Report on an inspection visit to court custody facilities in

Staffordshire and West Mercia

by HM Chief Inspector of Prisons

19 February – 2 March 2024

Contents

Introduction

This report details findings from an inspection of court custody facilities in Staffordshire and West Mercia. It covers four Crown courts 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.

There was good evidence of progress since our previous inspection, particularly in relation to risk assessments, meeting detainee needs, safeguarding and recording use of force. Overwhelmingly, we met decent, kind, compassionate and patient staff who worked hard to support detainee welfare. Senior managers in PECS, GEOAmey and HMCTS worked well together, but local relationships between GEOAmey and HMCTS were not always as cooperative.

We identified concerning detainee outcomes in several areas, all of which will require a response. They regularly arrived at court too late for hearings to start on time, due partly to long journeys caused by the centralisation of remand business in two courts and limited cell capacity. This also contributed to some detainees spending longer in custody than necessary.

We have raised concerns about excessive searching of detainees in several recent court custody inspections. Searching was rarely based on individual risk assessment, which meant many detainees were repeatedly searched unnecessarily.

Release arrangements were also not yet good enough, with staff often failing to inquire sufficiently into detainees' circumstances on release. More difficult to resolve was the fact that detainees being discharged from prison at court did not have important personal possessions (such as door keys) and could not easily retrieve them. These detainees also often waited too long for the prison governor to approve their release.

Other areas also required attention. Some of the environments were poor, particularly in cells, which was inexcusable considering that this was an announced inspection. There was a lack of accessible facilities for detainees with impaired mobility or disabilities and interpretation services were not used consistently enough to support detainees who spoke little or no English.

This report lists two priority concerns and seven key concerns. We hope they will assist HMCTS, PECS and GEOAmey to deliver the required improvements.

Charlie Taylor
HM Chief Inspector of Prisons
March 2024

What needs to improve in Staffordshire and West Mercia court custody

We last inspected court custody in Staffordshire and West Mercia in 2016 and made 27 recommendations overall, four of which were about areas of key concern (see Section 6 for a full list).

At this inspection we found that there had been good progress and 16 of the 27 recommendations had been achieved, including three of the recommendations about key areas of concern. Three 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. 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 two priority concerns. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

1. **Release processes were inconsistent and too often failed to inquire properly about detainees' personal circumstances to identify and address issues such as homelessness.**

2. **Those being discharged from prison at court had long waits for release.** Important possessions such as phones, house keys and bank cards were routinely left at the prison.

Key concerns

We identified a further seven key concerns.

3. **Too little was being done to understand and address the factors that led to some detainees being held in court custody for longer than needed.**

4. **The reception process at North Staffordshire Justice Centre was slow and some detainees waited too long in vehicles before alighting.**

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

6. **Telephone interpretation was not always used when required and staff therefore lacked information about some detainees' needs and welfare.**

7. **Detainees with mobility impairments often experienced long journeys to court and the available adaptations did not meet all needs.**

8. **Too many cells were not clean enough and poorly decorated. Toilets often lacked hygienic dispensers for soap, toilet paper and towels.**

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

Notable positive practice

We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for detainees, and/or particularly original or creative approaches to problem solving.

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

About court custody in Staffordshire and West Mercia

Data supplied by the HMCTS cluster and custody and escort provider.

HMCTS cluster	Staffordshire and West Mercia
Cluster manager	Olwen Kershaw
Geographical area	Counties of Herefordshire, Shropshire, Staffordshire and Worcestershire

Court custody suites and cell capacity

Cannock Magistrates' Court	8 cells
Hereford Justice Centre	10 cells
Kidderminster Magistrates' Court	10 cells
North Staffordshire Justice Centre	12 cells
Redditch Magistrates' Court	10 cells
Shrewsbury Crown Court	13 cells
Stafford Combined Court Centre	9 cells
Stoke-on-Trent Combined Court	9 cells
Telford Magistrates' Court	14 cells
Worcester Combined Court	7 cells
Worcester Magistrates' Court	14 cells

Annual custody throughput

1 January 2023 to 31 December 2023	10,791 detainees

Custody and escort provider	GEOAmey
Custody staffing	Two senior court custody managers Six court custody managers Four deputy court custody managers 37 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 There had been good progress since the last inspection. Most of the previous recommendations had been achieved or partially achieved.

