Lay Observers

Independent monitors
of court custody & escort

Annual Report 2018 -2019

Annual Report of Chair of Lay Observers

Monitoring Decency, Respect and Welfare

INTRODUCTION

I was appointed in May 2018 by the Secretary of State at the Ministry of Justice (MoJ) as the Chair of the Lay Observers (LOs) who 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). I report annually to the Secretary of State for Justice and this is my first such report.

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.*[1] We are independent, unremunerated, public appointees.

PECS has overall responsibility for overseeing the transportation and holding of Detained Persons (DPs) with the two contractors Geo-Amey and Serco providing the transport vehicles and the court custody officers. HMCTS manage and maintain the fabric and furniture of the court custody suites.

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 under 100 LO members monitoring in accordance with the relevant specifications in the United Nations set of Standard Minimum Rules for the treatment of prisoners as set out in the Mandela Rules for adult males, the Bangkok Rules for adult females and the Beijing Rules for children (under 18s) and young persons (under 21s). This guarantees that LOs function independently of government, government agencies including the MoJ, HMPPS, HMCTS and other relevant organisations contracted to provide services and their managers and staff.

As a national organisation, the role of LOs is to monitor the conditions in which detained persons/prisoners (DPs) are transported or held by escort and custody contractors in England and Wales. We make judgements against a set of standards as set out in the Statement of Expectations (see pages 23 – 24), to ascertain that DPs are treated with **decency** and **respect** and their **welfare** is properly managed.

Over the past year LOs prepared 1722 visit reports, monitoring approximately 2.5% of the people in escort and court custody. Each month these reports are aggregated into a national 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 this criminal justice pathway - HMPPS, HMCTS central operations, HMCTS Property, Her Majesty's Inspectorate of Prisons (HMIP), National Police Chiefs Council (NPCC), Youth Justice Board (YJB), Youth Custody Service (YCS), NHS, Justice and MoJ sponsor teams.

This report summarises the findings against our expectations and makes recommendations requiring action by the various bodies with a duty of care in relation to DPs.

The year 2018-2019 has seen a number of developments in the LO organisation as well the monitoring and reporting role. In October 2018, a revised set of Expectations was introduced along with a new reporting form. The LO National Council was expanded with two new appointees and a number of new LOs undertook training and mentoring.

Whilst the areas of good practice noted in the last Annual Report have been largely maintained and extended, it is disappointing that areas of concern noted in previous reports are also still much in evidence.

John Thornhill, National Chair, Lay Observers - August 2019

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

Key findings for the Secretary of State

This report acknowledges that a number of initiatives have been implemented; improved sanitary provision for females; the introduction of a distraction pack pilot offering DPs a range of reading materials, puzzles and quizzes; improvements in food provision; a project to more effectively control extreme temperatures; introduction of ecoSpoons for safety and environmental reasons; improvements in management of medical provision and medication.

It also notes that serious issues highlighted in previous reports continued largely unmitigated during 2018-19. LOs report such concerns using the following scale: 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*. Every month the HMPPS PECS provides a detailed report on the actions taken on all Level 3 issues. However, overall, there are still too many at Level 1, 2 and 3.

The table below provides data on the activities of LOs and the levels reported for each quarter of the year, with the total for the year in the final column. Of the DPs observed in the custody suites a very high percentage were interviewed – 69% of male adults, 75% of female adults 77% of male children and young people (CYPs) and 89% of female CYPs.

Vehicle Inspection Notices indicating deficiencies in transport vehicles have reduced overall compared with the previous year.

There are still a significant number of cells out of use, resulting in too many DPs having to share cells and not having privacy when they are already stressed by a court appearance. The number of inaccuracies and omissions in Person Escort Records (PERs) remains unsatisfactorily high.

Item	Q1	Q2	Q3	Q4	Year
Visits undertaken	419	419	431	453	1722
Adult Male Seen	2054	1804	1926	2071	7855
Adult Male Interviewed	1439	1236	1355	1404	5434
CYP Male	124	123	106	103	456
CYP Male Interviewed	90	95	92	78	355
Adult Female	206	205	181	206	798
ADULT Female Interviewed	161	152	136	157	606
CYP Female seen	4	6	14	4	28
CYP Female Interviewed	3	6	13	3	25
Level 1	1350	1154	858	1019	4381
Level 2	303	235	222	213	973
Level 3	30	37	28	38	133
Vehicles Inspected	143	154	172	207	676
Vehicle Inspection Notices issued	8	12	18	31	69
Number of cells out of use	273	163	186	205	827
Number of detainees sharing cells	289	241	260	192	982
DPs vulnerable seen	250	223	17	15	505
Number of DPs who needed medication	619	582	141	111	1453
Number of DPs without their medication	57	85	66	40	248
Number of PERs with inaccuracies	1132	916	874	1072	3994

THE MAIN ISSUES

1 Grave concern remains over the completeness, quality and effectiveness of the Person Escort Records (PERs). Many of the records sent by police and prisons when handing over custody to the PECS contractors are inaccurate and incomplete. These omissions and inaccuracies affect the decency with which DPs are treated and impact on their welfare whilst in court custody. The continued lack of accurate and detailed data in turn hampers transport and custody suite staff in the making of proper risk assessments of the security and welfare for each DP.

2 Healthcare continues to give cause for concern with adverse impact on the processes which are required to ensure that health needs, including medication, of DPs are properly met. The impact of any failings on this area is that the DP may not be in the best possible health for their court appearance.

3 Reports from LOs clearly indicate that there are inconsistencies in the delivery of a range of services. The consequence is that some DPs are not treated with **decency** and **respect** and their **welfare** is not always properly managed. LOs remain disturbed that there is too little timely positive response to the major points that are raised, with continued adverse impact on the welfare of the DPs.

