Report on an inspection visit
to court custody facilities in

Wales

by HM Chief Inspector of Prisons

1–13 July 2024

Contents

Introduction

This report details findings from an inspection of court custody facilities in Wales. It covers three Crown courts, three combined courts, 11 magistrates' courts and one immigration and asylum tribunal centre.

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 throughout the country.

This was a positive inspection with progress evident against many of our previous recommendations. Leaders in HMCTS, PECS and GEOAmey had established strong working relationships, and they used data well to understand the detainee experience and drive improvement. Inside the custody facilities, we met polite, kind and caring staff who worked hard to meet the needs of detainees. There was now a much more proportionate approach to handcuffing and searching, and we were particularly impressed by the considerate and patient de-escalation work we witnessed.

Going forward, leaders in the Wales court cluster need to address some weaknesses we identified, with a particular focus on improving processes for release from court, physical conditions and detainee dignity.

Release arrangements also needed to be better. While staff routinely provided detainees with the means to get home, they often failed to inquire about their personal circumstances. As a result, they missed opportunities to support detainees with problems such as homelessness or addiction. However, leaders were making progress in reducing the time taken to obtain release authorisations from prison governors, which was positive.

While most courts were reasonably presentable, many cells were still not clean enough. Although there was less graffiti, floors and walls remained grubby and needed more consistent attention. Some toilets lacked privacy and others were in poor condition or had no dispensers for toilet paper, soap and towels. The cells in Swansea magistrates' court were very small and barely fit for purpose.

Finally, we encourage more attention to detainee dignity. Detainees who alighted from vehicles on to a public road were exposed to public view and staff did too little to mitigate this.

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

Charlie Taylor
HM Chief Inspector of Prisons
July 2024

What needs to improve in Wales court custody

We last inspected court custody in Wales in 2015 and made 37 recommendations overall, seven 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 29 of the 37 recommendations had been achieved or partially achieved, including all the recommendations about key areas of concern. Six recommendations had not been achieved and two were no longer relevant.

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

1. **Some detainees were locked back into cells before their release, which was inappropriate, and in most release interviews, staff did not ask sufficient questions about detainees' personal circumstances to identify and address issues such as homelessness or addiction.**

Key concerns

We identified a further eight key concerns.

2. **Staff did not do enough to shield detainees from public view when they alighted from vehicles, compromising their privacy and dignity.**

3. **There were too few custody facilities for detainees with disabilities, and provision and suitable adaptations within these facilities was too limited.**

4. **Telephone interpreting services were not always used when necessary for communicating with non-English speaking detainees.**

5. **Staff were not always briefed about detainee risks and observation checks, including for those deemed to pose the highest risk; checks were not always completed at the required frequency or accurately recorded.**

6. **The main agencies responsible for court custody did not do enough to understand and address the reasons why some detainees were held in court custody for longer than necessary.**

7. **In many courts, cells were not sufficiently clean with ingrained dirt on floors and unpleasant stains on the walls.**

8. **The cells at Swansea magistrates' court were too small and the male toilet at Swansea Crown court was significantly lacking in privacy; other toilets were in poor condition or lacked dispensers for toilet paper, soap and towels.**

9. **Staff training in resuscitation skills was not frequent enough to maintain confidence and competence.**

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 one example of notable positive practice during this inspection, which other places may be able to learn from or replicate. Unless otherwise specified, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other locations. They show some of the ways our expectations might be met, but are by no means the only way.

Example of notable positive practice		
a)	The paramedic assigned to the custody facilities in South Wales routinely met new custody officers during their induction to make sure they understood the medical advice phone line and were confident in using it.	See paragraph 4.16

About court custody in Wales

Data supplied by HMCTS, PECS and GEOAmey.

HMCTS cluster	Wales
Cluster manager	Lynne Mills
Geographical area	Wales
Court custody suites and cell capacity	
Aberystwyth Justice Centre	4 cells
Caernarfon Justice Centre	9 cells
Cardiff Crown Court	13 cells
Cardiff Magistrates' Court	21 cells
Cwmbran Magistrates' Court	12 cells
Haverfordwest Magistrates' Court	5 cells
Llandrindod Wells Magistrates' Court	2 cells
Llandudno Magistrates' Court	7 cells
Llanelli Law Courts	6 cells
Merthyr Tydfil Combined Court Centre	12 cells
Mold Justice Centre	12 cells
Newport Crown Court	7 cells
Newport Magistrates' Court	12 cells
Swansea Crown Court	10 cells
Swansea Magistrates' Court	14 cells
Welshpool Magistrates' Court	3 cells
Wrexham Law Courts	7 cells
Newport Immigration and Asylum Tribunal Centre	One holding room
Annual custody throughput	
1 May 2023 to 30 April 2024	16,061 detainees
Custody and escort provider	GEOAmey
Custody staffing	3 senior court custody managers 3 deputy court custody managers 11.6 court custody managers 66.9 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 reasonable progress since our last inspection and over three-quarters of our previous recommendations had been fully or partially achieved. There had also been significant restructuring and rationalisation since the last inspection and there were now seven fewer custody facilities across the cluster.

