Lay Observers

Independent monitors
of court custody & escort

Annual Report 2019 - 2020

npm
national
preventive
mechanism

Annual Report of Chair of Lay Observers

Monitoring Respect, Decency and Welfare

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1 INTRODUCTION

Lay Observers play a crucial role by monitoring the treatment and conditions of detention of people held in court custody and those in vehicles while being brought to and from the court.[1]

1.1 Lay Observers (LOs) are appointed by the Secretary of State for Justice under the Criminal Justice Act 1991 (CJA 1991) to inspect *the conditions in which prisoners are transported or held in pursuance of the arrangements and to make recommendations to the Secretary of State.*[2] They are independent, unremunerated, public appointees with statutory powers to go anywhere within the custody suite, talk with detainees and inspect documents.

1.2 LOs monitor the Prisoner Escort and Custody Services (PECS) run by Her Majesty's Prison and Probation Service (HMPPS) and court custody facilities run by Her Majesty's Courts and Tribunal Service (HMCTS).

1.3 PECS has overall responsibility for overseeing the transportation and holding of Detained Persons (DPs) with the two contractors GEOAmey and Serco providing the transport vehicles and the court custody officers. HMCTS manages and maintains the fabric and furniture of the court custody suites.

1.4 LOs are a national organisation arranged into regional groups. The members of each region visit local courts, vehicle bases and prisons to monitor the conditions in which detained persons/prisoners are transported or held. Following each visit a detailed report is submitted indicating the level of concern for each of the expected standards as set out in Appendix B - Current Standard Expectations on pages 32-33. Reports comment on how far detainees are treated with **respect** and **decency** and how successfully their **welfare** is managed.

1.5 Over the past year LOs have prepared 1641 visit reports, monitoring approximately 2.5% of the detainees in escort and court custody. Each month these reports are aggregated into a summary visit report to illustrate the national picture and the direction of key trends. It is circulated monthly to stakeholders and those with an operational or policy role in the criminal justice pathway: HMPPS, PECS, HMCTS central operations, HMCTS Property, Her Majesty's Inspectorate of Prisons (HMIP) and Ministry of Justice sponsor teams.

1.6 LOs are members of the National Preventive Mechanism (NPM) which is the United Kingdom structure for complying with its commitment to the United Nations Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). This guarantees that LOs can function independently and impartially of government, government agencies, the ministry, all agencies and their staff providing contracted services, custody suite managers and contract delivery managers.

1.7 The year 2019 - 2020 has seen a number of developments in the monitoring and reporting role of LOs, which are set out on pages 28–29.

1.8 The response to the outbreak of Covid–19 impacted adversely on LO activities. It was agreed, with the Minister's support, to cease physical visits to custody suites and vehicle bases on 20th March 2020. However, mindful of the statutory duty a programme of distance monitoring was introduced on 27th March 2020.

1.9 The report summarises the main issues of concern observed during the visits throughout the year. It recognises developments initiated to improve the quality of the detainees' experiences. Future reports will provide a standard against which further developments can be judged. It is proposed to introduce quarterly summaries of the regular reports to highlight the current issues.

John Thornhill, National Chair, Lay Observers – June 2020

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1 United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Report on visit to United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019, Para 93.

2 Section 81 (1) (b) of the Criminal Justice Act 1991.

2 EXECUTIVE SUMMARY

KEY FINDINGS FOR THE SECRETARY OF STATE

2.1 The emphasis of the LOs' visits changed direction during the year from monitoring compliance to focusing on how detainees are treated with **respect** and **decency** and their **welfare** properly managed.

2.2 Reports are overall positive about the care offered by escort and custody officers whilst detainees are in their charge. This report recognises that many of the concerns are out of the individual control of such officers and the contracted-out stakeholders.

2.3 The summary table below provides a pleasing picture of improvement in many areas, but still highlights serious concerns. It records the summary statistical data for each of the sections for each quarter of the year, with the total for the year in the Total column with last year's figures in the column 18-19. The figures remain fairly consistent across the quarters. LOs conducted 1641 visits, a 5% reduction on last year due to the impact of the Covid-19 outbreak reducing March visits significantly.

2.4 There was a considerable increase in males, females and vulnerable detainees observed from the last reporting period, though the number of children and young persons (CYPs) reduced. A very high percentage of those observed were interviewed – 69% of male adults, 79% of female adults, 75% of male CYPs and all female CYPs.

2.5 Vehicle inspections reduced in numbers from 2018-19 but the percentage of notices indicating deficiencies in transport increased slightly compared with the previous year.

2.6 The number of cells out of use also reduced but the number of detainees sharing cells increased slightly with still too many having to share cells and not having privacy at a time when they may already be stressed by a court appearance.

2.7 The significant decrease in the number of detainees needing medication who did not receive it may indicate that the new medication procedures introduced by PECS have impacted positively.

2.8 The number of inaccuracies and omissions in Person Escort Records (PERs) remains unsatisfactorily high – a significant increase of 27% over the previous year to 5021.

Section	Q1	Q2	Q3	Q4	Total	18-19
All Visits	457	452	388	344	**1641**	**1722**
Adult Males Seen	2193	2203	2216	2084	**8696**	**7855**
Adult Males Interviewed	1509	1605	1482	1341	**5937**	**5434**
Adult Females Seen	208	245	203	173	**829**	**456**
Adult Females Interviewed	170	188	168	125	**651**	**355**
CYP Males Seen	116	96	109	101	**422**	**798**
CYP Males Interviewed	82	71	89	73	**315**	**606**
CYP Females Seen	6	3	6	4	**19**	**28**
CYP Females Interviewed	6	3	6	4	**19**	**25**
Level 1	1155	1086	978	812	**4031**	**4381**
Level 2	226	211	221	206	**864**	**973**
Level 3	26	24	17	14	**81**	**133**
Vehicles Inspected	182	263	112	98	**655**	**676**
VINs Issued	28	17	11	7	**63**	**69**
Cells Out of Use	171	181	142	121	**615**	**827**
Prisoners Sharing Cells	200	225	291	272	**988**	**982**
No of DPs presented in error	17	24	22	17	**80**	
Vulnerable DPs Seen	544	569	587	444	**2144**	**505**
DPs Needing Medication	142	116	123	86	**467**	**1453**
DPs Without Medication	54	44	41	16	**155**	**248**
Number of PERS with inaccuracies	1256	1257	1329	1179	**5021**	**3994**

3 THE MAIN ISSUES

3.1 The evidence from reports indicates that the main area for concern is the **welfare** of detainees. The Person Escort Record (PER) is the central vehicle for communication between the various agencies tasked with their care. The data shows that there is no substantial improvement in this aspect of management of the welfare of detainees. Over the year, findings show that 61% of the PERs examined were unsatisfactory, which is a significant increase on the previous year.

3.2 The poor quality of many PERs with omissions and inaccuracies hampers the escort and custody officers in the making of precise risk assessments for the security and welfare for each detainee and may adversely affect the administration of the healthcare needs of those in their care during transportation and in court custody. The processes which are required to ensure that health needs, including medication, of detainees are appropriately addressed are not therefore fully delivered. The failure to include vital health information, particularly in relation to medication, places detainees at serious risk of harm, may impact on mental health and result in short or long-term illness. It means detainees will certainly not be in the best possible health for their court appearance.

3.3 Whilst the report acknowledges the overall commitment of escort and custody officers, it emphasises concerns that some detainees are not always treated with the **respect** and **decency** to which they are entitled. There is a lack of consistency of delivery across the estate and extracts from reports suggest examples of good practice are not replicated elsewhere. The risk still continues of serious consequences to the **welfare** of detainees and their access to justice resulting from them '*falling through the net*' of disconnected contracts and responsibilities across all agencies engaged in their care including police, prisons, other agencies, escort and court custody services.

3.4 The lack of **respect** is evidenced in the high number of Level 2 and 3 (serious or unacceptable issues/incidents) grades given by LOs for the two main standards: cleanliness and graffiti. The conditions in a number of custody suites with a large footfall of detainees continue to fall below expected standards.

3.5 Too many detainees still experience more than a two-hour delay after sentencing before being transported back to their establishments. Often timescales for detainees who are moved to prisons a long distance from the sentencing court are being unacceptably extended and so they often miss their evening meal. A number of detainees from prisons are released by the courts but still retained in custody suites awaiting a release note from the prison.

3.6 Some reports state that support services such as Liaison and Diversion (L&D) and probation are not usually available either at police stations or courts for the often large number of detainees brought by police to court on a Saturday or Bank Holiday morning.

3.7 The concerns raised in the 2018 – 2019 report about the escort and court custody arrangements for and treatment of CYPs facing court, despite improvements, still remain.

REPORT STRUCTURE

3.8 This report provides the summary judgements over the reporting year with the tables indicating the number of scores at each level for each of the expected standards in a section. LOs report such concerns using the following scoring scale:

Level 0 - no concerns;
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.

3.9 The final column indicates the total number of scores at Levels 1, 2, 3, as a percentage of all reports submitted. So, for the assessment of PERs, 61% of all reports gave a level of 1, 2 or 3 and therefore indicated concerns, with only 39% attracting a level score of 0, indicating no concerns. The case studies shown in the boxes highlighted in pink for adverse and green for positive are direct extracts from Lay Observer reports. A small number have been slightly adapted, for example to remove information which might identify a detainee.

4 WELFARE

The custody suite is managed and run in a manner that ensures the wellbeing of DPs	0	1	2	3	Percent
Assessment of PERs	598	747	184	9	61
The recording of events in the custody suite are maintained accurately and promptly	1608	29	4	0	2
Where there is inaccuracy in the PER that impair risk assessments staff refer the matter back to the originator for clarification.	1572	56	13	0	4
Where DPs are sharing a cell	1640	1	0	0	0
DP property is kept safely and the tagging of property is accurate	1635	5	1	0	0
Handcuffing of DPs is based on risk assessments	1558	81	2	0	5
Staff work effectively as a team to ensure the safety of all in the custody suite	1629	9	3	0	1
Defects are raised formally with the HMCTS team in the court	1609	17	13	2	2
One of the HMCTS team visits the custody suite at least monthly and makes an inspection of the whole custody suite	1593	42	5	1	3

DPs have access to the medicines they need during their time in the court and are satisfied with their medical care	0	1	2	3	Percent
Medical information on the PER enables staff to make an accurate assessment of each DP's health care needs	1120	454	67	0	32
The arrangements for assessment & support of DPs with mental health concerns or learning disabilities is satisfactory	1556	69	15	1	5
The physical, mental and psychological needs of DPs are adequately met	1527	95	17	2	7
Medication is stored securely	1627	14	0	0	1
DPs have access to any medication that they should have during their time in court custody	1550	80	11	0	6

PERSON ESCORT RECORDS (PERS)

4.1 The purpose of the PER document is to ensure that all staff transporting and receiving detainees are provided with all necessary information about them, including any risks or vulnerabilities that the detainee may present. It is very clear from these figures that inaccuracies in PERs still remain a serious problem. This vital element of risk management was introduced in May 2009 following the Zahid Mubarek Inquiry.[3]

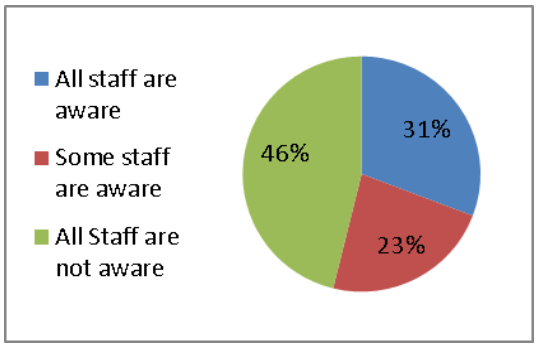
4.2 Despite recommendations in a report by Her Majesty's Inspector of Prisons in 2012 to *the Independent Advisory Panel of the Ministerial Board on Deaths in Custody*, it is apparent that the failings identified are still live. The omission of relevant detailed information places detainees at risk of harm as well as the staff or others who come into contact with them. Consistent themes running through the PERs include failing to provide appropriate information about medical issues and medication and the lack of contact numbers for healthcare staff, preventing custody and other staff from seeking expert advice when necessary. Also, many reports identify that the section on whether the detainee has to take medication is left blank on the PER and places staff in a difficulty about how it might effectively be administered in the custody suite. Access to that medication is often difficult as it is in the property bag accompanying the detainee, which some officers, for valid reasons, are reluctant to open.