4 The risk still continues of serious consequences to the welfare and access to justice for DPs resulting from them '*falling through the net*' of disconnected contracts and responsibilities across all stakeholders engaged in the care and management of detained persons including prisons, police and the escort and court custody services.

5 The condition of a number of custody suites holding large numbers of DPs continues to fall below expected standards with large quantities of unacceptable and ingrained graffiti and poor overall cleanliness.

6 The escort and court custody arrangements for and treatment of CYP's facing court appearances for trial in particular are completely unsatisfactory.

7 Too many DPs still experience more than a two-hour delay after sentencing in their transportation. Often timescales for DPs who are moved to prisons a long distance outside the vicinity of the sentencing court are being unacceptably extended.

8 Significant reliance is being placed on deferring action to address the deficiencies highlighted by monthly and annual LO reports to the implementation of the 4th Generation PECS contract (otherwise known as PECS 4) which will not be implemented until 2020.

9 There is a lack of cohesion and consistency in the delivery of services across the range of agencies and the estate within the structure of those groups and organisations providing services under HMCTS.

1 WELFARE

1.1 The summary reports for each of the four quarters of the year indicate the real concerns. They show how, under LO Expectations, a number of DPs are not being treated with respect and decency and their welfare is not being managed properly. This section focuses on the new set of Expectations introduced in October 2018, but the summaries for April 2018 – Sept 2018 (pages 16 -17) also highlight and support the major issues.

1.2 *The case studies shown in the green tint boxes below are direct extracts from Lay Observer reports; a small number have been slightly adapted, for example to remove information which might identify a DP.*

The custody suite is managed and run in a manner that ensures the wellbeing of DPs		***0***	***1***	***2***	***3***
Assessment of PERs	Q3	191	**153**	**30**	**1**
	Q4	176	**174**	**33**	**4**
The recording of events in the custody suite are maintained accurately and promptly	Q3	355	6	2	0
	Q4	364	7	0	0
Where there is inaccuracy in the PER that impair risk assessments staff refer the matter back to the originator for clarification	Q3	217	21	1	0
	Q4	236	22	3	0
Where DPs are sharing a cell a formal cell share risk assessment has been completed before the DPs are placed together	Q3	116	2	3	0
	Q4	118	4	2	0
DP property is kept safely and the tagging of property is accurate	Q3	302	1	0	1
	Q4	313	3	1	0
Handcuffing of DPs is based on risk assessments	Q3	210	6	0	0
	Q4	251	8	0	0
Staff work effectively as a team to ensure the safety of all in the custody suite	Q3	360	0	2	0
	Q4	380	2	1	0
Defects are raised formally with the HMCTS team in the court	Q3	304	12	2	0
	Q4	317	11	4	1
One of the HMCTS team visits the custody suite at least monthly and makes an inspection of the whole custody suite	Q3	275	18	1	0
	Q4	291	18	1	1

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***
Medical information on the PER enables staff to make an accurate assessment of each DP's health care needs	Q3	230	94	**18**	**1**
	Q4	250	76	**22**	**3**
The arrangements for assessment & support of DPs with mental health concerns or learning disabilities is satisfactory	Q3	217	25	**5**	0
	Q4	238	11	**5**	1
The physical, mental and psychological needs of DPs are adequately met	Q3	233	20	**6**	0
	Q4	267	14	**5**	0
Medication is stored securely	Q3	134	2	0	0
	Q4	174	2	0	0
DPs have access to any medication that they should have during their time in court custody	Q3	135	32	5	1
	Q4	162	25	3	0

PERSON ESCORT RECORDS (PERS)

1.3 It is very clear from these figures that PERs remain a serious problem. This vital element of risk management was introduced in May 2009 following the Zahid Mubarek Inquiry.[2]

1.4 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 DP may present.

1.5 In 2012 Her Majesty's Inspector of Prisons initiated a two-stage report at the request of the Independent Advisory Panel of the Ministerial Board on Deaths in Custody.

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

1.6 It describes the process by which information about a person's risk of self-harm is transferred and used as they move between police custody, court and prison and on other external journeys. The main vehicle for conveying this information is the PER. The findings of that report expressed the view that the process of completion of the PERs requires agencies to co-operate to fulfil the duty of care; they highlighted the importance of the maintenance of quality in large-scale processes where the risks might be infrequent but serious for the individuals concerned, and the role of ensuring communication between the operational staff involved is effective and informed by a good understanding of each other's needs.

1.7 However, despite the various recommendations, it is clear that the issues are still live. In both Q3 & Q4 reports, findings show that 55% of the PERs examined were not satisfactory. They are evidence of the failure to manage this aspect of the service in the best interests of those who are detained. The reports provide a range of observations which **must surely concern everyone**. The failure to include relevant detailed evidence places staff or others who come into contact with the DP at risk of harm as well as the DP themselves. A consistent theme running through the PERs is the omission of appropriate medical contact numbers for custody and other staff to access when necessary. Often this results in recourse to using already busy A&E facilities at nearby hospitals. Also, many reports identify that the section on whether the DP has to take medication or not is left empty.

1.8 Another serious concern is around medication issues, how well the medication is noted on the PER and how it is effectively dispensed whilst in the custody suite. The most recent guidance provided by NHS England and by an NHS England pharmacist on this matter has been disseminated to LOs and it will be for future reports to identify if the issues have diminished or been eradicated.

1.9 During the year an electronic PER has been trialed which does not allow an entry box to remain empty so ensuring that every section is completed. However, LOs have already reported that despite this, the contents of some of the boxes still cause concern with omissions and inaccuracies.