1.2 At a senior level, multi-agency relationships were mature and properly focused. A range of data were used to monitor outcomes for detainees. These, along with learning from previous inspections, were often used to influence necessary improvements.

1.3 At a local level however, some operational relationships between GEOAmey and HMCTS staff were not as well developed or cooperative. Some staff did not fully understand the impact their action, or inaction, had on detainees. For example, when clerks failed to record the outcomes of cases promptly on the shared digital platform, this unnecessarily delayed releases for those who originated from prison (see paragraph 5.2).

1.4 The decision to centralise the remand courts in two facilities (one in Staffordshire and another in West Mercia) was leading to some poor outcomes for detainees. Neither of the facilities had adequate cell capacity to deal with the volume of detainees expected each day. This, coupled with GEOAmey staffing issues, led to some detainees experiencing lengthy journeys and arriving late at court which, at times, affected the timeliness of hearings and the time detainees spent in custody.

1.5 External scrutiny provided by Lay Observers was valued by leaders, who carefully considered the findings from their inspections.

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 travelled in suitable vehicles and received good care, but a few vans were not clean and some detainees had long and circuitous journeys to court. Women often had to share vehicles with men and staff did not always use the partition to minimise the likelihood of verbal abuse.

2.2 At North Staffordshire Justice Centre, staff managed the risks associated with the insecure vehicle dock well. However, detainees sometimes waited too long to alight because the reception process was slow and procedures were inefficient.

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 Detainees were treated with respect by court custody staff. We observed many patient, polite and respectful interactions and saw compassion and kindness from staff towards detainees.

3.2 Reception interviews were reasonable and identified most risks, although in the busier courts there was a tendency to rush them, which reduced their effectiveness. In most courts these interviews lacked privacy and did not allow detainees to disclose personal information discreetly.

3.3 Staff provided good levels of support for detainees and we saw examples of one-to-one care for some who were anxious. Staff took time to talk to detainees and communicated well with them.

3.4 In most courts white boards containing personal details were not visible to other detainees.

Meeting individual and diverse needs

3.5 Most staff were keen to meet individual needs and spent time patiently listening to and talking to detainees to understand how they could help. This approach was especially effective with elderly, nervous and neurodivergent detainees. Staff understood how they should care for transgender detainees and meet the specific needs of women.

3.6 Most courts now had appropriate religious artefacts, but they were rarely used, and some staff did not know the direction for Muslim prayer. Key documents, including custody rights, were available in a range of languages and Braille. Telephone interpretation was now available in every court, and although we saw it used well, it was not always employed when needed.

3.7 Only Worcester Magistrates' court accepted detainees with limited mobility. These detainees travelled in adapted vehicles when necessary, but often experienced long journeys to court. As at our previous inspection, the physical adaptations in the custody suite were still too limited. For example, cell bells were not close to benches and cell doorways were not wide enough for large wheelchairs.

Risk assessments

3.8 The identification and management of risk was generally good. Staff were mostly well briefed about detainees in their care. Detainees were monitored at the required frequency and checks generally involved a reasonable level of interaction. Staff were alert to signs of vulnerability, and they managed and responded dynamically to presenting risks.

3.9 Routes to court were safe. Custody staff carried anti-ligature knives and responded quickly to cell call bells.

Individual legal rights

3.10 Information detailing detainees' rights in custody was readily available, but rarely explained, even when detainees struggled to read or understand it. Some facilities lacked sufficient consultation rooms and some were still not appropriately sound-proofed.

