Report on an inspection visit
to court custody facilities in

Lincolnshire, Leicestershire & Rutland and Northamptonshire

by HM Chief Inspector of Prisons

23 June – 5 July 2025

Contents

Introduction

This report presents an overview of the current state of court custody services in Lincolnshire, Leicestershire & Rutland and Northamptonshire. It covers three Crown courts, five magistrates' courts and one combined court. The prisoner escort and custody services (PECS) arm of HM Prison and Probation Service (HMPPS) had contracted GEOAmey on behalf of HM Courts & Tribunals Service (HMCTS) to provide escort and court custody services in the region. The findings reflect both commendable progress and persistent challenges, including across leadership, detainee care, legal rights and facilities management. Since our last inspection, over 90% of previous recommendations had been either fully or partially implemented.

A key strength was the dedication of custody staff, who consistently demonstrated patience, respect, and compassion in their interactions with detainees. Their ability to defuse tensions and manage complex situations was particularly noteworthy. The introduction of effective training had enhanced staff competence, especially in managing diverse and vulnerable detainees.

Senior leaders showed a commitment to detainees' welfare, consistently monitoring performance data to improve service delivery. Liaison and diversion teams were present at all courts and had significantly improved support for those with mental health or substance misuse issues. Health care provision had transformed since 2018, with reliable and trusted telemedicine services and paramedic support now widely available. The use of force remained rare and was generally applied as a last resort, with appropriate oversight in place.

Despite these strengths, several areas required improvement. Custody facilities continued to suffer from underinvestment. Some cells were in very poor condition and cleaning routines were inadequate. Although risk assessment procedures were in place, they were applied inconsistently and required closer attention. Delays in court processes often resulted in unnecessarily prolonged detention. Processes for engaging with detainees who spoke little or no English were still not followed consistently. Release procedures lacked rigour, and minimal support was provided to make sure detainees were discharged safely.

The inspection also identified systemic issues beyond the immediate control of custody staff, such as the shortage of mental health beds and the absence of community-based alternatives for detainees in acute mental health crisis. Coordinated action from the NHS, local authorities, and justice services is needed to prevent inappropriate custodial placements.

While the inspection revealed many examples of good practice and dedicated service, it also highlighted critical areas that must be addressed to ensure good outcomes for detainees. This report sets out the findings and concerns to be addressed to support continuous improvement across the court custody estate.

Charlie Taylor
HM Chief Inspector of Prisons
July 2025

What needs to improve in Lincolnshire, Leicestershire & Rutland and Northamptonshire court custody

We last inspected court custody in Lincolnshire, Leicestershire & Rutland and Northamptonshire in 2018 and made 23 recommendations (see Section 6 for a full list).

At this inspection we found that there had been good progress and 10 of the 23 recommendations had been achieved. Only two recommendations had not been achieved.

During this inspection we identified areas of concern to be addressed by HMCTS, 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 four priority concerns. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

1. **Custody facilities required investment and improvement. In particular cells were too often in poor condition and interview space was limited.**

2. **Too many detainees were spending too long in court custody. A coordinated response to reduce or mitigate avoidable delays was required.**

3. **Not enough was done to make sure acutely mentally unwell detainees in court custody received timely Mental Health Act assessments and prompt diversion to specialist care and treatment.**

4. **Release processes were often completed without sufficiently exploring detainees' personal circumstances.** They often failed to identify issues such as homelessness or addiction, or to ensure detainees had enough funds to travel home.

Key concerns

We identified a further five key concerns.

5. **Some dirty and poorly maintained vehicles were used to transport detainees. Staff failed to adequately protect detainees' privacy and dignity when they disembarked from the vehicle in public view.**

6. **Staff did not consistently use telephone interpreting services when communicating with detainees who did not speak English.**

7. **There were too few suitably adapted custody facilities for detainees with disabilities.**

8. **There were weaknesses in risk management.** Staff were not always adequately briefed. Digital person escort records were often incomplete, and some staff were unfamiliar with risk codes. Sometimes there were no staff in the rear of occupied vehicles, which created avoidable risks.

