Tamlyn Cairns Partnership

NATIONAL COURT CUSTODY HEALTH NEEDS ASSESSMENT

Commissioned by NHS England
Health & Justice National Team

Version 2.1

Claire Cairns

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List of Abbreviations and Acronyms

Abbreviation/ Acronym	Meaning
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BMJ	British Medical Journal
CEWS	Custody Early Warning Score
CHD	Coronary Heart Disease
CIE	Community Innovations Enterprise
CJ	Criminal Justice
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach (Mental Health)
DH	Department of Health
DP	Detained Person/Prisoner
FME	Forensic Medical Examiner
HCP	Health Care Professional
HMCTS	Her Majesty's Courts and Tribunal Service
HMIP	Her Majesty's Inspectorate of Prisons
HMPPS	Her Majesty's Prison & Probation Service
HNA	Health Needs Assessment
KPI	Key Performance Indicator
L&D	Liaison & Diversion
LD	Learning Disability/Difficulty (defined in report)
LTC	Long-Term Condition
MH	Mental Health
MIR	Management Information Report
MOJ	Ministry of Justice
NDTMS	National Drug Treatment Monitoring System
NHSCB	National Health Service Commissioning Board
NHS(E)	National Health Service (England)
NOMS	National Offender Management Service
NRT	Nicotine Replacement Therapy
OPCC	Office for the Police and Crime Commissioner
OST	Opiate Substitution Therapy
PACE	Police and Criminal Evidence
PCO	Prisoner Custody Officer
PECS	Prison Escort Contract Services
(e)PER	(electronic) Person Escort Record
PHE	Public Health England
PPO	Prisons and Probation Ombudsman
SCH	Secure Children's Home
STC	Secure Training Centre
TBI	Traumatic Brain Injury
VA	Voluntary Attendance/Interview
VP	Vulnerable Prisoner
YOI	Young Offenders Institutions

Project Team

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Claire would also like to thank the member of her team – Rich for providing overall Quality Assurance to the process, Jen for analysing and interpreting the data and Don for his expertise in developing the Predictor Tool.

As ever, this work needed completing on a very tight timescale so the responsiveness of colleagues has been greatly appreciated.

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Chapter One – Introduction, Background and Methodology

Anyone can end up in court custody: the guilty and the innocent; those who are a threat to the safety of others and those who are a danger to themselves; healthy adults, children, and those with the range of mental health and substance misuse problems familiar from police and prison custody. (HMIP Thematic Review, 2015)

1.1 Overview and Purpose

This Health Needs Assessment (HNA) was commissioned by NHS England in August 2018 to determine the nature of health needs amongst both adults and children who are detainees in criminal courts in England.

The purpose was to better understand the current (a) footfall and (b) likely health needs of individuals detained in criminal courts in order to influence the development of a future commissioned service model.

1.2 Aims and Objectives

The stated aims and the NHS England specification for the HNA are as follows:

- Identify a baseline of current services
- Identify gaps in provision and inform future models of services
- Identify best practice and opportunities for development
- Identify options for developing and changing services that promote health and wellbeing
- Identify health inequalities and implement improvements
- Identify health profiles of the population within prison, court cells and police custody.

The stated objectives, as written in the specification, were to:

- Involve a broad range of stakeholders within prisons, courts, HMPPS, PECS and police healthcare environment
- Gather information to obtain an overview and understanding of existing healthcare services and social care needs. Identify the baseline to work forward, enabling an understanding of the needs of prisoners/detainees that can be linked into analyses across the stakeholder spectrum
- Identify services required for population capacity and type
- Ensure equitable service and resource provision transferable between prisons police and courts
- Provide information and advice to assist with the development of future commissioning models.

1.3 Context

The NHS England specification for the HNA included the following helpful contextual information:

> *Health care in criminal courts in England has traditionally been the responsibility of the Prison Escort Contract service providers (PECS) under a long-term contract with HMPPS. From 2013 the responsibility for commissioning healthcare in criminal courts became the responsibility of NHS England. The duty on NHS England is to ensure healthcare services that are considered reasonable. This provision is an important link between those detained in police custody and prisons who then find themselves escorted to criminal courts to await court appearances. This also includes those persons who come from the community to courts on bail and are subsequently remanded in criminal court cells usually after being sentenced to a term of imprisonment.*
>
> *NHS Commissioning Board (NHSCB) operating as NHS England with National Offender Management Service (NOMS) and Her Majesty's Prison and Probation Service (HMPPS) are working together to establish a service specification for healthcare for those so detained in courts cells. Currently the healthcare is provided via a sub-contracting arrangement through the two national PECS providers.*
>
> *The current PECS contracts expire on 31st July 2020 and a retender process is being managed through a strategic HMPPS retender programme board.*
>
> *A requirement of the programme to commission a new service specification for criminal courts healthcare is that a full and comprehensive health needs assessment is completed.*
>
> *The NHSE national health and justice team has the initial commissioning responsibility for the healthcare in criminal court settings as a new programme of work. The focus for this HNA is for the healthcare of those persons detained in criminal court settings to the extent that NHSE considers reasonable.*

An initial stakeholder consultation exercise was commissioned by NHS England and delivered in early 2018 by Community Innovations Enterprise (CIE). This involved interviews with key people and a stakeholder event to begin to consider this area of work and influence the next steps.

1.4 Scope and Definitions

The scope of the work includes the whole country of England and involves children (from the age of criminal responsibility) and adults. Note that whilst PECS have responsibility for England *and* Wales, NHS arrangements in Wales are different to the rest of England. Notably, Liaison & Diversion provision has not been rolled out in Wales.

The focus is on healthcare needs, we have not covered the issue of 'fitness to plead' as this forms part of a far wider judicial process and was thus deemed out of scope.

