Lay Observers

Independent monitors
of court custody & escort

ANNUAL REPORT

TO THE SECRETARY OF STATE FOR JUSTICE

2017-2018

CONTENTS

INTRODUCTION

Lay Observers are independent people appointed by the Secretary of State under S.81(1)(b) of the Criminal Justice Act 1991. As a national organisation[1] they inspect the conditions in which Detained Persons/Prisoners[2] are transported or held by escort and custody contractors in England and Wales. The conditions considered appropriate by Lay Observers are set out in a Statement of Expectations (see page 12) and are assessed in respect of the welfare and access to justice by reference to a framework of National Standards (see Appendix C).

The Chairman of the Lay Observers reports annually to the Secretary of State for Justice. This is my third annual report as Chairman of the Lay Observer National Council, covering the period from April 2017 to March 2018.

The standards of conditions in escort and court custody that we monitor and the method for assessing their compliance were implemented in March 2017. This is the first Annual Report to benefit from the evidence of consistent, objective, regular and systematic Lay Observer observations for a full year.

Over the past year Lay Observers prepared 1800 visit reports monitoring approximately 2.5% of the people in escort and court custody. Each month these reports were aggregated into a national visit report to illustrate the national picture and the direction of key trends with my assessment. This report (see example Appendix D) was circulated monthly to all stakeholders and those with an interest in this Criminal Justice pathway: HMPPS, HMCTS Central Operations, HMCTS Property, HMIP, National Police Chiefs Council, YJB, YCS, NHS Heath and Justice and MoJ sponsors.

This report summarises our findings against our expectations and makes recommendations to address issues requiring action by the various bodies with a duty of care in relation to Detained Persons/Prisoners.

Tony FitzSimons
Chairman, Lay Observers
2017/18

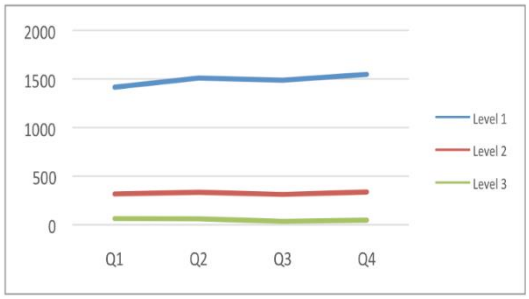
[1] For more information on the Lay Observer organisation, please see Appendix A.
[2] Those held within court custody suites and transported by escort services are referred to by Lay Observers as 'Detained Persons' and those being transported between prisons as 'Prisoners'. Throughout the report, together, they are summarised as "DPs"

EXECUTIVE SUMMARY

Key findings for the Secretary of State

This report, whilst identifying some improvements in performance and ambition by stakeholders in the care and access to justice of DPs, notes that the problems highlighted in the last report for 2016/17 have continued largely unmitigated during 2017/18. In the 1800 Lay Observer visits in the year there were 7500 concerns raised (with some repeats); 1500 of which were serious or unacceptable.

NO of REPORTS	Q1	Q2	Q3	Q4	Total
Level 1	1415	1509	1487	1547	5958
Level 2	317	334	312	337	1300
Level 3	63	61	35	47	206
Total	1795	1904	1834	1931	7464



1. The average level of four concerns (one of which was serious/unacceptable) per custody visited and the lack of improvement over the year do not appear to justify Ministry of Justice reliance on "there is effective co-operation especially between police, HMCTS and HMPPS which will alleviate problems highlighted in this report"[3]

2. The risk of serious consequences to the welfare and access to justice of the DPs resulting from the system of disconnected contracts and responsibilities for the different elements of services for escort and court custody remains.

3. Although a review has been initiated, healthcare provision is still not embedded in court custody for the approximately 25% of DPs with health problems, which could mean that at least 6% of all DPs are exposed to the potential for incorrect decisions made by the judiciary due to inadequate medication.

4. Despite monitoring by HMPPS, close to half of the records sent by police and prisons when handing over custodies to the Prison Escort Services (PECS) contractors are inaccurate and more than half do not give sufficient information to allow proper risk assessments of the security and welfare of the DP to be made.

5. The condition of custody suites continues to fall below acceptable standards; 52% have graffiti; 30% poor cleanliness and 10% inadequate facilities.

6. The escort and court custody arrangements for children and young people facing trial are unsatisfactory:-

    a. they have been excluded from the remit of the Youth Custody Service and its REFORM programme principles emphasizing person centred treatment and

    b. they risk contributing to embedding their criminal behaviour due to their inappropriate treatment as an adult prisoner

[3] Minister Gymiah response to 2016/17 Annual Report (November 2017)

7. At least 45% of DPs experience more than a two-hour delay in their transport after sentencing; this delay is further extended for around 15% of these DPs as a result of being moved to prisons outside the "local" area.[4]

8. At least 15% of DPs freed after trial are kept in a cell for over two hours waiting for release documentation.

9. Training for staff, especially training for the management of custody suites, lacks a formal structure and is too often haphazard. This has a negative impact on the welfare of those in custody.

10. Too much reliance is placed on deferring action on addressing deficiencies highlighted by monthly and Annual Lay Observer reports to the implementation of the 4th Generation PECS contract (otherwise known as PECS 4) which will be mobilized in 2020 to 2021.

Recommendations for the Secretary of State

All recommendations are addressed to the Secretary of State for Justice as the office holder with the overall responsibility for the safe operation of escort and court custody services.

Recommendations in relation to the overall duty of care for Detained Persons

1. The Secretary of State for Justice should ensure that the contract for PECS 4 is specified in conjunction with the whole system redesign of the pathway for the escort and court custody of DPs which provides:

    a. assurance that there are no gaps in responsibility for the continuous welfare and access to justice of DPs

    b. appropriate policy and performance oversight of the pathway,

    c. adoption of key principles of the Ministry of Justice's reform programme.

2. Critical improvements in the arrangements for the provision of care to DPs/Prisoners such as:

    a. transfer of risk and medical information,

    b. healthcare provision,

    c. treatment of CYPs,

    d. assessment of fitness for trial.

    These improvements should not be delayed until the mobilisation of the PECS 4 contract but be implemented as soon as possible, preferably in a manner likely to be consistent with the specifications for the new contract.

[4] The local area is the prison to which the court is normally aligned e.g. HMP Bullingdon for Oxford Crown Court

Recommendations relating to inadequacies of the Person Escort Record

1. DPs should not be accepted where there is any omission on their Person Escort Record (PER) and written instructions and training must be provided to staff on the action to take when presented with a potential Detained Person with a non-compliant record.

2. A record of the number of DPs refused because of non-compliant PERs should be kept and regular reviews should be held with senior managers of each originating establishment to review the causes of non-compliance.

3. Specific guidance should be issued for completion of the medical and mental health sections of the PER to allow the inclusion of the following information.

4. Updated guidance should be produced on the risks sections of the PER to ensure inclusion of the dates when the risk-related events took place until the ePER is introduced nationally.

5. HMPPS to consult the Lay Observer Chair and National Council on any updates to the format, content and completion process of the PER.

6. Make training of staff in police & prisons compulsory for those who complete PERs.

Recommendations relating to healthcare

1. DPs should have access to medical and mental health support with medication dispensing authorisation located:
   - within the court precinct for custodies with more than an average of ten Detained Persons per day
   - within fifteen minutes guaranteed response time for custodies with fewer than ten DPs per day.

2. Police and prison custodial suites should provide DPs with identified medical conditions, documented in the PER, with medication sufficient to last until 8pm on the day of the DPs court appearance. The originating authority should confirm this provision and any dispensing instructions in the PER, which should then be agreed and evidenced by the signature of the Detained Person (separate arrangements will be needed for those who cannot read or write).

   HMPPS should instruct its contractors to train their escort and custody staff to ensure that the location of any medication (and its dispense instructions) noted in the PER is verified before departure and to refuse to take custody of DPs whose PERs and medication verification do not comply.

3. Medical protocols should be established that allow doctors to administer medication to DPs to alleviate symptoms affecting their ability to participate in court proceedings.

4. Liaison and Diversion teams should be able to support the custody staff and the solicitor/court in determining the ability of all DPs to participate in court proceedings.

5. CCTV should be installed to cover at least three cells in custody suites with more than fifteen DPs per day; two cells for those with ten to fifteen DPs per day and one cell for those with up to five DPs per day to provide coverage of those persons requiring constant/more frequent watch.

Recommendations relating to suitable accommodation

1. HMPPS PECS Contractors and HMCTS Property Directorate should agree and document the criteria for prioritising facilities management actions in court custody suites in the interests of the welfare and security of the DP.

2. HMPPS PECS Contractors, HMCTS Operations and HMCTS Property Directorate should agree on a process and format for the documentation and communication of facilities defects in the court custody area with planned actions.

3. HMCTS Property Directorate should be instructed to provide an expected completion date for all defects accepted for remediation to the Court Delivery Manager.

4. HMCTS Court Delivery Managers should be instructed to visit the custody area on at least a monthly basis and agree/document mitigation action plans for expected delays (advised by HMCTS Property Directorate) in remedial works.

5. Appropriate accessible court custody provision should be available within a two-hour journey for disabled people (whether on bail or off bail); if not available, appearance by video link should be arranged.

6. Guidance (similar to that produced by the Home Office for police custody) on the recognition and removal of potential ligature points should be prepared by HMCTS Property Division following consultation with HMPPS and issued to Facilities Management.

Recommendations relating to access to justice

1. The concept of 'fitness for trial' should be reviewed and more detailed criteria and guidance, which take account of the cognitive state of DPs whilst in custody, should be developed for medical professionals, lawyers and court staff. It is recognised that the process for such a review may be complicated but the concerns raised by Lay Observers and other bodies about this matter could at least be raised with the judiciary and expert professionals consulted.

2. The Legal Aid Agency, the Law Society and Bar Council should consider standards and guidelines for the accessibility of lawyers to Detained Persons whilst in court custody awaiting court appearance. These should specify a wait of no longer than two hours after arrival in court or two hours before the scheduled court appearance. (The same recommendation was made in the last Annual Report to which the Minister in his reply offered that the LAA would meet Lay Observers to discuss specific courts causing concern. This proposal has been referred to the LO National Council for consideration.)

3. A confidential complaint process should be developed for DPs which includes the ability to make complaints against police and prison treatment.

4. Increased use of video appearances for those with vulnerabilities and medical conditions from prison and police custody whilst close to embedded healthcare support, which has confirmed their fitness for trial. This would reduce the number of DPs exposed to deteriorating mental and physical condition in escort and court custody and therefore the risk of being unfit for trial. It is recognised that this recommendation would require support and regulation by the judiciary.

Recommendations relating to suitable transport

1. A separate contract should be developed by the Youth Custody Service as part of the 4th generation PECS contract for the movement of all CYPs from secure homes, Youth Offender Institutions and police custody to court and their supervision in court custody.

2. Prior to the implementation of the recommendation above, HMPPS should improve the administrative arrangements for the safe escort and custody of CYPs to reduce the transport delay after sentencing by no more than two hours.

3. Prior to the implementation of PECS 4 each contractor vehicle base should deploy "sweep" vehicles to collect and transport those in court custody sentenced/remanded to prison during the early afternoon each day.

4. The PECS 4 contract should specify:

    a. The maximum delay of transport after sentencing to be no more than two hours,

    b. The maximum journey length for a DP should be no more than two hours without a mandatory rest period,

    c. Vehicles which have suitable headrests and seat belts and seat covers to ensure that all (but the very exceptional) DPs can be accommodated with safety and comfort appropriate to two-hour journeys.

5. Data relating to inappropriately scheduled and unnecessary court appearance should be compiled by HMPPS PECS to pursue and remedy their causes.

Recommendations relating to respectful treatment as an individual

1. CYPs appearances in court should be prioritised.

2. HMCTS, HMPPS, Prisons and escort contractors should work together to create a process for the release of DPs (in particular children and young people) to achieve a maximum delay of one hour. The good practice found in Cambridgeshire and Hertfordshire courts, where Judges and Magistrates inform the DP that their release may involve a short delay, should be extended across all courts.

3. The PECS 4th generation contract should specify the provision of at least a daily supply of free newspapers to each custody suite and suitable reading material/activities for young people.

4. The specifications of the PECS 4th generation contract should aim to mirror, for all DP movements, the conditions of the previous YJB contract for the escort from secure homes and the principles of the reform programme being developed for the custody of CYP offenders.

5. To reduce the waiting time for release of a DP, HMPPS should streamline the "Request for Authority to release Prisoner" process by:

- Relying on the accuracy of the “Not for release” declaration on the PER
- Placing in the PER a statement of entitlement to a discharge grant
- Enabling the court Probation Officer to issue the Licence as part of the court warrant
- Agreeing with HMCTS a protocol for the time taken to issue a warrant
- Consider allowing a person to be released to stay outside of their cell (perhaps an interview room or staff room) whilst they await documentation.

6. Consider allowing a person to be released to stay outside of their cell (perhaps an interview room or staff room) whilst they await documentation

Recommendations relating to minimising risks to wellbeing

1. HMPPS PECS contractors should develop and implement formal training and refresher courses for Court Custody Managers (CCM) (especially those newly appointed) and District Court Custody Managers (DCCM) to ensure that they are aware of the up to date Standard Operating Practices and expected standards of care and access to justice.

2. Assurances should be sought from each local fire officer that fire drill and prevention procedures are adequate in every court.

LAY OBSERVER EXPECTATIONS FOR DETAINED PERSONS

For all those in escort and court custody we expect:

- **Duty of care is properly exercised**
  DPs have access to health and personal care suitable to their needs during their time in transport and court custody.

- **Held in suitable accommodation**
  DPs are held in a court custody environment that is clean, safe and fit for purpose.

- **Access to justice**
  DPs are informed of their rights and are capable of accessing suitable legal advice.

- **Transported promptly in suitable vehicles**
  DPs are transported to and from court correctly and with minimal delay. Inter-prison transfers are efficiently planned and completed with all movements using appropriate vehicles and equipment.

- **Treated with respect as an individual**
  All DPs are treated with dignity and respect, free from discrimination and victimisation.

- **Risks to wellbeing are minimised**
  Transport and custody are managed in a manner that ensures the wellbeing of DPs/

ASSESSMENT STANDARDS

Assessment standards have been developed and adopted for each expectation to provide a basis for consistent, objective and scalable assessments by Lay Observers. In most cases the judgement as to whether a standard has been met can be observed and stated as a simple yes or no. If an area of a DPs care is observed to be below the standard, the Lay Observer makes a judgement as to the severity of the impact on the DPs welfare and access to justice, in their particular circumstances, on a scale of 1-3.

Level 1 – requires attention, but not immediately.

Level 2 – a serious matter that requires urgent attention.

Level 3 – an unacceptable incident that should be remedied immediately.

Standards in relation to cell temperature or graffiti are assessed against a set of descriptors for each level. As the impact on the DPs welfare and access to justice can differ depending on the circumstances in a particular court, the Lay Observer provides a description of the observation and rationale for the rating against the assessment standards.

Please see Appendix C for more detail on of each of these standards, which have been updated since the reporting period.

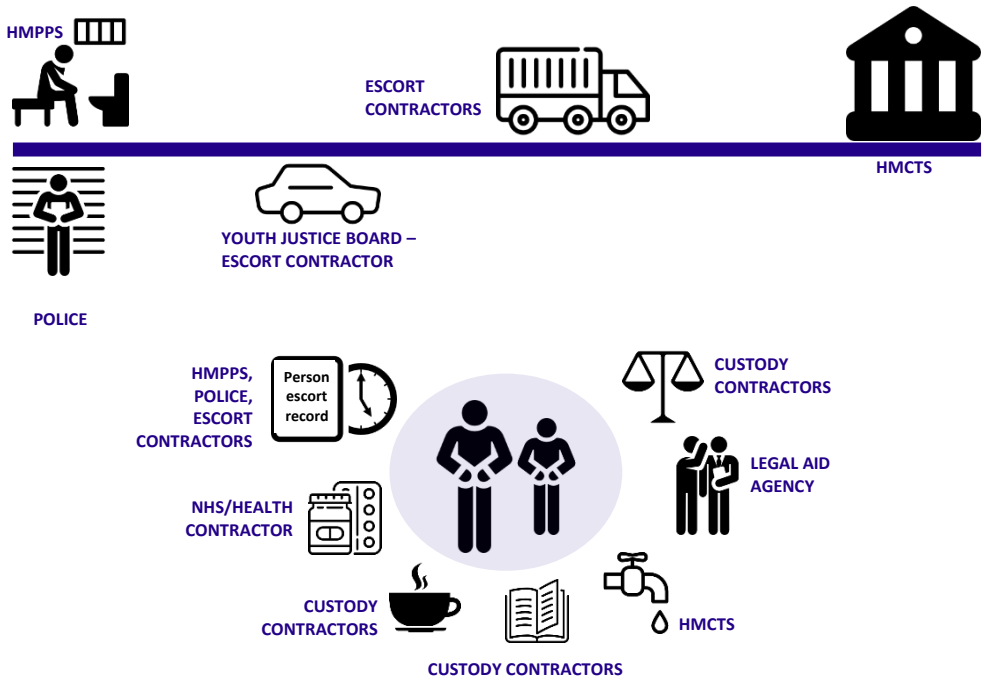
DUTY OF CARE

1. Responsibility for the overall care and access to justice for Detained Persons

The Secretary of State for Justice has a duty of care[5] in relation to the welfare and access to justice of the DPs involved in the 50,000 movements of people under escort and court custody each month. The Lay Observer Expectations for DPs and the related Standards provide the framework for how Lay Observers monitor the fulfilment of this duty

In its 2016/17 Annual Report Lay Observers expressed concern that the components of the Secretary of State's care of a DP under escort and court custody are provided by a number of different bodies in a fragmented way without any contractual or service level agreement between them as portrayed by the diagram below.

Monitoring the welfare and access to justice of Detained Persons



The Annual Report recommended "The Secretary of State for Justice should have an explicit duty of care to all DPs which should be delegated to an overarching authority to provide assurance and oversight of all contractual arrangements"

In his reply to the 2016/17 Lay Observer Annual Report Minister Gymiah responded that, "there were no plans to transfer responsibilities…..the law imposes a duty of care to Detained Persons, principally to ensure that the contractual arrangements in place and the systems and

[5] In Razumas v Ministry of Justice 2018 Cockerill J found that the MOJ did have a direct duty to the Claimant …..Such a duty arose from the fact of custody – 'to take care as to a safe environment and also as to the less obvious risks such as that of suicide which has been found to be linked to the state of custody'. It was held that the duty 'probably extends to matters relating to access to healthcare'. Further, the clinical governance process made it likely that a duty arose under the legislative and regulatory framework but it was one that was limited to oversight of systems in place and to raising and seeking solutions to known and identified problems

process ensure a DP's safety." The law was apparently clarified in Razumas v Ministry of Justice 2018 where Mr Justice Cockerill held:

"MOJ did have a direct duty to the Claimant ….to oversight of systems in place and to raising and seeking solutions to known and identified problems". In light of this case it is of concern that the Ministry of Justice has direct responsibility through outsourced contracts for the provision of healthcare to Detained Persons and therefore could have liability for any deficiencies in its provision.

To address the fragmentation of services provision, the 2016/17 Annual Report recommended that, "Appropriate written protocols, service level agreements or contracts, should be developed and agreed between the parties currently delivering elements of a Detained Person's care to provide an assurance framework."

The Minister in his reply noted that, "there is effective co-operation especially between police, HMCTS and HMPPS which will alleviate problems highlighted in this report." However, the framework and interrelationships of services provision remained unchanged during the 2017/18 period of this report. The following sections of this Report which report on Lay Observer Expectations and Standards, whilst identifying some improvements in performance and ambition by stakeholders, note that the problems highlighted in the last Report have largely continued unmitigated in 2017/18.

NO of REPORTS	*Q1*	*Q2*	*Q3*	*Q4*	*Total*
Level 1	1415	1509	1487	1547	5958
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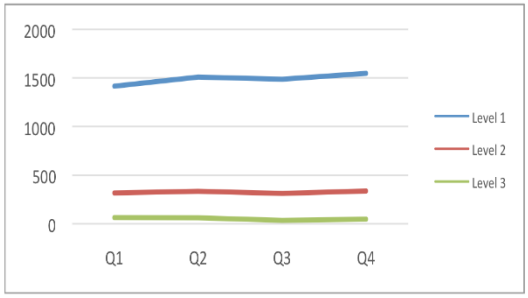


The above table summarises the number and severity of concerns to the welfare and access to justice of DPs in the 2017/18 year. In total 7500 issues of concern were noted in 1800 Lay Observer visits during the year with no indication of a trend to improvement. Although some of these observations will be a repeat of previous issues, nevertheless the average total number of concerns of four per visit or 80% of DP custodies indicates that "problems highlighted in this report do not appear to have been, "alleviated by effective co-operation," in this year.