1.10 LOs have noted that Liaison and Diversion (L&D) teams are hardly ever available at police stations or in courts on a Saturday or Bank Holiday to assess the mental state of the DP. As a result, any DPs arrested over Friday night or Bank Holiday who have not been assessed by L&D at a police stations or in court may be unreasonably remanded in court custody to a prison until the next full court day.

Leeds Magistrates

A female DP's PER stated they were contagious with no further details. We spoke with staff regarding this and how they would deal with the DP and were advised they would wear gloves and masks if necessary.

A DP from a police station did not indicate any prescribed medication though the DP said she had to take some.

A further PER states self-harm marker with no further details and no medical number provided.

Chester Magistrates

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. There was an assault recorded but no date attributed to it.

It was recorded that an interpreter was needed but no details of this had been arranged.

Southampton Crown Court

PER was almost blank - there were no risks, no ethnic code, no religion, and no health contact number. The DP was Vietnamese and effectively spoke no English - none of this was obvious from the PER.

Liverpool Combined Court

24 PERs were examined with 16 having inaccuracies (66%). Most of these inaccuracies involved the lack of a health contact number or failure to check the box (yes/no) confirming whether or not the DP requires medication.

The lack of accurate PER recording for medication was further highlighted with another very difficult and aggressive DP who arrived from a local police station. The DP had been threatening violence towards the escorts and custody staff and appeared very agitated. During his induction and risk assessment his medication was found to be in his property but not recorded on the medication section of the PER. Inaccurate or incomplete information like this reduces the ability for staff to make accurate risk assessments. In addition, staff had to open the DP property bags to find the medication.

Oxford CC

DP from a YOI had an open Assessment, Care in Custody and Teamwork (ACCT - the care planning process for prisoners at risk of suicide or self-harm) which was indicated on the PER. However, the significant issues with his care were not obvious from the PER, (indicated risk of 'may attempt suicide') and were only in part found buried in the lengthy ACCT folder. The Court Custody Manager had established from the YOI that he had been in segregation and were therefore moving him separately from the co-defendant. They felt they could consult L&D by phone if necessary but fundamentally more information and support was required.

There was some consistency across all of the PERs. In all of the PERs the section on 'Religion' was completed but in none of the PERs were any of the 'Risks' dated, nor was there an entry in the contact number for medical queries box.

Nottingham CC

Due to the error in one of the PERs, it is not likely that mental health need of this particular DP would have been met.

During the visit 4 DPs arrived and the handover was observed, staff were polite and welcoming to DPs asking if they had solicitors and if they required refreshments.

A DP arrived from a police station who was not on the expected list; CCM telephoned the courts prior to acceptance to ensure this was possible.

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

Liverpool Combined Court

This is an extremely busy Combined Court with a very challenging throughput of DPs not helped by a poor infrastructure layout which continues to be highlighted but not addressed. Despite this the CCM maintains a well-motivated team that appears to manage the facility very well under difficult circumstances.

1.12 In an initiative to help improve the completion of PERs a large local prison set up a meeting to discuss this matter with LOs who reported that it was a positive and productive meeting. Their report states:

The issue of how much detail to include in the PER on current and historical violence will continue to be the most difficult area. Arguably it will remain so due to its subjective nature, however I would highlight the conversation we had with the staff member responsible for completing that section, who as we left stated her main takeaway from the meeting was the "realisation that somebody had to read the PER and make a risk assessment from her notes!" A real learning point and one we probably all took for granted.

1.13 This comment and the regular visit reports highlight the issue of training and quality assurance of PERs.

2 DECENCY

2.1 One of the main Expectations is that the DPs should be treated with respect and decency. However, far too often LO reports indicate that the quality of the custody suite does not show respect or provide a decent environment for both the DPs and the staff.

DPs are held in a custody suite that is clean, safe and in a good state of repair		*0*	*1*	*2*	*3*
Graffiti assessment	Q3	221	**142**	**24**	**3**
	Q4	249	**130**	**21**	**5**
Cleanliness assessment	Q3	323	**55**	**14**	**1**
	Q4	335	**54**	**16**	0
Kitchen has functioning equipment for hot and/or cold food	Q3	366	21	4	0
	Q4	378	24	7	0
There are hygienic facilities for all DPs to use a toilet and wash & dry their hands	Q3	320	42	**13**	2
	Q4	356	37	**10**	3
Female sanitary provision is available, and routinely offered both on arrival and on request	Q3	257	12	0	0
	Q4	274	4	2	0
Cell temperatures adequate (neither too hot nor too cold)	Q3	349	26	**13**	0
	Q4	359	32	**11**	4
There are no potential ligature points in areas used by DPs	Q3	277	12	2	3
	Q4	302	21	5	4
The custody suite and areas used by staff & DPs are in good condition and fit for use	Q3	257	**57**	**40**	**10**
	Q4	269	**66**	**42**	**11**

2.2 The figures for Q3 show that 43% of custody suites had unacceptable levels of graffiti with the figure for Q4 reducing slightly to 39%. Some reports indicate that the graffiti is 'ingrained.' As regards the Q3 assessment of cleanliness, 18% of custody suites were not satisfactory though in Q4 there was a very small improvement to 16%. Nevertheless, these figures suggest in a number of suites there is a lack of respect for DPs.

> ***Westminster Magistrates' Court***
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> At the last visit the condition of the toilets was so bad that it was given a Level 3. If anything, things are worse now than they were then. This is the only magistrates' court in London that is DDA compliant. All disabled DPs who need to appear in a magistrates' court are sent here. The toilet has been out of use for months. Today the toilet is still blocked and there is no water in the disabled toilet. It is impossible to flush the toilet and should a disabled DP wish to wash his or her hands there is no water in the taps: there is no disabled toilet.