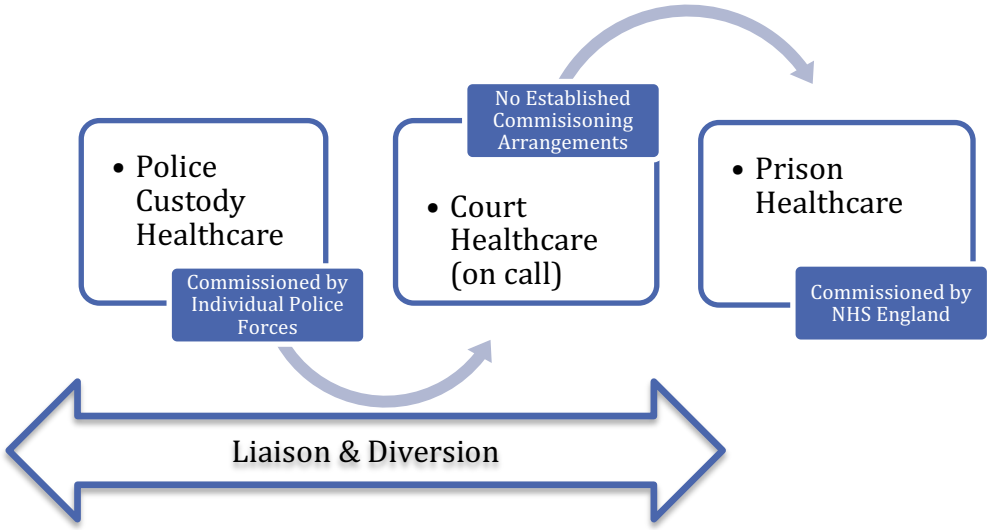
For the purpose of this specification the following definitions are used:

- **Courts** – means *criminal* courts only and, unless otherwise specified includes both Magistrates' and Crown Courts
- **Juveniles** – relates to youths in the criminal justice (CJ) system in accordance with the age of criminal responsibility
- **Detainees** – Whilst PECS have responsibility beyond court custody cells (predominantly for transport and dock supervision), the definition of a *detainee* for the purpose of this report is an individual who is actually detained in the court cells (regardless of how they got there).

1.5 Strategic and Operational Landscape

Court healthcare sits in the middle of two critical criminal justice services whereby full healthcare provision is offered:

Figure 1 - Healthcare in Criminal Justice Settings



Police Custody Healthcare is currently the commissioning responsibility of individual force areas who, over the last decade, have shifted from historical models of on-call FMEs to more embedded services with the ability to assess an increasing proportion of all detainees coming through custody suites. A national plan to shift the commissioning responsibility for police custody healthcare to NHS England in late 2015 was halted, albeit discussions regarding the potential benefit of such a transfer are still ongoing.

The importance of a clear pathway through the criminal justice pathway is underlined for both adults[1] and young people[2] in recent national publications.

There has been no equivalent 'healthcare' provision in criminal courts to date, other than an 'on call' arrangement.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/697130/moj-national-health-partnership-2018-2021.pdf

[2] https://www.england.nhs.uk/publication/the-children-and-young-people-secure-estate-national-partnership-agreement/

Prison Healthcare is commissioned by NHS England and delivered by commissioned providers in each prison establishment. Healthcare in prisons commences with a full reception screen of every individual who comes in through the prison gates.

Liaison & Diversion Services span the criminal justice system from the point of contact with criminal justice services through to entry into prison. L&D services provide screening, assessment, and referral for individuals caught up in the criminal justice system who are vulnerable. This includes offering advice to both the police and courts to support decision-making processes.

Originally evolving as mental health services, L&D is now an all-age, all-vulnerability model with staff typically embedded in police custody suites and also in the majority of courts.

NHS England has commissioning responsibility for L&D provision, via the regional Health & Justice teams. L&D is generally commissioned on a police force footprint area and delivered to a single national service specification.

The national prison reform, alongside the national court reform are a significant part of the landscape within which this HNA was undertaken. This is explored further in Chapter Two.

1.6 Independent Scrutiny of Court Custody

1.6.1 HMIP Inspections

Court custody facilities are included in the range of facilities that are inspected by HMIP. A document produced in 2012 highlights the following expectations for healthcare:[3]

- *A protocol is in place for obtaining emergency health care services and staff know what to do in a health emergency.*
- *Staff are trained in how to administer first aid, and they have access to first aid and suitable resuscitation equipment that is regularly checked, maintained, and ready to use.*
- *Any health interventions, including any medication provided, is recorded in the PER.*
- *A protocol is in place for the administration of medication. Medicines are handled safely and securely and detainees are able to receive prescribed medication they were taking prior to arrest or custody for any existing medical condition.*
- *Custody staff have access to health professionals who can advise on mental health and substance misuse issues and see detainees in custody if appropriate.*

[3] https://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/02/expectations-court-custody.pdf.

In 2015, a damning thematic review was undertaken, consolidating the findings from inspections of 97 courthouses. The review, which highlighted the need for urgent remedial action, stated:

> *Health care was inadequate. Of most concern and despite, in many cases, the best efforts of custody staff, we found a dangerous disregard for the risks detainees might pose to themselves or others. Court custody is an accident waiting to happen.*

The review also noted that whilst a healthcare service was available to be contacted by phone, there was minimal take-up of this by officers.