This Report notes that many concerns are rooted in inadequate co-operation between the many stakeholders to the overall escort and court custody process. For example, HMCTS provide most of the court custodial facilities to the HMPPS PECS contractors (GeoAmey and Serco) to operate their contract. In the 475 cases in 2017/18 of inadequate cleanliness (noted by Lay Observers) of the custodial facilities, the HMPPS PECS contractor can raise concerns with the Authority but has no right of complaint and remediation from HMCTS since there is no obligation to provide or specification of a clean environment in their contract with HMPPS PECS.

Without whole system policy oversight of the pathway for the escort and court custody of DPs or any form of protocol bringing the various elements of their welfare together to form a unified whole, the Secretary of State lacks proper assurance that the risks to the welfare and access to justice of people under escort and court custody are managed and mitigated.

In the 2015 case of Mr Sivaraj Tharmalingham's death in court custody, the coroner commented that the lack of coordination between organisations and the failures to meet appropriate standards by those responsible for the care of Mr Tharmalingham under escort and custody had contributed materially to his death.

The risks to the welfare and access to justice of DPs are real and, for the Secretary of State, are multiplied by the 1,500 movements that take place each day.

In his reply to the Lay Observer recommendations in the 2016/17 Annual Report the Minister added, "Arrangements can be reviewed and improvements considered as we work to retender this contract. We would like to review the current reporting process and how such data is used to inform and monitor contract obligations …"

We have been informed that the Programme Management of the PECS contract retender is intent on taking a whole system oversight to the pathway of persons under escort and court custody and developing the contract specifications for tender in that context. This ambition could address Lay Observer concerns of a lack of systems assurance of the welfare and access to justice for Detained Persons; however, any fulfilment will not occur until full mobilisation of the new PECS contract in 2021.

In the meantime, it does seem that the current reporting process adopted by PECS has been modified to reformat the Security, Safety, Decency and Compliance reports by the contract management service on contractor performance to align with the Lay Observer Monitoring Standards and feedback is now provided monthly to Lay Observers by HMPPS PECS on the progress of concerns assessed as Level 3.

Beyond these developments, it does not appear the overall system is being addressed to provide assurance of DPs welfare over the next 3 years.

1.1 Recommendations in relation to the overall duty of care for Detained Persons

- The Secretary of State for Justice should ensure that the contract for PECS 4 is specified in conjunction with the whole system redesign of the pathway for the escort and court custody of DPs and Prisoners which provides:
    - assurance that there are no gaps in responsibility for the continuous welfare and access to justice of DPs/Prisoners,
    - appropriate policy and performance oversight of the pathway,
    - adoption of key principles of the Ministry's REFORM programme.
- Critical improvements in the arrangements for the provision of care to DPs/Prisoners such as:
    - transfer of risk and medical information,
    - healthcare provision,

- treatment of CYPs,
- assessment fitness for trial.

This should not be delayed until the mobilisation of the PECS 4 contract but be implemented as soon as possible, preferably in a manner likely to be consistent with the specifications for the PECS 4 contract.

ASSESSMENT AGAINST EXPECTATIONS

Detailed below are our assessments against the agreed expectations for DPs for the year from April 2017 to March 2018. References are made to the dimensions of the concerns in relation to the total number of courts or DPs monitored.

2. Duty of care is properly exercised

DPs have access to health and personal care suitable to their needs during their time in transport and court custody.

2.1 Inadequacies of the Person Escort Record (PER)

Most people who are escorted to court custody are transferred to a Prisoner Escort and Custody Services contractor from either a prison or police custody, where it is most likely that they will have stayed overnight. We understand that they will have received a healthcare visit to review their fitness for trial if coming from police custody or their fitness to travel if coming from prison. However, the Person Escort Record does not require a signed declaration to that effect by prison or police custody officers respectively.

In some cases, where a DP is coming from police custody, the Person Escort Record is accompanied by a document signed by a healthcare professional declaring that the person is fit for trial and whether it should be subject to review. In all cases where a DP is moved - including inter-prison transfers - a Person Escort Record (PER) should be completed.

This important document is intended to record all the information that escort and custody officers need to make assessments and minimise risk to the security and wellbeing of a DP. The PER should record information on an individual's medical needs, medication, healthcare contacts, any self-harm risk, accompanying property, ethnicity, religion and details of the offence they are accused or convicted of. This provides staff with the information they need to provide adequately for their welfare and assess their ability to participate effectively in court proceedings.

	Q1	Q2	Q3	Q4	Total
No of detainees with identified medical conditions	473	496	497	537	2003
% DPs in custody	19	23	20	23	20

In the case of DPs arriving at court after being on bail, there will be no knowledge of any risks in relation to the individual, which is of particular concern in relation to medical treatment for mental health, unless they declare issues to the custody staff on arrival.

2.1.1 PER Completion Guidance is insufficient

In our judgement, the guidance provided for completion of the PER does not ensure that the information requested will meet the purpose intended. The section on risks merely asks for information, without guidance on the level of detail, the date or the severity of the incident.

The sections on medical and mental health care do not require information on the nature of the condition, when treatment/medication was provided, when treatment/medication should be next administered, what medication is required and whether/where it is being transported.

There are concerns by HMPPS as to the medical information which should be communicated since they have not sought the DP consent to share.

The General Medical Council guidance is clear that it is in the patient's interest to share information.[6] The mental health section, in particular, should include information on access by/to a Liaison & Diversion team (or similar) in police or prison custody eg the practice of Hampshire police is to include L&D assessments. It should also detail any court custody supervision or support needed to effectively participate in court proceedings.

Police and prison staff may believe that they have completed the PER satisfactorily according to the guidance, whilst the escort contractors may find that the information is inadequate for them to understand the risks associated with each DP. In addition, escort staff receiving DPs from prison or police custody need certainty as to whether a PER is completed correctly so that they can decide whether or not to accept a DP into their custody.

We suggest that inadequate guidance is a significant contributor to the failure of PERs in general to communicate relevant and timely information to escort staff to assure the welfare, security and access to justice of people being escorted to and in custody.

2.1.2 PER format does not assist effective communication

The space provided in the PER is insufficient to allow a complete documentation of the behavioural and medical risks relevant to the DP and any mitigations recommended by competent officials. Information is, therefore, often perfunctory, comprised of unknown acronyms or too vague to be properly understood. The PER is, therefore, not a reliable source of information for the transfer of risk management between the various bodies with a duty of care to the DP.

A number of court custodies do not record events affecting the DP on the paper PER, preferring to make direct entries onto proprietary computer systems and attaching a print out to the paper PER at the end of the day. This approach carries the risk that information collection is fragmented and not always current and available to monitor. As a result, staff may not have immediate access to relevant information to be able to respond effectively to immediate issues or any subsequent inquiry.

At the time of writing, trials are underway of a new electronic PER. At this point we are unable to comment on how effective the new system may be to address the weaknesses highlighted. Also within the South-Central region of England there has been a trial for the last two years of a paper PER with space for enhanced health and social care information. The trial does not appear to have been extended and we are unaware of any evaluation of its impact.

2.1.3 Incomplete PERs

Lay Observers have noted that PERs often have omissions of important information, even to the extent of being blank (a rare occurrence). Accompanying medication data, no known risk boxes, ethnicity, religion, offence, healthcare contact phone number and medical information sections are routinely left blank by the originating police and prison custodies.

[6] In GMC guidance, this is described as: 'Patients may be put at risk if those who are providing their care do not have access to relevant, accurate and up-to-date information about them.'

Originating police and prison custodies have little incentive or supervision to ensure the compliance of the PER accompanying each DP. There do not appear to be any arrangements or protocols between the various agencies in contributing to, or using, PERs to ensure compliance and address the potential consequences of non-compliance in the documentation that accompanies around 50,000 people movements every month.

In October 2017 both PECS contractors issued instructions to their custody staff to report inaccuracies (missing information) in PERs to a proprietary central data base which were passed to PECS management to review. Whilst this was a welcome action to focus on this matter of concern we note the potential for under reporting of the scale of inaccuracies and the paucity of risk information. For example:

- the requirement to report was not made mandatory by contractors
- the guidance on their completion did not specify the inclusion of poorly communicated and erroneous risk information
- the format of the report was not common between contractors

	Q1	Q2	Q3	Q4	Total
No of PERs with inaccuracies	472	587	757	1114	2930

The number of PERs with inaccuracies was on a rising trend throughout the year to a total of nearly 3000 or 30% of the total number of DPs in custody at the time of our visits. The rising trend was mainly as a result of increased diligence by Lay Observers in finding and reporting errors; the level of errors being counted is still lower than the anecdotal level reported by court custody staff. The error level of 46% reported by Lay Observers in Q4 is certainly more reflective of the reality perceived by court custody staff.

Nevertheless, a number of prisons and police custodies have made efforts to improve the accuracy and relevance of their PERs during the year and visit reports have reflected this improvement, although in a number of cases it is not maintained. This, perhaps, indicates that improvements are often dependent on people rather process and therefore at risk of not being sustainable.

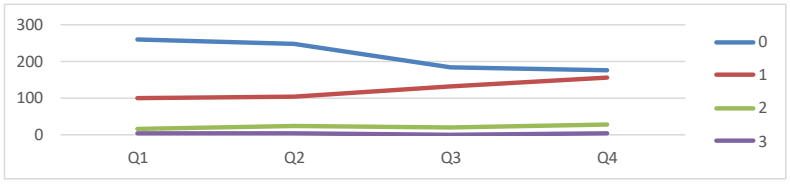
The ePER, whose preparation can only be permitted if all the required elements of the PER are completed has been successfully trialled at two prisons for several months and migration to a further 3 prisons is expected. If the ePER is extended to all prisons the completion error rate and dating of risks should be virtually eradicated. However, we understand that further migration of the ePER is being limited in favour of a more ambitious process to electronically link the PER to all relevant data bases and users at all stages of the DP escort and custody pathway in preparation for the new contract from 2020. On the other hand, we understand that the ePER has been favourably endorsed by the National Police Chiefs Council and a trial involving Surrey, Sussex and West Midlands forces will commence.

It therefore appears that there are real policy related actions underway with the potential to virtually eliminate errors and misleading information on the Person Escort Record accompanying the DP.

2.1.4 PER inaccuracies in relation to health issues and medication

Inaccuracies or missing information in PERs often come to light when Lay Observers speak to DPs about their health history, treatment and medication needs. The DP may thus be placed in a position where his or her needs are not being met. This can mean distress and discomfort with the result that they may not be able to effectively participate in the court process. It may be that they do not have their needs met until their release/transfer to prison. These inaccuracies and alleged failures (by both police and prison custody) to supply medication for reported illnesses occurs frequently, i.e. 30% of those DPs with medical needs for the whole of last year are on a rising trend.

PER accurately records healthcare administration relevant to escort and court custody period including contact and accompanying medication details



Q1	259	101	15	1
Q2	247	104	22	2
Q3	185	133	18	0
Q4	177	156	28	4
Total	868	494	83	7

In 2017/18 there were seven cases where the failures led to unacceptable risks to the welfare and access to justice of the DP and 83 where the failures were assessed to be serious. The widely varying interpretations of the definition of medical confidentiality by prisons and police custodies lead to different policies and practices in providing medical information on the PER and therefore widely different reliability of risk assessments and DP welfare risk potential.

At present, there is no nationally agreed means of collecting and following up medical and healthcare issues with originating custodies. We are not aware of any initiatives likely to contain or remedy the rising trend of such situations in the short term. The ePER project has developed a PER which requires a specific response to a number of identified medical conditions. This can be a lengthy completion process and is still not providing precise information relating to the risks of the condition, the availability of medication and its dispense.

When advised of their right to complain about deficiencies in their medical care, DPs are most likely to reply that it is pointless to do so as they believe that nothing will happen as a result.

It therefore appears that the criminal justice processes place inadequate emphasis on assuring the welfare of the DPs and may discourage them from complaining.

2.1.5 Accepting the transfer of Detained Persons with inaccurate or incomplete PERs

Lay Observers have noted that DPs have been accepted into court custody with omissions and inaccuracies, leading to a lack of proper risk understanding by escort and custody staff. In these cases, staff must either rely on conversations with DPs themselves, their own prior knowledge of individuals, or must contact the originating custody for clarification.

It is the policy of HMPPS that the contractor may refuse to accept a DP from their previous custody if the accompanying PER is non-compliant. HMPPS PECS have reinforced, during this year, to contractors and staff that they may refuse to transport DPs with non-compliant PERs.

Many escort and court staff appear unsure of the criteria or circumstances when they may refuse to accept a DP into their custody. The PECS contractor GeoAmey is developing custody

management training which incorporates more explicit guidance. It does not appear that any formal records are kept of the number of DPs whose transfer of custody has been refused and given that at least 46% of all PERs checked by Lay Observers are non-compliant, that such refusals to transport have occurred with any regularity.

2.2 Recommendations relating to inadequacies of the Person Escort Record

- Detained Persons should not be accepted where there is any omission on their Person Escort Record (PER) and written instructions and training must be provided to staff on the action to take when presented with a potential DP with a non-compliant record.

- A record of the number of DPs refused because of non-compliant PERs should be kept and regular reviews should be held with senior managers of each originating establishment to review the causes of non-compliance.

- Specific guidance should be issued for completion of the medical and mental health sections of the PER to allow the inclusion of the following information:

    - Name and status of reviewing medical professional
    - Nature of current medical condition
    - Nature of any relevant previous medical condition and relationship, if any, to current condition
    - Any risk to the Detained Person's ability to communicate their defence if any condition(s) are inadequately treated during the planned escort and custody period
    - Treatment required for condition and frequency
    - Time and location of treatment provision
    - Time for next treatment provision(s)
    - Location of medication provided for use during escort and custody
    - Guidance to escort and custody staff on giving accompanying medication to Detained Person and on seeking further medical advice whilst under escort and custody
    - The signature of the DP confirming and consenting to the information recorded.

- Updated guidance should be produced on the risks sections of the PER to ensure inclusion of the dates when the risk-related events took place until the ePER is introduced nationally.

- HMPPS to consult the Lay Observer Chair and National Council on any updates to the format, content and completion process of the PER.

- Make training of staff in police and prisons compulsory for those who complete PERs

2.3 Healthcare

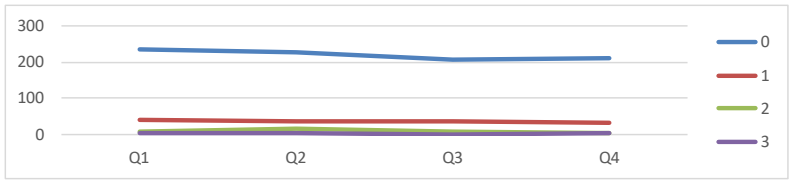
It is expected that people under escort and in court custody should have access to healthcare support at least equal to a member of the public and should be given appropriate treatment required to ensure that they are able to participate effectively in the court proceedings.

2.3.1 Medication availability

The NHS specification for police custody healthcare states “When a detainee is released or transferred to hospital or another custodial environment (e.g. prison), the provider, in partnership with the police custody team, should ensure that the detainee has sufficient medicines and dressings, in dispensed packs, to ensure continuity of care and detainee safety, until the detainee can reasonably be expected to see another healthcare professional.” A similar duty may be inferred for transfers from prison.

Thus, where a treatment requiring medication is identified in police or prison custody, it is expected by Lay Observer Standards that such medication will be made available to the DP for a period which covers the whole day of the court hearing to ensure that there is no deterioration in the DPs condition until they can receive further scheduled medication either on release or in prison.

Medication to cover journey day available or administered



Q1	234	38	5	1
Q2	229	36	14	1
Q3	205	35	6	0
Q4	210	32	3	2
Total	878	141	28	4

It is a common observation by Lay Observers that a DP on medication will not have insufficient medication for the full day, or that medication is in the person’s property but is not made available during the day or that the dispensing instructions accompanying the medication are not specific enough to allow administration. In all these cases the DP receives no medication at all. It is a common misconception with custody staff and their management that the police do not provide medication and therefore do not apparently escalate issues with police (or prisons) where the medication or the dispensing instructions have been inadequate.

With a number of health conditions, such as withdrawal from drugs (including heroin or methadone), anxiety, depression and personality disorders, the result of this can be a gradual deterioration in cognitive capability during the custody day due to the distress caused by the condition which may impair the capability of the individual to participate in court proceedings.

Of particular concern, because of the frequency of its occurrence, is the apparent absence of any protocol permitting the provision of methadone to a person suffering withdrawal whilst in court custody due to failures to ensure adequate provision by the originating custody. The impact of withdrawal on a person’s ability to participate in court proceedings can be quite severe, yet no treatment other than a sedative can be supplied even if a doctor attends.

It was of concern that Serco, the Region Two contractor, had a Medical Standard Operating Procedure, that includes the phrase: “treatment of withdrawing (i.e. from drugs) symptoms is seldom urgent, although the abuser will claim it is. If the doctor is unable to attend for a few hours, unless the prisoner looks genuinely ill no harm will follow”. It does go on to say: “If you are worried about the prisoner’s condition inform the doctor”. This SOP has now been updated on 2 May 2018 to exclude this guidance.

The response by DPs is mostly to wait out the distress since they feel that complaining will be ineffective and they do not want to raise the matter with their solicitor since they may prefer to get their appearance, “over with” rather than seek an adjournment.

These failures to provide adequate medication and the potential consequences were highlighted in both our 2015/2016 and 2016/17 Annual Reports. Regrettably, there has been

no improvement this year despite repeated reference to this issue in monthly reports and quarterly meetings with our stakeholders. It is possible that the low number of deaths in custody gives rise to a perception of limited need for adequate healthcare in court custody but the deaths in custody measure does not include unmeasured deaths occurring immediately after court custody where medication or other healthcare deficiencies have occurred (eg non-provision of heroin substitutes).

However, following the provision of Lay Observer consolidated national visits reports to the Custody Lead at the National Police Chiefs Council, consideration is now being given to reinforcing the NHS specifications across all police forces since there are variations away from the standards eg one police custody considers that the healthcare contact number should not be included in the PER since it is medical confidential, which can place the health of a DP at risk.

2.3.2 Medical healthcare support

All DPs have the right to request to see a healthcare professional. However, there is no on site medical support located in the custody area of any court. The escort and custody contractors are required by their contract to make suitable arrangements for a healthcare professional to be available if needed in the court custody area. The escort contractors have sub-contracted a company to provide a helpline/triage service and the provision of medical advice, which is paid for within the overarching contract with minimal specification by HMPPS PECS.

Whilst there are no statistics publicly available on the level of service provided by the third-party company, the routine reports from custody staff outside the London area are that the response time for a doctor at court is often four hours or more.

Visit reports have noted that as a result court custody staff rarely call for advice on supporting DPs who have medical needs indicated on their PER, relying instead on closer observation of the DP and, if there is serious deterioration in their health, adding to emergency response pressure by calling for an ambulance.

In effect, custody staff make decisions on the treatment in custody of those Detained Persons who are at risk, and those whose condition deteriorates whilst under escort or court custody, without the benefit of informed medical advice. Yet the Standard Operating Procedure (SOP) of both contractors requires that a doctor be consulted if there are any concerns about a DPs health. It is of great concern that despite regular auditing medical provision is inadequate.

The SOPs of both contractors place the responsibility for determining whether the health of a DP is a cause for concern on custody staff. In the higher volume courts (those with more than ten Detained Persons per day in custody), the custody staff can have insufficient understanding of the health and welfare issues of the DPs. On occasions, Lay Observers in their interviews with DPs have uncovered several issues of concern that were apparently unknown to custody staff. In response, staff have reported that they have little time to engage with Detained Persons unless they express concerns directly to them.

Neither of the escort contractors' SOPs require their staff to seek to inform the DPs solicitor of any unresolved concerns they may have about a DPs fitness to participate in court proceedings (although there have been numerous reports of staff taking it upon themselves to seek out the solicitor and ensure that they are aware of their concerns).