1.2 Leaders from the three main agencies, HMCTS, PECS and GEOAmey, were properly focused on achieving good outcomes for detainees and worked well together to accomplish this. Leaders monitored a range of data, including arrival times and how long detainees waited before their cases were heard, which they used to influence required improvements. All were sighted on and considerate of how the geography of the country impacted the detainee experience, although were powerless to change the sometimes long distances required to get detainees to and from court.

1.3 Leaders were responsive to issues that arose during the inspection. For example, they took immediate action to stop enforcement officers taking compliant people into custody - a concern at the last visit - when we raised this during this inspection (see paragraph 3.12).

1.4 Initial training and ongoing development opportunities for custody staff were reasonable. However, not all learning was as embedded as we would expect, particularly in the awareness of safeguarding (see paragraph 4.11).

1.5 Leaders valued the external scrutiny by lay observers (see Glossary) and carefully considered the contents of their reports.

Immigration and tribunal centre holding room

Section 2 Transfer to court custody

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

2.1 Most detainees had relatively short journeys to court in reasonably clean vehicles, which were appropriately staffed and suitably equipped. However, a few journeys, particularly on Saturdays, were very long. Women and children sometimes travelled with male detainees, but when this happened, staff mitigated risks by using a partition to provide a degree of separation.

2.2 Most facilities had a secure area for vehicles to park. Staff made sure that detainees alighted swiftly after arrival. However, when vehicles parked on the road (rather than in a secure area) – notably at both Crown and magistrates' courts in Cardiff and Merthyr Tydfil – detainees often alighted in public view and staff did too little to shield them or maintain their privacy and dignity.

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 very respectfully. We observed empathetic, kind, reassuring and patient staff interactions. However, some reception procedures and the collation of information required for admission to prison were often rushed and lacked privacy. In some courts we saw interviews conducted at cell doors, and in cells that detainees were sharing with others. Detainees were rarely offered the opportunity to speak to a member of staff individually to disclose personal information discreetly.

3.2 We saw some excellent examples of custody staff comforting detainees who were feeling anxious or worried. Staff took time to talk to detainees to help reduce tension.

3.3 In most facilities, noticeboards displaying information about the individuals in the court facility were visible to other detainees, which was inappropriate and breached confidentiality.

Meeting individual and diverse needs

3.4 There was a reasonable focus on meeting the individual needs of detainees. The specific needs of women were mostly met, and staff generally understood how they should care for transgender detainees. There was good awareness about how to support detainees with neurodivergent conditions.

3.5 The lack of sufficient custody facilities for people with disabilities often meant long journeys to one of the few courts that were accessible for detainees with mobility and other needs. There was a general lack of physical adaptations in the cells we visited, and most had no hearing loops available.

3.6 Detainees were generally asked about their religious needs on arrival, and most courts had religious artefacts available on request.

3.7 While the use of telephone interpreting for non-English-speaking detainees had improved, this service was not always used when required. Staff did not always make best use of it to explain fully to detainees all the processes, either before court or the next steps on

conclusion of their cases. Neither did they use telephone interpreting with detainees when they returned from their court hearing to see how they were feeling, or to check that they understood what had happened. Key documents, including custody rights, were available in a range of languages and Braille. However, in most custody facilities very limited information was displayed in Welsh.

Risk assessments

3.8 There were some gaps in the identification and management of risk. While escort staff usually shared relevant risk information about detainees, digital person escort records (dPERs, see Glossary) were not always thoroughly checked, and managers often missed important information. Custody staff were not consistently briefed about the risks posed by those in their care, but they were alert and responsive to detainee vulnerabilities and changes in mood, and we saw some excellent interactions from staff when caring for vulnerable detainees. Some observation checks were, however, cursory and lacked engagement, and did not always take place at the required frequency, including for those deemed to pose the highest risks. Records did not always accurately reflect the level of checks that were conducted.