The most recent comments from HMIP relating to court custody are within the 2017-2018 Annual Report, which draws specifically on the findings of a recent (2017) inspection to the London North, North East and West Courts:

> *Detainee risk was not always identified or managed well enough. Staff did not routinely complete a standard risk assessment for each detainee, and subsequent risk management was sometimes inadequate and compromised detainee safety. For example, some cell-sharing risk assessment documents were not completed, and staff did not always adhere to observation levels set to check detainee safety and welfare.*

1.6.2 Lay Observers

Lay observers are independent individuals who form part of a national network and inspect standards in court custody. A recent national report was published drawing upon some 1800 site visit reports which included the following findings:[4]

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

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

1.6.3 Prisons and Probation Ombudsman (PPO) Reports

The PPO is responsible for the independent investigation of any death in custody, including those in court custody. The following (all male) are publicly reported:

Figure 2 - Deaths in Court Custody

Court	Date of Death	Cause	Age at time of Death
Derby Crown Court	7/8/2008	Self-inflicted	41-50
Peterborough Magistrates' Court	20/2/2008	Natural causes	22-30
Isleworth Magistrates' Court	28/6/2007	Self-inflicted	31-40
Norwich Crown Court	4/12/2006	Self-inflicted	41-50

[4] https://s3-eu-west-2.amazonaws.com/layobservers-prod-storage-nu2yj19yczbd/uploads/2018/07/Lay-Observer-Annual-Report-17-18.pdf.

1.7 Methodology

It should be noted that health needs may be *met* or *unmet* and that there is a difference between a *need* and a *demand* for a service. These concepts are addressed later in this report.

The HNA was undertaken between September and November 2018 and overseen by a steering group involving stakeholders from NHS England, PECS, HMPPS and HMCTS.

1.7.1 Data Gathering and Analysis

Data was obtained from various sources and subsequently amalgamated and analysed, including:

- PECS (management information reports (MIRs)) from the two current contractors)
- Serco (incident report data)
- GEOAmey (incident report data)
- L&D Team (national data set, specifically in relation to those seen in court settings)
- United Healthcare (calls to current healthcare service)
- NDTMS (substance misuse)
- Ministry of Justice (MOJ) safer custody statistics (self-harm and self-inflicted deaths)

In addition, and critical to our approach, is the amalgamated data we have from undertaking health needs assessments in: 18 police forces, 69 prisons (including young offenders institutions (YOIs)), two secure training centres (STCs) and five secure children's homes (SCHs). We used this to develop an amalgamated picture of known healthcare needs, with a focus on those on remand.

Community data is also used to highlight the different needs and inequalities between geographical areas (which subsequently inform the PECS 'lots').

1.7.2 Stakeholder Consultation

A series of interviews and site visits were undertaken at various locations and with numerous stakeholders. The full list of those interviewed is included as Appendix A. We also drew upon the stakeholder consultation undertaken by CIE and, where relevant, have included some of the quotes from the stakeholder workshop within the report.

We undertook site visits to a selection of Magistrates' and Crown Courts to speak with the most operational staff and also to observe the process in custody relating to healthcare. We also made site visits to remand/local prisons to speak with healthcare teams about the 'handover' of prisoners from court.

We consulted with 54 service users, including groups of older prisoners (VPs), young offenders, women prisoners and prisoners with disabilities, by means of informal discussions in addition to a series of focus groups in local/remand prisons, wherever possible speaking with service users while they were in the first-night centre about their recent experience in court cells. This includes focus groups within the following local prisons:

- HMP Altcourse
- HMP Durham
- HMP Manchester
- HMP Preston
- HMP Winchester

1.8 Report Structure

The report is structured into the following chapters. As the chapters often contain some very weighty information/data, a chapter summary is included as a box at the end of each chapter for ease of reference.

Chapter Two considers the current footfall in the criminal court cells across England. It also includes a summary of the context of future policy direction which may impact upon court custody footfall. This gives a baseline for the *current* recorded demand for healthcare.

Chapter Three considers the resources that are currently available to meet the needs and explores the available data from the current healthcare provider to court custody in addition to other sources, such as Liaison & Diversion.

Chapter Four is the main body of the report and this specifically considers the health needs of individuals passing through the court cells. This chapter summarises our extensive (and sometimes complex) methodology for arriving at our health prevalence estimates for individuals detained in court cells. Critical to this chapter therefore is Appendix B which includes our full data sets and methodology/rationale for this chapter.

This chapter introduces our Predictor Tool which we have developed to 'bring alive' the data and findings in this health needs assessment to make it searchable by court, court type, PECS lot etc.

Chapter Five concludes the report, summarises the findings and presents a series of recommendations for future service models.

Appendices are used for important supporting information as illustrated in the Table of Contents.

Chapter Two – The Current Demand (Court Custody Footfall)

2.1 Overview of PECS Regions

Nationally, PECS are divided into four 'lots', which are currently serviced by two contractors as illustrated below:

Figure 3 - PECS Contracts (Generation 3)

Element	Area Served	Current Provider	Subcontracted Healthcare Provider
Lot 1	South West and South East	GEOAmey	United Safe Care
Lot 2	London and East of England	Serco	United Safe Care
Lot 3	East Midlands, Yorkshire & Humber, North East	GEOAmey	United Safe Care
Lot 4	North West, West Midlands and Wales	GEOAmey	United Safe Care

The next generation of PECS contract (PECS4) is going to market in 2019, this time based upon just two lots as illustrated:

Figure 4 - PECS Contracts (Generation 4)

Lot	Areas
Lot 1 (South)	Former Lot 1 & 2 (Gen3)
Lot 1 (North)	Former Lots 3 & 4 (Gen3)