The medical healthcare support process does not adequately ensure that DPs are a) not in distress whilst in court custody, or b) not at risk of being unable to participate effectively in

court proceedings. Health care support is not specified, monitored, relied on nor accessed consistently by custodial staff and there is an over-reliance on custodial staff to diligently and consistently engage with all DPs in custody about all aspects of their care.

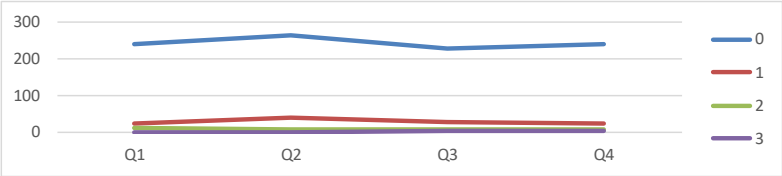
The risks posed by the medical support process were highlighted in our annual reports for 2015/16 and 2016/17 with the recommendation that the Minister undertake a comprehensive review of the adequacy of healthcare support for DPs. In April 2018, the NHS and MoJ have begun to review the potential provision of healthcare support in court custody in the context of the next PECS contract from 2020.

In addition, in the last quarter of 2017/18 HMPPS PECS has requested proposals for upgraded healthcare provision from each contractor. The proposals have been submitted but no decisions have yet been made on implementation. In view of the importance we have attached to the issue of healthcare support in court custody the Lay Observers National Council has appointed a Healthcare Group comprised of medically qualified Lay Observers to develop appropriate assessment standards and guidance for all Lay Observers in preparing their reports on healthcare related observations (the Guidance is detailed in Appendix F).

2.3.3 Mental health support

The Ministerial responses to our 2015/16 and 2016/17 Annual Reports highlighted the planned rollout of Mental Health Liaison and Diversion teams to support those with mental health problems involved in the criminal justice system. The rollout of these teams appears to presently cover approximately 80% of England and Wales by population) with full coverage scheduled to be in place by 2020. However, a number of courts have access to community health nurses and mental health nurses based locally. Lay Observer visit reports indicate that approximately 10% of courts do not presently have any form of mental health support. Additionally, there are courts notionally covered by the L&D service but which are not adequately resourced to cover all the courts in their designated area (eg Winchester Crown Court, Worle Magistrates' Court).

There is mental health provision to assess and report to the court on DPs ability to participate in court process



Q1	240	22	9	0
Q2	265	40	8	0
Q3	228	25	7	1
Q4	240	24	7	1
Total	973	111	31	2

The Minister in his reply to the 2016/17 Annual Report noted, "providing advice on an individual's fitness to participate in proceedings……is not within the scope of L&D services…however this early intervention could include advising the court that a further fitness to plead investigation is required." The Lay Observer Healthcare Group has worked with NHS Health and Justice Group to update guidance to the L&D team to emphasise their capability to provide information to the Court on the DPs' ability to participate in proceedings.[7] We remain concerned that the L&D teams do not seem to operate consistently across England with regard to the selection of DPs to visit in court custody, recording and communicating the outcome of

[7] The L&D service will facilitate timely referral to appropriate services. Where appropriate, and by agreement, the service will support the individual to attend their first appointment(s) and offer them on-going support until they engage with services.

their visit on the PER and communicating with the court any concerns related to capacity of DPs to participate in proceedings.

Lay Observers are not aware of the number of DPs diverted from the criminal justice system, but the flow of DPs with identified mental health disorders does not appear to have been reduced at all remaining at about 8% of total custodies.[8] Whilst court custody is normally alerted to the need to provide enhanced supervision to those noted as vulnerable on the PER, their utilisation of the L&D teams varies considerably in accessing their support. We remain concerned that the criminal justice system has the potential for inaccuracies as a result of the lack of a consistent, qualified and universal appraisal against clear benchmarks of vulnerable DPs' ability to participate in proceedings.[9]

Many DPs are received into court custody with identified risks such as self-harm, violence and mental health disorders which require close and frequent observation during their stay in court custody (every ten minutes is a common protocol). With high volumes of DPs, and sometimes stretched resources, it can be very difficult to address these risks with such close and routine supervision. CCTV in specific cells for such DPs would help to minimise the risk associated with failure to carry out observations in the cell. A recent survey by Lay Observers on the adequacy of court facilities has shown that fewer than twenty courts of those surveyed have CCTV installed to monitor individual cells.

2.4 Recommendations relating to healthcare

- DPs should have access to medical and mental health support with medication dispensing authorisation located:
  - within the court precinct for custodies with more than an average of ten DPs per day
  - within fifteen minutes guaranteed response time for custodies with fewer than ten DPs per day.

- Police and prison custodial suites should provide DPs with identified medical conditions, documented in the Person Escort Record (PER), with medication sufficient to last until 8pm on the day of the DPs court appearance. The originating authority should confirm this provision and any dispensing instructions in the PER, which should then be agreed and evidenced by the signature of the DP (separate arrangements will be needed for those who cannot read or write).

- HMPPS should instruct its contractors to instruct and train their escort and custody staff to ensure that the location of any medication (and its dispense instructions) noted in the PER is verified before departure and to refuse to take custody of DPs whose PERs and medication verification do not comply.

- Medical protocols should be established that allow doctors to administer medication to DPs to alleviate symptoms affecting their ability to participate in court proceedings.

[8] As measured by the number of vulnerable individuals

[9] In the Mental Capacity Act (2005) a framework and guideline for determining mental capacity is given.16 Mental capacity is defined as follows in Article 2(1): '[A] person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (whether permanent or temporary).

- Liaison and Diversion teams should be able to support the custody staff and the solicitor/court in determining the ability of all vulnerable DPs to participate in court proceedings

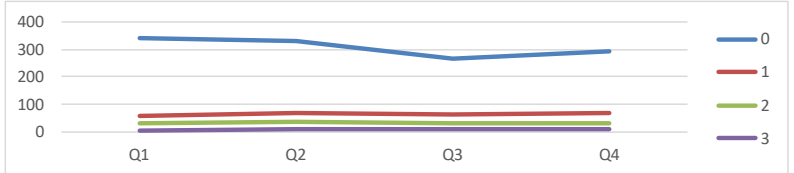
- CCTV should be installed to cover at least three cells in custody suites with more than fifteen DPs per day; two cells for those with ten to fifteen DPs per day and one cell for those with up to five DPs per day to provide coverage for those persons considered at risk of self-harm or violence.

3. Held in suitable accommodation

Detained Persons are held in a court custody environment that is clean, safe and fit for purpose.

Our previous Annual Reports report drew the Minister's attention to the poor condition of the court custody estate. The Minister's response was that, "necessary works remain prioritised to ensure facilities are safe and secure… Regular inspections…ensure cleanliness …HMCTS recently launched a Building Champions campaign ...This programme will help minimise waiting times on necessary maintenance works including custody facilities." Local HMPPS, PECS, CDMs and HMCTS staff have in most places noted Lay Observer visit reports and continued to collaborate to identify and prioritise remedial works during the year. There have been a number of instances where stakeholders have acknowledged that Lay Observer reports have influenced improvements in coordination and remedial action. The HMCTS Building Champions programme has been in place for about half of the year and has had an undoubted impact in accelerating the remediation of defects in some but not all courts.

Nevertheless, the overall condition of the estate remains poor, as shown by the fact that in 25% of all observations, custody suites are assessed in varying degrees unfit for purpose.



Q1	340	55	29	5
Q2	333	68	33	6
Q3	268	63	29	8
Q4	293	68	32	7
Total	1234	254	123	26

Every month at least one court is reported as having a concern rated as unacceptable. requiring immediate resolution. The main areas of concern are outlined below and have shown no discernible improvements during the year as reported in the Consolidated National Visit Report to stakeholders every month.

3.1 Graffiti

Over the year there have been initiatives to remove graffiti from benches, walls and doors in the cells in a number of courts. These initiatives have been supported by warnings of, and administration of, sanctions against DPs causing damage to the cell. However, there are still a significant number of court custodies where graffiti is still a cause for concern. Over 52% of courts visited had concerns with graffiti with 250 observations of a serious or unacceptable nature.

3.2 Cleanliness

As with graffiti, there has been a concomitant effort between agencies, contractors and Lay Observers to prioritise and improve the cleanliness of cells and corridors in the custody suite. A number of deep cleans and changes of cleaning contractor have taken place to reduce the incidence of concerns about ingrained dirt.

However, often the walls and floors may appear to be free of visible dirt but a wipe with a cloth will reveal that surface dirt is still in place. Custody staff and Lay Observers remain concerned about the quality of cleanliness and of the cleaning contractor, which is contracted to HMCTS

and not HMPPS in a number of custodies. During the year 29% of all observations of cleanliness were assessed as unsatisfactory with 6% rated serious or unacceptable I.e. unhygienic to the point of a risk to health.

3.3 Heating/Cooling/Hot water

There have been frequent reports of boiler/cooling breakdowns which take a long time to rectify and remain on the court defect logs for some time before repair, causing frustration to court staff and discomfort to DPs. The standard temperature guidelines issued as a result of the *Workplace (Health, Safety and Welfare) Regulations 1992* do not apply to DPs but are frequently, and unreasonably breached.

Lay Observers have noted temperatures in courts that can range from causing discomfort to unacceptable conditions, especially in the winter months. Courts do not routinely measure with reliable thermometers the temperature in the cells themselves at the beginning of and during the day. There is a tendency to ignore long standing issues in the warmer months only to be rediscovered in the colder periods of the year.

The detailed evidence is presented in the Summary Consolidated Visit Report for 2017/18 in Appendix D, in general the reports concerning heating, hot water and cell temperatures have related to between 10 and 15% of the courts consistently over the year with rectifications often taking many weeks. Lay Observer reports have resulted in cells and, on infrequent, occasions court custodies being taken off line due to serious defects e.g. unacceptably hot or cold.

3.4 Sanitary facilities

There has been an improvement over the last two years in the provision of toilet, hand washing and female sanitary facilities. However, there are a small number of custodial suites still refusing to provide soap and hand drying other than on request by a DP. Lay Observers have reported this practice as unacceptable (endorsed by the Ministerial response to the 2015 cleaning audit) and yet it is still allowed to continue in this minority of custodies. The detailed evidence is included in the Summary in Appendix D. In general, poor toilet facilities have affected about 10% of custodies consistently through the year with ten observations of totally unacceptable conditions requiring immediate remedy.

3.5 Safety

There have been a number of courts where the affray alarms have not been working for some considerable time, putting staff and DPs at risk. In most cases the repairs were not given the highest priority by facilities management, meaning that custody staff had to rely on localised contingency plans, including hand held units. Most cases were rectified by the end of the year.

Potential ligature points identified and reported by custody staff in the cell area have in a few cases not been rectified for several years. There does not appear to be national guidance on the recognition and remedy of potential ligature points for Facilities Management contractors.

For much of the year the number of anti-ligature knives have been restricted to the designated cells officer and a spare in the office, which was insufficient to address the risk of self-harm by DPs. Towards the end of the year HMPPS PECS invested in the distribution of modern anti-ligature knives for every escort and custody officer. This policy has materially addressed the risks previously apparent.

3.6 Food and kitchen facilities

There were incidents where food was found to be out-of-date but this was usually rectified rapidly when identified by a Lay Observer. Overall the food available to DPs was of limited range and, on rare occasions, it did not meet the religious or health needs of the DP. Usually this was rectified by custody staff. There have been complaints from DPs (usually on long trials) about the food and lack of a hot meal at lunch time if they are at risk of a late return to prison. 10% of the kitchens and equipment observed were not well maintained and clean; with 48 instances of a serious or unacceptable nature involving health risks from unclean equipment and unrefrigerated sandwiches.

3.7 Accommodation for vulnerable and disabled Detained Persons

As noted under the section on healthcare, few courts have CCTV in individual cells. Similarly, few are accessible for disabled people (fewer than thirty in both cases). In these cases, mitigation action is often taken at the expense of the welfare of the DP.

In the case of DPs with a disability, this may mean transporting them over long distances to attend compliant courts. Whilst the use of cellular vehicles is not the default for DPs with limited mobility or a disability, when they are used this means long uncomfortable journeys in cramped cells in vehicles with no seat belts. There are reports of disabled persons being sent to non-Equality Act compliant courts and being unable to reach the court room dock have had their case heard without them. This appears to be poor administration of justice and involving further discomfiting journeys for the affected DP.

About 8.5% of DPs in custody are identified on their PER as vulnerable (usually as a result of the nature of their offence, mental health or age). Along with female DPs they should have cell accommodation and toilet facilities separate from male adults. There are about 5% of courts, which do not undertake appropriate separation, usually as a result of building design but also increasingly as a result of court closures increasing the pressure on limited separation facilities. Despite the physical constraints, custody staff in most cases seek to maintain maximum separation in the circumstances.

The supervision of vulnerable DPs can stretch cell officer resources, creating a risk to the effective supervision of DPs by limiting the availability of custody officer resources and their responsiveness especially when there a high volume of dock appearances requiring escort.

3.8 Cell Sharing Accommodation

	Q1	Q2	Q3	Q4	Total
No of detainees sharing cells	249	235	275	213	972

The number of DPs sharing a cell occurred in 10% of all DPs monitored across the year with a significant rise in Q3. Variations are due to the incidence of trials involving a number of defendants in the smaller courts which increase the need for cell sharing. However, with court closures placing pressure on the court to which DPs are transferred there is a notable increase in cell sharing. We note that in higher volume courts, in particular, completion of the cell sharing risk assessment may be done later in the day indicating less rigour in their assessment than may be desirable. There are reports (small in proportion) of incidents between DPs sharing cells.

We are concerned that in addition to the risks posed by the resource demands of the supervision of vulnerable DPs the risks of assessing and supervising the sharing of cell accommodation may place further pressure on the custody staff's ability to manage the welfare of DPs.

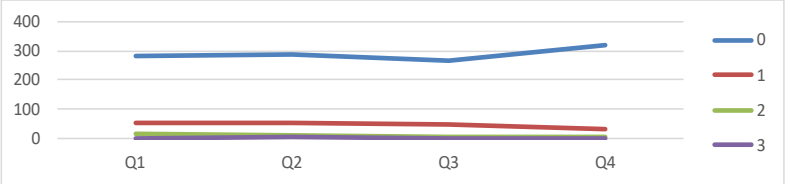
3.9 Facilities management

Court custody facilities management became the responsibility of HMCTS Property Directorate from MoJ Estates Department in February 2017. Actions by HMCTS court staff to improve the monitoring of custody defects, the full deployment of Building Champions and increased focus on Lay Observer reports have increased the overall awareness and coordination of actions to remedy faults in the court custody estate. However improved awareness and communication are not translating into comprehensive, prompt and remedial action as indicated by the consistent trends in reported defects in Lay Observer visit reports.

Whilst it is not clear whether HMCTS Property Directorate have sufficient budgeted financial resource to remedy the facilities defects in the estate, it is evident that a major contributory factor to the delays in remedial action has been poor communication between custody contractors and HMCTS operations and property teams. The defect and action logs maintained by each party were rarely aligned and comprehensive.

Whilst there have been improvements since last year, in 15% of court custodies (with regional variations) the HMCTS Court Delivery Manager still does not visit the custody suite on a regular basis (monthly) to see at first hand the conditions affecting the welfare of DPs.

Court manager/facilities manager visit the custody suite regularly



Q1	282	54	12	0
Q2	289	49	7	2
Q3	266	45	5	0
Q4	321	29	5	0
Total	1158	177	29	2

As a result, there has been frustration, misunderstanding and insufficient mitigation planning - with "matters are in hand" as a common refrain. It is understood that business cases are required for large items of expenditure, but the criteria for prioritisation does not seem to have been agreed between the parties in any formal manner

3.10 Recommendations relating to being held in suitable accommodation

- HMPPS PECS Contractors and HMCTS Property Directorate should agree and document the criteria for prioritising facilities management actions in the court custody suite in the interests of the welfare and security of the DP.

- HMPPS PECS Contractors, HMCTS Operations and HMCTS Property Directorate should agree on a process and format for the documentation and communication of facilities defects in the court custody area.

- HMCTS Property Directorate should be instructed to provide an expected completion date for all defects accepted for remediation to the Court Delivery Manager.

- HMCTS Court Delivery Managers should be instructed to visit the custody area on at least a monthly basis and agree/document mitigation action plans for expected delays (advised by HMCTS Property Directorate) in remedial works.

- Appropriate accessible court custody provision should be available within a two-hour journey for disabled people (whether on bail or off bail); if not available appearance by video link should be arranged.

- Guidance (similar to that produced by the Home Office for police custody) on the recognition and removal of potential ligature points should be prepared by HMCTS Property Division following consultation with HMPPS and issued to Facilities Management contractors.

4. Access to justice

DPs are informed of their rights and capable of accessing suitable legal advice.

4.1 Fitness for trial

DPs are normally seen by a healthcare professional prior to being transported. The Ministry of Justice does not appear to have provided these professionals with guidance on their requirements for such an attendance. The Person Escort Record requires medical or mental health risks to be identified but it does not require that the statement of risks is based on the attendance of a healthcare professional nor does it require a statement as to nor a definition of fitness.

As noted above in the healthcare section, there appear to be no guidelines [10] for establishing whether a DP is capable of participating effectively in court proceedings. This can have a particularly adverse impact if the DP's condition in custody has deteriorated since having been seen the previous day. Court custody staff are therefore, understandably, reluctant to challenge where a DP has been confirmed, "fit for trial with no need for review."

The custody contractor has stated that court custody staff will alert the DPs solicitor and the court clerk in the event that they have concerns about an individual's ability to participate in proceedings. Lay Observer reports have confirmed that this can happen, but it relies on the confidence, experience and willingness of the court custody manager. It may not, however, be possible for them to contact the solicitor in advance of the DPs court appearance and it is not clear, in the absence of advising the solicitor, how the court should be informed of their concerns. There is no direction or training given to custody managers on the circumstance and process for undertaking such action.

The Minister's reply to the 2016/17 Annual Report noted that, "the process for assessing fitness for trial is owned and managed by the independent judiciary." If a defendant in a trial is unwell, an officer of the court (their solicitor or barrister) is expected to notice this whilst taking instructions and then bring this to the attention of the judiciary who have responsibility for taking a view on whether the case can proceed at that time or whether an assessment of fitness for trial is needed in line with the criminal code; the test is known as the Pritchard test. [11] Unless the judge orders an investigation to be conducted and documented to the court by two qualified professionals, there is a presumption of fitness.
The criteria for, and the process of, determining a DPs fitness for trial, both before transportation and during court custody, does not appear to provide the assurance that they are capable of effectively participating in court proceedings and, therefore, providing the

[10] Psychology Direct Network of Professionals "There is no statutory provision for the legal test of whether or not an accused person is unfit to plead…. particularly if, as we propose, there is a standardised psychiatric test to assess decision-making capacity.

[11] The Pritchard test as operationalised by HHJ Norman Jones, QC, in *R v Whitefield* (1995) (unreported) "Have the defence satisfied you that by reason of the defendant's state of mind it is more likely than not that he is unable to either:

i) instruct his solicitor and counsel so as to prepare and make a proper defence in this case. This applies to his ability to instruct his legal advisers before and/or during his trial; or
ii) understand the nature and effect of the charge and plead to it; or
iii) challenge jurors; or
iv) understand the details of the evidence which can reasonably be expected to be given in his case and to advise his solicitor and counsel of his case in relation to that evidence; or
v) give evidence in his own defence in this case;

If the answer to any one of the above questions be yes then your finding should be that he is under a disability such that he is unfit to plead and stand his trial."

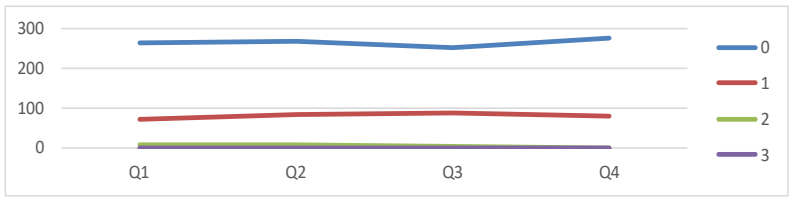
appropriate access to justice as required by the Optional Protocol for the Convention against Torture (OPCAT), to which the UK is a signatory.

It is recognised that there are many legal, procedural and medical issues involved in determining and separating fitness for trial which are perhaps beyond the scope of the Lay Observers remit. However, it does seem that the threshold for fitness to plead is set too high and as recommended by the Law Commission in 2013 should be reviewed.