3.11 We were concerned about the length of time some detainees spent in custody and the lack of action to understand and address the issues that led to unnecessarily long stays (see paragraph 1.3). A variety of factors contributed to these issues including significant delays arriving at court, which potentially delayed hearings; 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. Some detainees, arriving in the morning for afternoon listings, had long waits for their case to be heard. Many detainees experienced delays while waiting to be moved to prison once their hearings had concluded.

Complaints

3.12 Detainees were consistently advised of their right to complain. Complaints were rare, but if received 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 While some suites were reasonable, too many cells were poorly presented. We found dust on benches, ingrained dirt on floors, food or drink stains on walls and some offensive graffiti. In some locations staff had not noticed these defects. No cells had natural light, and some had excessively bright lighting. Suites were not routinely cleaned before Saturday hearings commenced. We provided a comprehensive report of our findings to HMCTS, which was responded to appropriately.

4.2 Staff knew fire evacuation routes, but fire drills had not been practised consistently in the year prior to our inspection.

Cell at North Staffordshire Justice Centre

Cell at Telford magistrates' court

Use of force

4.3 Force was rarely used against detainees. Custody staff were skilled at defusing tense and challenging situations, and we were assured that force was only ever used as a last resort.

4.4 We reviewed documentation that had been compiled to report and account for incidents. It was completed properly and subject to robust quality assurance.

4.5 The use of handcuffs when needed was proportionate, but searching was inconsistent and sometimes excessive. Too many detainees were searched multiple times during their stay in custody, without good reason or a clear justification.

Detainee care

4.6 The detainees we spoke to told us they felt well cared for, and this was consistent with our observations.

4.7 There was a good range of drinks, sandwiches, meals and snacks available that met most cultural and dietary needs. Staff could use petty cash to buy suitable alternatives if needed. Drinks and food were provided regularly and detainees who were hungry were not made to wait until a recognised mealtime.

4.8 The selection of materials available to occupy detainees was better than we usually see and they were offered readily. There were games and reading materials, as well as distraction packs, which included puzzles and word searches.

4.9 Sensory fidget toys had been introduced, which were helpful, particularly for detainees who were neurodivergent.

4.10 Most toilets were without a seat and some were not sufficiently private, although staff supervised them discreetly. Toilet and handwashing facilities were generally clean and soap, hand dryers and toilet paper were available, but not always stored hygienically in dispensers.

Safeguarding

4.11 Oversight of safeguarding procedures was good and staff were mostly aware of what constituted a safeguarding concern and how to report it. The GEOAmey safeguarding team contact numbers were readily available to all staff.

4.12 We viewed the records of several safeguarding concerns that had been submitted over the last 12 months. They were reported to the relevant authorities or agencies swiftly and appropriate support was provided for the detainees involved.

Children

4.13 Relatively few children were held in court custody. Specially trained staff were nearly always available to supervise and transport them to and from court. Children were held in the most suitable place available, which was generally either a cell with the door left open or a legal visits room, although some of these rooms lacked privacy which meant children could be observed by adult detainees.

4.14 There were very few child safeguarding concerns. The only referral in the preceding 12 months was handled very well. Leaders had subsequently visited the child to make sure the concern was fully resolved.

Health

4.15 Health services had significantly improved since the last inspection. Health Finder Pro (HFPro) provided rapid medical advice for custody staff and efficient assessment and treatment of detainees by visiting paramedics.

4.16 Custody staff now had ready access to automated external defibrillators and, intra-nasal naloxone to reverse the effects of opiate overdose. While custody staff were up to date with first aid training, they were not sufficiently refreshed in resuscitation skills.

4.17 Some digital person escort records that accompanied detainees lacked sufficient health information, but custody staff actively sought to obtain missing information and incidents were appropriately escalated to leaders for discussion in multi-agency meetings.

4.18 Liaison and diversion services were readily accessible and signposted detainees to helpful resources about mental health, substance misuse

and housing services. Psychological treatments were available to detainees placed on mental health treatment orders, which provided diversion from custody for hard-to-reach individuals.