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

Individual legal rights

3.10 There was now a good focus on requesting prioritisation of detainees for appearance in court, particularly women and children and those with vulnerabilities. Despite this, a range of factors meant some detainees continued to spend longer in custody than necessary. These factors included: court sessions starting late and long waiting times to see legal representatives, sometimes linked to delays in receiving electronic case papers; detainees arriving in the morning for afternoon listings; and some long waits to move detainees to prison at the conclusion of hearings. It was not always clear why there were delays, and leaders from the three main agencies had not done enough to understand and address these issues to make sure all detainees were dealt with as quickly as possible.

3.11 Information detailing detainees' rights was available in cells but was sometimes in a poor condition. Staff rarely explained detainees' rights to them, even when they disclosed that they struggled to read or understand the documentation.

3.12 In data analysis conducted before the inspection, we continued to find many cases where civil enforcement officers took compliant people into court custody without a dynamic risk assessment to show that this was necessary. Although leaders had not acted on our previous concern about this raised at the last inspection, it was positive that once we highlighted this to them this practice stopped, with credible measures to prevent it recurring (see paragraph 1.3).

3.13 Legal consultations for detainees were managed appropriately and were supervised discreetly, and there were no unnecessary delays moving detainees to court when requested.

Complaints

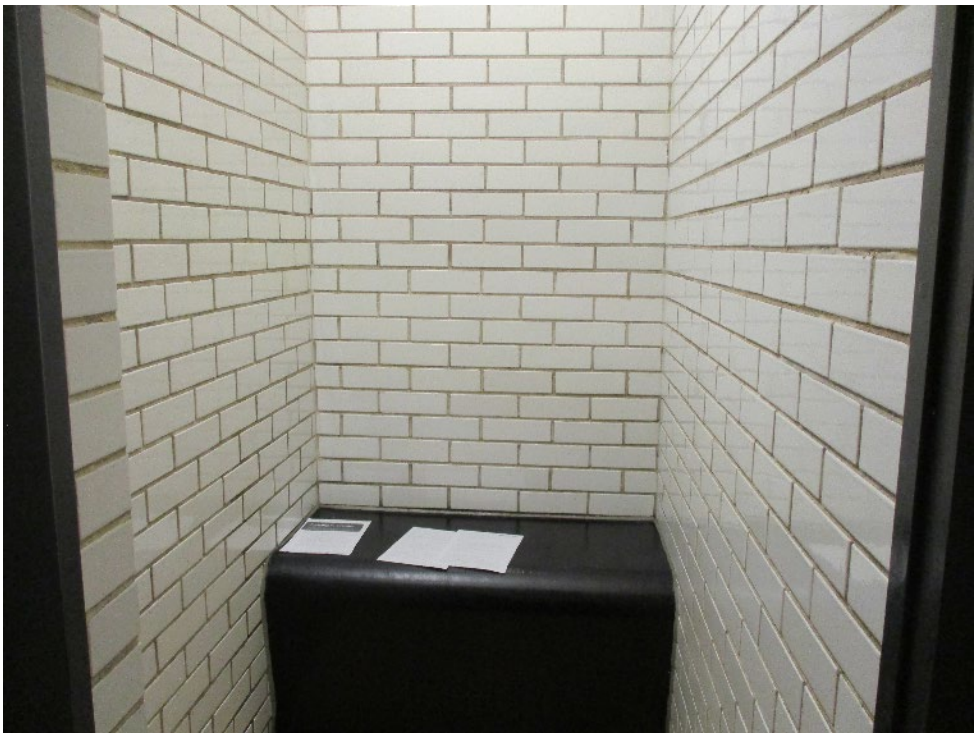
3.14 Custody staff did not explain the complaints procedure well enough to detainees. Notices detailing the process were displayed in custody facilities and were mostly available in cells, but many were in a poor condition and contained out-of-date information. Although complaints from detainees were rare, responses to them, when required, were not always comprehensive.

Section 4 In the custody cell, safeguarding and health care

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

Physical environment

4.1 Most physical conditions were adequate but there were some significant exceptions. Most of the cells at Swansea magistrates' court were too small and barely fit for purpose. There was less graffiti in cells than at our previous inspection, but most cells still had ingrained dirt on floors and unpleasant stains on walls. Routine cleaning was often ineffectual, and cells were not always cleaned between use, particularly for Saturday sittings. We were told that periodic deep-cleans no longer happened.