4.2 Access to a solicitor

DPs normally arrive in court custody before 9.30am (as required by contract). It would seem appropriate to the DPs ability to participate effectively in court proceedings that they see their solicitor within two hours of arrival to ensure that there is adequate time for consideration of their case, particularly when it is a first-time contact (with the duty solicitor, for example). It can be a matter of extreme frustration for a DP (sometimes resulting in a serious disturbance) when they haven't seen their solicitor within a reasonable time and don't know when this will take place. It is commonly observed for a Detained Person's meeting with a solicitor to occur more than two hours after their arrival in custody.

All DPs access legal representation within 2 hours of arrival or court appearance when solicitor retained



Q1	266	69	8	0
Q2	270	84	8	0
Q3	254	87	2	0
Q4	276	79	0	0
Total	1066	319	18	0

Custody staff often make attempts to contact solicitors in these situations, but sometimes with little result.

It seems that there are no standards for the attendance by solicitors with their clients at court, including DPs on Legal Aid. In our assessment, this does not provide assurance that Detained Persons are receiving adequate access to justice, particularly when the attendance takes place immediately prior to the court appearance.

4.3 Access to rights and complaints

HMPPS require their custody contractors to place a leaflet documenting the DPs rights and the process for making a complaint in each custody cell each day as part of the contract.

Q	*0*	*1*	*2*	*3*
Rights forms in cells in language of DPs				
Q1	338	70	11	1
Q2	376	43	6	0
Q3	328	37	3	0
Q4	351	41	9	0
Total	1393	191	29	1

There has been considerable improvement during the year due to the monitoring of Lay Observers and the actions taken in response by PECS contract management to ensure compliance with this standard. The issues now mainly relate to assuring that they are issued in the language of the DP so that each DP is capable of reading the document and understanding their entitlements whilst in court custody.

The complaints process requires the DP wishing to make a complaint to request a form from the custody office and to present it to the custody office for submission to HMPPS. The identity of the complainant and nature of the complaint are immediately evident to the staff against whom the complaint may be being made, increasing the risk of reprisals against DPs. In addition, some DPs have made complaints about their treatment/experience in police or prison custody but lack confidence that any complaint will be effectively processed and responded to since the complaints process is not mentioned in the Rights leaflet.

It is reported by custody contractors that there are few complaints from DPs about their treatment under escort and in court custody. However, no complaint does not necessarily mean that there is no cause for complaint. When Lay Observers have advised DPs that they may make a complaint, the reply from the Detained Person is often that it is a, "it's a waste of time, nothing will happen," or, "I don't want to get into trouble," or, "I just want to get it over with." DPs expectations of the observance of their rights are often very low when they enter custody and are confirmed by the absence of procedures to assure them of their access to their rights and justice.

Lay Observers are, therefore, concerned by poor management practices that are affecting DPs' access to their rights and justice.

4.4 Recommendations relating to access to justice

- The concept of 'fitness for trial' should be reviewed and more detailed criteria and guidance, which take account of the cognitive state of DPs whilst in custody, should be developed for medical professionals, lawyers and court staff. It is recognised that the process for such a review may be complicated but the concerns raised by Lay Observers and apparently other bodies about this matter could at least be raised with the judiciary and expert professionals be consulted.

- The Legal Aid Agency, the Law Society and Bar Council should consider standards and guidelines for the accessibility of lawyers to DPs whilst in court custody awaiting court appearance. These should specify a wait of no longer than two hours after arrival in court or two hours before the scheduled court appearance. (The same recommendation was made in the last Annual Report to which the Minister in his reply offered that the LAA would meet Lay Observers to discuss specific courts causing concern. This proposal has been referred to the LO National Council for consideration.)

- A confidential complaint process should be developed for DPs which includes the ability to assure complaints against police and prison treatment, once they have arrived at court.

- Increased use of video appearances by those with vulnerabilities and medical conditions from prison and police custody would reduce the number of DPs exposed to deteriorating mental and physical conditions in escort and court custody and therefore the risk of being unfit for trial. DPs making video appearances would be close to embedded healthcare

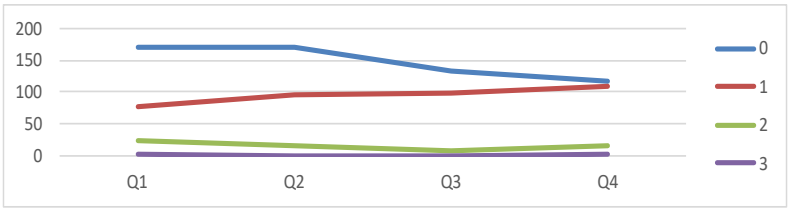
support, which has confirmed their fitness for trial. It is recognised that this recommendation would require support and regulation by the judiciary.

5. Transported promptly in suitable vehicles

DPs are transported to and from court correctly and with minimal delay. Inter-prison transfers are efficiently planned and completed with all movements using appropriate vehicles and equipment.

5.1 Minimal delay

The average number of prisoner movements per month in 2017/18 at 50,000 has remained at the same level as 2016/17, however the number of DPs experiencing extended delays in transport after their court appearance seems to have increased over the year.



Q	0	1	2	3
Q1	170	77	22	2
Q2	172	95	16	0
Q3	132	97	8	0
Q4	118	110	15	2
Total	592	379	61	4

Lay Observers cannot measure all such delays without researching all the journey logs; our evidence from visit reports above confirms that at least 45% of DPs experience more than a 2-hour delay; this delay could well be further extended for about 15% of such DPs as a result of being moved to prisons outside the, "local" area.[12]

The lack of a "sweep vehicle,"[13] in the early afternoon and the use of escort staff to assist in custody duties are the primary causes of delay. These cases result in DPs spending at least eight hours in court custody (maybe less for those on all day trials) regardless of the timing of their appearance. Court custody (for those not in the dock) is a windowless cell with a hard, wooden bench, with a significant prospect of it being dirty and graffitied, and with no official reading materials.

Furthermore, those already in prison miss a significant part of the day's regime which could include education, rehabilitation activity, access to healthcare or meals. A reasonable expectation would be for a one hour wait with a maximum of two hours after being sentenced.

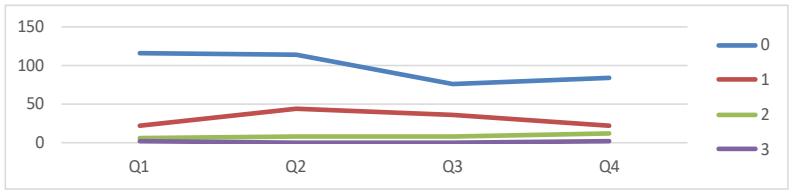
Towards the end of the year a pilot process was implemented in HMP Chelmsford, with the cooperation of HMPPS, for Lay Observers to be given access in prison to prisoners within two days of their arrival to interview them about their treatment during the overall journey under escort and court custody. This has allowed additional perspectives from DPs particularly on the length and experience of journeys, which accords with our concerns for the welfare of DPs as a result of long journeys in cramped, uncomfortable conditions. It is planned to extend this trial to other prisons in 2018/19 and the evidence added to normal Lay Observer visit reports.

[12] The local area is the prison to which the court is normally aligned e.g. HMP Bullingdon for Oxford

[13] A 'sweep' vehicle is available to move to different locations to pick up prisoners who have been sentenced to prison in the morning rather than waiting until the end of the day.

5.2 Transport of Children and Young Persons (CYPs)

CYPs transported quickly after their court appearance



Q1	117	22	6	1
Q2	114	44	7	0
Q3	75	35	7	0
Q4	84	21	11	2
Total	390	122	31	3

A significant proportion of journeys to prison/secure homes for CYPs start well after two hours from their court appearance. Whilst our observations cannot accurately determine the departure time for every CYP in custody during their visit, evidence indicates that on a rising trend over the year, at least 30% of all CYPs were transported over two hours from their court appearance, which may well have required a journey up to four hours in the morning.

The reasons for these delays are that their court appearances are often scheduled late in the court day and after sentencing their custodial destination can take youth justice authorities several hours to determine. The result is CYPs can arrive in the late evening in their destination establishment, which can be many hours distance from the sentencing court. Some Youth Offending Institution Independent Monitoring Boards have expressed concerns at the number of prisoners apparently arriving as late as midnight.

During the period of journey delay the CYP will be spending their time in the windowless, activity free, uncomfortable cell they occupied for their court appearance day whilst their extended journey will be in a constricted claustrophobic cell, with uncomfortable moulded plastic seating without seatbelts, similar to the transport experience they probably had from police or prison custody earlier the same morning.

5.*3 Correct court appearance*

It is reported by court custody managers that unnecessary journeys and mistaken court appearances occur in about 10% of DPs moved, as indicated in the attached table, but the instances do not follow a consistent pattern through the year.

Q	*0*	*1*	*2*	*3*
No DP presented at court unnecessarily				
Q1	312	24	4	1
Q2	307	37	5	3
Q3	277	32	5	0
Q4	316	18	4	1
Total	1212	111	18	5

The instances reported below are mainly the result of mistakes in scheduling although in some cases can be related to those who could have appeared by video. Such errors are stressful for the affected DP who can often react in an aggressive manner to custody staff who are not responsible for such mistakes. We are not aware of any monitoring of court scheduling takes place by HMCTS to help correct these issues.

We are aware that HMCTS plan to increase the number of video appearances particularly from police stations which should assist in reducing the number of unnecessary appearances.

5.4 Inter prison transfers

An established protocol allows Lay Observers to be present at prisons when Inter-Prison Transfers (IPTs) arrive. Monitoring IPTs remains an unsatisfactory process for Lay Observers since there is limited opportunity to interview a prisoner between the van and reception. The expansion of the in-prison interview pilot of prisoners (see above) should allow the inclusion of IPT monitoring in the future.

5.5 Appropriate vehicles and equipment

The vehicle specification remains unchanged in key respects of DPs welfare; the hard-plastic seats without seatbelts and confined cells remain and are unfit for journeys greater than 30-45 mins. We understand that a new vehicle specification is being developed for the next PECS contract.

These large cellular vehicles are particularly unsuited to the transport of children and young people from police custody to court. An entirely different and more suitable specification is used for the transport to court from secure establishments; a car with single occupancy and two escorts. The type of transport used is dependent upon the escort contract; the former is with PECS and the latter is with the Youth Justice Board. We estimate that about 1000 children and young people are transported with adults from police custody in the cellular vehicles rather than by car each month. This is an unacceptable method of transporting children and young people.

Approximately 15% of all vehicles inspected by Lay Observers have defects; ranging from dirty cells to unpadded headrests to omissions from the required inventory. These defects are reported to the contractors.

5.6 Recommendations relating to suitable transport

- A separate contract should be developed by the Youth Custody Service as part of the 4th generation PECS contract for the movement of all CYPs from secure homes, Youth Offender Institutions and police custody to court and their supervision in court custody.

- Prior to the implementation of the recommendation above. HMPPS should improve the administrative arrangements for the safe escort and custody of CYPs to reduce the transport delay after sentencing by: -

    - Creating a separate and appropriate PER for CYPs

    - Developing tools for predicting likely custodial sentences so that work on appropriate potential custodial provision can begin much earlier in the day

    - Liaising at an early stage in the day with PECS contractors for the provisional scheduling of transport

    - Allowing the equipment bag from the secure homes transport into the custody suite for the use by all CYPs in custody that day

- Allowing the CYP badged escort officers accompanying DPs under the YJB contract to become the supervisors of the custody of all CYP persons in the custody suite that day.

- Ensuring CYPs are never transported in cellular vehicles with adults

- Ensuring that CYPs are escorted by an officer trained to supervise young people

- Ensuring that each custody suite has an on-duty officers nominated and trained in child (and vulnerable adults) safeguarding and protection to ensure the appropriate care of CYPs whilst in custody.

- Prior to the implementation of 4th generation PECS each contractor vehicle base should deploy, "sweep" vehicles to collect and transport those in court custody sentenced/remanded to prison during the early afternoon each day.

- The PECS 4th generation contract should specify:

    - The maximum delay of transporting DPs after sentencing to be no more than 2 hours

    - The maximum journey length for a DP should be no more than 2 hours without a mandatory rest period

    - Vehicles to have suitable headrests, seat belts and seat covers to ensure that all (but the very exceptional) DPs can be accommodated with safety and comfort appropriate to 2-hour journeys.

- The data relating to inaccurately scheduled and unnecessary court appearance should be compiled by HMPPS PECS to pursue and remedy their causes.

6. Treated with respect as an individual

All detainees/prisoners are treated with dignity and respect and are free from discrimination and victimisation.

6.1 Children and young people in court custody

The specifications for the escort of children and young people from secure establishments to court require that they be accompanied by two specifically trained escort officers in a manner suitable to a young person (for example, in an unmarked car with blacked-out windows and with an equipment bag with items relevant to a young person).

What actually happens is that children and young people are transported from police custody in cellular vehicles with adults (albeit separated by a sliding partition) and escorted by staff with no special qualifications in escorting children and young people. In court custody, although located in a separate area, they are treated like an adult in a windowless cell with a hard-wooden bench with no diversionary materials and are supervised by a custody officer with no specific qualifications.

The PECS contract does not require appropriate consideration for the welfare of children and young people as provided by the Youth Justice Board (YJB) contract (overseen by the same government department). It clearly does not provide an appropriate level of respect to the individual and can involve risks to custody officers who are not trained in the proper treatment and restraint of children and young people. This inconsistency has been raised with the YJB and HMPPS with no apparent change in policy or practice as a consequence. Indeed, the newly formed Youth Custody Service has confirmed that a gap covering the escort and court custody exists in the Ministry's development of their REFORM programme.

It is a concern that this inappropriate treatment of under 18s may contribute to confirming their future criminal behaviour.

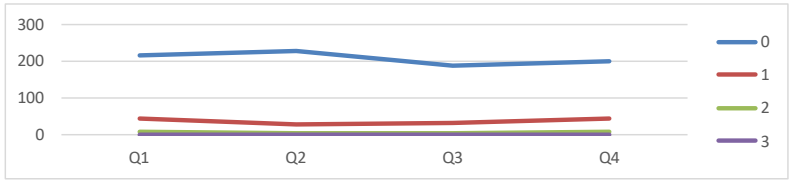
6.2 Delays to children and young people's court appearances

Although HMCTS has provided assurance that children and young people's court appearances are scheduled as quickly as possible, visit reports indicate that, for example, in March 2017 the appearance in court of children and young people was delayed until late in the day in over 20% of cases. These delays are routinely reported, at their request, to the YJB. Given the harshness of the accommodation conditions (see above), these delays do not appear to respect the vulnerability of children and young people, and have not been adequately addressed by HMCTS.

6.3 Delays in discharging those released from custody

The response time in the processing of DPs who are released from custody and were originally transported from prison can result in delays of up to three hours from the judgement of the court to their release; they remain in the cell for this period. These extended delays are reported to be frequent and not exceptional: approximately 10% of observations.

DPs released with minimal delay



Q1	218	43	7	0
Q2	229	28	1	0
Q3	187	31	3	0
Q4	201	41	5	0
Total	835	143	16	0

They are caused by the unavailability of prison staff at certain times of day, delays securing the warrant from the court office and issues related to the DPs property.

This treatment is not respectful of the individual, causes confrontations with staff and has not, to our knowledge, been addressed by HMCTS or the escort contractors.

6.4 Reading materials

There has been a dramatic improvement in the number of custodies where reading material is made available to DPs, albeit sometimes in a heavily used state. Some DPs have been reported to have refused the reading material because of its heavily soiled state. However, it remains the case that the availability of materials to occupy DPs for long periods in the harsh physical conditions of the cell is not developed and organised centrally by the contractors. The consequences of this are boredom for the DP and, therefore, an increased propensity towards violence in the custody suite.

6.5 Recommendations relating to respectful treatment as an individual

- Children and young people's appearances in court should be prioritised.
- HMCTS, HMPPS Prisons and escort contractors should work together to create a process for the release of DPs (in particular children and young people) to achieve a maximum delay of one hour. The good practice found in some courts, where Judges and Magistrates inform the Detained Person that their release may involve a short delay, should be extended across all courts.
- The PECS 4th generation contract should specify the provision of at least a daily supply of free newspapers to each custody suite and suitable reading material/activities for young people.
- The specifications of the PECS 4th generation contract should aim to mirror, for all DP movements, the specifications of previous YJB contracts for the escort from secure homes and the principles of the REFORM programme being developed for the custody of CYP offenders.
- To reduce the waiting time for release of a DP, HMPPS should streamline the "Request for Authority to release Prisoner" process by:
    - Relying on the accuracy of the "Not for release" declaration on the PER
    - Placing in the PER a statement of entitlement to a discharge grant
    - Enabling the court Probation Officer to issue the Licence as part of the court warrant
    - Agreeing with HMCTS a protocol for the time taken to issue a warrant
    - Consider allowing a person to be released to stay outside of their cell (perhaps an interview room or staff room) whilst they await documentation.

7. Risks to wellbeing are minimised

Transport and custody are managed in a manner that ensures the wellbeing of DPs

Whilst the Lay Observers mandate precludes observations about the commercial conduct of the escort contractors, we feel the need to assess management practices which could impact on the welfare and access to justice of DPs.

7.1 Management and staff training

Many of the observations detailed in this report relate to the inconsistent application of good practice by management and staff in the escort and custody suite. Where our observations and reports have identified practices below the standards implied by the Lay Observer expectations, we have enquired about any related training that management and staff have received. It appears that the likely cause of many of the issues raised in this report could be traced to a lack of documented instructions and supported training for both staff and management. For example, it has been reported to us by custody staff that:

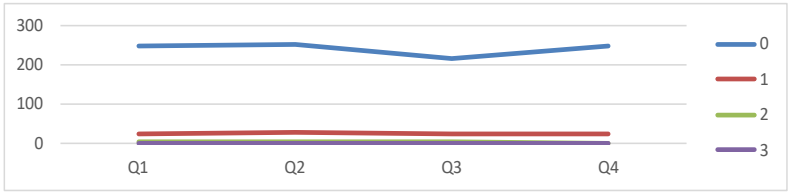
- new custody managers are not routinely given a formal management training course/induction/knowledge assessment to ensure their comprehensive understanding of appropriate SOPs;

- escort staff are not formally instructed and trained on the criteria and process for refusing the transfer of custody from prison/police station in the event of the presentation of a non-compliant Person Escort Record (PER);

- Custody managers are expected to escalate issues in respect of facilities, PERs and healthcare to HMCTS, prisons and police, however they have little guidance or established agreement/protocols to give them the confidence to raise concerns.

- Custody staff are sometimes diffident about escalation of issues such as cell closures since the protocols to guide such matters do not exist and they can be wary of upsetting the flow of DPs to court (and upsetting the judiciary).

Issues, including inaccurate PERs, escalated quickly and efficiently



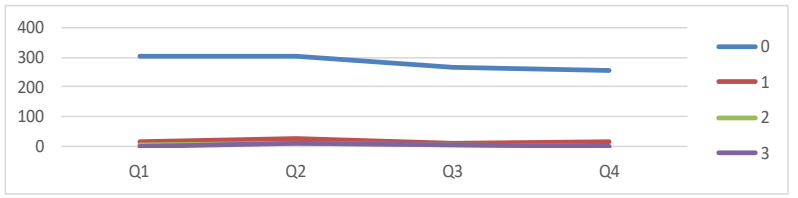
Q1	249	23	2	0
Q2	251	26	1	0
Q3	215	24	2	0
Q4	249	24	0	0
Total	964	97	5	0

- Custody managers receive little feedback in respect of escalation of issues relating to PERs and other related issues from partner organisations.

7.2 Fire prevention

The duty to undertake fire prevention actions falls to HMCTS. The Minister's response to the 2016/17 Annual Report, "Fire drill and prevention procedures are tested every 6 months in every courthouse." Some custody managers' report (as indicated in the table below) that they cannot remember such a fire drill. Reliance is often placed on desktop exercises. Given the, "rabbit warren" nature of many custody suites, this policy appears to be contrary to the

welfare of its occupants. There does not appear to be any evidence that these policies and practices have been reviewed and approved by local fire officers.

Precautions to prevent and react to fires in the custody suite are rigorous					
	Q1	305	16	3	0
	Q2	304	27	10	6
	Q3	266	11	4	1
	Q4	255	12	0	0
	Total	1130	66	17	7

7.3 First night leaflets

There has been a significant improvement in the appropriate provision of first night leaflets compared to the previous year. It is rare for a custody suite not to have a stock and give them to those going to prison for the first time. The only exception is the provision of the information in foreign languages, which can vary between courts.