2.3 A number of reports indicate there is inadequate 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. HMCTS appears to be over-reliant on outside contractors to operate effectively the building control management systems. At one court it was observed that painters had part-painted over the fine ventilation grilles, impacting on the effectiveness of the ventilation system. PECS have positively responded by collaborating with HMCTS in closing a number of custody suites but such action must surely have impacted on listings and trial dates.

2.4 The failure to provide a satisfactory balanced environment was often overcome by some considerate court custody managers (CCMs). During the cold winter, there were concerns about the lack of adequate heating. A number of CCMs are to be complimented on the measures they undertook to make sure the DPs were warm by acquiring jumpers and carrying out laundry duties themselves. Others sought support from the police or local groups to provide blankets of various kinds. Whilst they are to be commended for their kindness they should not be placed in a situation where they have to do this.

2.5 However, such consideration is not consistent across the estate. If **the Standard Operating Practice (SOP)** instruction which, for security reasons, prevents the opening of prisoner's property is to be maintained and upheld, then provision should be made for DPs to be provided with adequate clothing or blankets.

Birmingham Magistrates Court

There is evidence of ingrained graffiti in many of the cells.

It was reported that up to yesterday there had been a foul odour in the office attributed to mice infestation and rotting mice corpses. Continued pressure from the CCM resulted in these corpses being removed and the office fumigated.

It has been reported by the CCM to HMCTS that the Visitor's Intercom was not working properly. It remains unrepaired. It was reported to HMCTS by the CCM and by the court delivery manager that the camera system was seriously defective with only 50% operating. HMCTS apparently are seeking a quote. The CCM again asked for urgent action on 13th and 20th June.

It was noted in the last LO report and I was shown by the CCM that there is serious leakage through the gents staff toilet into the kitchen when there is heavy rain. This has been reported several times but remains unrepaired.

There are often foul odours by the closed off entrance to the outside from the stairs leading from the custody suite to the main hall/foyer upstairs. This is used when DPs are escorted from courts when they are remanded off bail and for delivering paperwork from the suite to court officials. The odour is believed to be caused by people urinating in the street against the doors of the entrance. The stairwell used to be disinfected regularly but this I am told has stopped.

Thames Magistrates Court

The toilet areas are poor. There is no hot water. One of the taps in the male toilet area shuts off the second the handle is released, making it impossible to use this hot water tap (not that there is any hot water). If DPs decide to wash their hands there are no paper towels. On my last visit I was told that the cleaners will not provide paper towels. Today I was told this is because DPs cannot be trusted to use them sensibly: they may use them to block the toilet. This is unsatisfactory and shows a lack of dignity for the vast majority of DPs.

2.6 Again, custody officers often take measures to counter the poor quality and cleanliness of accommodation showing examples of good practice and consideration.

I raised an issue at ***Oxford Magistrates Court*** about paper towels thrown on the floor in a pile and cleared by cleaners. At April visit a builder's bucket complete with metal handle had been provided. Some courts in Thames Valley have bins.

At ***Swindon Crown Court*** I found towels are placed on the side after use and individually removed by staff using disposable gloves.

Winchester Crown Court

- Graffiti levels are relatively low with a little largely historic graffiti in some cells (L1).
- Cleanliness is generally good. Although there has been no deep clean, the cleaning staff have gradually giving all cells as deep a clean as possible. They are now looking much better.

DPs have good access to legal advice and support		*0*	*1*	*2*	*3*
Where necessary adequate interpreter facilities are available	Q3	171	4	2	0
	Q4	173	5	2	1
Custody staff make good use of interpretation services to communicate with non-English speaking DPs	Q3	118	4	1	0
	Q4	124	10	0	0
In MCs all DPs have access to legal advice within 2 hrs	Q3	208	53	4	2
	Q4	246	40	4	0
DPs are satisfied with the legal support they have in court	Q3	248	21	3	1
	Q4	277	11	0	0
DPs have access to their legal papers when they ask for this	Q3	212	10	4	0
	Q4	217	4	0	0

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

3 RESPECT

3.1 In general, it appears that custody managers and staff show a creditable 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 DPs, as shown in this report about a pregnant woman's experience at court:

> ***Southampton Magistrates Court***
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> The female DP had been brought from the prison. This DP was known to staff having last appeared here about a month ago. At that time, her PER indicated she was 7 months pregnant. Today her PER stated she was still 7 months pregnant. Staff were surprised by this knowing the woman was now 8 months into her pregnancy. The PER had possibly one risk marker. It showed an open ACCT, but this had also been crossed out. No attempt had been made to indicate if there were no known risk markers. Once again staff were surprised because this DP had not been on an open ACCT when last in the court. The health risk markers still stated she was 7 months pregnant and also suffering from anxiety. She was not shown as being on any prescribed medication.
>
> When I spoke to this female she told me this was to be her third baby. Both her other two children were delivered two weeks early. She told me she is a methadone user and also takes many other medicines for 'various' ailments. She had been given her medication prior to leaving prison. There was, however, no mention of any of this in her PER. Being so close to her due date staff were concerned about the lack of accurate health information should it be necessary for this DP to be taken to hospital.
>
> The pregnant female was taken to and from court without being handcuffed. During her court appearance she was accompanied by two members of staff.
>
> This female DP had been brought to court in an MPV. She left her prison at 07:40, arriving at Southampton at 09:20. The PER indicated she had been double cuffed when being placed onto the vehicle. She made her court appearance at 11:05 and was returned to the custody suite at 11:15. Staff then attempted to obtain a suitable vehicle. I contacted the custody suite at 14:45 and was told they had received an ETA of 16:30 for a vehicle. This long wait for any individual is unacceptable but especially so for a woman who is three weeks from her due date.

