Report on an inspection visit to court custody facilities in

Avon, Somerset & Gloucestershire

by HM Chief Inspector of Prisons

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Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary in our 'Guide for writing inspection reports', available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Minimising and managing restraint (MMPR)
The behaviour management and restraint system, minimising and managing physical restraint. MMPR aims to provide secure estate staff with the ability to recognise young people's behaviour, and use de-escalation and diversion strategies to minimise the use of restraint through the application of behaviour management techniques. 'Minimising and Managing Physical Restraint Safeguarding Processes, Governance Arrangements, and Roles and Responsibilities'. NOMS, Young People's Estate, Ministry of Justice, Youth Justice Board.

Introduction

HM Inspectorate of Prisons' inspections of court custody facilities contribute to the United Kingdom's response to its international obligation to ensure regular independent inspection of all places of detention. The inspections focus on outcomes for detainees in three areas: leadership, strategy and planning; individual rights; and treatment and conditions, including health care.

This inspection covered the court cluster in Avon, Somerset and Gloucestershire and included nine courts in use with custody facilities, comprising three Crown courts and six 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 court custody and escort facilities in the region.

The positive findings of this inspection centred on the way custody staff dealt with and managed detainees, and how these relationships mitigated some of the shortcomings identified. Custody staff engaged well with detainees during their time in court custody facilities and detainees were complimentary about their treatment.

There was however, room for improvement with regard to several important issues. The greatest concern was that some detainees spent too long in court cells without good reasons – this was more acute than we have experienced in other recent inspections. Environmental conditions across the estate varied greatly. Some were very good, but others used to hold detainees were barely fit for use and maintenance arrangements were hindered by contractual complexities and budgetary constraints.

A consistent criticism when inspecting court custody concerns the routine handcuffing of detainees, including children, in the secure and controlled custody environments in the absence of an individual risk assessment. We again saw this practice in Avon, Somerset and Gloucestershire.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons
April 2020

Fact page

Data supplied by HMCTS Avon, Somerset and Gloucestershire Cluster and GEOAmey, Custody and Escort Provider.

HMCTS cluster	Avon, Somerset & Gloucestershire
Cluster manager	Sharon Boreham
Geographical area	Avon, Somerset & Gloucestershire

Court custody suites	**Cell capacity**
Bath Magistrates' Court	10 cells
Bristol Magistrates' Court	29 cells
Cheltenham Magistrates' Court	6 cells
North Somerset Magistrates' Court	13 cells
Taunton Magistrates' Court	6 cells
Yeovil Magistrates' Court	4 cells
Bristol Crown Court	17 cells
Gloucester Crown Court	7 cells
Taunton Crown Court	6 cells

Annual custody throughput
1 January to 31 December 2019 — 7,724 detainees

Custody and escort provider
GEOAmey

Custody staffing
7 court custody managers
1 deputy custody manager
42 prisoner custody officers

Section 1. Background and key findings

1.1 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.

1.2 The inspections of court custody look at strategy, individual rights, and treatment and conditions, including health care. They are informed by a set of *Expectations for Court Custody* (available on our website at: https://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.

Leadership, strategy and planning

1.3 The three key agencies: HM Courts & Tribunal Services (HMCTS). Prisoner Escort and Custody Services (PECS) and GEOAmey (the service provider) generally worked well together to deliver court custody services. There were gaps in leadership arrangements but they did not detract greatly from positive outcomes, particularly the care afforded to detainees.

1.4 HMCTS managers had good oversight of issues affecting custody. Visits to court cells to conduct audits had started to take place more regularly but were not yet well embedded. Cleaning and maintenance contracts delivered some mixed results and were hindered by the age of some facilities. Contractual challenges and budgetary constraints caused some delays in the completion of work, particularly more expensive projects.

1.5 There were generally sufficient GEOAmey staff, although they were sometimes stretched. Court custody managers provided visible leadership when they were present. Initial training for custody staff was adequate but continuing training and development were not always effective or well understood by staff, particularly in mental health and safeguarding.

1.6 There was a commitment to ensuring that custody cases were prioritised for court, but this was not always achieved and was less successful than at other recent inspections. Not enough was being done by the three key agencies to understand or address the causes of the problem.

1.7 There was no overarching HMCTS safeguarding policy. The standard GEOAmey operating procedures and policies were well promoted and we saw good evidence of appropriate action being taken to safeguard vulnerable people. However, most staff lacked a real understanding of what constituted a safeguarding concern.

1.8 A small group of lay observers provided independent scrutiny of custody facilities. Their reports were shared widely and were appreciated by managers from the three key agencies.

Individual rights

1.9 Despite regular and significant delays in dealing with the cases for some detainees, good attention was given to ensuring that detainees received their rights in custody. Our overriding concern related to the inconsistent priority given to dealing with the cases for people held in court custody who potentially spent too long there.

1.10 A number of factors contributed to many court custody cases not being prioritised including: smaller courts with a variety of functions which did not concentrate on remand cases; acute delays in the attendance of solicitors; delays or non-attendance of court appointed interpreters; detainees arriving from police custody when they were not ready for court; and delays in receiving formal authority to release from prison.

1.11 There were not always enough private interview rooms for legal and professional visits. Visits were however mostly facilitated promptly once legal and other visitors arrived in the custody suite.