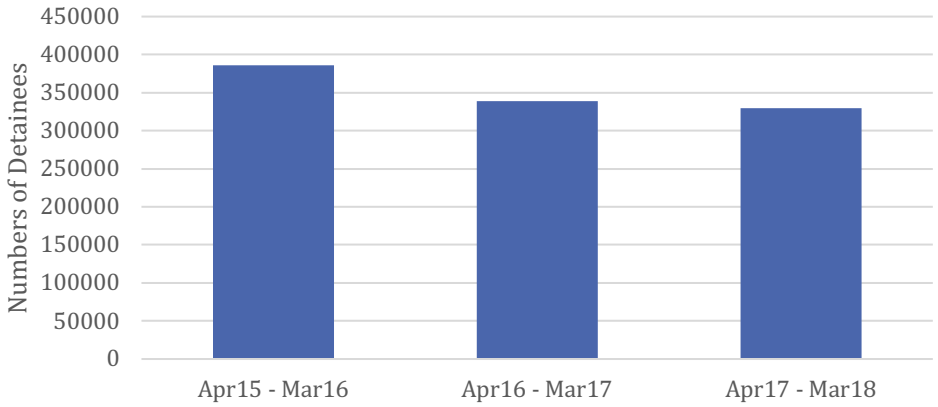
Both the providers (Serco and GEOAmey) submit identical management information reports (MIRs) to the PECS team on a monthly basis. These were used to form the basis of the analysis of court footfall data in the following section.

2.2 Overview of Footfall

The total court custody footfall for the 2017 calendar year was 358,617 defendants in both Magistrates' and Crown Court (including those appearing off bail).

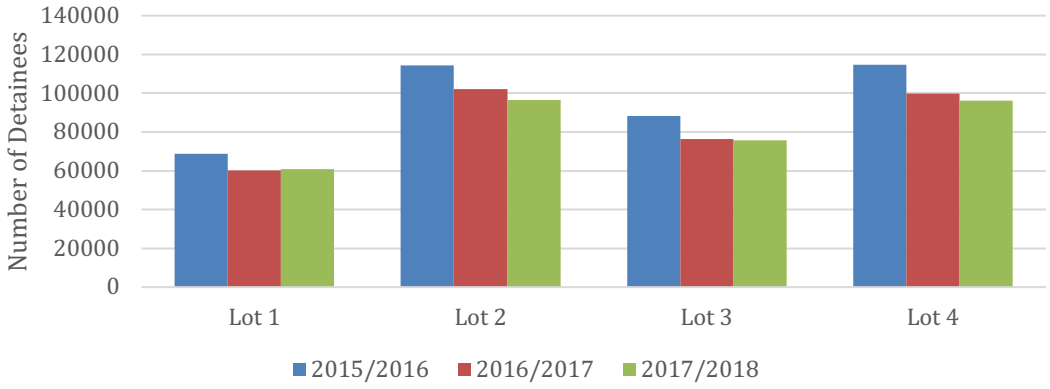
Over the last three years, footfall within court custody nationally has decreased by 15% as shown below:

Figure 5 - Total Court Custody Footfall (Three Year Comparison)



This same data is broken down by geographical PECS lots as illustrated below:

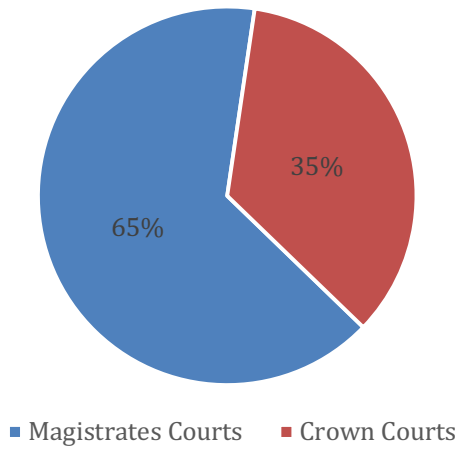
Figure 6 - Footfall by Lot (Crown and Magistrates')



Broken down by lot, the reduction in footfall is most pronounced in Lots 2 and 4, with a reduction of 16% between 2015/16 and 2017/18. Lot 1 saw a reduction of only 11%, and in Lot 3 a reduction of 14% in the volume of detainees.

2.2.1 Footfall by Court Type

Figure 7 - Footfall through Magistrates'/Crown Court Custody 2017/2018



2.2.2 Footfall by Court

Data was calculated on the total footfall in each court across the country and from this it was possible to categorise the low, high and medium footfall courts.

The criteria we used for categorising the court footfall was as illustrated in the following table. Appendix D includes a list of the actual courts in each category for Magistrates' Courts and Appendix E includes the same for Crown Courts.

Figure 8 - Criteria for Categorisation of Courts

	Magistrates'		Crown	
	Minimum Detainees per Day	Average Detainees per Day	Minimum Detainees per Day	Average Detainees per Day
High Footfall	10	17	9	12
Medium Footfall	6	8	5	7
Low Footfall	<6	2	0	3

As a result of this categorisation, the below left shows the number of Magistrates' Courts in each category and the below right shows the proportion of defendants in each court category.