3.2 The experience indicates a serious lack of respect for a woman not far from her due date. However the custody officers were not only considerate but also concerned about the woman and showed significant respect and ensured her dignity. Given that her court appearance was only 10 minutes long, the lengthy delays and the poor health and risk information provided in her PER meant that treatment of this woman was wholly insupportable. This is an area where serious consideration should be given to women in such a condition and whether an appearance in court is necessary in this modern age of video technology.

3.4 This report and the one below again highlight the issue of handcuffing. The use of this control measure and double locking of the cuffs is based on SOPs rather than individual risk assessments. The blanket cuffing of all DPs in secure areas, even to go to the toilet or a legal visit, is not acceptable. It is important to protect staff and other DPs from danger of harm, but each DP should be individually risk assessed taking into consideration their mental state and vulnerability. However, the inadequacies, omissions and inaccuracies in a majority of PERs would not allow court custody staff to do this with any degree of confidence.

Portsmouth Magistrates Court

I observed the handover of one female DP to PECS. This female was due to appear in court on a drink-drive case. She had been taken into custody because she had failed to appear. There were no risk markers. In line with the GEOAmey Standard Operating Practice (SOP) the Police Custody Officer put the DP into handcuffs to take her from the police station through a secure passage into the court custody suite. The female told me she had not been handcuffed whilst in the police custody but did not object to the cuffing. This rigidity in the handcuffing regime is understandable because it guarantees the protection of staff at all times. It does, however, seem overly rigid when extremely low risks such as this female are placed in handcuffs. She was also handcuffed to take the three or four paces from the cell block to the legal room when seeing her solicitor. I have no criticism of the custody staff who acted with sensitivity, making a joke to the obviously concerned female about the requirement to place handcuffs on her. The lack of any limited flexibility is lacking in respect and dignity for those DPs with minimal risks.

3.5 These indicate that there is a lack of respect and decency in the treatment of some CYPs. A number of vulnerable young persons were involved in a two-week trial at Liverpool Crown Court. Each day they were transported to and from Wetherby – a distance of over 90 miles with journey times up to two hours. Such long journeys on a daily basis will drain any individual and especially for younger defendants it would mean that they may not have been at their best when giving evidence on the Friday of the first week.

Southampton CC

A 14-year-old CYP had been placed in the female cell away from all adults. Despite the low risks and the knowledge of the YJB staff **he was treated in exactly the same way as all adults** when being moved around the custody suite. When going for his visits he was handcuffed in the same way as all DPs. He appeared to have a good relationship with the escorts who brought him to the court but had no contact with them during his time inside the custody suite. He was placed in a cell **without any access to adults or something to take his mind off his court appearance.**

Plymouth Magistrates

A young female CYP was remanded. This girl had been brought from police custody in the morning. By the time she had been seen in court she was finally remanded and to be placed in a secure unit at 15:50. Eventually a vehicle had been dispatched from a vehicle base in Kent. **The vehicle crew finally took the girl into custody at 22:55 to then transport her to her establishment**. This necessitated a journey in excess of 3 hours. This is quite unacceptable for any DP and especially for a CYP.

Bradford Magistrates Court

There are sometimes long waits for transport, especially for CYPs. A 14-year-old child was brought to court and the PER showed that he arrived in the custody suite at 08:46. He was then kept in his cell until his court appearance at 15:08. His court appearance ended at 16:05. He eventually left the custody suite for his onward journey to a YOI at 20:00. That meant [he] had been held in the cells here for **over 11 hours.**

4 CONCLUSIONS

4.1 There are many projects to enhance the conditions for DPs with clear objectives at senior management level to improve their experiences of DPs. However, there were still many serious issues at the operational level during the reporting year.

4.2 The inadequate level of cohesion across the number of agencies and staff involved in PERs has not been satisfactorily addressed. The lack of acceptable interface between the computer systems used by the three main groups – police, prison and courts - means risk factors and markers are not consistent and place anyone that comes into contact with DPs at risk. Evidence suggests the information gained in court may not always follow the DP during their journey through the justice system, especially if re-arrested at a later time.

4.3 The poor quality of some of the accommodation in larger custody suites is not decent, despite the efforts of custody staff to provide a respectful experience. In a comment for this annual report a LO stated that:

4.3.1 *I have rated graffiti highly solely in terms of graffiti that fully identifies others such as '(full name) is a grass/nonce', as the clear identification of people could put those individuals at risk from anyone else who uses the cell and may know of them, particularly if it is gang- related.*

4.3.2 *A 'near miss' incident occurred at Oxford Magistrates soon after Christmas in which a ligature knife was used. When I visited in January, no investigation had been made by management (or one later). An investigation is essential to enable management to audit whether their own procedures were followed and whether a review of them is required. I found that the CCM was unaware that the ligature knife should be re-bladed after use. Enquiries at several other Thames Valley courts several months later revealed this information was still not known elsewhere. One CCM was however able to identify a Standard Operating Procedure which does give this information. Had an investigation been carried out this lack of knowledge would have been identified along with any other issues as something to disseminate to staff.*

4.4 The observation reported in 4.3.2 indicates a serious failure to ensure that all staff are fully aware of the requirement in relation to ligature knives and again reveals inconsistent delivery of a vital service across the estate. It further suggests that training may not be consistent or effective and that adequate quality assurance procedures to mitigate risks to staff and other DPs are either not in place or enforced.