1.12 Information on detainees' rights in court custody was placed in each cell before the detainee arrived and was pointed out to most detainees. Information on rights in custody was available in a range of languages but not in an easy-read format or in Braille. The promotion of complaints procedures was adequate and staff demonstrated a reasonable awareness of the process.

Treatment and conditions

1.13 Most journeys were reasonably short. Vehicles used to transport detainees were well equipped but not always clean. Women and children were on occasions transported with men, which was inappropriate. Detainees alighted from the vehicles quickly. Secure vehicle docks ensured that privacy was maintained. If secure docks were not available, staff were sensitive and did what they could to maintain detainees' privacy.

1.14 Custody staff in all suites behaved very humanely and respectfully towards detainees and were skilled in establishing a rapport with them. Many custody staff told us they did not feel confident that they had received sufficient training in equality and diversity, but we observed them identifying and meeting most individual and diverse needs appropriately.

1.15 Women in custody were given good support and most custody staff were confident about interacting with transgender detainees. Religious requirements were met and there was generally good provision for people with mobility difficulties. Telephone interpreting was used well in some courts but could have been used more proactively in others.

1.16 Relatively few children were held in court custody. However, the majority of custody staff had not been trained to manage children and we felt that children were generally treated no differently from adults.

1.17 The identification of risk was good but there were some weaknesses in the management of those risks. Custody staff were skilled at noticing signs of risk in individuals and responded appropriately to keep them safe. Most individual person escort records were completed reasonably well. but some still lacked information on risk. The reception checklists on arrival were not always completed thoroughly but the alertness of staff to signs of risk in the individual's behaviour mitigated these shortcomings. Reception procedures for detainees received off bail (people who were sentenced or remanded to prison by the court having previously been subject to bail in the community) were thorough and conducted well.

1.18 Briefings were inconsistent and staff were not always made fully aware of the risks associated with each individual held. Cell call bells were usually answered promptly. Cell checks were normally carried out to ensure safety, but we saw a small number of occasions where checks were missed, not properly recorded or carried out in too cursory a manner. Searches were carried out too frequently and often without sufficient thoroughness. All detainees were taken to court promptly via routes that were private and reasonably safe.

1.19 Detainees we spoke to said they were treated well by custody staff. Appropriate food and drink were available and offered freely. Food preparation areas were generally appropriate and clean but adequate hygiene was difficult in some smaller courts, especially in the oldest buildings. All sites had a limited range of reading materials and distraction activities were issued freely.

1.20 There were good arrangements to ensure detainees were released safely. Custody staff took care to help detainees, particularly the most vulnerable, to cope with their release from court. Where needed, detainees were given the means to travel home.

1.21 Overall, the use of force seemed low and we were reasonably confident that force was used as a last resort. Staff were patient and frequently defused potentially volatile situations. The standard of individual use of force statements, however, varied greatly and many lacked sufficient detail. The apparent use of a non-approved technique was a concern. The oversight of use of force was not developed well enough to identify the shortfalls that we found. Detainees, including children, were routinely handcuffed in secure areas of custody suites which was inappropriate and very concerning.

1.22 Conditions across the estate varied. There had been a significant effort to reduce potential ligature points throughout the cluster, but some remained. Most cells were clean with little graffiti but some, particularly in the older buildings, were barely fit for use. They were small, cramped, cold and damp. In comparison, the facilities at some courts were excellent. This resulted in inequitable experiences and outcomes for detainees across the cluster.

1.23 Communal toilets were clean but often not sufficiently private, including the accessible toilet facilities at two sites. Access to handwashing and drying was adequate. Toilet paper was freely available but not always dispensed hygienically.

1.24 Fire evacuation plans were displayed prominently and practised regularly.

1.25 Custody staff were aware of the telephone health advice service, but it was not widely used. Staff often reverted to calling emergency services as their first option or when not an emergency tried to prioritise detainees for court to release them or transfer them to prison for their health issues to be dealt with. This was not ideal. There was no provision for detainees experiencing drug and/or alcohol withdrawal and some detainees appeared to suffer unnecessarily as a result. Procedures for assisting detainees to take prescribed medication were appropriate. First aid boxes were not always checked regularly or stocked appropriately.

1.26 Liaison and diversion services were well embedded in police custody suites which reduced the need for them in court custody. Some courts received an inconsistent service from mental health professionals, but staff had access to contact details if they were required.

Main recommendations

1.27 Concern: Some detainees were held in court custody for longer than necessary. Not enough was done to understand and address the issues, which were more acute than we have

experienced in other recent inspections. The reasons delays occurred were numerous and included:

- children did not always have their cases prioritised and sometimes waited too long for placement orders to be issued;
- custody cases at smaller courts were interspersed with other hearings, such as trials;
- the court sometimes did not start promptly in the morning;
- some detainees arrived at the court in the morning but did not appear in court until after lunchtime;
- some detainees brought by the police were not ready for court;
- the late attendance of legal representatives, some of whom could be representing several clients including multiple defendants held in court custody;
- some detainees were not always transferred to prison promptly after their cases were completed;
- a wait for a governor to authorise a detainee's release from prison.

Recommendation: Detainees in court custody should have their cases prioritised according to their needs and these should be heard promptly. The reasons for delays should be understood and addressed.

1.28 Concern: Handcuffs were routinely applied to detainees, including children, even in the secure and controlled custody areas, with no individual risk assessment.

Recommendation: Handcuffs should only be used on detainees if this is proportionate and justified by an assessment of the risk.