4.3 In June 2019 PECs re-issued the document *Guidance on Medications in Transit* produced by Denise Farmer, the Pharmaceutical Adviser (NHS England & NHS Improvement). This followed correspondence from a medically-qualified member of the LOs and PECS responded positively to our reports. LOs conducted a focused survey in a small number of courts on the implementation of these changes in December 2019. The results support the contention in 2.2 above that the issue is outside the control of escort and custody staff. Whilst in over 50% of custody suites, all officers were aware of the guidance, the second chart clearly indicates that 79% of responses state there is no knowledge about how holding establishments implement the policy. Forty-four percent of custody suites indicate that the policy is difficult to implement and in 50% of cases it indicates that three or more detainees have not had their medication. The inference could be drawn that a PECS policy designed to ensure greater care of the medical health of detainees cannot be managed effectively by custody officers because the originating agency has not accurately completed the medical section of the PER.

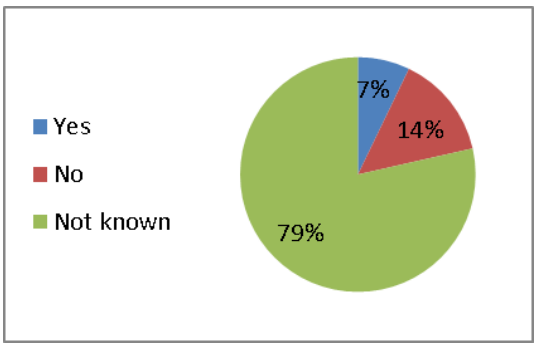
3 The Inquiry into the racist murder of Zahid Mubarek at HMYOI Feltham in March 2000.

Response numbers to each question are in brackets

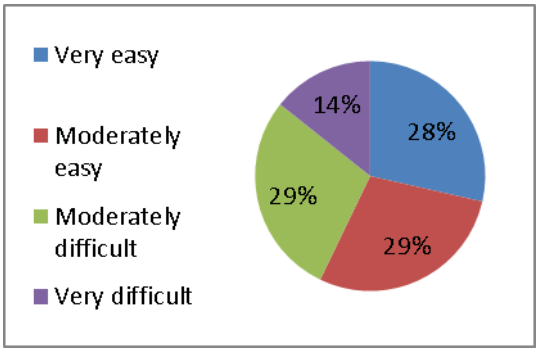
Are CCMs and custody staff aware of the new Guidance issued by NHS England? (15)



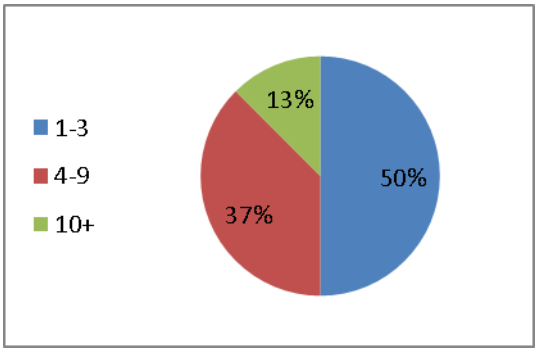
Are the guidelines being implemented by the holding establishment? (14)



How easy are they to implement? (10)



Of the DPs you have spoken how may have not had their medication as per the guidelines? (6)



4.4 The individual extracts below give a range of observations which clearly indicate a **lack of respect and decency** at times for detainees and failure in the proper management of their **welfare** (health, safety and security).

Liverpool Combined Court

The major issues on this occasion come from the **unclear recording of medication** on the PER as in the case of two detainees from HMP Liverpool one of whom is an **insulin dependent diabetic**. In both cases the medication section was circled as 'yes' but in neither case was the medication **bagged up or marked up** separately, but left in property bags.

More seriously, from Wavertree Custody Suite, the PER **did not indicate that a detainee was asthmatic**. The medication section was **left blank**. It was left to custody staff to rectify the situation.

4.5 A number of reports indicate that this section is often left blank as reported in the second paragraph above. Fortunately for the detainee the escort officer was alert to the situation and wrote on the front page of the PER 'blue inhaler in property.' Custody officers were then able to find it and gave it to the DP and then stapled the empty bag to the inside of the PER.

Chester Crown Court

A detainee had medication bagged with their property and had annotated on his PER that his Co-Codamol was required three times a day. Officers were reluctant to do this without clear **instructions on the PER**. After investigation with HMP Altcourse and a discussion with the detainee it was made clear that this medication would not be required until the he returned to Altcourse.

4.6 The above extract indicates that just completing the 'yes/no' tick box is **not enough** and the omission of **clear instructions about the nature, management and timing of medication** places the detainee at risk of serious consequences including possibly death.

4.7 There should not be any ambiguities in relation to medication and its administration as evidenced here and custody officers should not be put in such a position. This issue and its importance were highlighted in last year's annual report and although some improvement has been seen, it remains a problem. Frustratingly, it is an issue that can be easily rectified by simply ensuring the check box is ticked and contains information about the nature and location of the medication and any required administration.

4.8 The extract below further shows the difficulties that custody officers face when the originating agency does not adequately complete the PER. In this case the detainee came from a police station and reports indicate that this is a common occurrence. He had been arrested off the street and taken to the court and was expecting to be remanded into custody. Although the PER did mention that he suffered from depression and anxiety, it would appear that the police did not question whether he took medication. Information about the medication should have been included in the PER. The consequence of this failure meant that the detainee had to wait until he was at a prison to obtain any medication with a possible subsequent impact on his mental health and **welfare.**

> ***Barnstaple Magistrates' Court***
>
> PER showed only risk as **'Heroin user'** and **'Due prescription for medication'** - no details of the medication listed. Mental Health noted **'Depression/ Anxiety'.** Discussed his medication and **he stated that he took** it for Depression and that he was due to collect a prescription for this today but could not now do so. (**No detail of this medication was included in the PER**). He was advised at court to inform the prison medical staff if returned to prison, in order that appropriate medication could be prescribed.

4.9 There was a complete failure of the police initiator to provide detail in the PER of health requirements with regard to the prescribed medication needed. This is not an isolated occurrence as the extract below from Taunton shows. It is clear that in this case the detainee's mental health had not been assessed which it should have been before being moved from the police station**.**

> ***Taunton Magistrates' Court***
>
> The limited Health/ Mental Health information noted on the PER for a DP **did not assist the Custody Staff** in managing a DP **with serious communication challenges**. Though he was **treated with care and sensitivity while in Court custody**, there was potentially significant frustration in his attempts to engage with or relate to the criminal justice system cells and his fitness to appear in Court.

4.10 The custody officers, whilst treating him with consideration, were prevented for responding in an appropriate manner to his mental condition. It is clear that he needed support to ensure proper communication with the staff and the court but this was not available. This detainee's human right to access the justice system fairly and in his best interests was impeded. He was not accorded the **respect** to which he was entitled. Following the 2009 Bradley Report[4] Liaison and Diversion (L&D) teams were introduced to assess and monitor the mental health of those involved with the Criminal Justice System. Sadly these extracts suggest this did not happen for these two detainees – a failure to manage properly their **welfare** and mental health.

4.11 The next extract raises issues about how **decently** this female detainee was treated. She should have been properly supported during the day and not have had to wait for medication until she arrived at a prison after a long journey and therefore probably late at night.

> ***Birmingham Magistrates' Court***
>
> I spoke to a female arrested yesterday at Perry Barr. She appeared **to be suffering from drug withdrawal**. She refused to see a solicitor and was anxious to get through the court hearing and travel to prison. She had been sick and soiled herself. She **could not receive her medication while in the court cells and faced a long journey** before she arrived at prison reception. *Cases like these are common these days* ….

[4] The Bradley report : Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. 2009

4.12 The fact that she was unable to *receive her medication while in the court cells* may have impacted on her mental health such that she wasn't in a fit state to be heard in court. She was anxious to get to a prison as soon as possible to obtain some relief via medication. There is a risk that she would therefore say anything to achieve that and so not do herself justice in court. If **any** detainee needs medication, then it should not only be present in the custody suite but also be properly administered. The comment '*Cases like these are common these days'* suggests that such examples of medication management are not uncommon.

4.13 A vital document to assist staff with managing the welfare of detainees is the very important **Assessment, Care in Custody and Teamwork** (**ACCT**) form. This is a HMPPS care planning process for prisoners identified as being **at risk of suicide or self-harm** with required processes and actions to ensure that such risks are reduced. One requirement of an open ACCT is that custody officers should conduct more frequent observations of such detainees. In both the examples below the detainees were on an open ACCT, but because it was not included with the PER the custody officers could not maintain this necessary close watch. Another impact is that responses to unacceptable behaviour will be tempered by the ACCT and again custody officers were not able to respond in an understanding manner.

Westminster Magistrates' Court

When I last saw this female who is on an open ACCT she **was very unstable**. Today she was well dressed and cheerful when she arrived at court and laughing. Within minutes, however, **her mood had changed**. …. She demanded to go to court, telling staff she intended to throw her hardback book at the jury. Staff told me that on her previous appearance, having been brought from HMP Bronzefield, **she had been sent with her diazepam**. Officers were concerned because **the woman was adamant she needed to take her medication at noon**: it had **not been sent** out from the prison. At 11:20 two staff opened the cell door in response to her calls. The woman immediately **ran from the cell** in a **threatening manner**.

4.14 In the case of this female the PER was better completed than many others with clear and dated risk markers. However, she was on an open ACCT which was not included and the failure to note her need for prescribed medication (diazepam) had an adverse impact on her behaviour and conduct with subsequent issues for the custody staff. In another case at Southwark Crown Court the open ACCT for a male detainee did not accompany him to court. The court manager advised the prison which acknowledged the failure to include the ACCT as an error on their part. It would seem that quality assurance or checking procedures are either not in place or properly implemented.