9. **Detainees did not have access to nicotine replacement therapy.**

About court custody in Lincolnshire, Leicestershire & Rutland and Northamptonshire

Data supplied by HMCTS, PECS and GEOAmey

HMCTS cluster
Lincolnshire, Leicestershire & Rutland and Northamptonshire

Cluster manager
Claire Mace

Geographical area
East Midlands

Court custody suites and cell capacity

Leicester Magistrates' Court	16 cells
Northampton Magistrates' Court	12 cells
Leicester Crown Court	16 cells
Lincoln Magistrates' Court	6 cells
Northampton Crown Court	9 cells
Lincoln Crown Court	6 cells
Loughborough Combined Court	12 cells
Boston Magistrates' Court	7 cells
Wellingborough Magistrates' Court	7 cells

Annual custody throughput	1 May 2024 to April 2025 – 13,597
Custody and escort provider	GEOAmey

Custody staffing

Senior court custody managers	3
Court custody managers	6
Deputy court custody managers	3
Court custody officers	46

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 Significant progress had been made since the last inspection, with over 90% of previous recommendations either fully or partially implemented.

1.2 Senior leaders across the three main agencies involved in delivering the court custody provision had a shared aim and were properly focused on detainees' welfare. They monitored a wide range of data and were aware of most shortfalls, including delays in detainees arriving at court and sometimes in onward moves to prison, as well as the lack of telephone interpreting for those who spoke little or no English. However, these issues have persisted since 2018 and remain unresolved.

1.3 While some custody managers and officers in charge were more effective than others in providing strong direction to staff, there was a consistent focus on detainees' care across the board. However, some inconsistent or unhelpful communication between court and custody staff remained, particularly in some magistrates' courts, which was undermining effective working relationships. Overall, custody staff were a key strength; their training was effective, and their compassionate treatment of detainees helped mitigate shortcomings in other areas.

1.4 Custody facilities lacked investment. Many were outdated and not designed for their current use. Some were very old and cramped. The required improvements were often hindered by a lack of available funding and complex procurement processes and/or contractual arrangements.

1.5 It is important to recognise that since our last inspection there had been a death following self-harm in a custody facility. This was dealt with by the coroner, who did not identify any systemic issues that could lead to future deaths.

1.6 We found poor outcomes for a small number of acutely mentally unwell detainees held in court custody. They were often sent to prison for their own safety which was inappropriate. Although leaders were sighted on this, there was no established pathway in place to effectively divert them to hospital instead of prison. This required prompt attention by leaders in local authorities, justice services and the NHS.

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 did not experience lengthy journeys to court, but some travelled in vehicles that were dirty and in a poor condition. Women and children still shared vehicles with adult men on occasions, primarily from police stations. However, screens were routinely used to offer a degree of separation and protection.

2.2 It was hot during the inspection and staff were aware of heat-related risks in vehicles. They generally took appropriate steps to manage the risks, including leaving air conditioning running when possible and providing additional water. However, we observed several instances where staff accompanying detainees in the back of larger vehicles left them unattended while they performed other duties, creating avoidable risks.

2.3 Most custody facilities had access to a secure vehicle dock. However, when detainees alighted in public areas, too little was done to protect their privacy and dignity. While most detainees disembarked promptly, some staff prioritised unloading property, causing unnecessary delays for detainees.

Section 3 In the custody suite: reception processes, individual needs and rights

Expected outcomes: Detainees receive respectful treatment in the custody suite and their individual needs are met. Detainees are held in court custody for no longer than necessary, are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

3.1 Custody staff treated detainees with respect. We observed them interacting with patience, politeness and kindness. They showed compassion and took time to talk to and reassure detainees who appeared anxious or worried.

3.2 Staff conducted routine reception interviews. However, these were often rushed and lacked privacy, which did not allow detainees to share personal information discreetly.

3.3 In most facilities, noticeboards with information about individuals in custody were displayed where other detainees could see them. This breached confidentiality and was inappropriate.

Meeting individual and diverse needs

3.4 Staff focused reasonably well on meeting detainees' individual needs. They mostly met the specific needs of older detainees and women, and generally understood how to care for transgender detainees. Staff showed good awareness of how to support neurodivergent individuals.

3.5 Staff asked detainees about their religious needs on arrival, and all courts provided religious artefacts on request.

3.6 Some courts had improved their use of telephone interpreting services for detainees who did not speak English, but some staff still showed reluctance to use the service. Important information was available in various foreign languages, but not in Braille.