1.29 Concern: The conditions across the court custody estate varied. Some suites, including the cells, were cold. Some cells, notably at Gloucester and Taunton Crown Courts, were small, cramped, cold and damp, lacked natural light and were barely fit for purpose. Cleaning and maintenance were not always carried out well enough to ensure that conditions were appropriate for detainees.

Recommendation: Conditions across custody facilities should be improved. In particular, court custody cells should be of an adequate size and properly cleaned. The temperature in cells should be appropriate, they should be free of damp and have access to natural light.

Section 2. Leadership, strategy and planning

Expected outcomes:
There is a strategic focus on the care and treatment of those detained, during escort and at the court, to ensure that they are safe, secure and able to participate fully in court proceedings.

2.1 HM Courts & Tribunal Service (HMCTS) in Avon, Somerset and Gloucestershire operated as a single cluster. Three key agencies delivered court custody services across the cluster: HMCTS, which had overall responsibility; Prisoner Escort and Custody Services (PECS), part of HM Prison and Probation Service; and GEOAmey, the contracted service provider. HMCTS had a clear line management structure for the cluster. An HMCTS cluster manager supported by three operations managers was responsible for managing courts across the region, including six magistrates' and three Crown courts. Six HMCTS delivery managers were responsible for the daily operation of court services in the courts that we inspected.

2.2 PECS commissioned GEOAmey to manage the court custody provision and deliver detainee escort services on behalf of HMCTS in the Avon, Somerset and Gloucestershire cluster. Two contract delivery managers supervised the contracts between PECS and GEOAmey and convened monthly performance and contract compliance meetings. PECS contract delivery managers visited custody suites reasonably regularly to provide oversight and conducted comprehensive audits approximately every two years which focused on security arrangements and detainee care at each site.

2.3 A general manager from GEOAmey had oversight of and responsibility for court custody and was supported by two area business managers, who managed the court custody services. Seven court custody managers (CCMs), supported by one deputy CCM, reported to the area business managers and were responsible for the daily operation of the custody suites.

2.4 During our interviews with managers from the three agencies, they showed interest in the treatment of and conditions in which detainees were held. At a strategic level, formal and informal meetings provided good oversight of the court custody provision. However, it was evident that operational staff in HMCTS and GEOAmey did not always fully understand how their respective roles inter-related to ensure good outcomes for detainees.

2.5 Most communication between GEOAmey and HMCTS staff was informal, which in many cases was sufficient to maintain reasonable working relationships. However, this was not always the case, particularly in the less busy magistrates' courts. Reliance was sometimes placed on email communication which was not always noted or responded to by HMCTS staff. This was a source of frustration for some court custody staff. Equally, court custody staff were not always fully aware of all the measures that HMCTS staff had to take before detainees were produced in court. The lack of effective communication had an adverse impact on detainees at times, particularly surrounding their prioritisation for court and the length of time they spent in custody.

2.6 The visibility of HMCTS managers in court custody facilities varied. We were told that visits had been sporadic in some courts and had become more frequent shortly before the inspection. Monthly audits of court custody were not yet well embedded or conducted consistently across all sites.

2.7 Cleaning and maintenance services across the cluster were delivered by a number of providers. A contractor, Mitie, was responsible for most court custody facilities, while others were responsible in the private funding initiative facilities in Bristol and North Somerset Magistrates' Courts, and the county council in Gloucestershire courts. The cluster included

very old, listed facilities where the cells were small and barely fit for use with inadequate heating and damp (see paragraph 4.44). There was good oversight of the cleaning and maintenance arrangements, including escalation where necessary, but contractual complexities and budgetary constraints made some maintenance work difficult to progress, particularly costly work. We provided HMCTS managers with a comprehensive report on the physical conditions in court custody facilities (see paragraph 4.45 and main recommendation 1.29).

2.8 The GEOAmey staffing of court custody was generally sufficient, although they were stretched at times. The staff were routinely supported by officers working on escort vehicles who contributed well to the running of custody suites. Initial training for custody staff was adequate but continuing development was not always effective, particularly in safeguarding and mental health awareness. CCMs offered visible leadership.

2.9 There was no overarching HMCTS safeguarding policy on how to protect detainees, including children, from harm, abuse or maltreatment. GEOAmey had its own, well promoted standard operating procedures. CCMs were aware of their responsibility for the safeguarding of vulnerable detainees and we observed good identification of safeguarding concerns and appropriate action to address those concerns. Custody staff had a far more limited understanding and we were not satisfied that concerns would be identified or addressed consistently.

2.10 The listing of court cases was a judicial responsibility and process, but an HMCTS listings protocol allowed for custody cases to be prioritised. There was a commitment to this but, for a variety of reasons, it was less frequently achieved than at other recent inspections (see paragraph 3.1 and main recommendation 1.27). GEOAmey staff were proactive in communicating the need to prioritise custody cases, particularly those involving women, children or other vulnerable detainees. However, their requests were not always acted on, often with no apparent reason. Not enough was being done to understand and address this problem.

2.11 Independent lay observers visited court custody suites regularly to observe the conditions in which detainees were held and their treatment. Reports were shared with representatives from the three key agencies, who told us they were helpful and valued.

2.12 Although there were gaps in leadership arrangements, there was a clear culture of care among GEOAmey staff and a number of positive outcomes for detainees, many of which are referred to throughout this report.

Recommendations

2.13 The relationships and communication between operational HMCTS and GEOAmey staff should be improved to ensure a consistent focus on delivering good outcomes for detainees.