4.15 In many cases the detainees from other areas in the country have been arrested on a European Arrest Warrant (EAW) and brought to Westminster Magistrates' Court. Whilst we appreciate that it is difficult to obtain information in such cases, it is nevertheless essential that such is gathered and included in the PER. The extract below outlines the difficulties and how the lack of important information puts other detainees, escort and custody officers in serious danger, as they are unable to undertake adequate risk assessments for transporting and holding detainees.

Westminster Magistrates' Court

Of particular concern were the **PERs from police stations outside London**. It is likely that those individuals arrested on European Arrest Warrants were previously not known to the local police but there **does not appear to have been any concerted effort to identify risks**. The DP from Hull police station was arrested for dangerous driving and had already appeared in the local court before being transferred to this court. Although staff here read the PERs and tried to assimilate information they **did not have confidence in the accuracy of the information** and therefore cannot use the information as the basis for risk assessments.

4.16 It is, however, pleasing to note that the February 2020 report for Westminster states there *appeared to have been an improvement in the standard of PERs.* That report, however, states that the PERs from HMP Wandsworth continue to be of concern with the worst having virtually no information or any identification other than the detainees' names. It is right to say that such concerns are not limited only to HMP Wandsworth as reports on PERs from other London prisons comment that similar issues are noted indicating a continuing tendency to ignore guidelines and recommendations.

4.17 The issue of assaults and how they are recorded is another area for concern. There are two examples of assaults within a few days of each other at the same court. The extract below relates how a detainee assaulted a custody staff member. In this incident the custody manager was very thorough in communicating important information to the receiving prison. They fully completed the PER together with HMMPS Disciplinary 1 Form (DIS1) and the Serious Incident Report (SIR). They also emailed these to a named officer at the prison. It is therefore particularly unacceptable that when the detainee returned to the same court three days later the prison had not updated the PER nor warned the custody officers of the previous assault. It was fortunate that the custody manager on duty on 6th January recognised the detainee and was able to alert his staff to the situation.

Westminster Magistrates' Court

A DP arrived at Westminster MC from HMP Wandsworth on Friday 3rd January 2020. At 10:45 **he assaulted a CO** in the custody suite. The police were contacted and attended.

The **PER was updated accordingly**. The DP was returned to HMP Wandsworth. The DIS 1 and the Serious Incident Report (SIR) were completed and supplied in hard copy form with the PER back to the prison. The court also emailed a named officer in HMP Wandsworth prison reception with the same information.

When the DP returned to Westminster on 6th January 2020 from HMP Wandsworth the 'Risk' section of his PER advised '**No alerts, no SIS Intel'** and there was **no mention of the assault**.

4.18 However this is not always the case. A further report records a similar incident of assault occuring at a Saturday morning court. Although the PER was completed correctly and returned to the prison, the acting custody manager did not complete the relevant DIS 1 and SIR forms nor inform the prison of a serious risk. When the detainee returned to the court four days later again the 'Risks' section of the PER advised only '***No Mercury Intel available'*** and ***no mention of the assault***.

4.19 In both these cases the prison clearly had **not responded** in any way to information provided by the court thus placing subsequent escort and custody officers at a serious disadvantage in managing risk. This lack of consideration for fellow custody officers could have resulted in a serious incident at the court on both occasions.

4.20 Other extracts from LO reports highlight the real concerns about this aspect of the management of the **welfare** of detainees. A new PER known as the 'Winchester' PER was rolled out during the latter part of the year with amended sections and very extensive accompanying guidance notes. Despite these, LO reports still highlighted the lack of accuracy and incompleteness. The phrase from a report on Isleworth Crown Court which records '*it does not appear that staff completing them had sufficiently understood the purpose and importance of this document'* pinpoints the underlying cause for concern. There is still a need for more effective training on the role and purpose of PERs.

4.21 The inadequate quality of some PERs is not restricted to the very large courts in London as this extract from a report at a regional court confirms. It indicates the poor quality of many PERs with inaccurate, incomplete and valueless information.

Chester Magistrates' Court

DP recorded *under suicide/self-harm/current thoughts* then written in brackets '*none - all historic*'. No **offence or record of previous custodial history was listed** on the PER. It was recorded that **an interpreter was needed but no details of this had been arranged**.

4.22 In relation to the treatment of CYPs there is also a mixed picture with some establishments being very diligent in the completion of PERs.

Cheltenham Magistrates' Court

COMMENT: **Compass House continue to produce a high standard** of PERs which help custody staff to prioritise the needs of DPs on arrival. The **completion of property section in detail** helps to remove the need to chase down DPs property if released or transferred to other detention.

4.23 However, this care for CYPs is not replicated across all establishments.

> One CYP from a secure children's' home **did not arrive in court until 11:50am**. The PER presented to court staff had been **quickly completed by the escorts**. However **a very detailed risk would have been provided by GEOAmey YJB** unit before the CYP was collected and **this they readily shared with custody staff** and gave the CCM a very detailed picture of the risks associated with this young man. The risk indicated the CYP was **extremely vulnerable with possible suicide risk**. It highlighted the psychotic episodes this youngster had been experiencing and other risks.

4.24 The LO reported that *there was little written on the PER and experience has shown that no PERs are generated at this establishment*. It is appreciated that it is not currently a requirement for Secure Children's Homes (SCH) & Secure Training Centres (STC) to complete PERs. This is a serious flaw in the system which results in CYPs from SCHs and STCs not always having important details recorded in a written PER about their needs - *social, educational, vocational, psychological, medical and physical.* The lack of proper written information could have had a serious adverse impact had it not been for the diligence of the GEOAmey YJB unit staff. These details will be recorded with the YJB staff but they are not always communicated effectively to the court custody manager. It was vital that court staff were aware that this CYP was **extremely vulnerable with possible suicide risk.**

> ***Wood Green Crown Court***
>
> A CYP had appeared at Highbury Corner MC earlier today on another matter. On leaving Highbury Corner **he was arrested by the police and brought to Wood Green CC**. There was **no PER accompanying the CYP**. **A PER was completed by the staff at Wood Green from information given to them by the CYP**. A completed 'Young Person Cell Location and Cell Sharing Risk Assessment' form and was enclosed in his PER.

4.25 In this case the custody officers were diligent in obtaining information from the CYP himself who may not have given the full picture of his needs. Yet again there was failure on the part of the police to properly assess the CYP and it was left to the receiving centre to do this. The failure to provide relevant detailed evidence places staff in custody suites who come into contact with the CYP at risk of harm as well as the CYP themselves.

4.26 Despite the issues with PERs, LO reports recognise that many custody managers and officers make every effort to improve the experience of DPs in difficult circumstances, treating them with care and showing commitment to delivering a decent and respectful service. However, this is not consistent across all suites and it does seem that examples of good practice are not disseminated across the estate.

> ***Leicester Magistrates' Court***
>
> There was **no mental health cover for this court today** despite two DPs requesting it and the officer in charge chasing it up. Custody **contacted L&D** to be informed there was no mental health provision to visit them at the court today. **This put the staff in a very difficult position and despite some very supportive interaction** neither DP was satisfied. One DP was going to HMP Lincoln but was worried that he would arrive there **after the mental health team had gone home**. Another was also sentenced and **was waiting for probation**; he had been waiting for two hours.

4.27 This extract indicates how sympathetic custody officers can be in difficult circumstances. Although they made every effort to care for the health and welfare of the detainees the failure of the support services to engage positively in a timely manner is not acceptable. This is an infringement of their human rights.

4.28 During the period covered by this report the use of handcuffing was strictly in accordance with the contractor's Standard Operational Procedures which provide allowance for risk assessments. However such risk assessments are **not** focused on the individual detainee. This contrasts with the way in which a male detainee was brought from a secure mental hospital who, despite his condition, was not handcuffed during his time in the custody suite in order to ensure humane treatment. It is appreciated that the concerns raised by LOs and HMIP have been heard and in the new HMPPS's Generation 4 escort and custody contract handcuffing will be based on risk assessments.

5 DECENCY

CLEANLINESS AND GRAFFITI

5.1 One of the main LO expectations is that the detainees should be treated with **respect** and **decency**. However, far too often reports indicate that the quality of the custody suite does not show **respect** nor provide a **decent** environment for both the detainees and the staff.

5.2 The figures for graffiti over the year show an increase on the previous year with 44% of all custody cells having unacceptable levels of graffiti. A number of reports indicate that the graffiti is 'ingrained.'

5.3 The assessment overall for the year indicates a 1% increase in poor levels of cleanliness with 17% of custody suites not of a satisfactory standard.

DPs are held in a custody suite that is clean, safe and in a good state of repair	0	1	2	3	Percent
Graffiti assessment	867	557	101	12	44
Cleanliness assessment	1280	207	57	6	17
Kitchen has functioning equipment for hot and/or cold food	1458	54	7	0	4
There are hygienic facilities for all DPs to use a toilet and wash & dry their hands	1312	152	54	1	14
Female sanitary provision is available, and routinely offered both on arrival and on request	1584	42	15	0	3
Cell temperatures adequate (neither too hot nor too cold)	1386	97	25	4	8
There are no potential ligature points in areas used by DPs	1537	86	15	3	6
The custody suite and areas used by staff & DPs are in good condition and fit for use	1188	254	166	33	28

5.4 The figures in the table above are based on a few larger courts, particularly Thames Magistrates' Court, which LOs consider one of the worst custody suites for graffiti and cleanliness. The comments in one report included '*very many of the cells contained **extensive splatters of food and liquids up the walls**. I was informed that the cells are cleaned daily, but officers (most from other courts**) did not know when the last deep clean was**. All cells need a full clean.*'

5.5 This would suggest that although last year's report highlighted this as a serious issue, no significant improvement has been achieved and the condition in a number of suites continues to demonstrate a lack of **respect** for detainees.

5.6 A major concern is the nature of graffiti and although some reports commend the efforts of custody staff to eradicate such, reports indicate that it is a continuing issue as exampled by the comments from Taunton Magistrates' Court which state that *both male and female cells have historic graffiti on bench tops this being particularly marked in the communal female cell*.

5.7 Much of it is obscene in content; some is racially abusive whilst some, as evidenced in the extracts below, provides information focusing on individual detainees and gang activities. Such information places those detainees at risk especially if the individual is a drug dealer or been convicted of a sexual offence.

Thames Magistrates' Court

In a male cell the **word 'nigga'** was observed in faded pen suggesting that either it had been there quite a long time or that there had been a previous failed attempt to remove it. In this cell there was also a clearly coded message a few lines long.

Isleworth Crown Court

Although mainly in pencil this included the name and address of a person and a 'fact' he **had been found guilty of rape**. There were also **gang related messages** in these cells as well as graffiti in languages other than English. In one cell there **is the name and address of an individual claimed to be a drug dealer**. There are numerous names of people in other cells linked to abusive or racist comments.

5.8 Such graffiti should be identified as a matter of urgency and all dangerous, offensive and racist graffiti removed immediately. Although most is in pencil the quantity is far too great to expect custody officers to manage. Once it has been removed there should be a protocol in place to support a zero-tolerance regime towards new graffiti.