4.19 Detainees' prescribed medicines accompanied them into custody, where they were stored and administered appropriately. Following suitable risk assessments, detainees could retain vital medicines such as inhalers and EpiPens. Optimal treatment for withdrawal from alcohol and drugs was no longer available, leading to unnecessary discomfort for some detainees. However, recommended treatment was due to be reinstated.

Section 5 Release and transfer from court custody

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

Release and transfer arrangements

5.1 Although we saw examples of appropriate release processes, they were applied inconsistently. Too often staff failed to inquire properly into detainees' circumstances on release, potentially missing safeguarding risks such as homelessness. Detainees were usually offered telephone numbers for support services, but these were rarely tailored to the location of the courts. However, staff organised onward travel for detainees, taking account of any vulnerabilities.

5.2 Detainees requiring a governor's authority for release from prison (see Glossary) often had long waits caused by slow court recording and prison processes. These detainees had usually travelled to court without their personal property and consequently their release plans were complicated by the lack important items such as door keys, money and phone. Staff could provide detainees with the means to travel back to the prison, but it was often too late for this to be a viable option on the day of release.

5.3 During our inspection several men waited over three hours for onward transfer to prison, which unnecessarily extended their stay in custody (see paragraph 3.11).

Section 6 Progress on recommendations from the last report

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

Main recommendations

HMCTS, PECS and the escort and court custody contractor should investigate the reasons for the prolonged detention of detainees, including children, in court custody cells. Measures should be put in place to ensure detainees in custody have their cases prioritised where possible and are transferred and released without delay.
Not achieved

Sufficient staff should be on duty at all times so that the safety and welfare of detainees and staff are maintained.
Achieved

Staff should complete a standard risk assessment for each detainee and receive training to do this.
Achieved

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

Recommendations

There should be a safeguarding policy and all staff should be made aware of safeguarding procedures for children and adults at risk.
Achieved

HMCTS should ensure that compliant defendants apprehended by court enforcement officers are not taken into court custody unless there are good reasons to do so.
Achieved

There should be sufficient private consultation rooms at Hereford Crown Court.
No longer relevant

Telephone interpretation services should be readily accessible in each custody suite and used as necessary.
Partially achieved

All detainees should be informed of the complaints process.
Achieved

Cellular vehicles should be clean and free of graffiti and men, women and children should be carried in separate escort vehicles, or the partition should be used.
Partially achieved

Information about detainees should not be displayed in public view.
Partially achieve

Staff should receive guidance on how to use the 'reception sheet' and 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

Staff should routinely provide detainees with access to religious items and all courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers, which should also be offered to detainees routinely.
Achieved

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

Set levels of observations should always be adhered to.
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.
Partially achieved

All incidents involving the use of force should be accurately reported and have appropriate documentation completed to justify its use.
Achieved

Searching procedures should be reviewed to ensure that it is proportionate to the risks posed.
Not achieved

All court cells should be clean and free of graffiti and all ligature points removed.
Not achieved

Custody staff should be appropriately trained and annually updated in emergency response skills, including basic life support and the use of AEDs.
Partially achieved

First aid equipment should include sufficient up-to-date kit, including basic equipment to maintain an airway and AEDs in custody areas.
Achieved

PERs should clearly identify each detainee's health risks while ensuring confidentiality is appropriately maintained. All inadequately completed PERs that have the potential to affect the safe provision of health care should be captured on the incident reporting system and the information formally escalated to the sending establishment.
Partially achieved

All detainees who require prescribed medication while in court custody should have access to it.
Achieved

Mental health liaison and diversion schemes should be available at all courts.
Achieved

Custody staff should have regular training to enhance their mental health and drug and alcohol awareness.
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
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/

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.

Lay Observers
Lay Observers are independent members of the public who are appointed by the Secretary of State to monitor those held in court custody. They report on whether the individuals held are being treated with decency and respect and whether their welfare is being looked after.

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

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:
HM Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England