2.14 The approach to delivering continuing training and development activity to custody staff should be improved to ensure they understand what is required of them and can implement their learning where necessary, notably in safeguarding and mental health awareness.

2.15 HMCTS should develop a safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable adults at risk.

Section 3. Individual rights

Expected outcomes:
Detainees are able to obtain legal advice and representation. They can communicate with legal representatives without difficulty.

3.1 There was a commitment to prioritise custody cases and a reasonable proportion of cases were dealt with before the court broke for lunch. However, for many reasons custody cases were not always prioritised and the situation was worse than at other court clusters inspected recently.

3.2 Court custody cases were not so likely to be prioritised at the less busy magistrates' courts where there was only one court running and no dedicated remand court. Most detainees' cases were interspersed with other hearings, such as trials. Across the cluster, courts did not always start promptly in the morning and there were some significant delays before the first detainee appeared in court, as late as 3.52pm at the time of the inspection. This potentially lengthened their time in custody and was unacceptable. The courts did not always progress requests from custody staff to prioritise the cases of vulnerable detainees, for example those with health concerns. The reasons for this were unclear.

3.3 Delays were caused when detainees were received into court custody and the police had not finalised their cases and/or transferred the electronic case papers to the Crown Prosecution Service (CPS). This was one of several reasons cited as delaying further the transfer of these papers between the CPS and solicitors, which in turn delayed consultations with detainees until the solicitors were fully informed of their clients' cases. Some solicitors were also delayed because they represented multiple clients including detainees, for example when acting as duty solicitor, and chose to deal with other matters before attending the cells to deal with their custody cases.

3.4 Non-English-speaking detainees were sometimes held in court custody for longer than necessary because of delays or non-attendance by court-appointed interpreters, which could result in detainees being remanded to prison for an additional night.

3.5 We also found some delays in detainees being transported to prison following their court appearance and this was reflected in data that we received. Staff at the less busy magistrates' courts said that delays were often caused because vehicles were not available or escort staff were occupied with court duties. These delays were slightly less prevalent at the Crown courts but there were still some significant waits before detainees were transferred to prison.

3.6 There were also delays, some significant, for detainees who had been bailed or acquitted by the courts but had previously been remanded in custody. These detainees, who should have been free to leave court custody, were moved around the custody suite in handcuffs (see paragraph 4.42) and required to wait in cells before the originating prison authorised their release. In the records that we reviewed, it was not uncommon for detainees to be held for between 90 and 135 minutes awaiting the authority to release them. In the most extreme case one detainee was returned to prison at 6.35pm after waiting just over two hours for the authority to release because court custody staff were told that no governor was available to facilitate this.

3.7 HMCTS, PECS and GEOAmey were aware of these shortcomings and had started to take action to address the delays. However, at the time of the inspection outcomes for detainees had not improved and were not consistently good. It was of concern that too many

detainees were deprived of their liberty for longer than necessary (see main recommendation 1.27).

3.8 Detainees held in police custody should be able to appear before a magistrates' court if the court is sitting and there is capacity to hear their cases. At the request of custody staff, we were told that the clerk of the courts routinely accepted detainees throughout the day. We observed a few detainees who were accepted from police custody later in the day, with the latest arriving at about 1.30pm. Records indicated that only a small proportion of detainees were received from the police later than 2pm. From our observations and the records we reviewed, we were not confident that detainees were always seen by the first available court and so potentially remained in police custody for longer than necessary.

3.9 Court enforcement officers or bailiffs, who executed warrants on behalf of the courts, delivered most compliant individuals directly to the court room. They seldom lodged detainees in court custody and HMCTS managers confirmed that this only happened subject to a risk assessment of the individual's behaviour or a health concern, which was appropriate.

3.10 All courts had appropriate arrangements, including on Saturday, for the Youth Offending Service (YOS) to establish if a child was held in court custody. When a child was detained in the court cells, YOS workers attended to present their needs, risks and circumstances to the court. We saw few children in court custody but those who were did not always have their cases prioritised to reduce the time they spent in the cells and there were often lengthy delays before they appeared in court. Children who were subsequently remanded in custody were sometimes delayed further awaiting placement orders for the establishment they were remanded to. Some of these delays were excessive and some children remained in court custody for longer than necessary (see paragraph 4.14).

3.11 Warrants of detention, required when a detainee is remanded or sentenced to a term of imprisonment, should be produced within 60 minutes of a court hearing or appearance. Warrants were produced electronically and forwarded to local prisons and we were confident that most warrants were issued in a timely manner. However, in one court it was common practice to check that the prison had received the warrant before arranging transport to transfer detainees. This extended the time that some detainees remained in court custody and was unnecessary.

3.12 Court custody staff told us that if a detainee wanted to tell somebody where they were, this was referred to their legal representative. However, we saw custody staff making telephone calls on behalf of detainees on two occasions, which was positive.

3.13 Printed copies of rights and complaints information were placed in cells before a detainee's arrival. They were available in a range of languages but not in an easy-read format or in Braille. A few were in a poor condition (see paragraph 4.17). On arrival at court, not all detainees were asked if they could read or understand the documents. However, we observed detainees at different courts indicating that they could not read and their rights were read and explained to them.