5.9 Many reports refer to the levels of cleanliness and as a major area for concern. The following extract highlights critical issues about the standard of maintenance and cleaning at one of the busiest courts in the country.

Birmingham Magistrates' Court

The toilets **were very dirty**; particularly the female toilet. The staff informed me that **ventilation in the toilet area was sub optimal**. On closer inspection I noticed that the air extractors in the **ceiling were filthy**. There was **flooding in the kitchen.** This presented a **slip hazard** for staff and an **unhygienic area to be preparing food**. **Water damage was evident in corridors**, the walls are damp and the plaster is flaking off leaving bare concrete in places. There was water damage in Interview 1 and 2, and the floors were dirty. **The cleaners do not clean above eye level**; a deep clean ceiling high needs expediting. The refrigerator needs defrosting.

5.10 The above report was written in May 2019 and subsequent reports provide an insight into the quality of maintenance of this big court. The June report adds to these comments although the July report indicates that some action had been taken – '*A programme of cell patching has started. This programme should be monitored and the condition of the cells should be checked.'*

5.11 However, in July it was reported that the '*custody suite is showing evidence of mice infestation <u>again</u>. They are evident in the office and behind the CCTV and computers where there are substantial cables.*' The report of the 30th September, two months later, confirmed that **no action** had been taken on the matter.

5.12 The October report suggests that the programme to upgrade cells started some months earlier had only resulted in **one** cell being painted, which was out of order on the day of the visit due to a faulty camera. A screen in the corridor to ensure CYPs are kept separate from adult detainees had been reported as faulty but still not repaired.

5.13 The November report refers that one of the LOs' standards is that '*One of the HMCTS team visits the custody suite at least monthly and makes an inspection of the whole custody suite*', commenting that - this is Level 2 because HMCTS visits occur when a problem arises and not on a regular (monthly) basis.

5.14 The December report is positive when it states – '*Pleased to see that regular meetings (every 6 weeks) had been set up with HMCTS to review the state of the Custody Suite, list deficiencies and agree on action to rectify them*.' It is clear that such meetings did have an impact as the extract from the February 2020 report states. However, it is disappointing that it took **so long** for these developments to be achieved and shows a lack of consideration for the detainees and also the staff who have to work in such conditions.

Birmingham Magistrates' Court

There was a **noticeable improvement in the physical condition** of the custody suite and there is now little graffiti in the majority of cells. Some cells still require painting as there is bare plaster in them. **Kitchen was dry and in good order. Toilets clean**.

5.15 Oxford Magistrates court is another busy courthouse on which LOs have made regular adverse comments. This report below raises serious concerns about the overall management of Oxford Magistrates' Court. Although outside the timescale of this report it should be noted that at least three distance monitoring reports recently made similar comments about this court custody suite.

Oxford Magistrates' Court

The **general cleanliness and graffiti concerns reported last month have remained unchanged.**

5.16 These photographs are from a custody suite that is not currently in operation, but give an indication of the state of cleanliness in some courts. It is fair to say that very many custody suites are maintained at a respectful level.

5.17 It is acknowledged that after the end of the reporting year we were made aware that the cleaning contract had been renewed with different companies. It is hoped that this will see a major improvement.

5.18 A number of reports indicate there is insufficient management of heating and air conditioning. Maintaining an appropriate temperature in cells appears a problem at many courts and it is reported that even when boilers are working there is often a cold draught from ceiling vents. It is not satisfactory to say that *'the date will be determined by the availability of funds.'* The health and welfare of detainees must be the first priority.

Hove Crown Court

The CCM had previously raised the fact that there is **no free flow of air in the custody suite** and today added that this matter had also been raised in a recent audit was the GEOAmey HSQE Adviser. The CCM stated that HMCTS were aware of the problem. However *no timescales* were available for the implementation of a form of 'comfort cooling' or air conditioning system stating **the date will be determined by the availability of funds.**

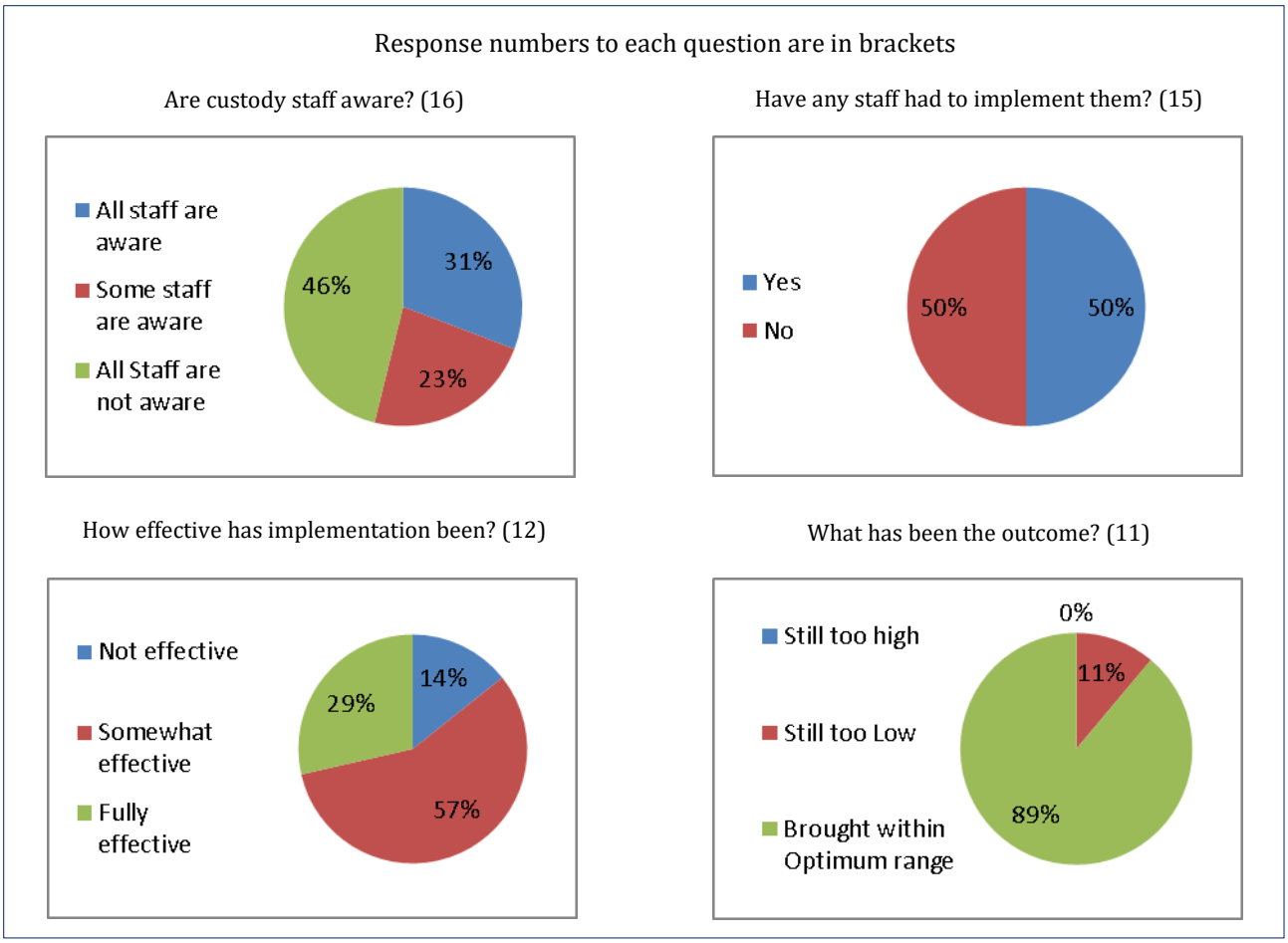
5.19 In this extract, again from Oxford Magistrates' Courts, detainees and officers are put at risk of heat exhaustion due to the lack of inadequate ventilation.

Oxford Magistrates' Court

There were concerns about conditions in the docks, particularly the secure docs during the heatwave. Both custody officers and detainees **were very hot in the secure docs as there is not adequate ventilation** and the air conditioning from the main courtroom is unable to circulate into the secure docks. For obvious safety reasons, they cannot use plug-in fans or air conditioning within the docks.

5.20 In July 2019 a coroner's inquest reported on the death of a detainee in 2017 from heat stroke.[5] HMCTS and PECS had previously published two flowcharts to advise custody staff how to manage extreme temperatures. The focused survey undertaken in a small number of courts by LOs in December 2019 on their implementation indicates that 80% of officers are aware of them with only 50% having had a need to implement them. However, the survey suggests that in 14% of cases, the implementation was not effective. This is not acceptable and is a cause for concern that in very high temperatures there may still be danger of over-heating for detainees and custody staff. It is pleasing to note that in almost 90% of cases the temperatures were brought within the appropriate range of 19 - 26 degrees.

[5] Inquest into the death of Rafal Sochacki, 43, from heatstroke at Westminster Magistrates' Court in 2017, verdict July 2019.



5.21 Although PECS have improved female sanitary provision with the introduction of sanitary boxes in toilets there still remain occasions when these are not always kept fully stocked as required. This shows a lack of **decency** for female DPs. A report from Southampton Magistrates' Court states that sometimes females are kept in the male cell and there is no access to female sanitary wear nor are they asked if they need this facility or told about it being available.

Thames Magistrates' Court

The 'females in custody' **leaflet was observed in all the female cells**, and there was a sanitary box in the female toilet. The sanitary box however **was barely stocked** and with the lid off, only containing paper underwear (one of which was not in a sealed packet) and nothing else, with only a box of Tampax separate to the box. There were no **sanitary towels.**

5.22 In principle females should be held in a separate female section of the custody suite or at least designated female cells. However, if there are legitimate reasons to house them in a male cell - reducing staff workload is not such a reason - then procedures need to be in place to take account of this and to ensure females are treated with **respect** and **decency**. The reverse situation where female cells are used for male detainees is also unacceptable and leads to a lack of consideration for females. This further lack of sensitivity to the needs of female detainees flies in the face of PECS intentions to make these products available to women without having to request them.

Preston Crown Court

There is **no female sanitary wear in the female toilet are**a. The acting court custody manager told us that this was **because the cells are sometimes used by male** DPs and CYPs. When I pointed out there were no males in the cell block today I was also told that **the plastic container is a potential weapon and cannot therefore be left out**. There are no signs in the female toilet explaining the policy for female sanitary wear.

5.23 An important aspect of the management of detainees is that they are protected from harm of any kind. This report suggests a failure to comply with health and safety regulations and adds the *HMCTS staff are aware of all of the above, but* ***resolution does not seem to be achievable.*** It is hoped that the rectifications at the court below have now been made.

Cardiff Crown Court

i Fire Alarm does not sound in the cell area; staff rely on hearing it sounding elsewhere in the building
ii Fire Door magnet faulty, reported by LO at previous visit.
iii Ongoing issue with Fire Panel

5.24 Some reports indicate that there has been improvement in the care of CYPs with the younger children often being well looked after by their supporting officers. The quality of youth offending team (YOT) support overall is commendable.

Basingstoke Magistrates' Court

The PER for this CYP was **well maintained by the YCS staff during the journey**. It showed they **had offered the youngster the opportunity to the toilet before leaving**. They had **given him snacks and a drink during the journey**.