3.7 Facilities for detainees with disabilities or impaired mobility remained inadequate, with only one custody suite in the region designated as suitable. We observed one detainee with limited mobility who arrived at a court with no adaptations. He could not be dealt with, and had to return to police custody, which was very poor. Custody suites did not have hearing loops.

Risk assessments

3.8 Despite some weaknesses in identifying risks, they were generally adequately managed. Escort staff shared relevant risk information about detainees, but dPERs (see glossary) often lacked sufficient important detail, including about health conditions.

3.9 Custody staff were not consistently briefed about the risks posed by detainees, and some were unsure about risk codes. However, staff remained alert to signs of vulnerability and responded dynamically to emerging risks. Detainees were checked at the required frequency, but some checks were superficial and inadequately recorded.

3.10 When detainees needed to share cells, staff appropriately assessed the associated risks. Staff responded promptly to cell call bells, and routes to court remained safe, with sufficient working affray alarms in place.

Individual legal rights

3.11 There was a better focus on requesting detainees to be prioritised for court, particularly children and those with vulnerabilities. However, several factors still caused some detainees to remain in custody longer than necessary. These included late arrivals at court, delayed court start times, insufficient custody staff to operate court docks, delays in legal consultations (often because electronic case papers were received late), morning arrivals for afternoon listings, and long waits to transfer detainees after hearings. The reasons for these delays were not always clear, and leaders from the three main agencies failed to fully understand or address them to ensure detainees were dealt with promptly.

3.12 Information about detainees' rights in custody was readily available, but staff rarely explained it, even when detainees had difficulty reading or understanding.

3.13 Some custody facilities did not have enough consultation rooms, and some rooms were still not properly soundproofed. However, staff supervised them discreetly. Most detainees were moved to court promptly when requested.

3.14 Court enforcement officers continued to take compliant detainees to magistrates' court custody for low-level matters, which was inappropriate. During the inspection, leaders told us that they would reinforce protocols to ensure such detention occurred only in exceptional cases, based on a dynamic risk assessment.

Complaints

3.15 Custody staff did not always explain the complaints procedure clearly enough. Complaints from detainees were rare but responses were not always thorough enough and lacked empathy.

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 The physical condition of custody facilities varied. Some were very old and cramped and lacked private spaces for interviews. Cleaning arrangements were substandard at some courts, and cells were not routinely cleaned between uses, especially before Saturday sittings.

4.2 Communal areas were generally clean, but the cleanliness of cells varied significantly. Some were reasonably clean, while others were in a very poor condition, with ingrained dirt and stains on the walls, benches and floors. We found graffiti, some of which was offensive, and potential ligature points in many cells. Detainees had to sit on hard, uncomfortable wooden benches, sometimes for extended periods. We provided HMCTS with a comprehensive report detailing our findings, which was responded to appropriately.

Cells at Northampton Crown Court (left) and Leicester Crown Court

Bench at Northampton Crown Court (left) and graffiti at Leicester Magistrates' Court

4.3 Repairs that affected safety or court operations were completed promptly, but routine repairs, such as replacing soap and towel dispensers, often took too long.

4.4 Staff had a reasonable understanding of emergency evacuation procedures. However, signage was poor in some custody facilities, and evacuation drills were not always practised frequently enough.

4.5 Custody facilities, including cells, experienced some extreme temperatures during the inspection (up to 30 degrees Celsius at Leicester Magistrates' Court on one day). Court and custody managers were not always aware of safe temperature limits, but custody staff were considerate of detainees and cared appropriately for them by providing regular drinks and short periods out of their cell to get some air.

Use of force

4.6 Force was rarely used and, when applied, was generally a last resort. However, in some incidents where detainees had self-harmed, staff could initially have used alternative approaches.

4.7 Custody staff demonstrated strong de-escalation skills and often resolved incidents without using force. When they did use force, they typically de-escalated the situation quickly, and prolonged restraint was uncommon. While some use-of-force records lacked sufficient detail, most showed that the force used was necessary and proportionate to the risks involved.

4.8 Managers followed adequate quality assurance processes and applied additional scrutiny to incidents involving children. They took firm action when they identified poor practice. However, not all staff had training in child-specific restraint techniques, which occasionally led to the inappropriate use of adult methods on children.

4.9 Staff now adopted a more proportionate approach to searching and handcuffing. However, they still routinely used handcuffs in some areas without an individual risk assessment and did not always remove them at the earliest opportunity.