3.14 Custody staff at all courts asked detainees when they arrived for the name of their solicitor. In several facilities there were not enough legal rooms to meet the need, and queues sometimes formed. Several interview rooms were cold, small and cramped and at Cheltenham Magistrates' Court were not fully soundproofed. We saw solicitors speaking to their clients at cell doors, which compromised privacy. Detainees at all courts could keep legal documents with them about their case.

3.15 Portable handsets and guidance on their use were available in all court custody suites to facilitate access to the telephone interpreting service. Data supplied by GEOAmey indicated

that this service was used infrequently at most courts. In courts where it had been used, staff were confident to use the service and understood the benefits of it. At other courts staff preferred to use court-appointed interpreters to check on a detainee. However, interpreters were not in the custody suites when detainees first arrived and, when they were present, staff did not always take the opportunity to use them (see paragraph 4.8 and recommendation 4.22). This had implications for the welfare of detainees and the assessment of risk.

3.16 Data supplied by GEOAmey showed that only three complaints had been received during 2019. Detainees at most courts were told on arrival of the complaints procedure and details of the procedure were placed in their cells. Notices about the complaints procedure and the right to appeal to an independent body were displayed in all custody suites but, in most cases, in areas where detainees did not have the opportunity to read them. Court custody staff had a reasonable awareness of the complaints procedure.

Recommendations

3.17 All detainees in court custody should be informed of their rights in an appropriate language and format that they understand.

3.18 HMCTS should ensure that there are sufficient interview rooms at each court and that they are soundproofed to ensure confidentiality.

Section 4. Treatment and conditions

Expected outcomes:
Escort staff are made aware of detainees' individual needs, and these needs are met during escort and on arrival. Detainees are treated with respect and their safety is protected by supportive staff who are able to meet their multiple and diverse needs. Detainees are held in a clean and appropriate environment. Detainees are given adequate notice of their transfer, and this is managed sensitively and humanely.

Respect

4.1 Most detainees experienced reasonably short journeys from local police stations or prisons. There was no evidence of comfort stops for the few detainees with journeys of more than two and a half hours. Cellular vehicles were not always clean enough and some contained graffiti but they were generally well equipped, including water, disposable urinal bags and first aid kits.

4.2 Women and children were routinely transported from police stations with men, which was poor practice. The partitions in cellular vehicles maintained some degree of separation but they were not used adequately to safeguard potentially more vulnerable detainees.

4.3 Detainees alighted quickly on arrival. Their privacy was maintained when courts had secure vehicle docks, but in courts with no private area to alight, staff ensured that risks were minimised and opportunities reduced for detainees to be seen by the public.

4.4 Staff in all suites were calm and professional in their approach to the care and safety of detainees. They behaved very humanely and respectfully and took care to explain each stage of the process, especially to those unfamiliar with the working of the courts. Their attitude was patient and encouraging, and they made every effort to reduce tension and anxiety. When detainees first came into their custody, they asked about their needs, using a checklist. However, they did not always cover each item on the list, for example whether the person could read and write.

4.5 Staff at all courts were skilled at establishing a rapport with detainees. Many experienced staff dealt well with detainees with mental health or drugs concerns, although they lacked full confidence because they had not received systematic training in these areas. They also felt that health professionals did not provide regular or on-call support in managing detainees with clinical concerns (see paragraph 4.51). A similar dynamic was evident in their support for people with protected characteristics: many did not feel that they had a full understanding of equality and diversity matters, particularly if their initial training had been some while ago.

4.6 There was always at least one female member of staff in each custody suite at the time of our inspection, and women received good support. There was a separate corridor of cells for female detainees in most suites. Boxes stocked with a reasonable range of menstrual care products were mostly freely available in the female toilet areas. The leaflet 'Females in custody' gave appropriate information and was placed in all cells occupied by females. Women were not always searched in private: one, for example, was searched in the main circulation area while handcuffed to a male officer. We observed good care being given to a pregnant woman.

4.7 In several suites, whiteboards containing the names of current detainees were located in a main area where detainees moved and might wait or were clearly visible from the area. Specific risks were not included but nevertheless detainees' personal information was compromised.

4.8 More staff than in many other court regions had used telephone interpreting which they found accessible and useful. We observed interpreting being used well on several occasions, although it was not used for some detainees whose experience of custody would have been improved by interpreting. Printed material was available in different languages, including the rights document which we saw being used, although not in all relevant cases.

4.9 The great majority of detainees were asked on arrival whether they wished to practise their religion while in custody, and each suite had a box stocked with a good range of religious materials, appropriately and respectfully stored. There was evidence that they had been used, and we saw them being offered and used.

4.10 Clear policy instructions had been issued on the treatment of transgender people, including searching practice. Most staff were confident in this area, but others were not familiar with the policies.

4.11 At two courts, Bristol Magistrates and North Somerset Magistrates, there were good facilities which made the whole building accessible to wheelchair users or others with mobility difficulties. These detainees were routinely sent to these courts for their case to be heard. However, in these newer buildings, toilets with low stable doors for people with disabilities faced the main circulation areas and did not afford enough privacy.

4.12 Only a small number of children were held in court custody. Custody staff received little or no training in dealing with children and few staff had an understanding of their distinct needs. The experience for most children was, therefore, similar to that of an adult. They were kept separate from adults, but they were generally accommodated in cells, travelled in cellular vehicles and were routinely handcuffed with no regard to their vulnerability (see main recommendation 1.28).