During the journey he had demanded to use the toilet and was given a urine bag. When I spoke to staff they told me he had initially suggested calling in at a supermarket and then suggested a tree as an alternative toilet. It was not a surprise to discover staff had refused both these suggestions

DPs have good access to legal advice and support	0	1	2	3	Percent
Where necessary adequate interpreter facilities are available	1602	32	7	0	2
Custody staff make good use of interpretation services to communicate with non-English speaking DPs	1609	28	4	0	2
In MCs all DPs have access to legal advice within 2 hrs	1393	234	14	0	15
DPs are satisfied with the legal support they have in court	1598	37	6	0	3
DPs have access to their legal papers when they ask for this	1633	3	3	2	0

5.25 A number of reports still indicate that the principle of accessing legal advice within two hours in a magistrates' court (MC) is not always achieved. Such delays can disadvantage detainees and compromise their access to justice.

5.26 In particular, there is serious lack of respect and concern for CYPs who **regularly** do not have their cases prioritised. In the extract below a very vulnerable CYP was held in the custody suite for a long period of time before being heard in court. It cannot be right that the CYP at Westminster had to wait for over **four** hours before his solicitor visited him.

Westminster Magistrates' Court

Many DPs had to wait **well in excess of 2 hours for their legal visit**. Some of these delays were inevitable because of the pressure on the visit rooms. Throughout the day most legal rooms were occupied. There **did not appear to be any attempt to prioritise vulnerable DPs**. One **DP who had arrived at 11:15 and had Downs Syndrome was still waiting to see his solicitor at 15:15.**

5.27 The cases of many CYPs are left until **late in the day** before being heard in court. This lack of prioritisation also occurs with young people who have arrived off-bail for sentencing and then receive a custodial sentence. Such unacceptable delays impact adversely on their mental welfare and ability to access justice in a fair and balanced manner.

Plymouth Magistrates' Court

A 16-year-old girl at did not appear in court for sentenced until late afternoon. By the time she had been assessed and the YJB transport had been arranged to take her to Rainsbrook Secure Training Centre, a journey of about 235 miles, she did not leave the court custody suite **until** 22:00, **eventually arriving in Rainsbrook at 03:00am.**

5.28 It is totally unacceptable for a 16-year-old to be treated in such an inconsiderate manner with a lack of decency and respect. Such a long wait to hear your sentence is not acceptable especially for vulnerable CYPs for whom the delays may well increase their worry and stress. In this situation if their case had been properly prioritised then an earlier departure and arrival at their holding establishment would have been achieved.

5.29 It is appreciated that the number of CYPs in custody has declined resulting in the reduction in the number of Secure Training Centres and Secure Children's Homes. These secure places are limited with the locations often remote from the courts where young people are appearing for trial. Therefore, their cases should be **prioritised** early in the day so they can return back to the STC/SCH at a reasonable time.

5.30 Another concern relating to the treatment of CYPs is the length of time they spend in the custody suite after court whilst placements are being found and the obvious impact this has on their final arrival time at the establishment and the length of their day in custody. A report from Bradford Magistrates' Court records that a **14-year-old child** arrived in the custody suite at 8.46am. He was then kept in his cell until his court appearance at 15.08pm which completed at 16.05pm. He eventually left the custody suite for his onward journey to a **YOI at 20.00pm**. That meant he had been held in the cells for over **11 hours**.

5.31 The CYP did **not arrive** at his destination at a **decent** hour, but late into the night. This does not happen with adults as most prisons have a cut off time for receiving detainees from court. Frequently CYPs are transported on vans with adults in contravention of the Beijing expectations '*that Juveniles under detention pending trial shall be kept separate from adults.'*[6] The impact of this is that they are held on the van until all adults have been returned to their establishments and then transported to theirs **last**. Yet again this is a lack of **respect** and **decency** for such young vulnerable persons.

5.32 Reports also indicate that the care of foreign nationals often lacks **respect** for their human rights with failures to use relevant interpretation facilities. Many detainees do not have English as a native or spoken language and their understanding of it is very limited. In such circumstances proper use of interpreters or the language line telephone translation service should be used to ensure that they understand their rights and what is happening to them. An already stressful situation is exacerbated by the lack of the ability to effectively communicate feelings and opinions. A wait of three hours is not acceptable and, in the case below, use of the language line would have reduced the stress for this detainee.

North Staffordshire Justice Centre Magistrates' Court

An interpreter **took 3 hours to arrive** in the custody suite as stated earlier custody staff could not communicate with this DP and neither could his legal rep.

Warwickshire Justice Centre Magistrates' Court

A Romanian national to whom I spoke **was unable to speak English**. In his PER it stated received Rights leaflet and Complaints procedure. I questioned if he understood the rights given to him and if he had received this in Romanian. The CCM stated "he's been here many times" and **we're waiting for an interpreter** for when he goes to court. During my interview with this DP **he was not able to communicate verbally with me**. I pointed to my mouth and mimed eating and drinking to which he shook his head indicating no. The CO informed me **he was offered a drink and refused. This was not recorded on his PER.**

Detainees are transported to and from court in reasonable me and in suitable vehicles	0	1	2	3	Percent
Females are transported to and from court separately from males and in a manner where they are safe and protected	1576	61	4	0	4
DPs do not have to wait for more than two hours after their court appearance	1422	202	15	2	13

[6] United Nations Standard Minimum Rules - Beijing Rules - for Administration of Juvenile Justice - 29 Nov 1985

Westminster Magistrates' Court

Two DPs, one man and one woman, were transported from Preston police (**230 miles** and journey time of **just under 4 hours**). The woman spoke good English. She told me that before **they started out the escort had told her they would not have a comfort stop**. **The woman accepted this and did not drink during the five hour journey**. The PER shows that **she was monitored but does not have any indication of an offer of a comfort stop.** The woman told me that the male DP had been quiet during the journey. She thought he was upset and had she been able to speak his language she would have tried to speak to him.

5.33 For such a long journey it is not humane to say there will **NOT** be a comfort stop and so force a detainee not to drink on the journey. It is commendable that the female attempted to speak with the other foreign national but she should not have been on the same vehicle as he was. Whilst we appreciate that both may have been arrested on a European Arrest Warrant, arrangements they should have been made to use a video remand hearing (VRH) or separate transportation. It is unacceptable to transport a male and female in the same vehicle for such a long journey.

5.34 Young people being brought from a Young Offenders Institution should normally be transported in a standard cellular vehicle without any adults on it. LOs have noted occasions where the PECS contractor has transported CYPs and adults in the same vehicle for long distances.

Southampton Crown Court

A CYP appearing in was transported to **Feltham YOI (65 miles**) in the same vehicle as an adult female being taken to HMP Bronzefield.

5.35 For many CYPs attending trial this means a long day, with very early departures and late arrivals back at their establishments. The availability of transport sometimes results in CYPs being left for long periods in court custody cells. There are frequent delays in transporting CYPs from court to their YOI or Secure Training Centre.

Southampton Magistrates' Court

An autistic and vulnerable CYP in Southampton Magistrates' Court **finished his court appearance at 12:40**. This youngster was **very emotional and unstable**. Due to his autism **he reacted badly to being in a confined space** such as a cell. He was **still in the cell at 15:00** awaiting his transportation.

5.36 There are also examples of good practice and sensitive treatment by court custody staff.

London Central Criminal Court

A CYP has been on trial for approximately three months and residing at Cookham Wood – a journey of 40 miles - since February. The youngster was in a cell in the same cell block as the other adult DPs but since these were nearly all his family members this seemed entirely appropriate.

He states that he makes his own breakfast in his room at Cookham Wood before he leaves each morning. The food in court is very monotonous and he does not like it although he recognises that it is sufficient in the short-term. He has, however, been offered the same microwave meals for the last three months.

Staff **appeared to have a very good rapport** with this youngster although they had not received any specific training in managing CYPs. This young man was quite mature for his age and related well to the younger court custody staff.

5.37 Despite the 'good rapport' engendered, one wonders why he has to make his own breakfast and why he has been offered *the **same** microwave meals for the last three months*.

5.38 The report below is another example of the deplorably long journey time taken to transport this female detainee, lacking in any **decency.** 'Failure to Attend' is not considered serious enough to warrant a round trip of over **12 hours**. The female was transported in a vehicle based in the South to Bradford.

Bradford Crown Court

A female arrived directly and separately in a vehicle from Worthing (on the south coast) some **260 miles one way under a warrant (for failing to attend a previous hearing - FTA) - a journey time of six hours** (07:07 – 13:12hrs). I was unable to ascertain the reason for this very long transfer to West Yorkshire.

I was informed that the **CCTV is full and therefore not recording inside the van.**

5.39 Maintenance of vehicles is essential to ensure the safety and well-being of detainees during journeys and particularly long journeys such as this one. Of those vehicles inspected by LOs just over 10% had defects. The failure of the CCTV, in the example above, placed the detainee and vehicle staff at risk without any evidence to support or refute any allegations of misconduct. It could and should have been easily rectified.

5.40 Clearly, properly operating fire extinguishers are essential for the safety of prisoners - and their escorts and drivers - travelling in the vehicles. In one Vehicle Inspection Notice, a LO raised concerns about a fire extinguisher on a vehicle which was overdue for a service. The Contract Delivery Manager for the area asked all area business managers to urgently check on the service status of all fire extinguishers in vehicles. He examined the procedures vehicle bases have used for making sure fire extinguishers are serviced regularly. In this case remedial action was taken.

5.41 However, whilst there are a number of serious areas of concern it is encouraging to see very positive responses to issues raised by LOs with them being taken very seriously as in the examples below.

Blackburn Magistrates' Courts

Three of the DPs I spoke to had been sentenced and were being held pending arrival of transport to take them to Preston Prison. I asked when this was likely to arrive and was told there was a shortage of vehicles available so they faced a wait of a few hours. **They were being looked after with early lunches, drinks and newspapers to occupy their time.**

5.42 The extract below from a report on Bolton Combined Court outlines positive responses to HMIP and LO reports. This is very encouraging and a constructive example of good practice which should be replicated across the estate.

Bolton Combined Crown Court

This visit follows soon after a HMIP inspection of the custody suite over the previous 2 weeks, and it was illuminating to discuss some of the issues raised in that inspection with the CCM. **One cell had been taken out of use following the inspection** and was awaiting remedial work. The CCM walked around the cells with me and we inspected the various points raised. Following this issue being identified, two other cells were also found to have similar metal strips although these were undamaged (cells 3 and 10). The resolution will be to remove the metal strips from these cells and to re-plaster the affected areas. Other potential ligature points had also been raised in the inspection in relation to bench backrests and the mesh covering ceiling air conditioning vents. The issues raised were all receiving consideration as to appropriate remedial action.

Two issues were raised in the previous LO report for this custody suite:

The lift up to court levels from the custody suite was out of operation on the previous visit. This is now fully operational and in daily use. The door between court 3 and the adjacent holding room for DPs had not been secure and had been an ongoing issue for several months. A **secure door with approved lock** has now been installed in this location, and so there is no longer a security concern. Other concerns which had been raised about dampness in the walls of the corridor to the custody suite **had been addressed**, and some repainting of affected areas was evident.