Figure 9 - Magistrates' Court Footfall by Category/Volume

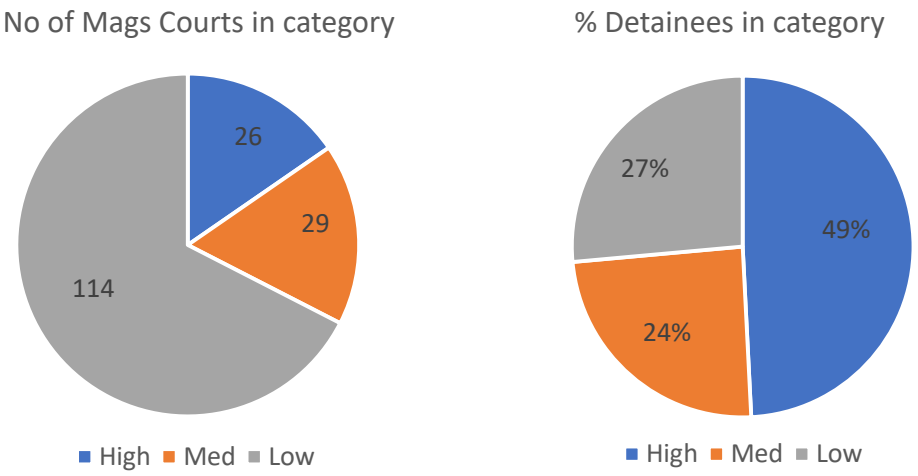
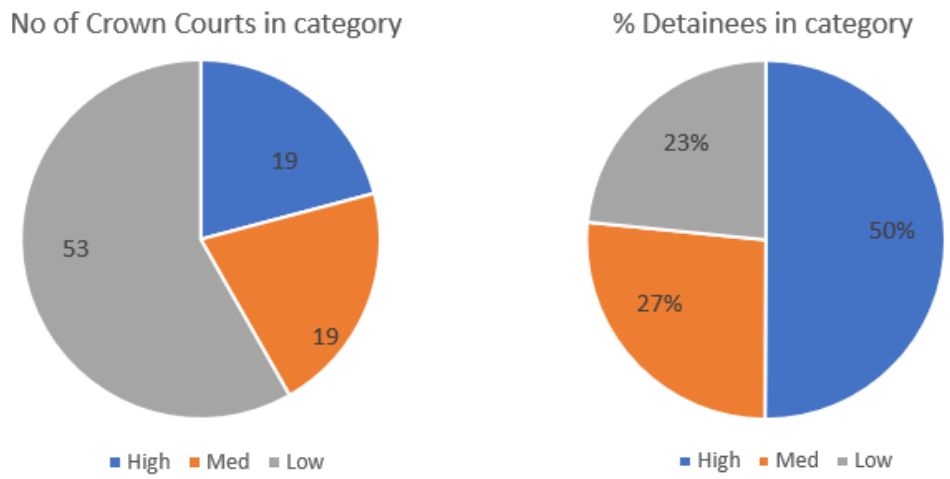


Figure 9 - Crown Court Footfall by Category/Volume

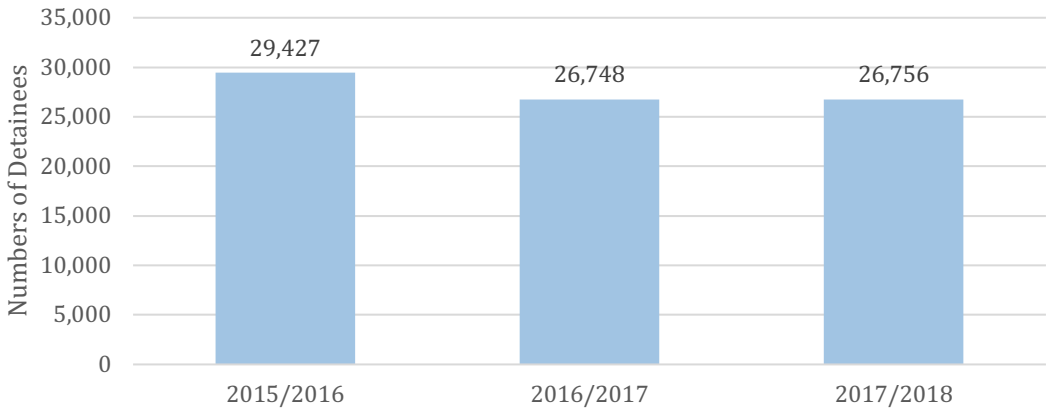


2.2.3 Footfall by Gender

To calculate the estimated numbers of male and female detainees, percentages were calculated based on the gender split of all detainees escorted by PECS. These ratios were then applied to the total court custody footfall.

Overall, 8.1% of court custody detentions in 2018/2018 were female, an increase from 7.6% in 2015/2016. Subsequently, the observed decrease in numbers of detainees can be seen to be more pronounced for male detainees with less change in the numbers of female detainees over three years.

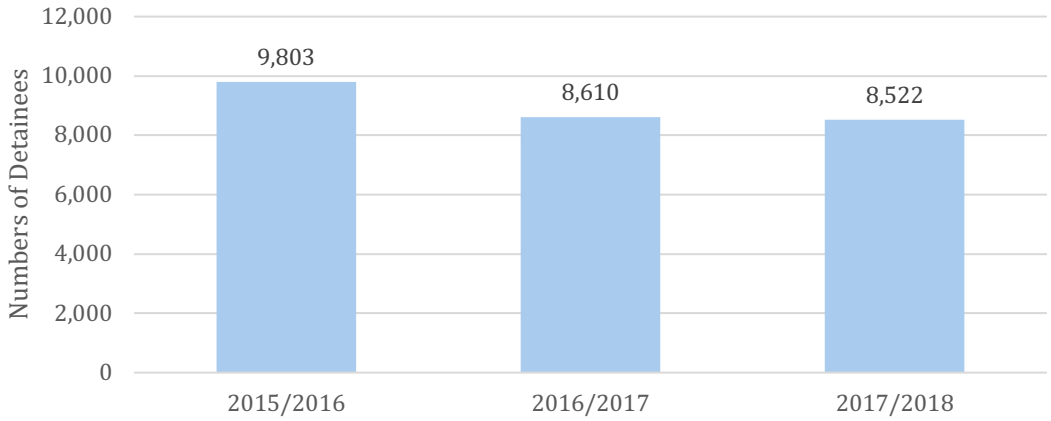
Figure 10 - Estimated Numbers of Female Detainees (Crown & Magistrates')



2.2.4 Footfall by Age (Adults and Juveniles)

Although the numbers of young people escorted by PECS were very low compared to the numbers of adults, numbers reduced by a similar amount over the last three years. The numbers of young people escorted by PECS reduced by 10% over the three-year period, while numbers of adults reduced by 12%. On average, 3% of detainees are juveniles.