4.13 GEOAmey had comprehensive child protection and safeguarding policies but they were not widely understood. Very few custody staff were trained in minimising and managing restraint (MMPR) techniques (see Glossary of terms). Instead they used control and restraint, which was not suitable for children and had been used with four children in the previous year.

4.14 Children who were remanded or sentenced to custody required a placement order specifying where they would be detained. Some placement orders did not arrive quickly, but most children were moved to their place of detention reasonably promptly on receipt of the placement order. The relatively few children escorted to and from local authority accommodation or secure training centres were accompanied by trained staff in non-cellular vehicles and their experience was slightly better.

4.15 All detainees to whom we spoke said that custody staff had treated them very well and had been considerate about their needs and concerns.

4.16 Microwave meals, crisps and biscuits and a limited range of sandwiches were available at all suites. Food and hot drinks were offered at various times, as well as at standard mealtimes. The areas for preparing food and hot drinks were clean and largely suitable, apart from some suites where no separate room was available. It was difficult to preserve good standards of hygiene at the more cramped suites such as Yeovil and Taunton Magistrates' Courts, and especially at Gloucester Crown Court (see paragraph 2.7 and main recommendation 1.29).

4.17 Custody staff brought in old or free newspapers to almost all courts. They were freely offered and well used. There was a small range of books in each suite, again brought in by staff. There was no budget for reading materials, and nothing in different languages or suitable for children.

4.18 Good use was made of 'distraction packs', compilations of quizzes and puzzles which were sourced each month from the RECOOP charity. They were offered very widely to detainees. Staff used them intelligently, removing items which were clearly unsuitable for the individual detainee, and adding open-access material which they sourced and printed from the internet.

4.19 Detainees' property was accounted for properly and held securely, except at Taunton Magistrates' Court. Some suites held small amounts of clothing for issue to detainees who did not have appropriate clothes or who were cold. Staff had taken the initiative to source these clothes but there were not enough at any suite to meet a normal range of needs.

Recommendations

4.20 Women and children should be transported separately from adult men.

4.21 Personal information about detainees, including names, should not be clearly visible in or from areas to which detainees and non-staff visitors have access.

4.22 Staff should use telephone interpreting services whenever necessary to check on the welfare, risk management and understanding of non-English speaking detainees.

4.23 The individual needs of children transported to, and held in, court custody should be understood and consistently met. Custody staff who work with children should receive specific training, including in the use of MMPR techniques.

Safety

4.24 The staff, many of whom had considerable experience, gave due priority to keeping safe detainees and all who worked in the custody suites. They were quick to notice indicators of risk in the behaviour of detainees, and to anticipate what might trigger an unsafe reaction in the individual detainee. It was not unusual for vulnerable detainees to be in the cells in custody suites for several hours, and we observed several occasions when staff gave positive and well-judged support to emotionally unstable detainees.

4.25 Detainees arrived from police stations or prison with a person escort record (PER). It was noticeable that these contained fuller information than we often see in other court regions, for example where evidence of risk related to a past event such as a suicide attempt, the date of the event was generally routinely recorded. A pilot project was under way for local managers to review each PER and record any weaknesses. This information was aggregated and considered by the monthly senior management meeting of stakeholder agencies. Some cases still remained where relevant information contained in other records was not included. At some sites, loose-leaf material such as health information which should have been in the detainee's private property was tucked into the PER.

4.26 The checklist to be used on arrival was not carried out in detail with all detainees, for example some who were well known to staff from previous detention. However, we did not see any adverse outcomes from this, largely because staff were vigilant and alert to signs of risk.

4.27 When remanded or sentenced detainees, who had answered bail, were brought to the custody suites before transfer to prison, they were given a personal interview in a private room, to discuss and record information required by the prison, and to give detainees information about what to expect.

4.28 In a few suites, the court custody manager called all staff together to brief them about the risks associated with each of the people in their care. In other suites, briefing was less formal, and some staff often did not receive an appropriate briefing. There was a daily briefing sheet, which all staff were required to sign that they had read it. We observed this happening consistently, but the written brief often did not contain any information about the individuals in custody.

4.29 Detainees were shown the cell call bells on arrival and in all suites the bells were almost always answered promptly. However, at Bristol Magistrates' Court it was not easy at busy times to see or hear the call signals. All staff carried anti-ligature knives.

4.30 Detainees were individually assessed to determine if they needed to be observed in their cells every 30 or 60 minutes, or six times an hour at random intervals. The checks were carried out as determined in most cases, but on several occasions we observed a check being omitted or not recorded accurately. Some of the checks consisted of too cursory a glance through a spyhole to be sure that the person was safe.

4.31 Court custody managers had a clear commitment to encouraging court officials to prioritise vulnerable people held in custody when they were arranging the order of hearings in courts. They were persistent and active in contacting the court clerks or other officials to explain why it was not good for a particular person to be held in the cells for most of the day. They did not always succeed through no fault of their own (see paragraphs 2.10 and 3.1).

4.32 There was a policy for each detainee to be given a rub-down search every time they entered or left their cell and, in some suites, a notice on each cell door confirmed this. This meant, for example, that detainees were searched every time they went to and from the toilet, within the secure cell corridor. In principle, this may have been justifiable, but the very frequent searches were often cursory and served little purpose.

4.33 There were generally enough cells in almost every courthouse to cater for the throughput of the courts in that building. There was often no need for cells to be shared unless there was a positive reason for two people to share. Not all suites had separate areas for men, women and children, but sufficient care was taken everywhere to keep the three groups separate.