7.4 Food

Observations of out-of-date, unchilled and mislabelled (e.g. Halal compliant) food have reduced significantly from about 15% in March 2017 to an average of 5% during 2017/18.

7.5 Recommendations relating to minimising risks to wellbeing

- HMPPS PECS contractors should develop and implement formal training and refresher courses for Court Custody Managers (especially those newly appointed) and their Deputies to ensure that they are aware of the up to date Standard Operating Practices and expected standards of care and access to justice.

- Assurances should be sought from each local fire officer that fire drill and prevention procedures are adequate in every court.

APPENDIX A: THE LAY OBSERVER ORGANISATION

Lay Observers monitor the welfare and access to justice of DPs being brought to court and held in court custody and the transport of detainees under the supervision of escort contractors. We aim for high standards of monitoring and, whilst being independent, we aim to be a reliable partner within the framework of organisations monitoring custodial environments.

Organisation governance

The Lay Observers organisation consists of approximately seventy Lay Observers, led by a Chair, a National Council and a number of Area Co-ordinators.

Under the leadership of the Chair, the National Council is responsible for:

- **the fair and open recruitment, training and professional development of Lay Observers**; (see Recruitment, Training and Development below)

- **agreeing national policies**; the following policies this year include:

    - The Organisation Guide
    - Code of Conduct
    - Complaints procedure
    - Recruitment competencies and OCPA compliant process
    - Sabbaticals
    - Visit standards

- **ensuring that visits are carried out and reports completed**; this year there have been:

    - 1800 court custody visits, an average of 150 per month

- **bringing concerns to the attention of the escort and custody contractors and other stakeholders**; this year:

    - All HMPPS PECs and HMCTS Delivery Managers receive level 2 and above reports

    - PECS feedback actions on level 3 reports

    - Monthly consolidated report and commentary (see Appendix D) circulated to HMPPS, HMCTS, HMIP, YJB, NPCCC, NHS Health and Justice, MoJ Commissioning; and quarterly to the Independent Custody Visitors Association (police custody monitors)

    - Regular meetings with Head of PECS, Deputy Director HMCTS Central Ops and MoJ sponsor

    - Initiated contact with NHS Health and Justice to update Liaison and Diversion guidelines

    - Initiated contact with National Police Chiefs Council Custody lead re PERs; MoJ ePer to be trialled in 3 police forces.

    - Initiated contact with YJB and Youth Custody Service re treatment of under 18s; new CYP visit report produced for use in 2018/2019.

During the year eight new Area Coordinators were appointed to bring the total in post to ten (leaving two vacancies) and a further appointment for Region 2 was made to the National Council.

In addition, a Healthcare Group and a Communications Group both reporting to the National Council were established to provide guidance and leadership in their specialist areas to the Lay Observer member. The Healthcare Group comprises and is chaired by a medical professional and the Communications Group also comprises experienced professionals, benefitting from the support of the Lay Observer Secretariat.

Six National Council meetings were held during the year with the Area Coordinators attending two of these to approve policy and process developments. Area Coordinators also attended two training and development meetings.

Lay Observers are supported in their role by a Secretariat provided by the Ministry of Justice.

Systems and reporting

A secure electronic document management system called STOWED was introduced in 2015 to receive and store Lay Observer's visit reports.

To support data protection of the distribution of court custody visit reports and related communications to and from Lay Observers, a secure encrypted dedicated server with dedicated email accounts was introduced.

With the introduction of the Statement of Expectations and the related Assessment Standards, the visit report template allows each standard to be displayed along with an assessment rating with related comments and rationale by the Lay Observer.

Since its launch on 1 March 2017, Lay Observers have been reporting their assessments and observations in a standard template. The template allows the consolidation of reports at area, region and national level and the systematic reporting of trends and issues at both court and national level. These reports have informed the Lay Observer Annual Report for 2017/18.

The visit reports are sent immediately to the distribution hub of each contractor for transmission to appropriate recipients in their organisations and in cases where a Level 2 or above has been assessed, to the PECS Contract Delivery Manager and the HMCTS Court Delivery Manager. A consolidated report (with individual court reports attached) for each Area and contract Region is sent to appropriate PECS CDMs each month to allow the issues identified to be immediately addressed.

Each month visit reports are consolidated into a national report, with a Chair of the Lay Observers commentary, which is distributed to all Lay Observers, PECS and HMCTS and other criminal justice monitoring organisations at the end of the month.

A mapping tool is now available to Area Coordinators which shows the location of Lay Observers in relation to courts and prisons and the distances involved for travel. The numbers of DPs at each court and prisoners arriving/departing each prison is also shown to allow prioritisation of visits. Lay Observers may also gain access to the last report from each court from this tool to inform their next visit.

Recruitment, Training and Development

For the second year in a row, there were severe delays (up to nine months) in the vetting and security pass for newly recruited Lay Observers. Therefore, unfortunately, there were no new Lay Observers from 2017/18 recruitment year available to offset the number of resignations from active Lay Observers during the year. The number of active members declined substantially as result. The exceptional commitment of a number of Lay Observers maintained the quantity at an increased rate to the prior year as well as the quality of the new visit report assessment standards.

About 20 new recruits and being trained and mentored on probation in the early part of 2018/19 year.

There were a number of reasons for resignations including sickness, sickness of close relatives, end of tenure, career and other commitments, dissatisfaction with the role and its requirements etc. There were lessons learned from the unexpectedly high turnover and the recruitment competencies and process have been appropriately adjusted as a result.

Training and mentoring of new Lay Observers has been challenging, given the very limited resources available this year. Nevertheless, a two-and-a-half-day training programme, with accompanying materials, has been developed for new recruits. The programme consists of a 2 day in a classroom and a half day of experience in court custody. An experienced Lay Observer mentor's the new member during their probationary period of 6 months.

Lay Observers meet quarterly with their Area Coordinator for personal development and the first national meeting was held in May 2018.

Forward look and areas for development in 2017/18

Lay Observers undertook an average of 150 (up from 145 last year) custody visits each month during the year, reviewing an average of 800 (up from 750) Detained Persons per month (approx. 1.6% of the 50,000 prisoners moved each month).

We aim to increase the coverage of Lay Observer monitoring to 5% of all DP movements. We have developed a resourcing model to determine the number of Lay Observers required, which depends on the average throughput of DPs each month, with each Lay Observer undertaking a minimum of two visits per month and interviewing a maximum of six DPs per visit, with each court custody suite being visited once every month.

Based on the throughput of DPs at each court in the third quarter of 2017/18, the number of Lay Observers required to deliver a 5% level of monitoring of court custody would be 130. Consequently, we are planning to recruit to that level with recruitment being targeted around an accessible radius of each court.

A trial of a review of a prisoner's experience of escort and court custody when they have settled into prison has been successfully undertaken for four months in HMP Chelmsford. Subject to additional Lay Observers becoming available, the process will be extended to further prisons; a Youth Offender Institution being the next. The increase in Lay Observer numbers to deliver the extended monitoring of inter prison transfers and prisoner movements from court to prison has been calculated to be 86 nationally.

A review of the Lay Observer Assessment standards has been undertaken after their first year in operation and the process has been further streamlined with an overall assessment of PERs included. The revised formulation and format of the standards will be introduced from October 1st, 2018.

Training initiatives to support consistency of assessments of differing scenarios in different court custody settings are underway but may be limited in their scope and impact by legal and security restrictions being imposed.

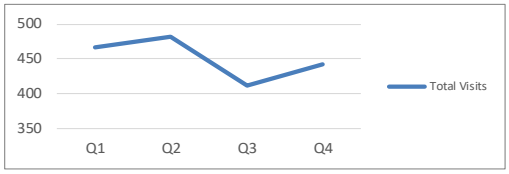
The process for the engagement of potential tenders for the 4th generation PECS contract is gathering pace with a number of new initiatives being contemplated and a focus on quality in tender submissions. Lay Observers will be available to contribute their knowledge of appropriate escort and custody standards and independence of assessment to, "bench test" new initiatives and to contribute to the quality review of tenders.

APPENDIX B: SUMMARY OF REPORTS APRIL 2017 TO MARCH 2018

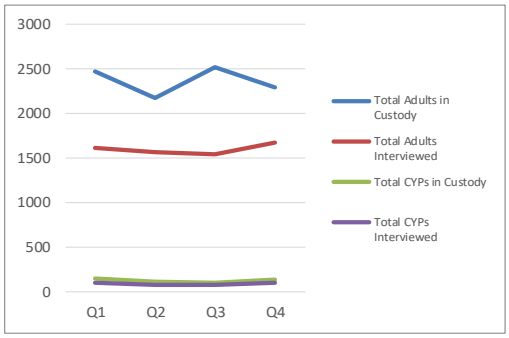
Lay Observers

Summary Apr 2017 - Mar 2018

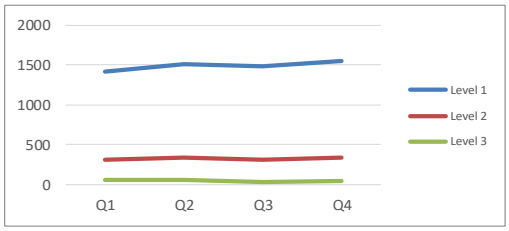
TOTAL VISITS	***Q1***	***Q2***	***Q3***	***Q4***	***Total***
	467	481	411	442	1801



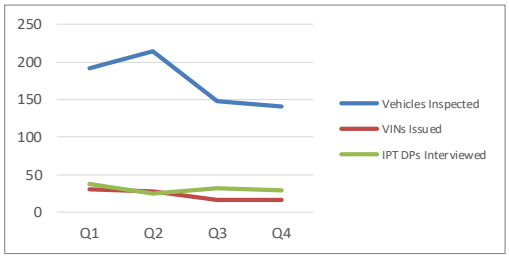
CUSTODIES	***Q1***	***Q2***	***Q3***	***Q4***	***Total***
Total Adults in Custody	2476	2171	2519	2294	9460
Total Adults Interviewed	1615	1570	1548	1671	6404
Total CYPs in Custody	148	116	107	133	504
Total CYPs Interviewed	101	83	78	103	365



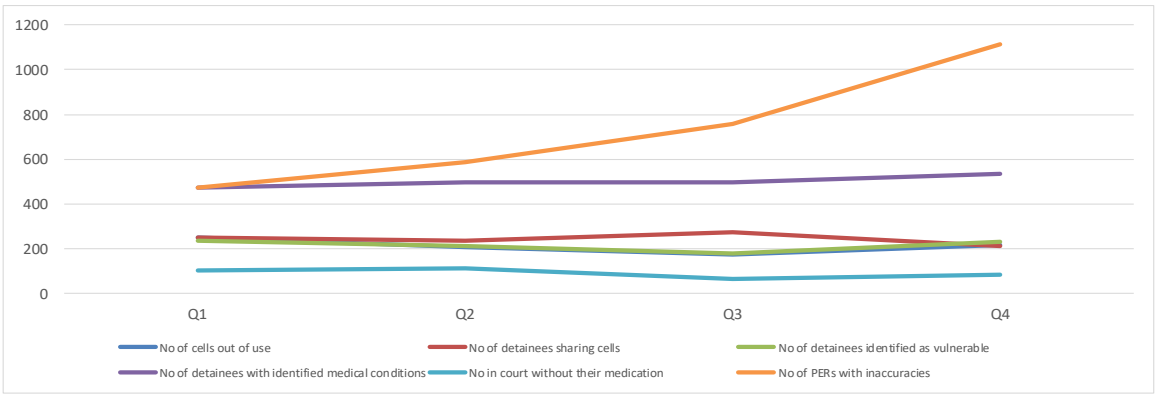
REPORT	***Q1***	***Q2***	***Q3***	***Q4***	***Total***
Level 1	1415	1509	1487	1547	5958
Level 2	317	334	312	337	1300
Level 3	63	61	35	47	206

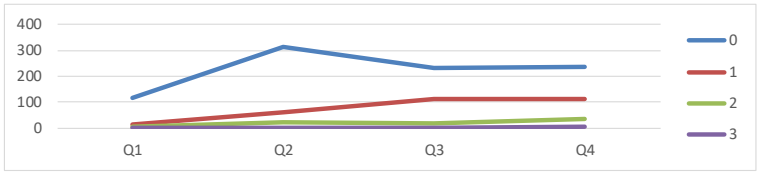
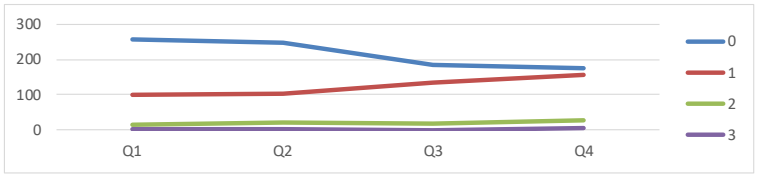
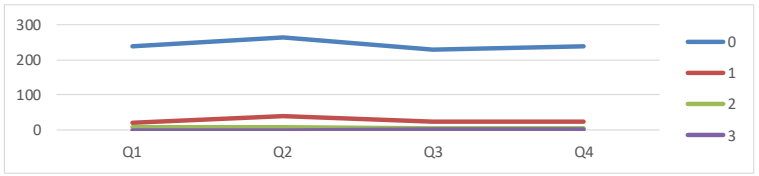
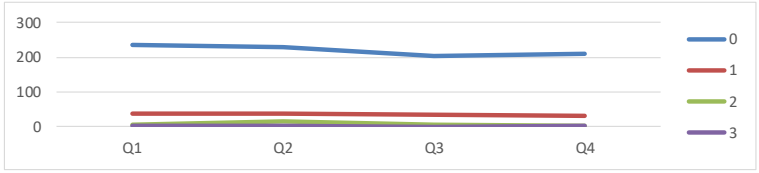
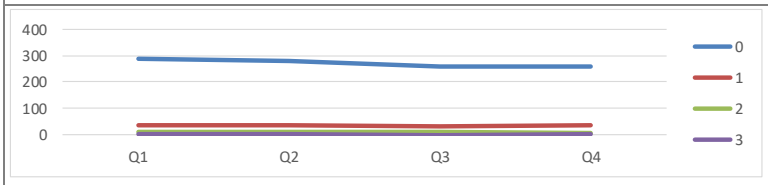


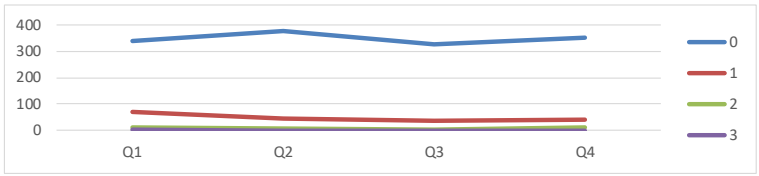
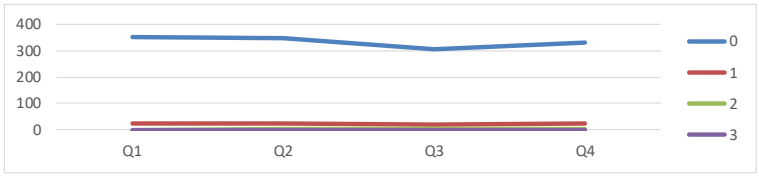
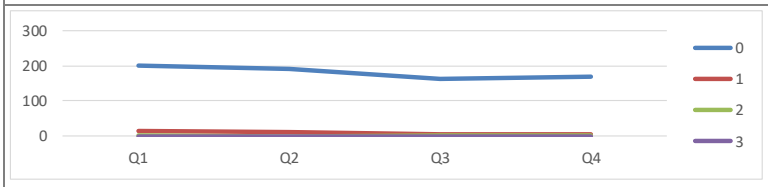
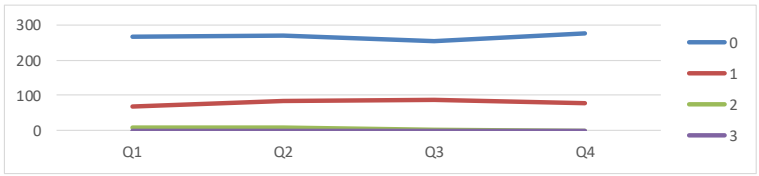
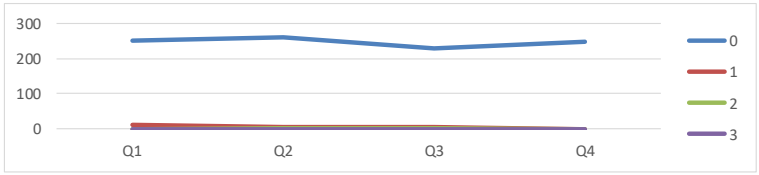
VEHICLES	***Q1***	***Q2***	***Q3***	***Q4***	***Total***
Vehicles Inspected	192	215	148	141	696
VINs Issued	30	27	17	16	90
IPT DPs Interviewed	38	25	32	29	124

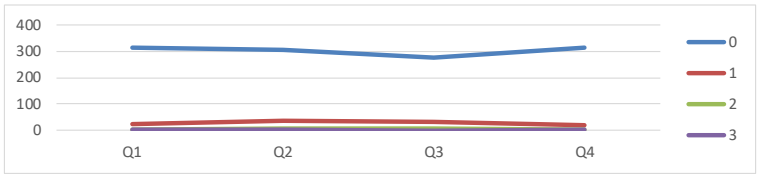
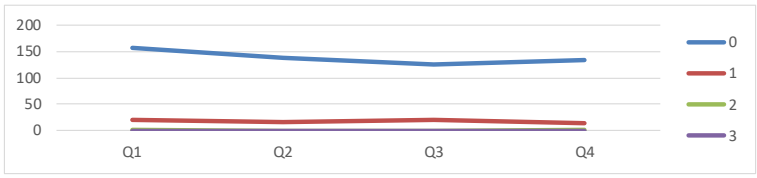
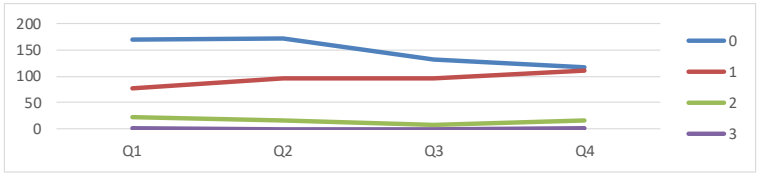
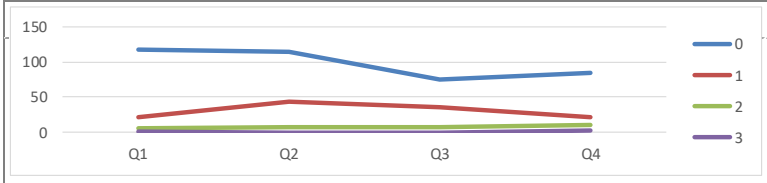
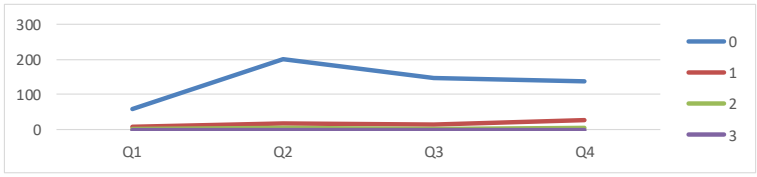