6 RESPECT

6.1 In general, it appears that custody managers and officers show a commendable degree of **respect** for those detained often in difficult circumstances. However, this consideration is not consistent across all agencies or groups responsible for the care of detainees and the examples of good practice are not widely disseminated.

Every DP is treated with respect his/her wellbeing and safety is considered at all times and he/she has an experience that enables him/her to access justice	0	1	2	3	Percent
The way in which DPs are received into the custody suite ensures they know what they are entitled to and they understand the procedures	1620	19	2	0	1
Rights leaflets are in each cell and staff take adequate steps to ensure each DP understands his/her rights	1444	51	7	0	4
DPs are told they can ask for reading materials. These are offered to all DPs	1605	34	1	1	2
DPs are treated with respect & any religious needs catered for	1608	21	11	1	2
DPs remanded are informed of what to expect when they go to prison (FNLs) for the first me	1624	15	2	0	1
There is adequate provision of food, in date	1464	52	2	0	4
When vulnerable DPs are released from custody staff take steps to ensure their safety and well being after they leave the court	1636	5	0	0	0
Females and vulnerable DPs separated from other DPs	1616	21	4	0	2
DPs on a SASH are monitored in accordance with the guidance in the SASH	1636	5	0	0	0
DPs on an ACCT are monitored in accordance with the stipulations	1639	1	1	0	0
Staff interaction with DPs is good	1630	11	0	0	1
When DPs are released they are given travel warrants and sufficient petty cash to travel home	1635	5	1	0	0
When DPs are released staff provide them with relevant support leaflets that are available in the custody suite	1637	4	0	0	0
DPs released with minimal delay	1593	42	5	1	3

Westminster Magistrates' Court

At 15:15, 14 DPs were being transported back to HMP Wandsworth. The CCM was hoping to have another vehicle fill before the end of the court session. There have recently been a number of occasions when **it has not been possible to return prisoners to HMP Wandsworth before they lock out**. This results in delays stretching into the late evening.

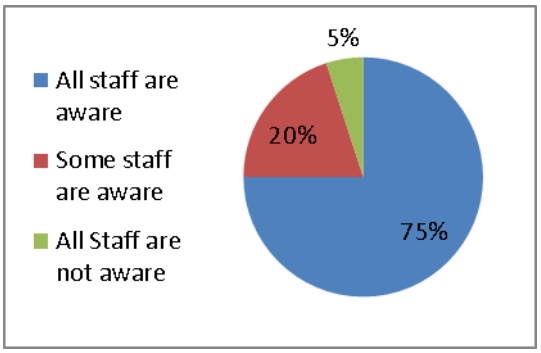
The last DP had not made his court appearance until the afternoon and **had not returned to the cells until 14:15**. He told me he had been released from court to return the following day and that if this release was not quick then he would have been better remaining in prison for a further night. He told me that he had been in prison for a simple driving offence, but when the warrant arrived it showed 7 outstanding offences. Officers were unsure if the prison would release him under these circumstances.

6.2 Delays in releasing detainees, who have either been discharged by the court, remanded on bail or had their case terminated raises a serious issue of possible false imprisonment. The explanation given to us is that the delay is due to waiting for authorisation from the prison with timescale in most cases far too long. The first section of the first page of the PER requires the prison to tick if the detainee is **NOT** for release and requires a reason to be given. So why then should they be retained in custody for further authorisation? If it is left blank then surely such detainees should be immediately released. In some cases, members of the public who have been proved innocent are being retained in a custody suite against their will and without appropriate authorisation for release.

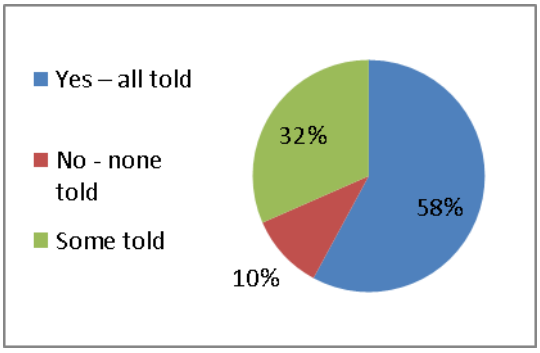
6.3 To relieve the boredom of long waits in cells, PECS introduced 'distraction packs.' The LOs' focused survey in a small number of courts showed a positive response that three quarters of all officers were aware of these packs but it is disappointing that in **only** 58% of custody suites were **all detainees** offered them. It is also encouraging that 60% of observations indicated that the pack had been used and on a fairly regular basis within those custody suites. The survey also elicited the response that only 42% of respondents felt they were suitable for all ages. From our regular meetings we are pleased to note that PECS have undertaken to respond to these findings.

Response numbers to each question are in brackets

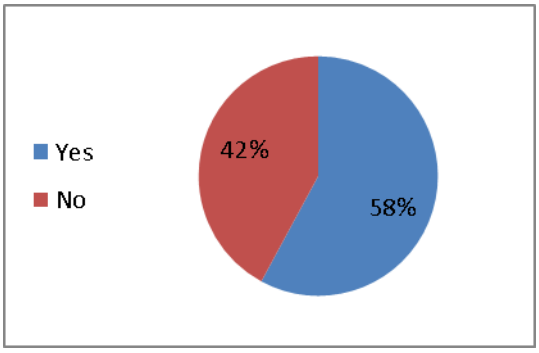
Are staff all aware of these packs? (20)



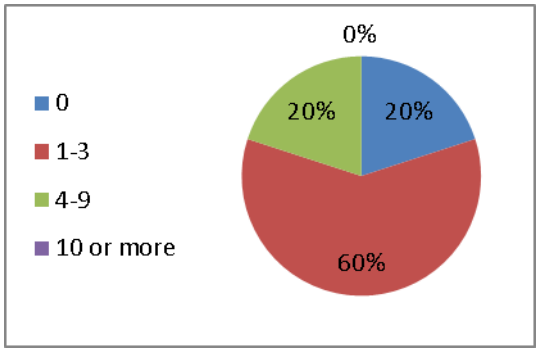
Have DPs been told about them? (20)



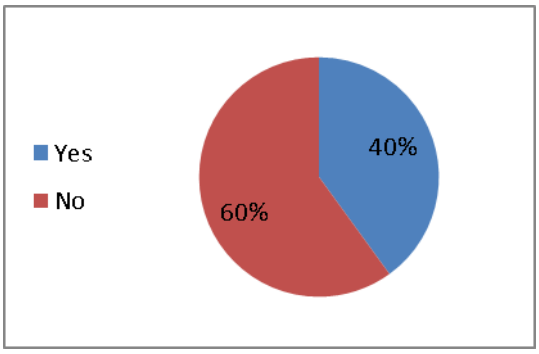
Did you see any evidence that DPs have been given any of this material? (20)



How many times have they been used either completely or in part? (19)



Are they suitable for all ages and DPs? (18)



6.4 There are some very good examples of how respect and decency are shown to detainees in differing circumstances. The first extract is positive about the recording of food items as well as an overall decent relationship with the detainees. The three other extracts show how officers manage delays that might adversely impact on the detainees and place them at further risk of detention. These are testament to the care which many custody officers show to those for whom they have a responsibility.

Reading Magistrates' Court

Food was plentiful and well within date. I asked staff about food for vegetarian, vegans, and gluten-free. This was explained well using the 3 plastic wall charts matching meals and suitability. **These are good charts and I had not seen before**. I will check them next me I visit a cell area without them on show. Officers have a **good team working well together and developed a good** rapport with the DPs in their care. The Wallboard contains all info on risks etc. and all staff know and understand.

Worle Magistrates' Court

All DPs said that **they'd been treated well**. All had had at **least one drink and more were given whilst I was there**. **Reading material had been provided**. One DP was schizophrenic; he had been shouting but was calm when speaking to the officers and me. **He had been given a sandwich and requested another which was provided**. He did not need to see the mental health team. Another **had been given a pen and said that the staff were very helpful.**

Blackburn Magistrates' Courts

Three of the DPs I spoke to had been sentenced and were being held pending arrival of transport. I asked when this was likely to arrive and was told that as there was a shortage of vehicles available they potentially faced a wait of **a few hours in custody cells. They were being looked after with early lunches, drinks and newspapers to occupy them.**

Birmingham Magistrates' Court

One detainee released with a curfew bail condition was poorly dressed. **A coat was produced by staff** from surplus property and the CCM **arranged that the local Police Station in Dudley be informed that he would not be home before curfew because of delays**.

7 CONCLUSION

INCONSISTENCIES IN DELIVERY

7.1 As services are provided by a range of agencies and groups, including contractors, this militates against smooth and consistent service delivery. There are examples of good practice but as LOs are a national service meeting together regularly, they observe and report on the inconsistencies in operation and the differences in approach. There is a clear feeling that there is a lack of '*joined-up thinking*' and no national management control or effective quality assurance programme across all agencies.

7.2 The inadequate level of cohesion across the number of agencies and staff involved particularly in relation to PERs has not been satisfactorily addressed. There still appears to be an absence of acceptable interface between the computer systems used by the three main groups – police, prison and courts. This means, as evidenced in the reports, risk factors and markers are not consistent and places detainees and anyone who comes into contact with them at risk. Evidence suggests the information gained in court may not always follow the detainee during their journey through the justice system, especially if re-arrested at a later time.

7.3 Our particular concern is that there is still no appropriate organisation nationally prepared to adequately address this issue. The principle recommendation in the report for 2018 – 2019 was:

the establishment of an overarching group of senior representatives of the all the relevant agencies - HMPPS, HMCTS, PECS, YJB, prison staff, courts custody managers and contractors;

7.4 This report clearly emphasises the need for such an organisation with evidence that the inconsistencies in delivery are still very prevalent. The positive response by PECS to the issues raised previously about the management of medication have been severely disadvantaged by the fact that relevant documents do not appear to have been made available to, or effectively operated by other agencies engaged with detainees.

7.5 Whilst is it appreciated that quarterly meetings of the Contract Review Group take place and will be replaced under HMPPS's Generation 4 escort and custody contract by a Partnership Board to which the LO organisation will be invited, this does not go far enough. The introductory paragraph 2.2 above states that many of the issues are outside of the control of PECS and HMCTS, as demonstrated by a number of the case studies outlined above. Agencies such as prisons and police who have a vital role in ensuring the wellbeing and safety of detainees would quite often appear to show scant adherence to the rules for completing PERs. The newly introduced 'Winchester' PER is an improvement but LO reports still show that the detailed guidance is not always followed - but this is not the fault of escort or custody officers. There is no national overall responsibility for quality assuring the completion of PERs across the range of agencies.

7.6 It is appreciated that an electronic PER will be introduced as part of the Generation 4 contract development but information from some of the trials suggest that although safeguards ensure each section must be completed before moving on to the next one, we cannot be confident that each section will be fully and accurately completed. As an example, the extracts referred to in Paragraphs 4.4 and 4.5 – based on an incident at Liverpool Crown Court – show that more complete information should always be included about medication. This suggests there is a lack of consistent thorough training programs in the preparation and management of PERs across all agencies.