4.5 LO reports are a vital aspect of quality assurance to ensure that DPs are treated with **decency** and **respect** and their **welfare** properly managed. Whilst there is a structure for stakeholder meetings, the LO Area Co-ordinators report that the management, quality and effectiveness of these 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. There is a very positive relationship in the Hampshire area where written responses to the reports are provided at the meeting to identify the actions taken to remedy any deficiencies in service. It would be a positive outcome if this example of good practice was disseminated and implemented across all regions.

4.6 It is recognised that services are provided by a range of agencies and groups including contractors and that this militates against smooth and consistent delivery. There are many 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'. Our particular concern is that there does not appear to be any appropriate organisation nationally prepared to adequately address this issue. This report raises the matter and makes appropriate recommendations to ensure a co-ordinated and connected approach so that in the future all who have a duty of care for DPs treat them all with **decency, respect** and manage their **welfare** consistently and effectively.

The custody suite is managed and run in a manner that ensures the wellbeing of DPs		*0*	*1*	*2*	*3*
Assessment of PERs	Q3	191	**153**	**30**	**1**
	Q4	176	**174**	**33**	**4**
The recording of events in the custody suite are maintained accurately and promptly	Q3	355	6	2	0
	Q4	364	7	0	0
Where there is inaccuracy in the PER that impair risk assessments staff refer the matter back to the originator for clarification	Q3	217	21	1	0
	Q4	236	22	3	0
Where DPs are sharing a cell a formal cell share risk assessment has been completed before the DPs are placed together	Q3	116	2	3	0
	Q4	118	4	2	0
DP property is kept safely and the tagging of property is accurate	Q3	302	1	0	1
	Q4	313	3	1	0
Handcuffing of DPs is based on risk assessments	Q3	210	6	0	0
	Q4	251	8	0	0
Staff work effectively as a team to ensure the safety of all in the custody suite	Q3	360	0	2	0
	Q4	380	2	1	0
Defects are raised formally with the HMCTS team in the court	Q3	304	12	2	0
	Q4	317	11	4	1
One of the HMCTS team visits the custody suite at least monthly and makes an inspection of the whole custody suite	Q3	275	18	1	0
	Q4	291	18	1	1

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*
Medical information on the PER enables staff to make an accurate assessment of each DP's health care needs	Q3	230	94	**18**	**1**
	Q4	250	76	**22**	**3**
The arrangements for assessment & support of DPs with mental health concerns or learning disabilities is satisfactory	Q3	217	25	**5**	0
	Q4	238	11	**5**	1
The physical, mental and psychological needs of DPs are adequately met	Q3	233	20	**6**	0
	Q4	267	14	**5**	0
Medication is stored securely	Q3	134	2	0	0
	Q4	174	2	0	0
DPs have access to any medication that they should have during their time in court custody	Q3	135	32	5	1
	Q4	162	25	3	0

DPs have good access to legal advice and support		*0*	*1*	*2*	*3*
Where necessary adequate interpreter facilities are available	Q3	171	4	2	0
	Q4	173	5	2	1
Custody staff make good use of interpretation services to communicate with non-English speaking DPs	Q3	118	4	1	0
	Q4	124	10	0	0
In MCs all DPs have access to legal advice within 2 hrs	Q3	208	53	4	2
	Q4	246	40	4	0
DPs are satisfied with the legal support they have in court	Q3	248	21	3	1
	Q4	277	11	0	0
DPs have access to their legal papers when they ask for this	Q3	212	10	4	0
	Q4	217	4	0	0

DPs are held in a custody suite that is clean, safe and in a good state of repair		*0*	*1*	*2*	*3*
Graffiti assessment	Q3	221	**142**	**24**	**3**
	Q4	249	**130**	**21**	**5**
Cleanliness assessment	Q3	323	**55**	**14**	**1**
	Q4	335	**54**	**16**	0
Kitchen has functioning equipment for hot and/or cold food	Q3	366	21	4	0
	Q4	378	24	7	0
There are hygienic facilities for all DPs to use a toilet and wash & dry their hands	Q3	320	42	**13**	2
	Q4	356	37	**10**	3
Female sanitary provision is available, and routinely offered both on arrival and on request	Q3	257	12	0	0
	Q4	274	4	2	0
Cell temperatures adequate (neither too hot nor too cold)	Q3	349	26	**13**	0
	Q4	359	32	**11**	4
There are no potential ligature points in areas used by DPs	Q3	277	12	2	3
	Q4	302	21	5	4
The custody suite and areas used by staff & DPs are in good condition and fit for use	Q3	257	**57**	**40**	**10**
	Q4	269	**66**	**42**	**11**

Detainees are transported to and from court in reasonable time and in suitable vehicles		*0*	*1*	*2*	*3*
Females are transported to and from court separately from males and in a manner where they are safe and protected	Q3	123	6	1	2
	Q4	158	6	0	0
DPs do not have to wait for more than two hours after their court appearance	Q3	127	**77**	**8**	0
	Q4	150	**82**	**3**	0