Detainee care

4.10 Detainees told us they felt well cared for by custody staff, and we frequently observed kind and supportive interactions.

4.11 Drinks were provided quickly on arrival and at regular intervals after that. A good range of food was provided, which met most dietary needs. This included microwave meals, sandwiches, crisps, and biscuits. However, the lack of allergen lists and poor labelling led to some confusion about what diets they were suitable for. At most sites, food was readily provided on request if detainees were hungry. A minority did not offer food before lunch time, although to their credit they rectified this during the inspection.

4.12 We found a broader range of distraction materials than usual. Most courts offered puzzles, board games, playing cards and some limited reading materials. There was also a good supply of sensory stress relievers, such as fidget toys and stress balls, which were popular with detainees. Detainees engaged more with these activities in facilities where they could browse and choose items themselves.

4.13 Toilets were screened by saloon-style cubicle doors, which offered limited privacy but were supervised discreetly. The toilets were mostly clean but lacked seats. Every facility had good supplies of toilet paper, soap, and hand towels, although some items were not hygienically stored in dispensers.

Toilets at Leicester Crown Court

Safeguarding

4.14 In the year before this inspection, staff submitted very few safeguarding referrals. None involved child protection issues. We reviewed all the referrals and found they were well managed, resulting in positive outcomes for the detainees involved.

4.15 There was an established safeguarding policy, which was promoted effectively to staff. The staff we spoke to understood their duty of care and how to respond to safeguarding concerns.

4.16 Safeguarding oversight was strong, with robust monitoring of referrals. The safeguarding lead brought extensive experience and knowledge, remained accessible to staff and provided effective support to custody staff.

4.17 Liaison and diversion teams operated at each court. Custody staff valued their input and regularly used the service to support vulnerable detainees, particularly those with mental health or substance misuse issues.

Children

4.18 Very few children were held in court custody. They were located in the most suitable area in the custody suite, usually in a legal visits room. When a cell offered more privacy, staff used this instead, keeping the door open, which was appropriate.

4.19 Trained staff supervised most children and provided good levels of care. However, due to staff shortages, untrained personnel occasionally provided short-term supervision. Encouragingly, even in those cases, staff maintained appropriate levels of supervision and privacy.

4.20 Youth offending teams engaged with children promptly after arrival and again following court proceedings. This helped to speed up release arrangements for those being discharged. It also facilitated timely placement orders from the youth custody service for those remanded or sentenced. Appropriate transport was usually readily available and meant that children did not have to wait too long in court custody.

Health

4.21 Health services had been transformed since the last inspection. GEOAmey now contracted Health Finder Pro (HFPro) to deliver medical services for detainees. Effective performance monitoring, robust quality governance, collaborative discussions, and shared learning were all evident, contributing to an effective working relationship.

4.22 Custody staff reported a marked improvement in medical support. They said that this had increased their confidence in managing detainees' health needs. Detainees also expressed satisfaction with the health

care they received. The clinical interactions we observed were respectful and professional. Paramedics demonstrated excellent clinical skills and used appropriate medical equipment.

4.23 Detainees often arrived with confidential medical information in paper form, which was unnecessary and posed a risk to patient confidentiality. Custody staff offered to screen all new detainees for health risks using the custody early warning score (CEWS, see Glossary) and a finger oxygen/pulse monitor, and flagged any concerns through HFPro's responsive telemedicine service.

4.24 Most custody suites were now equipped with automated external defibrillators, and staff had easy access to first aid kits. It was positive to note that a recent action resulted in staff now receiving annual updates on basic life support as part of their C&R training, along with awareness sessions on mental health and substance misuse.

4.25 Detainees benefited from well-established liaison and diversion services. These provided signposting and referrals to relevant support networks, including mental health, substance misuse, and housing services. However, in most facilities, liaison and diversion practitioners did not have access to sufficiently private and therapeutic spaces to see patients. Psychological therapies were available for detainees who were subject to mental health treatment orders, offering an alternative to custody.

4.26 In the 12 months before the inspection, at least seven detainees were sent to prison directly from court custody despite being acutely mentally unwell. Liaison and diversion practitioners told us that approved mental health practitioners (AMHPs) often refused to attend court custody to undertake a Mental Health Act assessment. This resulted in unwell detainees being denied access to inpatient treatment and being sent to prison for their own safety which was inappropriate. It was concerning there was no established pathway to divert these individuals from prison (see paragraph 1.6).