7.7 It is acknowledged that quality assurance initiatives such as the one introduced in London have been implemented with some moderate impact. But our experience is that this is only within the agencies under the control of PECS and HMCTS. There does not appear to be any effective programme to ensure such needed **national** quality assurance is in operation or even in documentation. Without a national approach the quality of PERs will not improve. It is recognised that the Generation 4 contracts include new guidelines for the treatment of females and CYPs with specific reference to transport, court facilities and waiting times and it is acknowledged there will be some developments.

7.8 As an organisation LOs now have regular and positive meetings with PECS and HMCTS at a national level and we appreciate that PECS provide feedback on any Level 3 issues which is then communicated to the relevant LOs.

7.9 However there has still not been a consistent agreement on the structure and management of the regional stakeholder meetings. Whilst there are regional meetings which include LOs these are at an operational level. Our concern is that at a strategic level there is still a major lack of understanding and consistency by the main agencies involved. LO Area Co-ordinators **still** report that the management, quality and effectiveness of these meetings vary. In some regions LOs are constituent members but this is not consistent across the estate; similarly, in some regions, the agenda includes responses to our reports. We reported last year that there is a very positive relationship in the Hampshire area. So far it does not seem that this example of good practice has been disseminated and implemented across all regions.

7.10 Detainees are being expected to wait for proper mental health assessments and medication until they have either been remanded or returned to custody with the consequence of serious impact on their welfare and health.

7.11 A continued failure to improve the quality of PERS places at risk the Minister's due of care to protect the human rights of those detained in custody.

MAINTENANCE

7.12 Reports provide clear evidence that in a number of custody suites there is no regular and effective maintenance and upkeep. There is indication that regular quality assurance does have impact but it is not consistent. Repairs are not undertaken on a routine basis. HMCTS visits occur when a problem arises and not on a regular (monthly) basis. Lack of regular visits may encourage poor quality maintenance and management.

CHALLENGES TO HUMAN RIGHTS

7.13 A consistent concern is the lack of appropriate support services in courts held on Saturdays and Bank Holidays. Very often such morning courts are very full with overnight arrests from the previous day. The lack of Liaison and Diversion and Probation teams often mean that the judiciary may not have adequate information on which to make a judgement about the detainee – as would be the case for weekday courts. This means that regularly requests are made for remands in custody which are usually granted whereas during the week, when support services are made available, many would be released on bail or sentenced. This contravenes the human rights of those who are judged as innocent at this stage and have not been charged with a serious offence.

7.14 LOs report that many detainees who have been brought from a prison in custody are, for one reason or another, released by the court. Far too often those detainees are retained in cells until the originating prison provides a document which says they can be released. This can take up to four hours during which an innocent person can be held in custody without any authorisation or reason. Not only is this an infringement of their human rights but it may also be illegal. LOs also report that often the detainee's property has not accompanied them to court. They have then to return to the prison which may be a considerable distance away and when they arrive there, they cannot access reception which has closed. They may be left on the street with no property, which would most likely have included any credit cards and money and no other clothes. This shows a clear lack of **respect** and **decency.**

CYPS AND FEMALES

7.15 Whilst a number of developments have improved the situation for CYPs and females there are still concerns about their treatment in terms of decency, management of their health needs and travelling times and delays.

7.16 This report raises the matter and makes appropriate recommendations to ensure a co-ordinated and connected approach so that in future all who have a duty of care towards all detainees to treat them with **decency** and **respect** and manage their **welfare** consistently and effectively.

8 RECOMMENDATIONS

MULTI AGENCY OVERARCHING GROUP

8.1 It is necessary to repeat the recommendation of last year's report in regard to the establishment of an overarching group of senior representatives of all the relevant agencies - HMPPS, HMCTS, PECS, YJB, NHSE/I, prison staff, courts custody managers and contractors, NPCC and PGA and other agencies involved with a commitment to publish across the group protocols that ensure:

i national standards to deliver:

a. quality assurance programmes for PERs;
b. consistent training programmes for the preparation and completion of PERs;
c. effective communication between the agencies on the treatment of detainees and in particular PERs;

ii national standards response programmes to deliver:

a. effective cleaning of custody suites;
b. the treatment and removal of graffiti;
c. effective monitoring and inspection of safety measures such as fire extinguishers.
d. more flexible opening hours for prisons

8.2 A full external review of the use and operation of Person Escort Records (PERs).

HUMAN RIGHTS ISSUES

8.3 A review of the issues relating specifically to human rights of those held in custody as referred to in paragraphs 7.13 - 7.14 above.

STATUTORY UNDERPINNING LO STRUCTURE

8.4 Section 10 of this report outlines the work of Lay Observers and specifically the National Council. The Ministry of Justice should put forward proposals for the statutory underpinning of the NC to secure a legal footing for its duties, responsibilities, accountability and strategic management of the Lay Observers.

9 SUMMARIES APR 2019 – MAR 2020

The custody suite is managed and run in a manner that ensures the wellbeing of DPs	0	1	2	3	Percent
Assessment of PERs	598	747	184	9	61
The recording of events in the custody suite are maintained accurately and promptly	1608	29	4	0	2
Where there is inaccuracy in the PER that impair risk assessments staff refer the matter back to the originator for clarification.	1572	56	13	0	4
Where DPs are sharing a cell	1640	1	0	0	0
DP property is kept safely and the tagging of property is accurate	1635	5	1	0	0
Handcuffing of DPs is based on risk assessments	1558	81	2	0	5
Staff work effectively as a team to ensure the safety of all in the custody suite	1629	9	3	0	1
Defects are raised formally with the HMCTS team in the court	1609	17	13	2	2
One of the HMCTS team visits the custody suite at least monthly and makes an inspection of the whole custody suite	1593	42	5	1	3

DPs have access to the medicines they need during their time in the court and are satisfied with their medical care	0	1	2	3	Percent
Medical information on the PER enables staff to make an accurate assessment of each DP's health care needs	1120	454	67	0	32
The arrangements for assessment & support of DPs with mental health concerns or learning disabilities is satisfactory	1556	69	15	1	5
The physical, mental and psychological needs of DPs are adequately met	1527	95	17	2	7
Medication is stored securely	1627	14	0	0	1
DPs have access to any medication that they should have during their time in court custody	1550	80	11	0	6

DPs are held in a custody suite that is clean, safe and in a good state of repair	0	1	2	3	Percent
Graffiti assessment	867	557	101	12	44
Cleanliness assessment	1280	207	57	6	17
Kitchen has functioning equipment for hot and/or cold food	1458	54	7	0	4
There are hygienic facilities for all DPs to use a toilet and wash & dry their hands	1312	152	54	1	14
Female sanitary provision is available, and routinely offered both on arrival and on request	1584	42	15	0	3
Cell temperatures adequate (neither too hot nor too cold)	1386	97	25	4	8
There are no potential ligature points in areas used by DPs	1537	86	15	3	6
The custody suite and areas used by staff & DPs are in good condition and fit for use	1188	254	166	33	28

DPs have good access to legal advice and support	0	1	2	3	Percent
Where necessary adequate interpreter facilities are available	1602	32	7	0	2
Custody staff make good use of interpretation services to communicate with non-English speaking DPs	1609	28	4	0	2
In MCs all DPs have access to legal advice within 2 hrs	1393	234	14	0	15
DPs are satisfied with the legal support they have in court	1598	37	6	0	3
DPs have access to their legal papers when they ask for this	1633	3	3	2	0

Detainees are transported to and from court in reasonable me and in suitable vehicles	0	1	2	3	Percent
Females are transported to and from court separately from males and in a manner where they are safe and protected	1576	61	4	0	4
DPs do not have to wait for more than two hours after their court appearance	1422	202	15	2	13

Every DP is treated with respect his/her wellbeing and safety is considered at all times and he/she has an experience that enables him/her to access justice	0	1	2	3	Percent
The way in which DPs are received into the custody suite ensures they know what they are entitled to and they understand the procedures	1620	19	2	0	1
Rights leaflets are in each cell and staff take adequate steps to ensure each DP understands his/her rights	1444	51	7	0	4
DPs are told they can ask for reading materials. These are offered to all DPs	1605	34	1	1	2
DPs are treated with respect & any religious needs catered for	1608	21	11	1	2
DPs remanded are informed of what to expect when they go to prison (FNLs) for the first me	1624	15	2	0	1
There is adequate provision of food, in date	1464	52	2	0	4
When vulnerable DPs are released from custody staff take steps to ensure their safety and well being after they leave the court	1636	5	0	0	0
Females and vulnerable DPs separated from other DPs	1616	21	4	0	2
DPs on a SASH are monitored in accordance with the guidance in the SASH	1636	5	0	0	0
DPs on an ACCT are monitored in accordance with the stipulations	1639	1	1	0	0
Staff interaction with DPs is good	1630	11	0	0	1
When DPs are released they are given travel warrants and sufficient petty cash to travel home	1635	5	1	0	0
When DPs are released staff provide them with relevant support leaflets that are available in the custody suite	1637	4	0	0	0
DPs released with minimal delay	1593	42	5	1	3

10 Lay Observer Operation

Structure

10.1 Lay Observers (LOs) monitor the welfare and access to justice of detainees being brought to court and held in court custody and the transport of detainees under the supervision of escort contractors. They aim for high standards of monitoring and, whilst being independent, aim to be a consistent partner within the framework of organisations monitoring custodial environments. LOs are supported in their role by a Secretariat provided by the Ministry of Justice.

10.2 LOs use a template with a set of standard expectations (pages 32 – 33) to report their assessments and observations. This 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 2019-2020 and the report extracts shown in the pink and green highlighted boxes in the text above are taken directly from LO reports - those in pink express concerns whilst those in green indicate actions and conduct by officers which show respect and decency. A small number have been slightly adapted, for example to remove information which might identify a detainee.

10.3 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. PECS provides a response and action for any Level 3 given.

10.4 Regular meetings with the Head of PECS, Head of HMCTS Contracted Services Operations and the MoJ sponsorship team for LOs are held.

10.5 A recruitment campaign was held early in 2020 but the impact of the Covid-19 pandemic prevented any training for these new recruits from being provided.

10.6 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. There were lessons learned from the unexpectedly high turnover and the recruitment competencies and process have been appropriately adjusted as a result.

10.7 The LOs role is to observe and highlight areas of concern, and to explore what actions have been taken to address such areas. They cannot and do not give advice about issues raised and especially not about the health problems of an individual detainee, but can raise concerns centrally so such matters can be considered and resolved by those with the legal duty of care for detainees.

National Council Developments

10.8 At the National Conference on 11 May 2019 a new philosophy for the monitoring role was introduced. It emphasised that the role was to *observe, monitor* and *report*. The keynote speech emphasised that the role was not to monitor compliance but to establish and judge how far those in detention either on vehicles or in court custody suites were treated with **respect**, **decency** and their **welfare** properly managed. The conference also published the Core Brief document - page 30 - specifying the purpose, operation and role of Lay Observers.

10.9 National Council had also published a new Visits Protocol in November 2019 with the principle aim to *conform to our role under the United Nations OPCAT provision as described in the Core Brief*. It is a detailed guidance document setting out how LOs should make a visit under the new approach which emphasises the LOs preventive role.