4.34 Detainees were taken up to court promptly when they were called for. The routes to court were private and detainees were never taken through public areas. The corridors and staircases were reasonably wide and in fair condition, except at Gloucester. In many buildings, the staircases did not have complete coverage of affray alarm buttons and an officer would have too far to go to press one. Where CCTV was installed, there were blind spots on some staircases.

4.35 Good support was given to those released from court custody. Staff in all suites took care to ask each person where they were going, how they would be travelling, and what help they needed. Rail travel warrants were offered where appropriate, and small amounts of cash for bus or taxi fares if required. In each case staff checked the address and the relevant fares. They liaised with liaison and diversion teams and social workers in some cases where extra help was needed.

4.36 People being released from custody were enabled to change into their own clothes before leaving the suite, and to open their sealed property bags before departure. They were given directions if they needed to report, for example, to the probation office and left discreetly

through the back entrance. Printed local street plans were available showing the route to bus and train stations, and staff ensured that each person understood where to go and answered any other questions. This approach to release helped to reduce anxiety about the immediate future for many detainees.

4.37 Most suites held a generic 'What happens next?' leaflet and a range of leaflets issued by each prison to which people were regularly sent from court. These were usually offered to detainees sent to prison, but not in all suites. Each of the three counties had also produced useful information sheets about local services with contact numbers. Some of these dated back two or three years, but they were a useful resource and we saw them being given to several detainees who were being released. However, this practice was not universal.

Recommendations

4.38 The assessment of each detainee's risks and needs on arrival in custody should be carried out consistently. Cell checks should be carried out on time, should normally include interaction with the detainee and should be recorded accurately.

4.39 Searching of detainees should be carried out effectively and consistently across all suites, in accordance with a policy which restricts searching to situations where it is clearly necessary.

Use of force

4.40 The number of incidents of use of force was reasonably low. Custody staff were skilled at defusing anxieties and communicated well with detainees to de-escalate situations with the potential for use of force. From our review of records and speaking to staff, we were confident that all incidents were recorded and that force was only used as a last resort.

4.41 We examined 37 records where force had been used. Much was at a low level, for example to prevent self-harm or to remove reluctant detainees from the dock when their case had been completed. The quality of written records varied greatly but overall generally reflected that force was necessary and proportionate to the risk or threat posed. We were, however, concerned at the lack of detail in some individual statements and by the apparent use of a non-approved technique to place detainees in a cell. Although managers monitored records, they had not identified these shortfalls, which suggested that quality assurance processes were ineffective.

4.42 Detainees, including children, were routinely handcuffed for most movements when they left their cells in spite of the secure and controlled custody environment. This included journeys to court (see main recommendation 1.28), although handcuffs were usually removed before detainees entered the dock.

Recommendation

4.43 The quality of individual statements accounting for the use of force against detainees and the quality assurance of use of force should be improved. Only approved use of force techniques should be used.

Physical conditions

4.44 The conditions in custody suites varied considerably. Most of the relatively modern suites in Bath, Bristol and North Somerset Magistrates' Courts were clean and free of graffiti. However, conditions were much worse elsewhere, particularly at Taunton and Gloucester Crown Courts where the cells were housed in old, listed buildings and were barely fit for use. In Taunton Crown Court the designated female cells were unacceptably cold and damp (see photograph) and at Gloucester Crown Court some of the cells were cold and so cramped that a detainee, who could be held there for several hours, could not even lie down (see photograph). This resulted in inequitable experiences and outcomes for detainees across the court cluster (see main recommendation 1.29).

4.45 There had been a considerable effort to reduce the potential ligature points across the estate. However, we looked at the cells we had access to at each court and found several potential ligature points. We provided a comprehensive report detailing the ligature points, together with our assessment of the physical conditions across the cluster.

4.46 Most cells across the estate lacked natural light and ventilation was not always adequate. Little graffiti was evident and any that was present was generally inoffensive. Ineffective heating systems had been a continuing problem for a considerable time in a number of courts. We received complaints in several suites that cells were cold. Unlike in police custody no blankets were available, but at some courts staff issued detainees with additional items of clothing from their property. At some courts, where detainees had no available clothing they were offered items which staff had donated to the suite for this purpose.

4.47 Cells were generally clean. Most cells were cleaned each day, although not if the cell was used by two people on the same day and not always before Saturday courts. Some cleaning arrangements were not effective, for example at Gloucester Crown Court some cells had ingrained dirt in the corners and what appeared to be blood on the wall of one cell (see photograph and main recommendation 1.29). Communal toilets were clean and toilet paper, soap and hand towels were freely available although supplies were not always stored hygienically because there were no dispensers. The use of stable doors in some toilet areas, including accessible toilets, did not afford sufficient privacy but visits to the toilet were generally supervised sensitively (see paragraph 4.11).

4.48 The provision and effectiveness of maintenance arrangements varied. Some defects were dealt with promptly while others depended on the nature and expense of the repair. One cell at Gloucester Crown Court had been out of action for almost two months after an act of vandalism by a detainee who had dislodged some of the brickwork.

4.49 Fire evacuation plans were displayed prominently in the suites. Court custody staff at all courts had taken part in fire evacuation drills, commissioned by HMCTS, in the previous year. We were, however, not provided with evidence of these drills, who took part or any learning that had resulted.