Swansea magistrates' cell

Cell in poor condition at Newport magistrates' court

4.2 Toilets often lacked privacy. Usually this could be mitigated by discrete supervision, but at Swansea Crown court this was not possible because the male toilet was located at the end of the cell corridor; this facility was disrespectful. Most toilets had no seats and too many facilities still lacked suitable dispensers for toilet paper, soap and paper towels.

Swansea Crown court toilet

4.3 Some reported defects remained unresolved several weeks after they had been reported, even though cells were out of action or key safety systems were malfunctioning. Fire evacuation arrangements were generally satisfactory.

4.4 We provided a comprehensive report of our findings to HMCTS, which were responded to appropriately.

Use of force

4.5 Force was used against detainees very infrequently. Custody staff were properly focused on using force only as a last resort and were skilled at defusing tense situations and on de-escalating incidents at the earliest opportunity.

4.6 The documentation we reviewed that detailed the rationale for using force was generally adequately completed. Where shortfalls in paperwork or poor practices were identified, they were remedied through robust quality assurance.

4.7 The approach to handcuffing and searching had improved and was now more proportionate. It was, therefore, disappointing that we found some sites where handcuffs were used without an individual risk assessment or remained in place longer than necessary.

Detainee care

4.8 We found an almost universally caring approach by staff looking after detainees, and detainees told us they felt well cared for.

4.9 Drinks were mostly provided quickly on arrival, and at regular intervals throughout the day. A range of food to meet most dietary requirements was available; sandwiches, microwave meals, biscuits and crisps were readily provided on request as well as at mealtimes.

4.10 There was now a good selection of materials to keep detainees occupied, and they appreciated activities to relieve the boredom and stress of being locked in a cell. Where available, chalkboards were well used. A range of puzzles, board games, playing cards, reading materials and stress relievers, such as sensory fidget toys, was provided. There was a much better take-up of distraction activities in the facilities where detainees could see what was available and select items themselves.

Safeguarding

4.11 Most staff had a reasonable understanding of their safeguarding duties and could give examples of when they had taken action to prevent harm. Although these staff knew of the safeguarding managers, they had not always shared with them concerns that might have passed a formal safeguarding threshold.

4.12 We notified managers of unacceptably poor awareness in one court where we were not assured that serious concerns would have been appropriately managed.

Children

4.13 Few children were held, but all courts had a plan for accommodating a child in an unlocked room should this be required. Some children had long journeys to and from secure sites. The limited availability of specially trained escort staff meant that children could wait several hours for transport. However, we observed good support for children in custody, including use of distraction activities.

4.14 The previous inappropriate practice of holding children in police cells after courts closed had now ceased.

Health

4.15 Support for detainees with health issues had improved significantly since our last inspection. Health Finder Pro Ltd provided an accessible and valued medical telephone advice line, which also enabled detainees to access their prescribed medication. Some suites had a tablet device to enable virtual, confidential health assessments, and a visiting paramedic could provide prompt face-to-face assessments at most courts. However, paramedics did not have access to dPERs or

the information held by the NHS. Solutions to improve detainee health care were being explored.

4.16 The paramedic assigned to the custody facilities in South Wales met every new custody officer during their induction to make sure they understood the medical advice phone line and were confident in using it, and all custody staff across Wales were trained to use custody early warning scores (CEWS, see Glossary), which enabled contemporary information to be available to the medical team. All custody staff also received basic life support refresher training, but not regularly enough to make sure they maintained adequate competence and confidence in resuscitation skills. First aid kits in most suites were too basic and not consistently checked.

4.17 All suites now had accessible automated external defibrillators (AEDs) and intra-nasal naloxone (to counter the effect of opiate overdose), which were positive developments. However, the lack of nicotine replacement remained a gap, and there was no current treatment to reduce the side effects of alcohol withdrawal. Though this was a weakness in provision, we were given assurances that actions to mitigate this risk were in hand.

4.18 The liaison and diversion services provided good mental health support to some courts, particularly where demand was higher, but this was inconsistent and very limited in some remoter areas. Courts in South Wales had seen piloted work to improve diversion from custody for detainees with addiction problems, which was being rolled out across the country, but individual contact and support for detainees with drug or alcohol problems remained limited.

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 Release and transfer arrangements were inconsistent and often not good enough. Some detainees who did not originate from prison were locked in a cell inappropriately while their release paperwork was completed. Staff provided all detainees with the means to travel home, taking account of individual needs. However, some faced extremely long journeys home (up to nine hours we were told), particularly if they lived in the west of the country, due to poor transport links. Most release interviews were cursory; staff did not ask sufficient questions about detainees' personal circumstances to identify and address issues such as homelessness or addiction. Detainees were rarely offered information about local support services or suitable bags for their property. In some courts, detainees could not open their property bags inside the court building and were therefore released wearing police clothing, which could be humiliating.