10.10 To further strengthen the OPCAT preventive role a working group of LOs began the process of updating the standards against which the treatment of detainees is judged. The emphasis of the new

approach was to reduce the number of individual standards that have to be scored and to focus more sharply on how detainees are treated with **respect**, **decency** and their **welfare** managed.

10.11 A number of meetings were held and the first significant draft of eight major new standards agreed focusing on respect, decency and detainee welfare. Each of the eight main areas is accompanied by a number of indicators which LOs can use to assist in their monitoring. Regional training sessions were conducted on the new philosophy, the approach to monitoring and the new standards which received positive responses from LOs.

10.12 In February 2020 the NC undertook a day of filming in a custody suite. The resources, both videos and stills, will provide material for future training events and, in particular, for proposed e-learning courses. The NC also agreed a programme of further regional training in the late Autumn of 2020 to introduce fully the new standards, accompanying notes, guidance on grading and example reports.

10.13 Regular bulletins are published to engage with individual LOs on a wide range of issues. One bulletin introduced three small focused surveys on developments undertaken by PECs and HMCTS. Graphs identifying the impact of these developments are included in this report.

10.14 NC also agreed a programme of further regional training in the late autumn of 2020 to introduce fully the new standards, accompanying notes, guidance on grading and example reports.

10.15 However the response to the Covid-19 pandemic has prevented many of these developments from being progressed further at this time.

NPM Role

10.16 The LO organisation is a constituent member of the UK National Preventive Mechanism (NPM). The Chair represents LOs at all meetings of this group and contributes to all relevant documents and reports.

10.17 In September 2019 the United Nations Sub Committee for the Prevention of Torture (SPT) visited the United Kingdom. The Chair of the LO was fully involved in all the meetings with this committee. The SPT accompanied the Chair and another Lay Observer on a visit to Westminster Magistrates' Court. The report on this visit was very positive and complimentary.

> 93. *Lay Observers play a crucial role by monitoring the treatment and conditions of detention of people held in court custody and those in vehicles while being brought to and from the court.*
>
> *94. The SPT observed the visit of two Lay Observers to the Westminster Magistrates' Court. It commends the professionalism, dedication and empathy demonstrated by the Lay Observers in the course of that visit…. The Subcommittee notes that, on that occasion, Lay Observers had a very clear understanding of their preventive role, beyond a mere compliance-check.*[7]

10.18 National Council would refer to the actions undertaken this year which should allay the concerns of the SPT about whether all Lay Observers received training on preventive methodology and have the same high standards as those observed by SPT.

[7] United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Report on visit to United Kingdom of Great Britain and Northern Ireland undertaken from 9 to 18 September 2019, Para 94.

11 Appendix A: Core Brief

Legislative & International Framework

Lay Observers (LOs) play an important role in the justice system by monitoring the welfare and access to justice of people being brought to court and held in court custody. We are appointed by the Secretary of State under the Criminal Justice Act 1991 (CJA 1991) to provide ***independent*** oversight of how people detained in court cells and cellular vehicles are cared for and their access to justice. They are independent, unremunerated, public appointees

LOs are members of the National Preventive Mechanism (NPM) which is the United Kingdom structure for complying with its commitment to the United Nations Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). There are just fewer than 100 LO members monitoring in accordance with the relevant specifications set out in the United Nations set of Standard Minimum Rules for the treatment of prisoners. These are set out in the United Nations' documents entitled the Mandela Rules for adult males, the Bangkok Rules for adult females and the Beijing Rules for juveniles and young persons.

Public Appointees

Lay Observers are members of the public drawn from the local community and appointed by the relevant Minister, through a public appointment process in line with Cabinet Office standard practices.

They do not need any special qualifications nor experience in the justice system as relevant training is provided.

They are unpaid but receive appropriate travel expenses and subsistence and Financial Loss Allowance is also claimable. The time commitment is about 1 - 3 days per month in addition to quarterly regional meetings.

Members usually live within a 50-mile radius of the courts, prisons or police station they visit. The Panel of Lay Observers is supported in their function by a professional Secretariat.

Statutory Duties

The CJA 1991 states that there should be appointed:

b) a panel of lay observers whose duty it shall be **to inspect the conditions** in which prisoners **are transported or held** in pursuance of the arrangements and to **make recommendations** to the Secretary of State.

They visit:

- courts to confirm that Detained Persons are being treated decently, inspect conditions in custody areas, and inspect the vehicles used by the contractors;
- police stations to observe the handover of Detained Persons from the police to the contractors;
- prisons to observe the handover of Detained Persons from prison to the contractors and vice versa;
- prisons to observe Detained Persons escorted there from other prisons using the Inter Prison Transfer [IPT] contract and inspect the vehicles used by the contractor.

Organisation

Lay Observers are appointed to geographic regions with an Area Co-ordinator managing the team for the region. The Area Co-ordinator produces a regular rota indicating for each member the visits they should undertake to courts, prisons, vehicle bases or police stations. It is a matter for the individual LO to plan when they should make a visit and they usually do this carefully by making contact with relevant staff to ensure that the visit will be effective.

Competencies and Skills

In performing their monitoring duties, Lay Observers generally work individually in compliance with the set codes and standards expected of those performing a public duty. They remain, at all times, apolitical, impartial and do not undertake any other activity related to the role nor engage in any

activity or relationship that would be considered to compromise independence or conflict with the monitoring role. Lay Observers will have:

- integrity;
- enthusiasm;
- open minds;
- sensitivity;
- good observational skills;
- good communication skills;
- sound and objective judgment;
- clear and concise reporting skills;
- good computer skills.

ROLE OF LAY OBSERVERS

The role of LOs is to monitor the facilities provided and treatment received by those detained in court custody suites to confirm if they are treated with **decency** and **respect** and that their **welfare** is properly managed.

They are also responsible for monitoring the facilities and quality of transportation used when detained persons are being moved between police stations, courts and prisons by observing and reporting the compliance with relevant rules and standards of decency. To ensure this is undertaken effectively LOs have unrestricted access to every part of the custody suite and transportation.

In performing their function individual LOs operate within the relevant guideline documents and a set of written Expectations.

There are currently six Expectations:

- The custody suite is managed and run in a manner that ensures the wellbeing of DPs.
- Detainees have access to the medicines they need during their time in the court and are satisfied with their medical care.
- Detainees have good access to legal advice and support.
- Detainees are held in a custody suite that is clean, safe and in a good state of repair.
- Detainees are transported to and from court in reasonable time and in suitable vehicles.
- Every detainee is treated with respect his/her wellbeing and safety are considered at all times and he/she has an experience that enables him/her to access justice.

Each of these six Expectations is supported by a number of criteria against which the LO inspects and reports on the treatment, the facility or the transportation to judge how well the detained persons are managed.

Each of the criteria is graded on a four-point scale 0 – 3 to identify the seriousness of a breach of the criteria or a failure to provide decent, respectful treatment. Following the visit, a detailed written report is produced which is disseminated to relevant agencies and contractors.

THE ANNUAL REPORT

This published report provides Ministers and the general public with a clear statement of how far detained persons are treated with decency and respect and how their welfare is properly managed.

3rd Floor Post Point 2
10 South Colonnade Canary Wharf
London
E14 4PU
0203 334 3265

12 APPENDIX B: CURRENT STANDARD EXPECTATIONS

The custody suite is managed and run in a manner that ensures the wellbeing of DPs
Assessment of PERs
The recording of events in the custody suite are maintained accurately and promptly
Where there is inaccuracy in the PER that impairs risk assessments staff refer the matter back to the originator for clarification.
Where DPs are sharing a cell
DP property is kept safely and the tagging of property is accurate
Handcuffing of DPs is based on risk assessments
Staff work effectively as a team to ensure the safety of all in the custody suite
Defects are raised formally with the HMCTS team in the court
One of the HMCTS team visits the custody suite at least monthly and makes an inspection of the whole custody suite.
DPs have good access to legal advice and support
Where necessary adequate interpreter facilities are available
Custody staff make good use of interpretation services to communicate with non-English speaking DPs
In MCs all DPs have access to legal advice within 2 hrs
DPs are satisfied with the legal support they have in court
DPs have access to their legal papers when they ask for this
DPs are held in a custody suite that is clean, safe and in a good state of repair
Graffiti assessment
Cleanliness assessment
Kitchen has functioning equipment for hot and/or cold food
There are hygienic facilities for all DPs to use a toilet and wash & dry their hands
Female sanitary provision is available, and routinely offered both on arrival and on request
Cell temperatures adequate (neither too hot nor too cold)
There are no potential ligature points in areas used by DPs
The custody suite and areas used by staff & DPs are in good condition and fit for use

Detainees are transported to and from court in reasonable time and in suitable vehicles
Females are transported to and from court separately from males and in a manner where they are safe and protected
DPs do not have to wait for more than two hours after their court appearance
Every DP is treated with respect his/her wellbeing and safety is considered at all times and he/she has an experience that enables him/her to access justice
The way in which DPs are received into the custody suite ensures they know what they are entitled to and they understand the procedures
Rights leaflets are in each cell and staff take adequate steps to ensure each DP understands his/her rights
DPs are told they can ask for reading materials. These are offered to all DPs
DPs are treated with respect & any religious needs catered for
DPs remanded are informed of what to expect when they go to prison (FNLs) for the first time
There is adequate provision of food, in date
When vulnerable DPs are released from custody staff take steps to ensure their safety and well being after they leave the court
Females and vulnerable DPs separated from other DPs
DPs on a SASH are monitored in accordance with the guidance in the SASH
DPs on an ACCT are monitored in accordance with the stipulations
Staff interaction with DPs is good
When DPs are released they are given travel warrants and sufficient petty cash to travel home
When DPs are released staff provide them with relevant support leaflets that are available in the custody suite
DPs released with minimal delay

13 GLOSSARY

ACCT	Assessment, Care in Custody and Teamwork
CC	Crown Court
CCM	Court Custody Manager
CCTV	Closed Circuit Television
CDM	Contract Delivery Manager
CJA 1991	Criminal Justice Act 1991
CYP	Children and Young Persons
DIS 1	Prison Disciplinary 1 Form
DP	Detained Person
EAW	European Arrest Warrant
HMCTS	Her Majesty's Courts and Tribunal Service
HMIP	Her Majesty's Inspectorate of Prisons
HMP	Her Majesty's Prison
HMPPS	Her Majesty's Prison and Probation Service
L & D	Liaison and Diversion
LO	Lay Observers
MC	Magistrates' Court
MoJ	Ministry of Justice
NC	National Council (of Lay Observers)
NHS	National Health Service
NPCC	National Police Chiefs Council
NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (United Nations)
PCO	PECS Custody Officer
PECS	Prisoner Escort and Custody Services
PER	Person Escort Record
PGA	Prison Governors' Association
SCH	Secure Children's Home
SIR	Serious Incident Report
SIS Intel	Special Intelligence Services Intelligence
STC	Secure Training Centre
VRH	Video Remand Hearing
YCS	Youth Custody Service
YJB	Youth Justice Board
YOI	Young Offenders Institution