4.27 When detainees arrived with their prescribed medications, they had access to them while in custody, and custody staff could administer paracetamol. Where clinically appropriate and following individual risk assessments, detainees were allowed to retain critical medications such as inhalers. However, none of the suites offered nicotine replacement therapy, which was a notable gap. All suites had access to nasal naloxone for treating opiate overdoses.

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 arrangements lacked rigour. Staff did not ask detailed questions about detainees' personal circumstances before release. As a result, they often missed issues such as homelessness or addiction. Staff often rushed the process and failed to identify the full range of support needs for each detainee. They typically offered a travel warrant and/or bus fare to the nearest station but rarely checked if this was adequate to get someone all the way home.

5.2 Although information on national support agencies, such as the Samaritans, was available, staff rarely offered it. There was limited information about local or community-based services.

5.3 Staff did not routinely provide detainees who were remanded or sentenced with information about the prison they were going to. This was a missed opportunity to reduce anxiety, especially for those entering prison for the first time.

5.4 Detainees who originated from a prison were regularly held longer than necessary after being released by the court. HMCTS staff did not always share the outcome of cases with prisons promptly, which in turn delayed prison departments from completing relevant checks before the release could be authorised. Waits of over three hours, and sometimes much longer, to receive the governor's authorisation to release (see glossary) were not uncommon. In some cases, detainees were returned to prison for their release, often having already experienced significant waits, which was a poor outcome for them.

Section 6 Progress on recommendations from the last report

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

Recommendations

The three key agencies should improve their relationships and communication and focus consistently on good outcomes for detainees.
Partially achieved

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

The courts should prioritise cases where detainees have been held in court custody, particularly those with vulnerabilities.
Partially achieved

HMCTS, PECS and the escort and custody contractor should investigate and address the reasons for the prolonged periods that some detainees spend in court custody cells.
Partially achieved

All detainees should be informed of their rights while in court custody in a language and format that they understand.
Partially achieved

HMCTS should ensure that there are enough interview rooms at each court, and that they are soundproofed for confidentiality.
Not achieved

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

Women and children should always be transported separately from adult men.
Partially achieved

Sanitary items should be routinely offered to women on arrival in court custody.
Achieved

All suites should provide a range of reading materials for detainees, including those in foreign languages.
Not achieved

Staff should receive diversity and mental health training.
Achieved

Staff should be trained in the use of minimising and managing physical restraint (MMPR) techniques.
Partially achieved

Every detainee in court custody should have a written assessment that gives clear summary information about their risks and needs.
Partially achieved

Person escort records should include detailed and specific information concerning risks posed by or to detainees to ensure they can be properly looked after in court custody.
Partially achieved

All custody staff should receive a comprehensive briefing at the start of duty that is focused on risk management and the care of detainees, particularly the most vulnerable.
Partially achieved

Staff should always adhere to set levels of observation.
Achieved

Detainees should only be searched in secure areas on the basis of a robust and individual risk assessment.
Achieved

Handcuffs should only be used on detainees if justified and proportionate.
Achieved

Repairs to court detention facilities should be carried promptly.
Partially achieved

All custody staff should receive annual first aid refresher courses to maintain their skills, and should have access to regularly checked equipment, including an automated external defibrillator.
Achieved

HMCTS/PECS should liaise with local police forces to ensure that all detainees who require prescribed medication while in court custody have access to it.
Achieved

Detainees should have prompt access at all times to mental health services.
Achieved

Custody staff should have regular mental health and substance use awareness training.
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 detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Inspection team

This inspection was carried out by:

Kellie Reeve	Team leader
David Foot	Inspector
Fiona Shearlaw	Inspector
Shaun Thompson	Inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find.

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.

Governor's authority to release
The formal authorisation required to release detainees from court custody if directed by the court if they have originated from a prison. The process involves checking to ensure there are no other reasons that the detainees should be returned to prison and providing any licence conditions that are applicable to the person on release.

Digital person escort record (dPER)
The dPER is the key document for ensuring that information about the risk posed by detainees when they are being moved out of prison or transferred within the criminal justice system is always available to those responsible for their custody. It is a standard form agreed with and used by all agencies involved in moving detained people.

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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