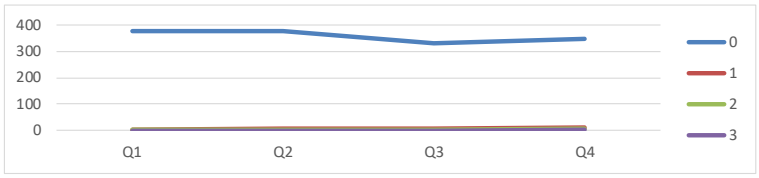
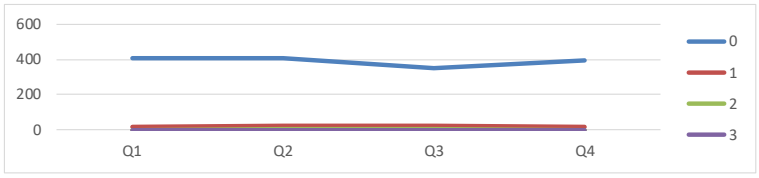
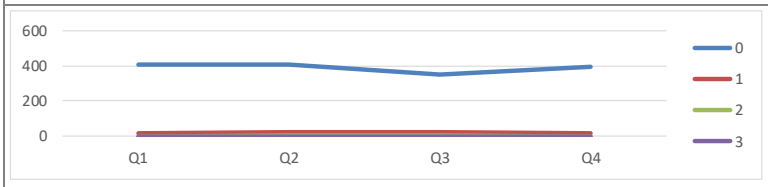
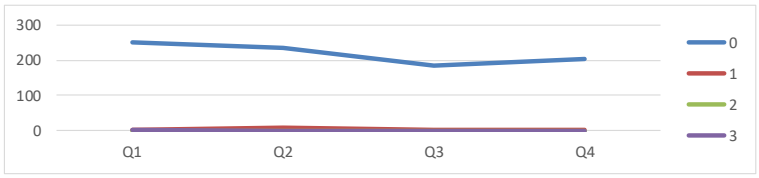
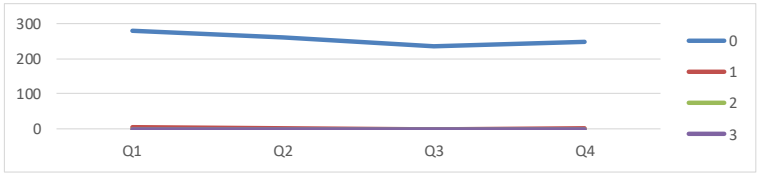
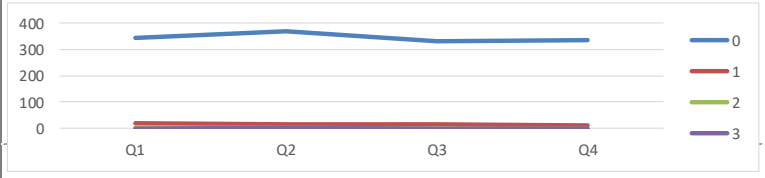
DATA COLLECTION	***Q1***	***Q2***	***Q3***	***Q4***	***Total***
No of cells out of use	249	209	174	219	851
No of detainees sharing cells	249	235	275	213	972
No of detainees identified as vulnerable	234	212	181	231	858
No of detainees with identified medical conditions	473	496	497	537	2003
No in court without their medication	104	111	63	86	364
No of PERs with inaccuracies	472	587	757	1114	2930

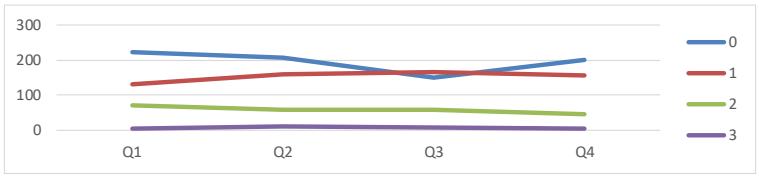
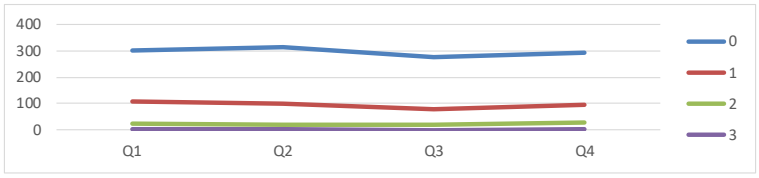
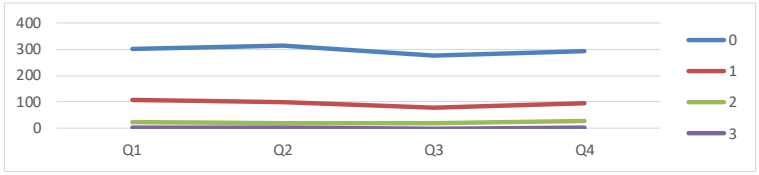
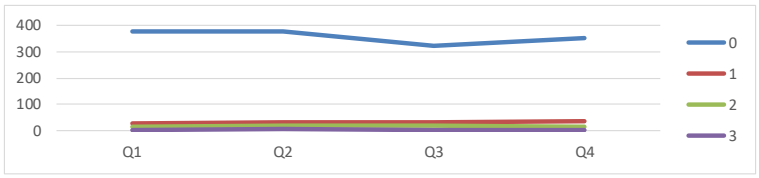
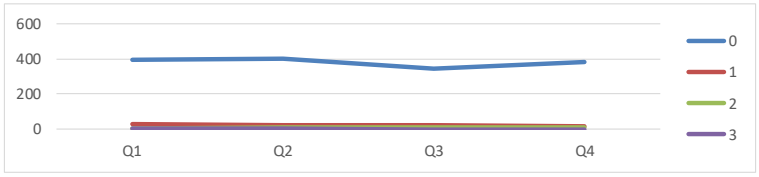
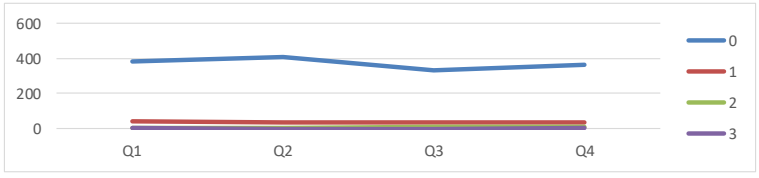
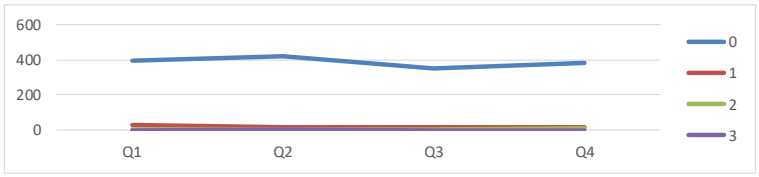
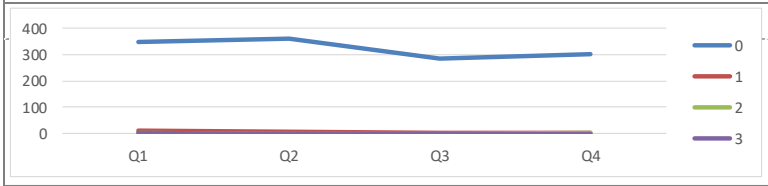


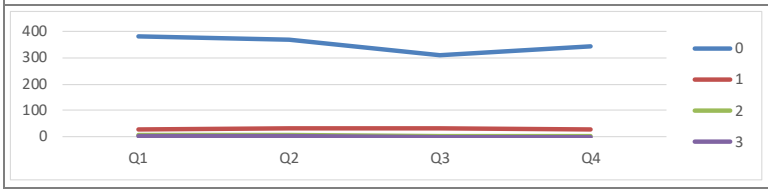
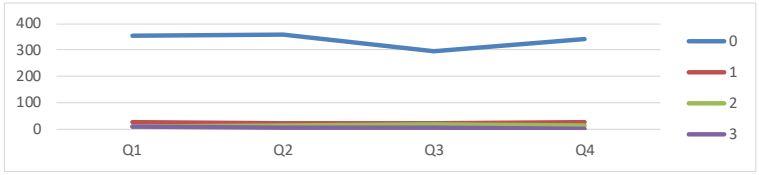
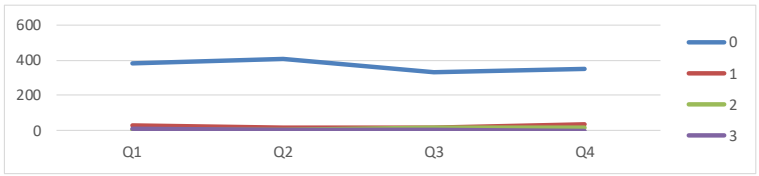
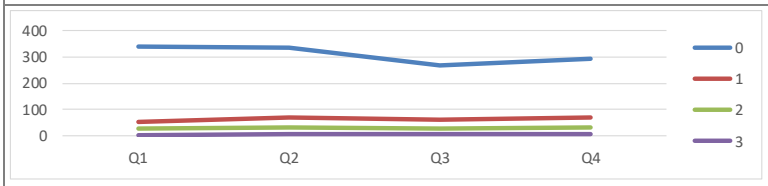
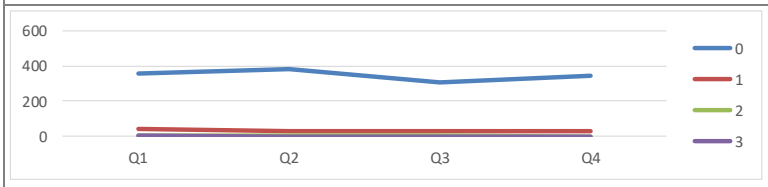
DPs HAVE ACCESS TO SUITABLE HEALTH CARE TO MEET THEIR NEEDS DURING THEIR TIME IN THE CUSTODY SUITE	*Q*	*0*	*1*	*2*	*3*
PERs enable staff to make risk assessments					
	Q1	118	16	6	1
	Q2	314	61	21	2
	Q3	230	114	19	0
	Q4	234	114	37	7
	Total	896	305	83	10
PER accurately records healthcare administration relevant to escort and court custody period including contact and accompanying medication details					
	Q1	259	101	15	1
	Q2	247	104	22	2
	Q3	185	133	18	0
	Q4	177	156	28	4
	Total	868	494	83	7
There is mental health provision to assess and report to the court on DPs ability to participate in court process					
	Q1	240	22	9	0
	Q2	265	40	8	0
	Q3	228	25	7	1
	Q4	240	24	7	1
	Total	973	111	31	2
Medication to cover journey day available or administered					
	Q1	234	38	5	1
	Q2	229	36	14	1
	Q3	205	35	6	0
	Q4	210	32	3	2
	Total	878	141	28	4
All DPs are satisfied that their medical needs have been met whilst at court					
	Q1	288	35	8	1
	Q2	281	37	9	2
	Q3	257	32	8	0
	Q4	260	37	4	3
	Total	1086	141	29	6

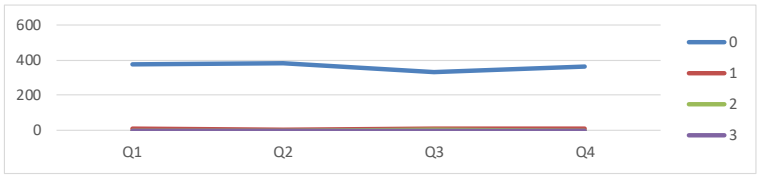
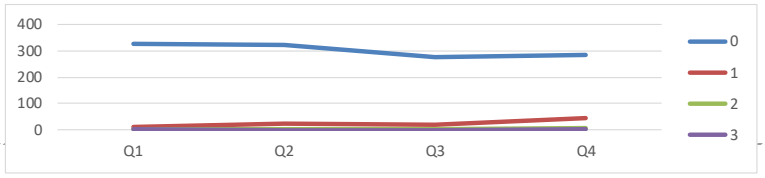
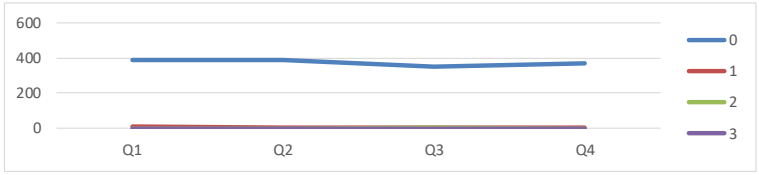
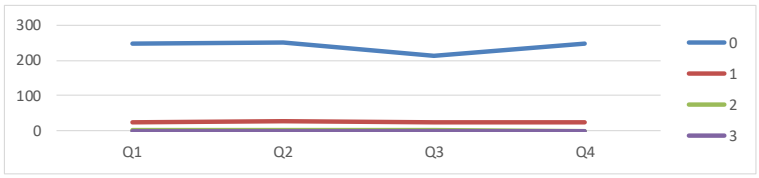
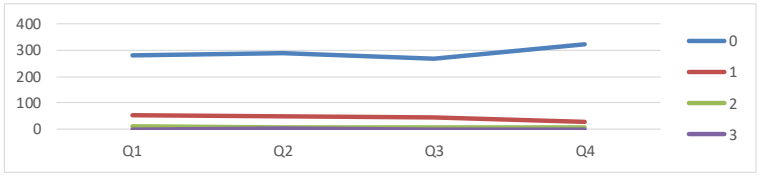
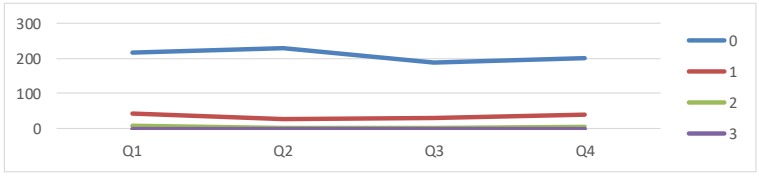
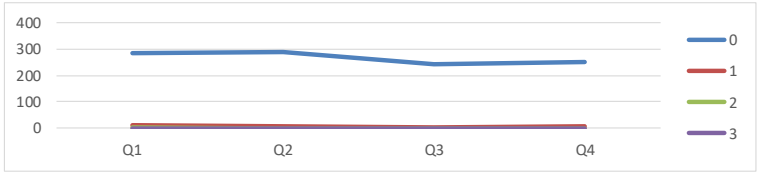
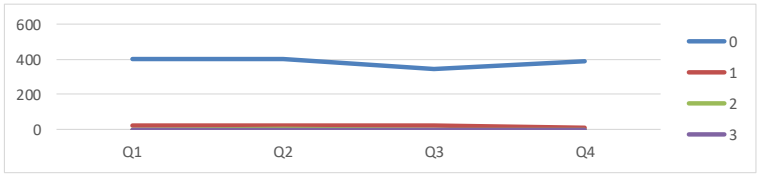
DPs HAVE ACCESS TO LEGAL ADVICE AND SUPPORT	*Q*	*0*	*1*	*2*	*3*
Rights forms in cells in language of DPs					
	Q1	338	70	11	1
	Q2	376	43	6	0
	Q3	328	37	3	0
	Q4	351	41	9	0
	Total	1393	191	29	1
DPs understand their rights					
	Q1	351	24	1	0
	Q2	349	24	3	0
	Q3	305	23	2	0
	Q4	331	25	3	0
	Total	1336	96	9	0
Where necessary adequate interpreter facilities are available					
	Q1	202	15	3	0
	Q2	190	10	0	0
	Q3	163	5	1	0
	Q4	168	4	1	0
	Total	723	34	5	0
All DPs access legal representation within 2 hours of arrival or court appearance when solicitor retained					
	Q1	266	69	8	0
	Q2	270	84	8	0
	Q3	254	87	2	0
	Q4	276	79	0	0
	Total	1066	319	18	0
DPs have access to their legal papers					
	Q1	250	11	0	0
	Q2	260	4	2	0
	Q3	230	4	1	0
	Q4	249	0	0	0
	Total	989	19	3	0

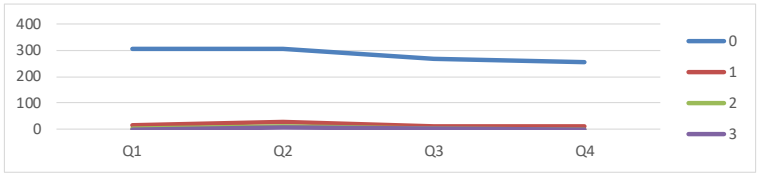
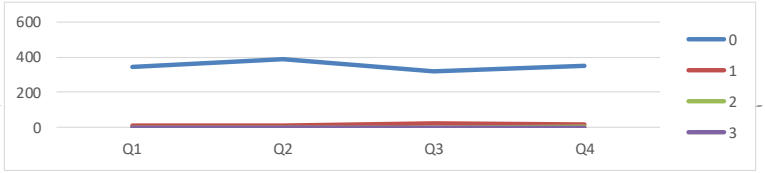
DPs ARE TRANSPORTED TO AND FROM COURT IN REASONABLE TIME AND IN SUITABLE VEHICLES	*Q*	*0*	*1*	*2*	*3*
No DP presented at court unnecessarily					
	Q1	312	24	4	1
	Q2	307	37	5	3
	Q3	277	32	5	0
	Q4	316	18	4	1
	Total	1212	111	18	5
Females all brought to court in vehicle with only female DPs. If shared was there separation from males or abuse from males					
	Q1	158	20	1	0
	Q2	139	17	0	0
	Q3	125	20	0	0
	Q4	134	14	1	0
	Total	556	71	2	0
DPs do not have to wait for more than 2 hrs in cells after their court appearance					
	Q1	170	77	22	2
	Q2	172	95	16	0
	Q3	132	97	8	0
	Q4	118	110	15	2
	Total	592	379	61	4
CYPs transported quickly after their court appearance					
	Q1	117	22	6	1
	Q2	114	44	7	0
	Q3	75	35	7	0
	Q4	84	21	11	2
	Total	390	122	31	3
Transport vehicle and equipment comply with PECS specification					
	Q1	59	7	1	0
	Q2	200	17	4	0
	Q3	147	16	1	0
	Q4	139	26	4	0
	Total	545	66	10	0

ALL DPs ARE TREATED WITH RESPECT AND ARE FREE FROM DISCRIMINATION	*Q*	*0*	*1*	*2*	*3*
DPs not subjected to any form of discrimination					
	Q1	379	3	1	0
	Q2	376	7	2	0
	Q3	329	6	1	0
	Q4	346	9	5	1
	Total	1430	25	9	1
Food available for a range of diets					
	Q1	411	17	0	0
	Q2	409	23	1	0
	Q3	349	21	2	0
	Q4	396	17	0	0
	Total	1565	78	3	0
CYPs/females and vulnerable DPs separated from other DPs					
	Q1	254	17	0	0
	Q2	269	13	1	0
	Q3	218	9	0	0
	Q4	217	13	2	1
	Total	958	52	3	1
Vulnerable DPs carefully monitored					
	Q1	252	3	0	1
	Q2	235	8	0	0
	Q3	186	2	0	0
	Q4	203	3	0	0
	Total	876	16	0	1
Handcuffs used appropriately					
	Q1	281	6	0	0
	Q2	262	1	0	0
	Q3	237	0	0	0
	Q4	247	1	0	0
	Total	1027	8	0	0
DPs given reading materials					
	Q1	345	20	4	0
	Q2	370	16	1	1
	Q3	329	13	0	0
	Q4	334	12	0	0
	Total	1378	61	5	1

DPs ARE HELD IN A CUSTODY SUITE THAT IS CLEAN, SAFE AND IN A GOOD STATE OF REPAIR	*Q*	*0*	*1*	*2*	*3*
Graffiti assessment (refer to standards)					
	Q1	223	130	71	6
	Q2	208	160	59	10
	Q3	150	165	58	7
	Q4	202	158	45	4
	Total	783	613	233	27
Cleanliness assessment (refer to standards)					
	Q1	300	107	22	4
	Q2	314	101	19	3
	Q3	278	77	19	1
	Q4	293	93	26	3
	Total	1185	378	86	11
Kitchen is clean with suitable clean, working equipment including microwave					
	Q1	388	36	9	2
	Q2	386	43	4	2
	Q3	321	39	11	3
	Q4	362	38	7	0
	Total	1457	156	31	7
Hot water available for hand washing					
	Q1	379	26	17	4
	Q2	378	33	20	5
	Q3	321	31	20	3
	Q4	351	35	14	4
	Total	1429	125	71	16
Toilets working satisfactorily					
	Q1	394	26	5	4
	Q2	403	24	11	3
	Q3	343	22	9	0
	Q4	383	19	8	0
	Total	1523	91	33	7
Soap, hand drying and toilet paper available without DPs having to request					
	Q1	383	43	5	1
	Q2	406	34	3	0
	Q3	333	33	7	0
	Q4	365	35	7	1
	Total	1487	145	22	2
Toilets clean					
	Q1	398	28	2	0
	Q2	420	17	3	1
	Q3	350	19	5	0
	Q4	383	19	8	0
	Total	1551	83	18	1
Female sanitary provision available					
	Q1	347	9	1	2
	Q2	361	5	0	0
	Q3	283	4	0	0
	Q4	300	4	1	0
	Total	1291	22	2	2