5.2 Detainees requiring governor's authority for release from prison (see Glossary) often had unacceptably long waits, caused by slow court, prison or probation processes. Staff now followed an escalation process to alert managers to delays and some recent decisions had been received within one hour, which was encouraging.

5.3 Detainees going to prison for the first time did not always receive written information about what to expect. They often had long waits in custody before they were moved, and women in particular sometimes experienced lengthy and circuitous journeys that meant they often arrived at the prison late into the evening.

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 should ensure that interagency meetings include a focus on court custody operations, particularly on improving the care and safety of detainees in court custody.
Achieved

HMCTS, PECS and the escort and court custody contractor should investigate the reasons for the prolonged periods that detainees, including children, spend 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.
Partially 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.
Partially achieved

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

National issues

HMCTS and PECS should establish agreed standards in staff training, detainee treatment and conditions, and detainees' rights during escort and in court custody.
Achieved

HMCTS and PECS should clarify the responsibilities of each organisation for resolving problems that have an impact on outcomes for detainees.
Achieved

Recommendations

Leadership, strategy and planning

HMCTS should engage with all partner agencies to ensure there are no unnecessary delays causing detainees to be held in court custody for longer than necessary.
Partially achieved

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

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

Individual rights

HMCTS should ensure that compliant defendants apprehended by court and civil 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 Wrexham Magistrates' Court and visitors to Wrexham court cells should not be locked in with detainees.
No longer relevant

All court custody staff should be made aware of the availability of a professional telephone interpreting service, which should be readily accessible in each custody suite and used as necessary.
Partially achieved

All detainees should be informed of the complaints process. Complaints should be recorded on behalf of detainees who make verbal complaints about any aspect of their period of detention. There should be a process for monitoring complaints and analysing trends.
Partially achieved

Treatment and conditions

Cellular vehicles should always be clean and well maintained.
Achieved

Men and women should not be transported in the same escort vehicle, and detainees should be transferred from cellular vehicles to court cells out of public view. Where this is not possible safeguards should be put in place to protect detainees from public view.
Partially achieved

The quality of PERs should be improved and should include more specific information about all risks posed by the detainee.
Achieved

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

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

All court custody suites should have a copy of the holy books of the main religions, a suitable prayer mat that is respectfully stored, and a reliable means of determining the direction of Mecca.
Achieved

All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers.
Achieved

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

Staff should complete observations at the required frequency, including for detainees identified as being at risk of self-harm or suicide, and there should be a formal process to amend levels of observation. The outcome of cell visits should be recorded accurately in the detention log on GEOtrack.
Partially achieved

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

Detainees handed over to court custody suites shared with the police should be able to keep their clothing and footwear.
No longer relevant

Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave and offer them a leaflet detailing local support agencies.
Not achieved

Detainees should only be searched if necessary and justified by a thorough, dynamic risk assessment.
Achieved

Cell checking procedures should include identifying ligature points and inadequate cleaning, which should be recorded, reported and rectified immediately.
Not achieved

HMCTS should ensure that graffiti is removed from all cells immediately; cells should remain graffiti free.
Partially achieved

All detainees should have access to clean toilets, which they should be able to use in privacy.
Not achieved

Emergency evacuation drills should be conducted and recorded at all courts. All staff should be familiar with emergency evacuation procedures.
Achieved

GEOAmey should routinely review the effectiveness and performance of Taylormade Medical Services.
Achieved

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

First aid equipment should include sufficient up-to-date kit, including basic equipment to maintain an airway and automated external defibrillators in custody areas.
Not 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.
Achieved

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

Custody staff should have regular training to enhance their mental health and drug and alcohol awareness.
Not 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 Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk), 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:

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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.

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.

Digital person escort record (dPER)
The PER is the key document for ensuring that information about the risks 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 electronic form agreed with and used by all agencies involved in the movement of detained people.

Governor's authority to release
The formal authorisation required to release from court custody detainees who have originated from a prison if directed by the court. The process involves checking to make sure there are no other reasons for the detainee to be returned to prison, and providing any licence conditions that are applicable to them on release.

Lay observers
Volunteers who provide independent oversight on the welfare of detainees in court custody and during transportation between prison and court.

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

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