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*
The way in which DPs are received into the custody suite ensures they know what they are entitled to and they understand the procedures	Q3	281	7	2	0
	Q4	286	7	0	0
Rights leaflets are in each cell and staff take adequate steps to ensure each DP understands his/her rights	Q3	347	**25**	6	0
	Q4	370	**19**	**7**	0
DPs are told they can ask for reading materials. These are offered to all DPs	Q3	332	14	0	0
	Q4	339	16	0	0
DPs are treated with respect & any religious needs catered for	Q3	311	7	1	0
	Q4	302	10	1	0
DPs remanded are informed of what to expect when they go to prison (FNLs) for the first me	Q3	170	9	1	0
	Q4	205	6	0	0
There is adequate provision of food, in date	Q3	371	**18**	1	0
	Q4	382	**22**	0	0
When vulnerable DPs are released from custody staff take steps to ensure their safety and wellbeing after they leave the court	Q3	134	3	1	0
	Q4	164	3	0	0
Females and vulnerable DPs separated from other DPs	Q3	215	7	0	0
	Q4	232	4	1	0
DPs on a SASH are monitored in accordance with the guidance in the SASH	Q3	140	0	0	0
	Q4	162	2	0	0
DPs on an ACCT are monitored in accordance with the stipulations	Q3	96	1	0	0
	Q4	135	1	0	0
Staff interaction with DPs is good	Q3	351	2	1	0
	Q4	371	3	0	0
When DPs are released they are given travel warrants and sufficient petty cash to travel home	Q3	195	2	1	0
	Q4	173	0	1	0
When DPs are released staff provide them with relevant support leaflets that are available in the custody suite	Q3	137	12	0	0
	Q4	161	3	0	0
DPs released with minimal delay	Q3	164	**17**	0	0
	Q4	162	**20**	0	0

DPs HAVE ACCESS TO SUITABLE HEALTH CARE TO MEET THEIR NEEDS DURING THEIR TIME IN THE CUSTODY SUITE		0	1	2	3
PERs enable staff to make risk assessments	Q1	238	**98**	**24**	4
	Q2	222	**106**	**27**	0
PER accurately records healthcare administration relevant to escort and court custody period including contact and accompanying medication details	Q1	177	**139**	**22**	2
	Q2	196	**114**	**24**	1
There is mental health provision to assess and report to the court on DPs ability to participate in court process	Q1	228	11	**5**	0
	Q2	226	18	**5**	0
Medication to cover journey day available or administered	Q1	226	27	**7**	0
	Q2	169	29	**7**	1
All DPs are satisfied that their medical needs have been met whilst at court	Q1	247	**41**	3	0
	Q2	246	28	3	0

DPs HAVE ACCESS TO LEGAL ADVICE AND SUPPORT		0	1	2	3
Rights forms in cells in language of DPs	Q1	354	**27**	9	0
	Q2	360	**24**	3	0
DPs understand their rights	Q1	300	**20**	4	0
	Q2	288	11	0	0
Where necessary adequate interpreter facilities are available	Q1	123	3	**5**	1
	Q2	129	9	2	0
All DPs access legal representation within 2 hours of arrival or court appearance when solicitor retained	Q1	252	**67**	2	1
	Q2	252	**52**	3	0
DPs have access to their legal papers	Q1	216	2	3	0
	Q2	197	5	1	0

DPs ARE TRANSPORTED TO AND FROM COURT IN REASONABLE TIME AND IN SUITABLE VEHICLES		*0*	*1*	*2*	*3*
No DP presented at court unnecessarily	Q1	297	15	**8**	0
	Q2	300	17	2	0
Females all brought to court in vehicle with only female DPs. If shared was there separation from males or abuse from males	Q1	124	11	0	0
	Q2	109	22	0	0
DPs do not have to wait for more than 2 hrs in cells a er their court appearance	Q1	139	**93**	1	0
	Q2	130	**70**	4	0
CYPs transported quickly after their court appearance	Q1	86	26	2	0
	Q2	66	18	6	0
Transport vehicle and equipment comply with PECS specification	Q1	139	14	1	0
	Q2	136	17	1	0

ALL DPs ARE TREATED WITH RESPECT AND ARE FREE FROM DISCRIMINATION		*0*	*1*	*2*	*3*
DPs not subjected to any form of discrimination	Q1	324	15	6	1
	Q2	330	6	2	0
Food available for a range of diets	Q1	379	16	0	0
	Q2	375	16	1	0
CYPs/females and vulnerable DPs separated from other DPs	Q1	215	8	2	1
	Q2	222	7	1	0
Vulnerable DPs carefully monitored	Q1	178	5	1	0
	Q2	175	2	0	0
Handcuffs used appropriately	Q1	228	2	0	0
	Q2	208	0	0	0
DPs given reading materials	Q1	342	10	0	0
	Q2	302	13	0	0

DPs ARE HELD IN A CUSTODY SUITE THAT IS CLEAN, SAFE AND IN A GOOD STATE OF REPAIR		*0*	*1*	*2*	*3*
Graffiti assessment (refer to standards)	Q1	187	148	**44**	4
	Q2	235	117	**26**	**10**
Cleanliness assessment (refer to standards)	Q1	276	78	**28**	**5**
	Q2	312	60	13	1
Kitchen is clean with suitable clean, working equipment including microwave	Q1	346	35	9	0
	Q2	348	38	6	0
Hot water available for hand washing	Q1	327	38	10	0
	Q2	334	24	12	3
Toilets working satisfactorily	Q1	354	17	5	1
	Q2	361	13	5	0
Soap, hand drying and toilet paper available without DPs having to request	Q1	328	42	**10**	0
	Q2	346	27	7	1
Toilets clean	Q1	366	16	2	0
	Q2	368	13	0	0
Female sanitary provision available	Q1	293	7	1	0
	Q2	276	6	0	0
The condition of all interview rooms is satisfactory	Q1	321	24	7	1
	Q2	321	17	6	0
Air cooling/heating working	Q1	296	23	6	0
	Q2	268	31	12	**2**
Cell temperatures adequate (refer to temperature standards)	Q1	364	15	4	0
	Q2	341	27	**10**	2
The custody suite and associated areas are in good condition and suitable for use by DPs	Q1	266	**67**	**36**	7
	Q2	272	**65**	**31**	**13**
All cell officers carry an anti-ligature knife while DP(s) in custody	Q1	356	15	0	0
	Q2	366	3	0	0