The condition of all interview rooms is satisfactory					
	Q1	380	28	8	1
	Q2	368	34	8	1
	Q3	309	32	5	0
	Q4	344	28	5	0
	Total	1401	122	26	2
Air cooling/heating working					
	Q1	356	26	10	9
	Q2	358	22	13	6
	Q3	293	20	17	6
	Q4	341	27	15	0
	Total	1348	95	55	21
Cell temperatures adequate (refer to temperature standards)					
	Q1	384	28	2	8
	Q2	405	19	3	5
	Q3	330	19	14	5
	Q4	350	36	19	0
	Total	1469	102	38	18
The custody suite and associated areas are in good condition and suitable for use by DPs					
	Q1	340	55	29	5
	Q2	333	68	33	6
	Q3	268	63	29	8
	Q4	293	68	32	7
	Total	1234	254	123	26
All cell officers carry an anti-ligature knife while DP(s) in custody					
	Q1	355	43	2	6
	Q2	381	28	3	0
	Q3	304	29	6	0
	Q4	344	32	1	0
	Total	1384	132	12	6

THE CUSTODY SUITE IS MANAGED AND RUN IN A MANNER THAT ENSURES THE WELLBEING OF	*Q*	*0*	*1*	*2*	*3*
Records completed quickly and accurately					
	Q1	377	12	0	0
	Q2	383	5	0	0
	Q3	332	9	1	0
	Q4	364	12	0	0
	Total	1456	38	1	0
Risk assessments made accurately					
	Q1	327	11	2	1
	Q2	324	22	4	0
	Q3	278	19	4	0
	Q4	283	45	8	2
	Total	1212	97	18	3
Staff interaction with DPs is always good					
	Q1	387	7	0	0
	Q2	392	4	0	0
	Q3	349	4	1	0
	Q4	369	6	0	0
	Total	1497	21	1	0
Issues, including inaccurate PERs, escalated quickly and efficiently					
	Q1	249	23	2	0
	Q2	251	26	1	0
	Q3	215	24	2	0
	Q4	249	24	0	0
	Total	964	97	5	0
Court manager/facilities manager visit the custody suite regularly					
	Q1	282	54	12	0
	Q2	289	49	7	2
	Q3	266	45	5	0
	Q4	321	29	5	0
	Total	1158	177	29	2
DPs released with minimal delay					
	Q1	218	43	7	0
	Q2	229	28	1	0
	Q3	187	31	3	0
	Q4	201	41	5	0
	Total	835	143	16	0
DPs remanded are informed of what to expect when they go to prison (FNLs)					
	Q1	285	11	2	0
	Q2	289	6	0	0
	Q3	244	2	0	0
	Q4	250	5	0	0
	Total	1068	24	2	0
Food is in date, stored correctly and sufficient for a range of diets					
	Q1	404	24	0	0
	Q2	404	23	1	0
	Q3	346	22	0	0
	Q4	386	11	0	0
	Total	1540	80	1	0

Precautions to prevent and react to fires in the custody suite are rigorous					
	Q1	305	16	3	0
	Q2	304	27	10	6
	Q3	266	11	4	1
	Q4	255	12	0	0
	Total	1130	66	17	7
The management of the custody suite ensures the wellbeing and access to justice for DPs					
	Q1	347	12	1	0
	Q2	389	10	1	0
	Q3	320	21	1	0
	Q4	350	16	5	0
	Total	1406	59	8	0

APPENDIX C: ASSESSMENT STANDARD

Custodies	A	B		A	B
Adult Male			Adult Female		
CYP Male			CYP Female		
Total			Total		
			Overall Totals		

No of cells out of use	
No of detainees sharing cells	
No of detainees identified on PER as vulnerable	
No of detainees with medical conditions identified on PERs	
No in custody without their medication	
No of PERs with inaccuracies	

DPs have access to legal advice and support

Rights forms in cells in language of DPs	Y/N
DPs understand their rights	Y/N
Where necessary adequate interpreter facilities are available	Y/N
All DPs access legal representation within 2 hours of arrival or court appearance when solicitor retained	Y/N
DPs have access to their legal papers	Y/N

Other notes re support/advice:

DPs are held in a custody suite that is clean, safe and in a good state of repair

Graffiti assessment	0/1/2/3
Cleanliness assessment	0/1/2/3
Kitchen is clean with suitable clean, working equipment including microwave & fridge	Y/N
Hot water available for hand washing	Y/N
Toilets working satisfactorily	Y/N
Soap, hand drying and toilet paper available without DPs having to request	Y/N
Toilets clean	Y/N
Female sanitary provision available	Y/N
The condition of all interview rooms is satisfactory	Y/N
Air cooling/heating working	Y/N
Cell temperatures adequate (neither too hot nor too cold)	0/1/2/3
Alarms all working	Y/N
All cell officers carry an anti-ligature knife while DP (s) in custody	Y/N

Other notes re safety & repairs:

Vehicles

Vehicles Insp.	
VINS Issued	
IPT DPs Intvd	

Detainees have access to suitable health care to meet their needs during their time in the custody suite

PERs enable staff to make risk assessments	Y/N
PER accurately records healthcare administration relevant to escort and court custody period including contact and accompanying medication details	Y/N
There is mental health provision to assess and report to the court on DPs ability to participate in court process	Y/N

Medication to cover journey day until early evening available or administered	Y/N
All DPs are satisfied that their medical needs have been met whilst at court	Y/N

Other notes re health care:

Detainees are transported to and from court in reasonable time and in suitable vehicles

No DP presented at court unnecessarily	Y/N
Females all brought to court in vehicle with only female DPs If shared was there separation from males or abuse from males	Y/N Y/N
DPs do not have to wait for more than 2 hrs in cells after their court appearance	Y/N
CYPs transported quickly after their court appearance	Y/N
Transport vehicle and equipment comply with PECS specification	

Other notes re transport:

All detainees are treated with respect and are free from discrimination

DPs not subjected to any form of discrimination	Y/N
Food available for a range of diets	Y/N
CYPs/females and vulnerable DPs separated from other DPs	Y/N
Vulnerable DPs carefully monitored	Y/N
Handcuffs used appropriately	Y/N
DPs offered reading materials	Y/N

Other notes re respect/discrimination:

The custody suite is managed and run in a manner that ensures the wellbeing of DPs

Records completed quickly and accurately	Y/N
Risk assessments made accurately	Y/N
Staff interaction with DPs is always good	Y/N
Issues, including inaccurate PERs, escalated quickly and efficiently	Y/N
Court manager/facilities manager visit the custody suite regularly	Y/N
DPs released with minimal delay	Y/N
DPs remanded are informed of what to expect when they go to prison (FNLs)	Y/N
Food is in date, stored correctly and sufficient for a range of diets	Y/N
Precautions to prevent and react to fires in the custody suite are rigorous	Y/N
The management of the custody suite ensures the wellbeing and access to justice for DPs.	Y/N

Other items of note:

APPENDIX D:

Lay Observers

Independent monitors of court custody & escort

CONSOLIDATED VISIT REPORT AND COMMENTARY

October 2017

TOTAL VISITS

137

CUSTODIES

A = number in custody, B = number interviewed

	A	B		A	B
Adult Male	678	467	Adult Female	69	55
CYP Male	45	33	CYP Female	1	1
Total	**723**	**500**	**Total**	**70**	**56**
			Overall Totals	**793**	**556**

REPORT	
Level 1	491
Level 2	120
Level 3	16

VEHICLES	
Vehicles Inspected	44
VINs Issued	5
IPT DPs Interviewed	13

DATA COLLECTION	
No of cells out of use	59
No of detainees sharing cells	107
No of detainees identified as vulnerable	54
No of detainees with identified medical conditions	159
No in court without their medication	23
No of PERs with inaccuracies	250

Comments

This month there were a similar number of level 2s and level 3s to previous months; 120 level 2s and 16 level 3s (3 of which were subsequently downgraded) ie over 130 serious or very serious welfare and access to justice issues in the escort and custody of DPs . This year the apparent actions taken by stakeholders do not seem to match the seriousness or spread of the issues. Following recent discussions at national level it is anticipated that there will be greater diligence in investigating and remedying the adverse incidents identified.

The total number of Lay Observer court custody visits has fallen by 11% since September reflecting a number of retirements, absences due to illness and resignations among Lay Observers which not been offset by new recruits due to material delays in vetting. However, the number of DPs in custody and interviewed increased by more than 10% reflecting the prioritization of visits to high volume courts. The number of on rota Lay Observers is expected to decline further in the coming months due to pending retirements and continued delays in vetting until the effects of the current recruitment campaign start to flow through into training.

I am therefore once again grateful to those colleagues who have stepped up their number of visits to maintain rotas.

Whilst the number of cells out of use has declined the number sharing cells has increased due to multi defendant trials in courts such as Snaresbrook which do not have sufficient cells for the volume now being concentrated there due to closures.

The percentage of DPs with medical conditions without their medication showed a welcome decline to 15% from the 21% in September. There remain a number of instances of DPs claiming they are on medication which is not reflected in the accompanying medical reports. Because the claims are not verified the LO has not incorporated the instance in the assessment. In these circumstances LOs should, if time and staff resources permit, ask the custody staff to call the originating custody to comment on the claim and assess the outcome.

I am pleased that colleagues appear to have responded to the request for diligence in reporting non-compliant PERs from the visit day and archive as reflected in the 35% increase over September in reported errors. This increase may not be reflected in the numbers centrally collected by the PECS contractors since there are a number of courts reported as not comprehensively submitting the errors noted. We are asked if there are material differences in the trends between prisons and police; at present we are not centrally collecting this information from LO reports but may seek to do so. It is therefore very important that reports should continue to note the number of errors from each source.

DPs HAVE ACCESS TO SUITABLE HEALTH CARE TO MEET THEIR NEEDS DURING THEIR TIME IN THE CUSTODY SUITE	*0*	*1*	*2*	*3*
PERs enable staff to make risk assessments	74	43	6	0
PER accurately records healthcare administration relevant to escort and court custody period including contact and accompanying medication details	60	43	8	0
There is mental health provision to assess and report to the court on DPs ability to participate in court process	72	7	4	0
Medication to cover journey day available or administered	70	10	1	0
All DPs are satisfied that their medical needs have been met whilst at court	88	8	4	0

Comments

Whilst there are no level 3 assessments in this category in the Statement of Expectations this month, the 7 from July to September do not yet appear to have been investigated and action taken by the originating custody/healthcare. The significant increase from September in reported inaccuracy of PERs in supporting accurate risk assessments particularly medical is worrying, there are a number of level 2 reports concerning misleading or inaccurate information on PERs relating to DPs with apparently distressing medical conditions which could affect their ability to participate in court proceedings. There does not appear to be a stakeholder worried enough about the impact on these DPs to take up the matter with the originating institution and to seek change.

The National Council is working with PECS to establish improved follow up and feedback on level 2 matters. We expect a protocol to be published by mid-December which will reflect these improvements. In the meantime, progress in bringing these concerns to light depends on LOs fully documenting and following through on the consequences of apparent failures in medical risk assessment.

DPs HAVE ACCESS TO LEGAL ADVICE AND SUPPORT	*0*	*1*	*2*	*3*
Rights forms in cells in language of DPs	108	12	1	0
DPs understand their rights	104	8	1	0
Where necessary adequate interpreter facilities are available	48	1	0	0
All DPs access legal representation within 2 hours of arrival or court appearance when solicitor retained	83	35	1	0
DPs have access to their legal	76	2	1	0

Comments

The incidents of failure to place rights leaflets in cells appear stubbornly locked at between 12 and 17 . The ability of the DP to best understand and apply their rights was affected by about 12% of the court custodies.

Failures by solicitors to meet with clients within a 2-hour window increased to 35 this month from 26 in September. Given the risk not only to their access to justice but also to the likelihood of their disruptive /non-compliant behaviour toward staff it is perhaps surprising that contractor management do not also raise the issue formally with the Legal Aid Board.

Lay Observers should also test the understanding of the DP of their rights; many claim to understand but when prompted do not (eg the rights leaflet mentions Lay Observers but few DPs seem to know about LOs when they introduce themselves).

DPs ARE TRANSPORTED TO AND FROM COURT IN REASONABLE TIME AND IN SUITABLE VEHICLES	***0***	***1***	***2***	***3***
Females all brought to court in vehicle with only female DPs. If shared was there separation from males or abuse from males	44	7	0	0
No DP presented at court unnecessarily	93	12	2	0
DPs do not have to wait for more than 2 hrs in cells after their court appearance	48	25	3	0
CYPs transported quickly after their court appearance	25	11	3	0
Transport vehicle and equipment comply with PECS specification	46	6	1	0

Comments

The trend in this Expectation category this month is generally one of improvement but the number of incidents is still significant particularly level 2, which total 9. There seems to be an increase in the number of DPs presented at court unnecessarily usually as the result of mistakes which can on occasions result in very lengthy wasted uncomfortable journeys for the affected DP. We are not aware of any actions being taken by stakeholders to remedy these occurrences (LO observations only represent at best 3% of the DPs moved each month so the total affected could be 300/400 per month or about 2% of all movements).

The number of CYPs kept at court after their hearing has reduced this month with the same number of CYPs monitored indicating a genuine improvement.

ALL DPs ARE TREATED WITH RESPECT AND ARE FREE FROM DISCRIMINATION	***0***	***1***	***2***	***3***
DPs not subjected to any form of discrimination	110	1	0	0
Food available for a range of diets	119	1	0	0
CYPs/females and vulnerable DPs separated from other DPs	76	4	0	0
Vulnerable DPs carefully monitored	64	0	0	0
Handcuffs used appropriately	83	0	0	0
DPs given reading materials	107	5	0	0

Comments

There are few adverse observations in this Expectation and show improvements against prior months. I repeat the guidance from last month.

"the judgment of the LO can relate to "any form of discrimination" and not just to overt discrimination as defined by the Equalities Act (i.e. sex, race, religion, age, disabilities). The Lay Observer standard can relate to any disadvantage to a DP which is systemic within the particular court custody for example failure to offer non- English speakers rights leaflets or reading material in their own language, failure to ensure that those with learning disabilities or mental health concerns fully understand their rights and the complaints process. Where such a judgement is made, an appropriate level should be applied and the rationale fully explained to avoid any misunderstandings."

In addition, the LO may hear comments or observe behaviour which indicates bias toward DPs. LOs should document such statements and confirm the statement with the person involved and include it in the report. If the LO is concerned that cooperative relationships with the court custody could be affected by such an inclusion they should consult their Area Coordinator.

At present we are interviewing 75% of CYPs in court custody which is very appropriate to their potential vulnerability; whilst understanding that court appearance or other factors can mitigate interview attempts it seems appropriate that we should strive for 100% of interviews of CYPs on every visit.

DPs ARE HELD IN A CUSTODY SUITE THAT IS CLEAN, SAFE AND IN A GOOD STATE OF REPAIR	***0***	***1***	***2***	***3***
Graffiti assessment (refer to standards)	49	58	16	6
Cleanliness assessment (refer to standards)	92	25	10	1
Kitchen is clean with suitable clean, working equipment including microwave	112	11	4	0
Hot water available for hand washing	108	9	7	1

Toilets working satisfactorily	115	8	3	0
Soap, hand drying and toilet paper available without DPs having to request	108	12	4	0
Toilets clean	116	7	2	0
Female sanitary provision available	96	1	0	0
The condition of all interview rooms is satisfactory	108	7	3	0
Air cooling/heating working	94	5	6	3
Cell temperatures adequate (refer to temperature standards)	116	4	2	2
The custody suite and associated areas are in good condition and suitable for use by DPs	84	23	14	3
All cell officers carry an anti-ligature knife while DP(s) in custody	105	11	1	0

Comments

I repeat last month's guidance since reports are generally short on the detail of proposed action or contingency plans.

"I would commend Lay Observers for their diligence in observing and reporting comprehensively the defects in the estate affecting the welfare of DPs. With 30% of the court custody suites still judged unsuitable for use by DPs we must continue to pursue the evidence of contingency plans agreed with the CCM whilst repairs are awaited and record the plan or its absence. Area Coordinators and Lay Observers are encouraged to maintain a longitudinal assessment of custody facilities i.e. identifying promised action or mitigation has subsequently taken place. It is helpful practice where subsequent reports (verbal or written) are received from stakeholders containing either a response or a proposed action plan to update the visit report within the last box so that there is a clear record and advice to the next LO visit"

The Heads of PECS, HMCTS and HMCTS Property are committed to working together to improve the communication of issues and consequent actions and follow up to reduce the incidents of inadequate facilities which remain at serious levels. Further guidance will be provided once the process and participation of the LO is clear.

The number of level 3s this month has reduced and remedial action has been taken or planned in the case of Birmingham and Sheffield albeit very slowly in the case of Leicester. The level 3s reported in Croydon were confirmed by the National Council as very serious but not quite level 3. However, after a month there has been no feedback on actions taken at Croydon. It is not our role to demand action but to document the responses in terms of actions or contingencies and to assess the effect on the overall welfare of the DP. Therefore, in the interim LOs should keep following through on adverse observations in some detail so that appropriate escalation can be made by the Area Coordinator or the National Council.

THE CUSTODY SUITE IS MANAGED AND RUN IN A MANNER THAT ENSURES THE WELLBEING OF DPs	***0***	***1***	***2***	***3***
Records completed quickly and accurately	110	3	1	0
Risk assessments made accurately	91	5	3	0
Staff interaction with DPs is always good	119	2	1	0
Issues, including inaccurate PERs, escalated quickly and efficiently	66	11	0	0
Court manager/facilities manager visit the custody suite regularly	86	18	3	0
DPs released with minimal delay	63	7	0	0
DPs remanded are informed of what to expect when they go to prison (FNLs)	79	1	0	0
Food is in date, stored correctly and sufficient for a range of diets	120	5	0	0
Precautions to prevent and react to fires in the custody suite are rigorous	87	3	3	0
The management of the custody suite ensures the wellbeing and access to justice for DPs	101	10	0	0

Comments

In respect of escalation of issues, I repeat last month's guidance

"although not mandatory, the management and Authority expectation is that all errors on PERs will be escalated. It is important to record as level 1 (persistent failure level 2) where reports have not been routinely made using the medium specified by the contractor. Oral reports indicate the incidence of such failures is much higher than the 9 reported above, although the system was only implemented in late August /early September"

Where court custody staff indicate that they intend to report any errors in PERS identified by the LO to their management this should be noted and the next rota report should identify whether they were submitted. Alternatively, a sample of archived PERs could be taken and cross checked against the submitted report.

HMCTS does not appear to have requested all their Court Delivery Managers to inspect the custody suite regularly so the number reported as not conforming remains the same monthly. However, we are told that Building Champions have been appointed to every court or cluster of courts and that they should be in the custody suite 2 or 3 times a week on behalf of the CDM.

APPENDIX E: COMMENTARY ON REPORTS, MARCH 2017

The number of visits in March recovered to more normal levels, although still a little below the peak of July 2016 with the number of Detained Persons/Prisoners being reviewed at 1.4%.

The new visit assessment and report form was introduced on 1 March and all of these visits were reported in the new format. Whilst the National Council acknowledge that the wording of some standards will require refinement over time (particularly the inventory for the van) and that it is not an appropriate format for prison visits, nevertheless we are grateful that all Lay Observers have adopted the new approach without too much disruption and are all now using their Lay Observer email address to send copies to the SCO/CCM.

I would like to thank LOs for their visits in the month while encouraging everyone to try to maintain at least the required minimum of 2 visits per month.

I am particularly pleased with the new consolidated national report, which mirrors at a national level the report on an individual court. The new report is on STOWED (entitled consolidated report March 17) and I would encourage all Lay Observers to have a look at this report since it is the aggregate product of each of your reports and allows you to see the overall national picture that we present and discuss with stakeholders. Hopefully you will appreciate the benefit in communication with stakeholders and Ministers of having quantified evidence of our concerns rather than anecdotes. Consolidations in the same format are available on STOWED at regional and area coordinator level to aid your communication with PECS and HMCTS on trends at a local level.

Whilst we will always be seeking to develop and improve, I firmly believe that we have now delivered on the vision of a Lay Observer process which is capable of being consistent, is based on objective standards and allows the evidential reporting of trends and can therefore deliver on our primary objective of being a reliable monitor of Detained Persons' welfare and access to justice for our stakeholders.

The number of Level 3s reported increased from 12 in February to 18 in March, 13 of which related to the Clean, Safe and Good State of Repair Expectation, 2 related to Healthcare Expectation and the remaining 3 to the Respect, Journey Length and Custody Management Expectations. The number of Level 2s increased substantially to 140 from 66 in February, 96 of which reflect serious inadequacies against our Expectations for Clean, Safe and Good State of Repair. Whilst there is evidence of attention to remediation of defects at a limited number of courts, it is disappointing to note that many Level 1and 2 assessments related to the same court each month and record that custody staff have no or unreliable information about work to be undertaken.