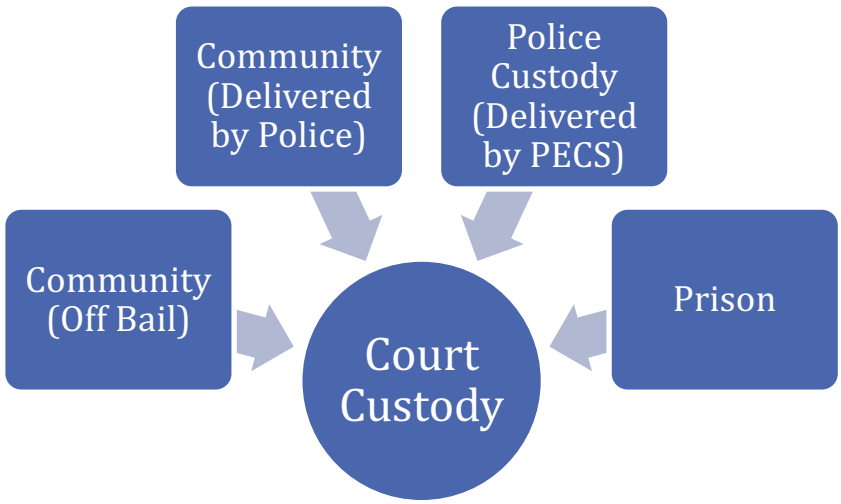
Figure 11 - Juvenile Detainees (Crown & Magistrates')



2.3 Origin of Individuals in Court Custody

It is important to note that all individuals who find themselves in court custody will get there by one of four means:

Figure 12 - Court Custody Entry Points



The chart below shows the origin of individuals in court custody over the past three years. There is a huge difference in the origin of court detainees between Magistrates' and Crown Court. As shown below, the vast majority of detainees in Magistrates' Court come from the police, whereas the vast majority of detainees in Crown Court come from prisons.

It became apparent during our site visits that whilst police custody is the commonly stated source, the reality is that a significant number of individuals are brought to the court cells by police officers from the street, with only a fleeting appearance via police custody (if at all) for the process of completing a PER. This means these individuals have no access to healthcare provision in police custody and are effectively straight off the street. This is common for breach of bail and warrants where there is no investigative reason to take individuals into police custody.

"Of the twelve people we have in today from Police, five of them didn't come off the van from the Police Station earlier. They've been brought in by Police officers. We get more from Police towards court closing time and on Saturdays

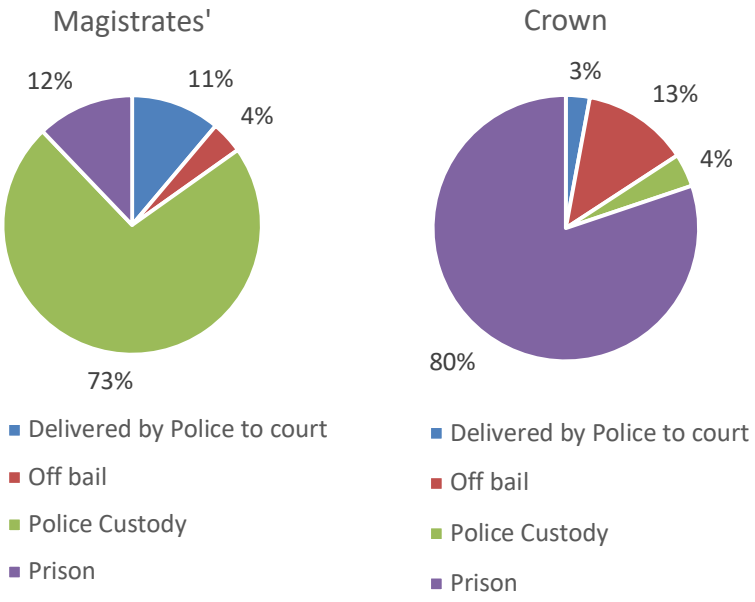
"We often get prisoners pretty much straight off the street who are brought in by the Police on warrant or breaches. I would say a couple every day. We won't accept anyone without a PER … sometimes they do it here at the desk!"

Of note is the proportion of people who come into court custody 'off bail' (i.e. individuals from the community who attend a court hearing via the front doors of the court then are subsequently taken straight into custody).

Individuals who come into court custody off bail or directly in police vehicles miss an opportunity for healthcare screening in police custody.

The below illustration clearly shows a far bigger proportion of individuals 'off bail' in Crown Courts. Given the serious nature of offences dealt with in Crown Courts, there is potentially a higher risk of suicide amongst first time offenders.

Figure 9 - Origin of Magistrates' Court Custody Detainees (2015-2018)



2.4 Factors on Horizon Influencing Likely Future Demand

At the time of writing, we identified a number of external factors which could affect the likely demand for court healthcare services. Almost universally, these relate to likely changes (reductions) in court footfall, rather than changes in health needs. Nonetheless, as footfall is the biggest determinant of the likely demand for court healthcare services, these are considered in turn below.

2.4.1 HMCTS Reform/Reconfiguration

Likely Impact – fewer court houses means further travel times to access court, thus periods in detention will lengthen.

2.4.2 Prison Reform/Reconfiguration

Likely Impact – reduction in the number of remand prisons will mean further travel times between court and prison, thus periods in detention will lengthen.