THE CUSTODY SUITE IS MANAGED AND RUN IN A MANNER THAT ENSURES THE WELLBEING OF DPs		*0*	*1*	*2*	*3*
Records completed quickly and accurately	Q1	344	12	2	0
	Q2	339	7	0	0
Risk assessments made accurately	Q1	255	**46**	6	1
	Q2	263	**39**	2	0
Staff interaction with DPs is always good	Q1	339	4	2	0
	Q2	345	3	0	0
Issues, including inaccurate PERs, escalated quickly and efficiently	Q1	217	24	2	0
	Q2	226	9	1	0
Court manager/facilies manager visit the custody suite regularly	Q1	288	**21**	5	0
	Q2	276	16	2	0
DPs released with minimal delay	Q1	177	**31**	4	0
	Q2	174	**30**	2	0
DPs remanded are informed of what to expect when they go to prison (FNLs)	Q1	250	1	1	0
	Q2	231	2	0	0
Food is in date, stored correctly and sufficient for a range of diets	Q1	365	**18**	0	0
	Q2	366	13	5	1
Precautions to prevent and react to fires in the custody suite are rigorous	Q1	233	8	4	1
	Q2	217	6	1	2
The management of the custody suite ensures the wellbeing and access to justice for DPs	Q1	332	10	**10**	0
	Q2	345	4	2	0

RECOMMENDATIONS

1. 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 – and a commitment to publish multi-group protocols with relevant *flow-of - information charts* that ensure;
    - i effective communication between the agencies on the treatment of DPs and, in particular, PERs;
    - ii each agency produces a consistent training programme for the preparation and management of PERs;
    - iii quality assurance programmes for PERs are published and implemented;
    - iv mechanisms for more regular written action reports back to the LOs on items of serious concern;
    - v the operation of consistent multi-agency stakeholder groups with LOs as a constituent member;
    - vi the publication of focused guidelines on the treatment of females and CYPs with specific reference to transport, court facilities and waiting times;
    - vii the publication of a consistent protocol that ensures DPs have:
        a. access to medical and mental health support with medication dispensing authorisation located within the court precinct for custodies with more than an average of ten DPs per day and
        b. a fifteen minutes guaranteed response time for custodies with fewer than ten DPs per day.

2. Detailed protocol for the treatment of CYPs, females and vulnerable DPs including:
    - i creation of a separate and appropriate PER for CYPs;
    - ii liaising at an early stage in the day with PECS contractors for the provisional scheduling of transport;
    - iii children and young people's appearances in court should be prioritised.
    - iv allowing the equipment bag from the secure homes transport into the custody suite for the use by all CYPs in custody that day.
    - v allowing the CYP badged escort officers to accompany DPs under the YJB contract to become the supervisors of the custody of all CYP in the custody suite that day.
    - vi the data relating to inaccurately scheduled and unnecessary court appearance should be compiled by HMPPS PECS to pursue and remedy their causes.

3. Statutory underpinning of the national LO structure should be introduced to support LO independence, give it the ability to recruit staff and provide clearer lines of accountability.

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 under 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 entitiled the Mandela Rules for adult males, the Bangkok Rules for adult females and the Beijing Rules for juveniles and young persons.

This guarantees that LOs can function independently and impartially of government and government agencies. At all levels LOs operate independently of the Ministry/Custody Suite Managers/ Contract Delivery Managers/ staff and those agencies providing contracted services.

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 the 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 responsble 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 :

1. The custody suite is managed and run in a manner that ensures the wellbeing of DPs.
2. DPs have access to the medicines they need during their time in the court and are satisfied with their medical care.
3. DPs have good access to legal advice and support.
4. DPs are held in a custody suite that is clean, safe and in a good state of repair.
5. Detainees are transported to and from court in reasonable time and in suitable vehicles.
6. 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.

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 relavent agencies and contractors.

THE ANNUAL REPORT

The Annual Report, which is published, 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.

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APPENDIX B : THE LAY OBSERVER OPERATION

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

During the year the National Council (NC) and Area Co-ordinators (ACs) met regularly though there is still a shortage of an ACs for the North West and North East. LOs meet quarterly with their ACs for personal development and the first national meeting was held in May 2018.

A Development Plan was presented to and agreed by the NC. An aspect of this Plan was to continue the Healthcare Working Group and establish a number of new ones to look at – Standard Expectations, Training Needs, the Treatment of CYPs and Prison Visits.

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

The set of Expectations was reviewed and a new more focused set implemented in Oct 2018.

LOs use a standard template 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 2018-2019 and the case studies shown in the green tint boxes in the text above are direct extracts from LO reports; a small number have been slightly adapted, for example to remove information which might identify a DP.

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.

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

Regular meetings with Head of PECS, Deputy Director HMCTS Central Ops and MoJ sponsor are held.

Most of the recruits in early 2018 have now been trained and mentored whilst on probation and were succesful and moved to fully active LOs.

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

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 and issues and especially not about the health problems of an individual DP, but can raise concerns centrally so such matters can be considered and resolved by those with the legal duty of care for DPs.

APPENDIX C : 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 is maintained accurately and promptly.
Where there is inaccuracy in the PER that impair risk assessments staff refer the matter back to the originator for clarification.
Where DPs are sharing a cell a formal cell share risk assessment has been completed before the DPs are placed together.
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 access to the medicines they need during their time in the court and are satisfied with their medical care
Medical information on the PER enables staff to make an accurate assessment of each DP's health care needs.
The arrangements for assessment & support of DPs with mental health concerns or learning disabilities are satisfactory.
The physical, mental and psychological needs of DPs are adequately met.
Medication is stored securely.
DPs have access to any medication that they should have during their time in court custody.

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 wellbeing 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.