As suggested previously it would be helpful to record the extent of delays with Court Delivery Managers and the Facilities Management helpline so that we can direct these concerns to HMCTS Property.

There were 10 serious concerns noted with inadequate documentation in the PER related to Healthcare.

A concern has been raised relating to the confidentiality of the medical information contained in a sealed envelope attached to the PER. This practice is used by some police custodies to record the treatment provided by their medical support. Whilst Lay Observers do not have the

right to see private medical records they are permitted to see the medical information pertinent to the Detained Person contained at the bottom of the second page of the PER. In some cases, there is no medical information in the PER but there is an envelope attachment to the PER. If practical, it is helpful to interview the Detained Person. If that interview raises concerns about the welfare of the individual the LO can relay their concerns to the SCO/CCM and request they open the envelope to determine whether they (SCO/CCM) should seek further medical support. These circumstances warrant at least a level 1 since the PER has been inadequately prepared and a level 2 if the welfare of the individual has been compromised as a result.

In a similar vein, a decision by court custody staff to relax the supervision regime recommended by the originating police or prison custody in the case of a self-harm risk without external advice should be pursued by the LO with the SCO/CCM for its rationale and its documentation in the PER. We should be particularly concerned if these decisions are not recorded or appear to be for resource reasons.

Lessons from Visit Reports

The following topics are the focus of discussion at area meetings this month and next:

1. There are still some courts where Rights leaflets are not placed in cells for Detained Persons to read. This is a contractual requirement. Level 1 initially but if noted a second time Level 2.

2. There is little evidence that non-English speakers are given Rights leaflets in their own language. Many LOs have reported that the leaflets have been provided only after the LO had commented. This should be noted and given a Level 1.

   Many Detained Persons are poor readers. Have any been given help in explaining their rights? Please note good practice.

3. Reading materials are seldom mentioned. Please note good practice e.g. where courts make a special effort to provide a range of reading materials.

4. Cleanliness of many custody suites is poorer than would be acceptable in other areas of the court. Always look in the corners of cells to see if there has been a build-up of dirt due to poor cleaning. Look at the lower part of the walls. Any food or drink stains should have been removed quickly before the stain solidifies and becomes difficult to remove. Are the benches clean or is there a build-up of dirt? Ask the custody staff if they have any concerns about the standards of cleanliness. If they have a concern, what has the SCO done to escalate the matter?

5. Children and Young People (CYPs). Are they in the cells for too long? The agreed intent is for them to be dealt with quickly and moved out of the cells quickly. Is this happening?

   CYPs are often brought to court in special vehicles. These children are accompanied on their journey by two escorts who have been specially trained. Are those children being treated as children when in the cells? Are they given any reading materials suitable for their age?

6. Sometimes Detained Persons need something that is stored in their property bag. LOs have noted that some have their medication in the property bag. There is a variation in the

response to these requests. In some courts the bag is opened in the sight of the Detained Person who then signs for what has been removed before the bag is then resealed. In other courts there is a refusal to open any property bag. Please note the practice if seen.

7. PERs from both police and prisons are often poorly completed. Sometimes the errors are obvious but more frequently they need careful scrutiny to discover their accuracy. Often the section on medications is ignored and occasionally this has been when a Detained Person has urgent need for medication during the day.

   Often the errors in the medical section can be implied. If, for example the markers indicate the Detained Person to be a heroin user but there is nothing in the medical section the Detained Person should be asked about his/her medication.

   Sometimes errors are through omissions. SCOs often know Detained Persons and will say if the PERs differ from one appearance to the next. Please note these.
   When a PER is found to be inaccurate please make a note, including reference to the Detained Person (not by name but by cell number and/or reference number). Also record the originating prison/police station.

8. It is common for Detained Persons sitting in cells to be unwell. This is particularly true for those withdrawing from drugs and/or alcohol. It is worthwhile asking the Detained Person about his/her access to medication. In the last month a number of reports have highlighted occasions when a Detained Person withdrawing from drugs had a superficial medical inspection whilst in police custody but no medication was prescribed because, at that time, the Detained Person was showing no outward manifestation of drug withdrawal. By the time the Detained Person had been in the custody suite for a short while the signs of drug withdrawal could be seen. Please ask the SCO what action has been taken about inaccurate PERs. Has the matter been escalated? Has the SCO contacted the medical helpline? (Many have no confidence in this helpline and do not use it). Actions to escalate issues or to contact medical help should be noted.

9. Legal visits. Whilst this is not part of any contract, it is useful for us to have some indication of the number of Detained Persons who have long waits to have a legal visit. Obviously, there are often good reasons, especially if the Detained Person has instructed his/her own legal representative and that person has not arrived at the court. In addition to noting the number of Detained Persons who have long waits, any additional information about the reasons for these delays is useful.

10. The treatment of CYPs is an increasing concern. Despite an acknowledgement that all CYPs should spend as little time in court as possible, our reports indicate that these youngsters are not being dealt with speedily. Where the young offender is brought to court by a dedicated CYP team (now a GEOAmey contract) please complete a form and make sure it is sent to Lyn-Marie Evans.

    The CYP teams are specially trained in dealing with children and young offenders. Too often when they arrive in the custody suite they spend their time just sitting in the staff area and are not allowed into the cells area to look after the young person they have brought to court. Too often these young offenders are treated no differently from adult offenders. If it is important to have dedicated and trained escorts, why is it acceptable to treat these

offenders as adults whilst they are in the cells? Any additional evidence will help our reporting.

11. When some significant defects in the condition or fabric of the custody suite have been noted some LOs have found it useful to speak to the court manager (or facilities manager in larger courts). This has been found useful in establishing links between the visiting LO and HMCTS and also to find out if the court manager receives copies of the visit reports. Where the reports have not been regularly received LOs have offered to email a copy to the manager.

12. Not all custody staff need to carry an anti-ligature knife at all times. The cells officer, however, should carry a knife.

13. Graffiti is being removed in a number of courts, particularly in London, but is rapidly being replaced. We should remember to record the existence of notices to Detained Persons confirming prosecution for making graffiti, whiteboards noting cell condition and any other good practices seeking to prevent graffiti.

Lay Observers

Independent monitors
of court custody & escort

Guidance for monitoring the health needs of detained persons

Lay Observer National Council
March 2018

Introduction

A key part of the Lay Observer role is to observe, monitor and question the way in which the health needs of detained persons are assessed and how their needs are met. Unmet health needs will not only affect an individual's welfare, but can also have a direct impact on whether they are able to participate in court proceedings and, therefore, have access to justice.

As well as observing objectively how needs are met, it is also important to report on this consistently so that the evidence collected can contribute to achieving improvements in this important aspect of the duty of care that detained persons are owed.

Assessing this aspect of care in custody suites is likely to be time consuming, but it is of great importance in ensuring that all detained persons are fit enough to be able to participate in legal proceedings to the best of their ability. Relevant information can be obtained from custody staff, PERs and the detained persons themselves.

It is important that Lay Observers highlight situations where extra support could improve a detained person's health in such a way as to maximise their ability to participate in the legal process. This is more nuanced than identifying a detained person who has medical/psychological problems at a level which means that they are completely unfit to appear in court. Getting this right relies on effective organisational systems and staff support and training. Lay Observers will need to use their communication skills with detained persons and staff in order to document their findings and judgments along with the evidence necessary to achieve change at a local or national level**.** We aim to provide some level of internal support for Lay Observers wishing to discuss such situations.

Lay Observers should report on whether or not an individual's health needs (as reported on a PER or by the detained person themself) are being met and/or addressed by the appropriate persons. In terms of what happens within PECS custody, any necessary actions will be coordinated by the CCM, but must be supported by direct instructions contained in a PER, or by a new assessment by a health professional such as a nurse or doctor, or a paramedic in emergency situations. CCMs and PECS staff should not be put in the position of making health assessments they are not qualified to make.

It is not the role of a Lay Observer to assess, or give advice about, the clinical management of the specific health problems of an individual detained person.

Information to be requested from CCM and COs (Cell Officers)

• Ask about the ease of access to a health professional who can provide an assessment of psychological and physical needs as they arise in the custody suite. These may be on or off-site, but they should be available for custody staff to contact, and they should respond in a timely manner, and be available to visit the detained person if necessary. Detained persons may need urgent assessment in the case of an emergency or if health problems are affecting their ability to engage in the judicial process. Useful information to note includes the times of the call to the health team and the time of the initial response, as well as the time that a final response was received from a health professional (if different).

• Ask about situations where such support has not been available or easy to access. How did staff handle these? What effect did the lack of access have on the detained person's wellbeing?

• Ask if there are any concerns about the health of any detained persons currently in the suite and how these are being managed. The relevant risk numbers on the whiteboard are 2 (suicide and self-harm) and 7 (medical/mental health). Do the COs have sufficient information on the detained person's PER to make a judgment?

• Ask if there are any PERs that do not include enough information (or have inaccurate information) about an individual's health (physical or mental) to enable COs to respond to their health needs.

• Ask if there are any detained persons who have travelled with medication. Does the PER contain full instructions about when and how this should be administered? Where is the medication and can it be accessed easily?

• If a detained person takes any prescribed medication, but will leave court to go to a new place (including home), ask what arrangements have been made for them to continue receiving their medication without a break.

Information from PERs

Read the PERs for each detained person in custody. Where a detained person has arrived from police custody, it is worth checking the police records that accompany the PER.

Note which police station or prison has supplied information and also note:

• Any discrepancies between police/prison and PECS information.

• Any information to suggest that the detained person has reported health needs (including anxiety, low mood, dependence on or withdrawal from alcohol/opiates/heroin/benzodiazepine/ 'sleepers'). If there is, are there clear instructions to guide the COs in meeting these needs? Is there a healthcare contact number recorded?

Check the Risk Indicator page:

• Any health risks, including self-harm or suicide risk, should be noted here and the information should include sufficient detail to enable the risk to be assessed and managed.

• There should be a phone number for health contacts recorded, particularly if any health problems are present (note a L1 if this is not included).

• If any abbreviations are used, check that the cell officers understand what they mean.

Escort Handover page:

• This is where there should be a record of any medication transported with the detained person. As a minimum, there should be a tick in the 'Yes'/'No' boxes.

• If medication has been transported, there should be a record of how (either with the Escort, or with the detained person themself).

• There is no requirement for names of individual medications to be entered here.

Information from detained persons

This is the only way to check any information from COs and PERs (checking vice versa is also important, to get all views of a situation). Checking will sometimes reveal health needs that are not recorded on the PER.

Detained persons may not be comfortable about discussing their health problems, especially if they are related to mental health or drug and alcohol dependence. Explaining your role, showing empathy, and listening to the detained person's story will often overcome this reluctance but, if the detained person does not want to share medical information, this should be respected.
Question 1 below provides a general enquiry that can start a conversation about more specific issues, detailed in the rest of the questions below.

1. Ask each detained person if they feel well enough, and as well as possible, to appear in court. Is there anything that could have been done, or still could be done, to help them feel as well as possible? Are they aware that they can request to see a health professional if they need to?

NB: If the detained person is not aware that they can make this request, check that they are aware of their general rights.

2. Ask each detained person if they have any problems with their physical or mental health (as a check against the information on PERs). Problems could include any intoxication or withdrawal due to alcohol or drugs. *Specific guidance to follow.*

3. Ask each detained person if they take medication on a regular basis: What medication? What time of day they take medication? Have they received all the doses that they usually would do up to the time of the interview (this may have been before transport)? Will any medication be due or needed before bedtime? Check with the CCM that there are arrangements in place for this.

NB: many medications are taken first thing in the morning or last thing at night and are, therefore, not likely to be transported or given by PECS.

4. Ask each detained person if they take medication that is taken 'when needed' rather than at specific times in the day. Examples of medication that may be needed during the day, but not taken at specific intervals, include painkillers and asthma inhalers. Asthma inhalers can be kept by the detained person whilst in custody if this has been authorised by a doctor or nurse.

5. If any detained person reports needing, but not having had, any medication, ask what effect this has had on them. What difference would it have made to have had access to the medication?

Any medication that is likely to be needed whilst in PECS custody and, taking into account any unexpected late release or prison transfer, should have been transported with the detained person. If this is not the case, ask:

- If the detained person believes that the medication has been sent.
- If the detained person feels that they need or will need the medication.
- What is the effect on the detained person of not having the medication?
- What difference would it have made to the detained person to have had the medication?

Please record these answers carefully, as far as possible in the detained person's own words, as they provide evidence for the effect on detained persons of the systems that are in place. It is not necessary to understand the details of any medication, but it is important to record the detained person's responses to these general questions, as an indicator of the consequences of medication not being available.

Please record any names of medication that you have from the PER or the detained person, and the condition that it is being taken for – the name or spelling may not be familiar to you, but can usually be worked out by others with medical knowledge.

If any detained person makes a complaint about his or her medical care during their time in custody, point out the complaints process and, before making a judgment, discuss the specifics with the SCO/CCM. Whilst neither account may be completely accurate this helps to triangulate accounts and helps to form a judgment about the significance of the complaint.

Monitoring the follow-up to any queries

Whenever you identify concerns about healthcare management (either inaccuracies in the PERs or issues identified during your conversations with staff and/or detained persons) it is important to also make an assessment of the way in which the CCM and staff are following up the issue. Are they sufficiently concerned about the wellbeing of the detained person? Have they followed up medical issues with the appropriate person? Have they contacted the medical helpline or Liaison & Diversion team where necessary? *(see Appendix 1 below for more information about the L&D service.)* Have they taken steps to escalate inaccurate PERs?

If any needs seem to be unmet, check with the CCM or CO what has been done and/or could be done to address them. Ask about any barriers to meeting health needs that have been identified during your visit, or situations where such barriers have caused problems in the past. The L&D team can also be consulted by Lay Observers *(contact details will be made available as soon as possible)*. Where possible, the detained person's solicitor should also be informed.

If the detained person has indicated medication has been sent by the police or prison, please check to see if there is any reference on the PER and, even if there is no mention of it on the PER, ask staff to check the detained person's property bag. This should not, however, include opening the property bag – an external observation of the contents will suffice.

If there appears to be medication missing (or if it was not administered prior to travel), follow up with the relevant police or prison custody, using the PCN number, which makes it possible to track the detained person and receive immediate feedback *(see Appendix 2 below for police guidance relating to medication).*

It is important to identify an outcome for any detained persons observed to be in distress during the day (e.g. drug withdrawal or absence of medication). What advice has the CCM sought? Has the solicitor/court been notified? Has an assessment by an L&D team been arranged? Where possible, the detained person's demeanour in court should also be observed and commented on.

It is also important to follow through on the outcomes for detained persons "at risk" due to inadequate information.

Recording an assessment

The information below is intended as a guide when deciding on assigning a level for any issues. The final decision about which level to assign will usually depend on a number of factors and is the judgment of the individual Lay Observer.

In the case of risk assessments, it is likely that errors undermine the confidence of staff in the accuracy of the information they receive from that originator and might imply that some more serious errors are missed.

It is often difficult to assign a level to a single error unless it is so significant that it obviously seriously affects the wellbeing of the DP. All such examples need to be carefully documented and an assessment made about the severity of the event. The most important consideration is the impact of any issue on the wellbeing of the detained person, other detained persons and their access to justice.

Level 1

• A small number of errors relating to healthcare that might have a minor impact on the wellbeing of one or more detained persons and on the ability of custody staff to make accurate risk assessments.

• Minor omissions in the recording of health needs.

• Minor difficulties in accessing health advice for COs or detained persons, which have little impact on the detained person's wellbeing and no impact on their access to the legal system.

• Medication that should be available but is not **and** its absence has not had any impact on the detained person's wellbeing.

• A Level 1 should always be reported if a healthcare contact number is not recorded on a PER.

Level 2

• A much more significant impact on the wellbeing of one or more detained persons in the court.

• The ability of custody staff to make accurate risks assessments is significantly undermined.

• A number of Level 1 errors combine to make a significant risk.

• A detained person has not received medication that could have improved their wellbeing.

Level 3

• This level should only be assigned when there is a very significant issue that needs urgent attention.

• A single healthcare issue has the potential for the detained person involved not to be able to access justice at all **and** has not been addressed.

• There is the potential for a serious health risk to the detained person, which has not been addressed.

Appendix 1

Liaison & Diversion Services

There are high numbers of people with mental health, learning disability, substance misuse and other psychosocial vulnerabilities who enter the youth and criminal justice systems, who could be managed more appropriately in the community, or diverted from the justice pathway altogether.

Liaison and Diversion (L&D) services aim to provide early intervention for vulnerable people as they come to the attention of the criminal justice system. L&D services provide a prompt response to concerns raised by the police, probation service, youth offending teams or court staff, and provide critical information to decision-makers in the justice system. L&D also acts as a point of referral and assistive follow up for these services users, to ensure they can access, and are supported to attend, treatment and rehabilitation appointments.

In this way, L&D services are expected to help reduce reoffending, reduce unnecessary use of police and court time, ensure that health matters are dealt with by healthcare professionals and reduce health inequalities for some of the most vulnerable in society.

The service is predicated on four phases: case identification, secondary screening/triage, assessment (including specialist assessment) and facilitating access to relevant services.

Case Identification

Normally individuals who may need additional support and help would be picked up early in the criminal justice process, prior to the police interview or following arrest and process at police stations, either by referral or routine 'cell sweep'. L&D services also have practitioners available for, and often based at, magistrates' courts (and increasingly Crown Courts), to allow for those whose vulnerability is identified (or changes) later in the youth and criminal justice process. There is currently no national expectation that L&D practitioners will attend court custody suites on a proactive basis, but in some areas a daily 'sweep' of court suites does take place.

Referrals to the service can be made by anyone having a professional interest in the detainee: Judges, Magistrates, court staff, defence solicitors, CPS, police, probation or court custody officers. Lay Observers can refer directly, but would normally only do this in collaboration with the CCM. Following a referral, the L&D practitioner will usually check a detainee's details against local health databases, look at the PER (in court custody), and discuss risk assessment with the custody officer before agreeing how and where an L&D intervention will take place.

Screening

Screening is performed for all referrals to assess suitability for on going L&D involvement. The outcome may be to progress to a full L&D assessment of vulnerabilities and needs, but could demonstrate the need for referral to an alternative service.

Assessment

The L&D assessment aims to clarify any needs identified during screening and may include facilitated specialist assessment (e.g. drug and alcohol, learning disability, mental ill health or housing).

The practitioner generates a report, even if the outcome is that no further action is needed. This report describes any vulnerabilities and current interventions or treatment plans that may be relevant to the court.

Custody staff will annotate the PER to note an L&D visit and/or assessment, as well as recording any outcomes, such as 'no further intervention required' or 'report will be required for court'.
If the L&D practitioner has concerns about the detainee's fitness to properly participate in court proceedings, they will bring this to the attention of court officials.

Facilitation of access to other services

The L&D service will facilitate timely referral to appropriate services. Where appropriate, and by agreement, the service will support the individual to attend their first appointment(s) and offer them on-going support until they engage with services.

Appendix 2

Police guidance relating to healthcare and supply of medication

The healthcare providers working within police custody follow the (edited) guidance below.

Continuity of care

The provider must ensure that there are policies and procedures that support the continuity of medicines already prescribed for the detainee prior to, or on admission, and continuity of medicines needed post-release or transfer, including stays in court cells. These policies and procedures should minimise the risk of harm from delayed and omitted doses as defined by the NPSA patient safety alert (and any future safety publications). The provider's policies and procedures should include a list of critical medicines where accessing continued doses is mandated.

Fitness for detention (including continued detention)

The assessment must include consideration of:

a) a referral to hospital or other outside agencies where it is not possible to treat the service user whilst in police custody; and

b) fitness to travel or transfer whether that be to prison or any court.

The HCP (health care professional) must ensure that they discuss and are aware of details of planned police actions (e.g. interview, charge, transport to court etc.) and, if known, the likely length of a stay in custody.

Release/transfer arrangements

When a detainee is released or transferred to hospital or another custodial environment (e.g. prison), the provider, in partnership with the police custody team, should ensure that the detainee has sufficient medicines and dressings, in dispensed packs, to ensure continuity of care and detainee safety, until the detainee can reasonably be expected to see another healthcare professional

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