Health

4.50 The court custody suites had access to a telephone medical helpline where advice could be sought from a specialist health adviser. Posters containing the helpline contact number were clearly displayed in each suite. The helpline could also arrange the attendance of a health professional within two to three hours if clinically required.

4.51 Data provided by GEOAmey indicated that the medical helpline had been contacted by courts in the area on 18 occasions during 2019 for advice or to verify the issue of medication

to detainees. Custody staff we spoke to understood the service that was available but said that, due to a perceived lack of responsivity, they would try to get the court to give priority to a detainee so that they could be released quickly or transferred to prison where their health issues would be dealt with. They were however confident to contact the ambulance service in an emergency.

4.52 All staff were required to complete a first aid at work qualification and they were in date with their training at the time of the inspection. First aid training updates were conducted every three years, which was not frequent enough to maintain an adequate skill level. Automated external defibrillators (AEDs) were available in some of the courts but were not always immediately available to custody staff. No oxygen or suction was available. First aid boxes were not always regularly checked, a few boxes contained out-of-date stock and one was understocked.

4.53 Custody staff relied on health information recorded on the PER and from detainees, but health issues were not always adequately identified on the PER (see paragraph 4.25). A detainee from prison had a prescription for methadone attached to his PER, with no record of the reason or that the detainee was a drug user. We observed one court custody manager routinely opening medical in confidence envelopes which accompanied PERs, which should only be opened in a medical emergency.

4.54 Court custody staff said on occasions they received detainees from police custody who required medication which had not been sent. While they may have received some medication in police custody, this was particularly concerning for detainees with alcohol or drug withdrawal symptoms and posed a risk of severe health complications if they had no access to medication while in court custody. We saw a few detainees in this position who appeared to be suffering unnecessarily because staff did not seek medical attention but simply attempted to expedite the detainee's case, sometimes without success.

4.55 Court custody staff were aware of the requirements for safe drug administration and the appropriate storage of medicines. We saw a few detainees allowed to keep their asthma inhalers in their cells, which was positive.

4.56 Most detainees with mental health conditions had been seen by mental health staff while in police or prison custody. Access to mental health practitioners varied considerably across the court cluster. Some courts had no dedicated service at all, although contact numbers were available in these cases. Most custody staff across all courts told us they had not received any training in identifying and supporting detainees experiencing mental health or substance use problems. In spite of this, most custody staff demonstrated a reasonable understanding of drugs and alcohol issues.

Recommendations

4.57 All custody staff should receive annual first aid refreshers to maintain their skills.

4.58 Person escort records should identify the detainees' health risks while maintaining confidentiality.

4.59 Custody staff should have regular mental health and substance misuse awareness training.

Section 5. Summary of recommendations

Main recommendations

5.1 Detainees in court custody should have their cases prioritised according to their needs and these should be heard promptly. The reasons for delays should be understood and addressed. (1.27)

5.2 Handcuffs should only be used on detainees if this is proportionate and justified by an assessment of the risk. (1.28)

5.3 Conditions across custody facilities should be improved. In particular, court custody cells should be of an adequate size and properly cleaned. The temperature in cells should be appropriate, they should be free of damp and have access to natural light. (1.29)

Recommendations

Leadership, strategy and planning

5.4 The relationships and communication between operational HMCTS and GEOAmey staff should be improved to ensure a consistent focus on delivering good outcomes for detainees. (2.13)

5.5 The approach to delivering continuing training and development activity to custody staff should be improved to ensure they understand what is required of them and can implement their learning where necessary, notably in safeguarding and mental health awareness. (2.14)

5.6 HMCTS should develop a safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable adults at risk. (2.15)

Individual rights

5.7 All detainees in court custody should be informed of their rights in an appropriate language and format that they understand. (3.17)

5.8 HMCTS should ensure that there are sufficient interview rooms at each court and that they are soundproofed to ensure confidentiality. (3.18)

Treatment and conditions

5.9 Women and children should be transported separately from adult men. (4.20)

5.10 Personal information about detainees, including names, should not be clearly visible in or from areas to which detainees and non-staff visitors have access. (4.21)

5.11 Staff should use telephone interpreting services whenever necessary to check on the welfare, risk management and understanding of non-English speaking detainees. (4.22)

5.12 The individual needs of children transported to, and held in, court custody should be understood and consistently met. Custody staff who work with children should receive specific training, including in the use of MMPR techniques. (4.23)

Safety

5.13 The assessment of each detainee's risks and needs on arrival in custody should be carried out consistently. Cell checks should be carried out on time, should normally include interaction with the detainee and should be recorded accurately. (4.38)

5.14 Searching of detainees should be carried out effectively and consistently across all suites, in accordance with a policy which restricts searching to situations where it is clearly necessary. (4.39)

Use of force

5.15 The quality of individual statements accounting for the use of force against detainees and the quality assurance of use of force should be improved. Only approved use of force techniques should be used. (4.43)

Health

5.16 All custody staff should receive annual first aid refreshers to maintain their skills. (4.57)

5.17 Person escort records should identify the detainees' health risks while maintaining confidentiality. (4.58)

5.18 Custody staff should have regular mental health and substance misuse awareness training. (4.59)

Section 6. Appendices

Appendix I: Inspection team

Kellie Reeve	Team leader
Martin Kettle	Inspector
Fiona Shearlaw	Inspector

Appendix II: Photographs

Damp in cell F2 in Taunton Crown Court

Cell 4 Gloucester Crown Court

Cell 6 in Gloucester Crown Court