to long and unsatisfactory delays. Information about specific prisons was not always readily available and few who were newly remanded or sentenced were given information about what to expect on arrival at the establishment.

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. **Where custody facilities did not have secure vehicle bays, detainees alighted in public areas or areas that could be overlooked, which was undignified and embarrassing.**

2. **Some custody facilities, particularly in Lancashire, were not sufficiently clean, safe, or well-maintained.** Identified potential ligature points could have posed a risk to some detainees.

3. **Serving prisoners who had been released by the court, and who were subject to a prison governor's authority (see Glossary) to release, often had long waits in cells before they were allowed to leave custody.**

Key concerns

4. **There was not always an effective shared strategic focus on the provision of court custody. HMCTS, PECS and GEOAmey were not always properly sighted on areas where treatment of and conditions for detainees needed to be better.**

5. **Accurate data concerning the treatment of detainees was not collated or used to inform organisational learning or to improve outcomes.**

6. **Women and children continued to be transported in the same vehicles as men, particularly when collected from police stations.** This did not adequately safeguard these detainees.

7. **Training and ongoing development activity to help custody staff to identify and meet diverse needs was weak.**

8. **Preston Crown Court housed the only designated court custody facility across Lancashire and Cumbria for detainees with impaired mobility.** Some detainees therefore had very long journeys to and from court, and often experienced delays in their cases being heard.

9. **Telephone interpretation services were not always used when necessary and some custody facilities had no access to the service.** As a result, staff missed valuable opportunities to identify risks and needs, promote welfare and make sure that the detainee understood what was happening.

10. **Custody staff did not always complete an initial assessment with detainees to explore risks or welfare issues.** Detainee checks were not always conducted at the required frequency and were not always recorded accurately.

11. **A range of factors led to some detainees being held in court custody for longer than necessary.** Not enough was being done to understand or address the extent of the problem.

12. **Only a very limited supply of reading materials and other distraction activities, such as puzzles and word searches, were readily available.** These were not offered or provided routinely to detainees who otherwise had little or nothing to help them pass the time in court custody.

13. **Care for children was not always good enough.**

14. **Custody staff completed first-aid training only every three years, which was not sufficient to maintain a level of confidence and competence.**

15. **Automated external defibrillators were not readily available in custody in the event of a cardiac arrest.**

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

A standard risk assessment pro forma should be completed for each detainee, and staff should be trained in completing it. (2.31)
N**ot achieved**

There should be a system for communicating introduction of and changes in policy so that staff can signal their understanding and compliance with the new policy. (2.32)
Partially achieved

Handcuffs should only be used if it is necessary, justified and proportionate. (2.33)
Partially achieved

A programme of regular deep cleaning should be implemented, graffiti should be removed and standards of daily cleaning should be improved. (2.34)
Partially achieved

Court custody staff should be trained to identify and appropriately refer detainees on issues of child protection, safeguarding, mental health or substance misuse-related problems. (2.35)
Achieved

National issues

HMCTS should establish agreed standards for training, treatment and conditions, including monitoring of complaints in court custody, and include these in the measurement of performance. (2.36)
Achieved

Recommendations

There should be regular liaison between HMCTS and GEOAmey managers so that court custody operations are reviewed and problems resolved. (3.5)
Partially achieved

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

HMCTS should ensure that defendants apprehended by court enforcement officers should not be taken into police custody unless there are good reasons to do so. (4.10)
No longer relevant

Detainees who have attended court 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. (4.11)
No longer relevant

Instances when detainees are brought to court in the morning but are not listed to stand trial until the afternoon should be monitored and the source of such delays resolved. (4.12)
Not achieved

HMCTS should liaise with HMP Durham to resolve the delays experienced in confirming that detainees can be released. (4.13)
Not achieved

HMCTS should liaise with the Youth Justice Board to reduce delays in transferring young people to more appropriate custodial facilities. (4.14)
Achieved

HMCTS should liaise with their local prisons to stop early 'lock-outs' on Saturdays. (4.15)
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. (4.22)
Partially achieved

Sufficient comfortable, private and sound-proofed interview rooms should be made available at all courts for legal consultations. (4.23)
Achieved

Staff should be made fully aware of the purpose and use of the telephone interpreting service, and telephones should be provided in suitable locations. (4.24)
Not achieved

Detainees should be transferred from cellular vehicles to the court cells in privacy. (5.7)
Not achieved

The policy on the use of the partition in cellular vehicles should be clarified, and all staff involved in transporting detainees on these vehicles should implement it. (5.8)
Partially achieved

All custody staff should receive diversity training. (5.21)
Achieved

Hearing loops and Braille versions of key information for detainees should be available. (5.22)
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. (5.23)
Achieved

At each court there should be a stock of appropriate reading materials, including some suitable for young people and those whose first language is not English, that is routinely offered to all detainees. (5.24)
Not achieved

Staff should only accept responsibility for a detainee, their property or Person escort record when the detainee is actually in their care. (5.43)
Achieved

Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits. (5.44)
Achieved

Standards of searching should be made consistent and rub-down searches within secure areas should not be routine. (5.45)
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 being released. (5.46)
Achieved

Young people in court custody should be supported by a named staff member who is trained to work with young people. (5.47)
Partially achieved

Mattresses, and blankets or warm clothing should be made available at all courts. (5.68)
Not achieved

The six small cells at Blackpool are not fit for purpose and should not be used. (5.69)
Achieved

The toilets at Preston Magistrates' Court should provide soap and hand-drying facilities. (5.70)
Achieved

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; all should be in date and subject to documented checks. (5.79)
Achieved

Airway maintenance equipment and an automated external defibrillator should be available in each of the court custody areas, and staff should be trained to use them. (5.80)
Not achieved

GEOAmey staff should assure themselves that consent has been obtained to access medical in-confidence information received from the police; medical information entered on the person escort record should be intelligible and describe all medications accompanying the detainee. (5.81)
Achieved

All detainees requiring their prescribed medication should have access to it while in court custody, and all medications for personal emergency use should be kept in the possession of the detainee unless a risk assessment demonstrates otherwise. (5.82)
Achieved

There should be access to mental health services for detainees appearing to have mental health problems. (5.83)
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 one of the following:

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 Services (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
Fiona Shearlaw	Inspector
Shaun Thomson	Health care inspector
Dayni Turney	CQC 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.

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.

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

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.

Digital Person escort record (dPER)
The PER is the key document for ensuring that information about the risk 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.

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

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

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