2.4.3 Prison Video-Link

Whilst video-link between prisons and courts is well established, the current national drive is to increase take-up of this to reduce the unnecessary transportation of prisoners to court.

Currently,36% of eligible hearings nationally are heard by video-link. The assumption made in the new PECS contract is that 50% of eligible hearings by 2020 will be heard via video-link. This *could* rise to 80% by the mid 2020s. **Note that eligible hearings are anything other than trials.**

Likely impact – fewer detainees in court cells as more court business is done by video-link.

2.4.4 Virtual Courts (Police Custody)

Some police forces have been trialling the use of a video-link between the custody suite and Magistrates' Court to reduce the need for individuals to be transferred and make the court process more efficient. However, the process is far less well developed than the video-link in prisons and funding has not yet been defined/agreed for the installation/maintenance of equipment, therefore take up is currently minimal.

Likely impact – fewer detainees in court cells if more court business is done by video-link into police custody suites.

2.4.5 Increased Voluntary Attendance/Interview – Postal Summons

Across all police forces nationally, we can see a clear decrease in the number of individuals who go through police custody and an increase in the number of individuals processed by means of voluntary attendance/interview (VA). This is in response to the greater application of PACE Code G (necessity to arrest test) and results in individuals attending court off bail via postal summons. These individuals do not benefit from a screening by healthcare providers in custody suites and L&D provision for this cohort is challenging, though some forces are looking at ways to include L&D practitioners in the VA processes.

Likely Impact – the proportion of court appearances 'off bail' will increase. As previously identified, those off bail are the higher risk individuals in terms of unknown health needs.

2.4.6 PECS4 Contract

Within the new PECS contract will be a requirement that individuals are processed through court custody and onto their receiving prisons faster than is currently the case. Specifically:

- Women will wait no more than **two hours** following their court hearing before being transported back to prison
- Men will wait no more than **three hours** following their court hearing before being transported back to prison

Likely Impact – adherence to the new tighter time regulations within the contract will result in shorter detention times in court.

Note that the above does not account for the actual time defendants are waiting in court custody until their case is hear din court.

The current position is that the majority of individuals who arrive into court custody do so between the hours of 8-9am and leave custody around 4-5pm. Therefore, the typical length of time in court custody is eight hours (not taking into account travel time to/from the court cells which for many women and young offenders is significant due to the geographical dispersal of women's prisons/YOIs. For example, HMP Eastwood Park is 180 miles (3-4 hour drive) from Truro Crown Court.).

Those taken into custody off bail will often have shorter periods of detention in court cells as their detention will start at the designated court room (which could be at any time of day). Likewise for arrivals directly from police which may happen at any time during the day.

It is not possible, at this stage, to specifically quantify what effect *any* of the above factors (let alone *combinations of* the above factors) will have on the demand as this is a moving process. However, the very strong indication is that court custody footfall will decrease. Any future service modelling should continually re-visit each of the above points to consider the most up-to-date position of what is known and the quantifiable likely impact on court footfall.

2.5 Chapter Summary

- There were over 358,000 instances of individuals being detained in court custody nationally in the last 12 months.
- Court custody footfall is greater in Magistrates' Courts (63%) than Crown Courts (37%).

- There has been a 15% reduction in the footfall across court custody suites over the last three years. This reduction is more pronounced in Crown Court custody.

- The current gender breakdown of court custody footfall is 8% female and 92% male. There has been an increase in the proportion of females in court custody over the last three years.

- On average, 3% of all detainees in court custody are juveniles.

- In Magistrates' Courts, the majority of individuals in custody arrive from police custody (82%)

- In the Crown Court, the majority (83%) arrive from prisons.

- 16% of detainees in both Magistrates' and Crown Court are directly from the community (off bail or delivered by police to court) – thus missing any possible healthcare interventions in police custody.

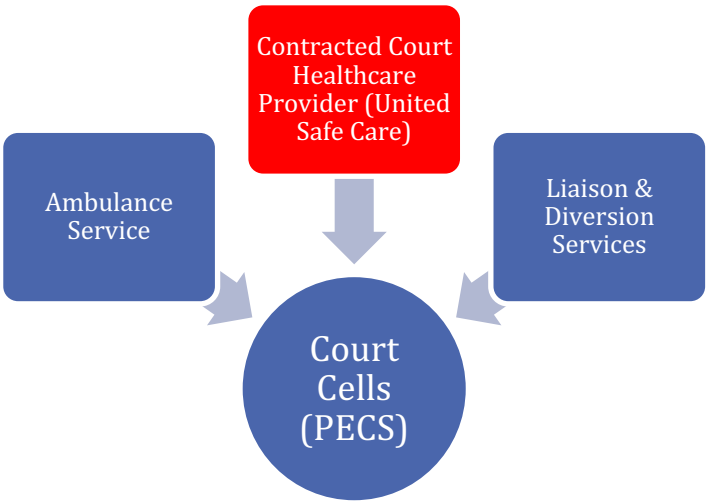
- There are a number of external factors (prison reform, court reform, increased use of video-link) which will likely affect (a) court custody footfall and (b) the subsequent demand for healthcare in court cells. See recommendation.

Chapter Three – Resources Currently Available to Meet Health Needs in Courts

This chapter explores the current services which (either directly or indirectly) assist in meeting the needs of individuals detained in criminal courts.

In summary there are three key services which, directly or indirectly, meet the various needs of defendants while in court custody. Critical in terms of health is the sub-contracted healthcare provider as illustrated:

Figure 13 - Current Provision (Direct and Indirect)



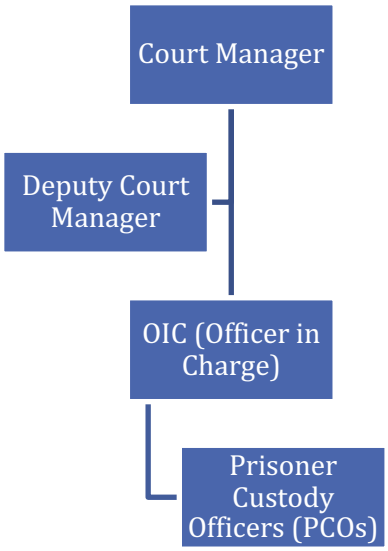
3.1 PECS Contract – Court Custody

As has already been established, a key element of the current and future PECS contract includes the requirement to run custody suites in both Magistrates' and Crown Courts.

As described in Chapter Two, the country is currently split into four contractual 'lots' with two providers currently delivering the contracts, effectively Serco for the London region and GEOAmey for the remainder of the country.

Court custody suites (both Magistrates' and Crown) are generally staffed as follows:

Figure 14 - Staffing of Court Custody



Court custody staff are responsible for the safe detention of defendants in the court cells, including management of risk. This can require undertaking constant observations whilst detainees are in their care.

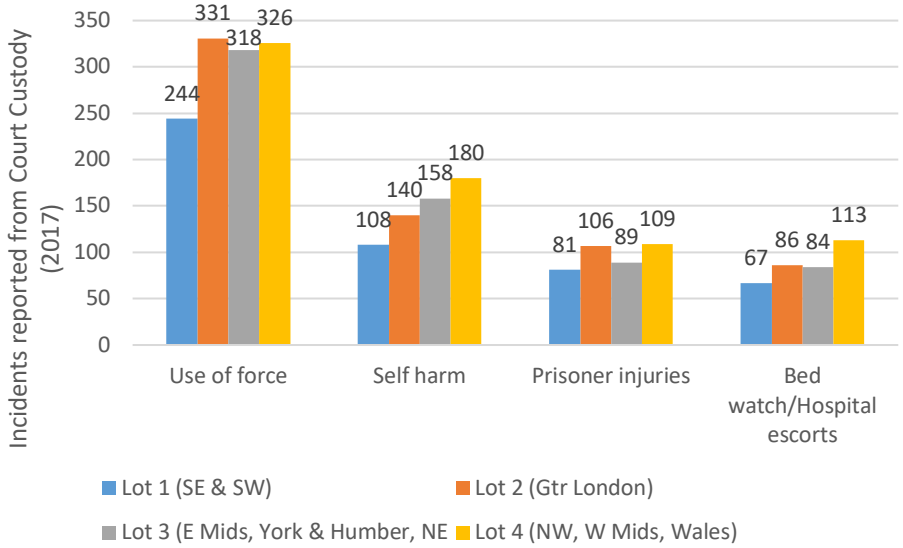
Incident reports are routinely completed by the PECS contractors for relevant issues to healthcare such as:

- Instances of Self-Harm
- Physical Injury
- Use of Force
- Hospital Watches
- Bed Watches

Note that bed watches are the responsibility of the prison service thus, when a hospital escort becomes a bed watch (i.e. the individual is admitted to hospital), the receiving prison is required to provide staff to undertake the bed watch within four hours.

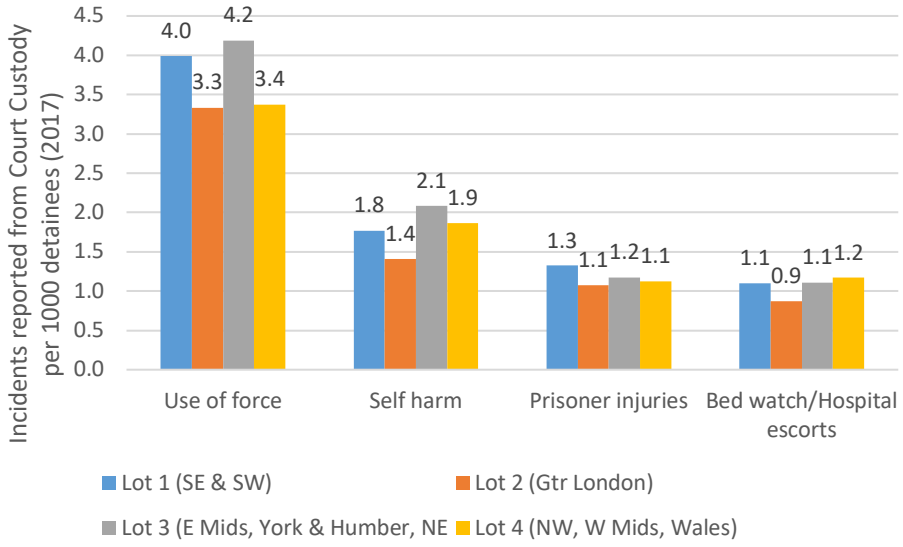
The below illustration shows the national incidents during the 2017 calendar year

Figure 15 - Incidents by Lot (2017)



More useful, is the below standardisation of the above incident data which shows the number of incidents per 1,000 detainees. This clearly shows the greatest rate of reported incidents is in the Lot 3 region:

Figure 16 - Standardised Incidents by Lot (2017)



3.1.2 Prisoner Escort Record and ePER

The PER is the universal record by which risks are communicated along the pathway (from police custody, through court cells and to/from prison). There are currently three versions of the PER being used nationally, however work is now underway to develop a single national PER. See Appendix C.

There is well documented evidence in numerous other reports, including independent scrutiny reports of court cells, that show the consistency of reporting on the PER of healthcare information is poor. This was echoed in our stakeholder consultation:

"We get minimal information relating to health other than immediate risk."

"The hardest thing I find with the PER is it doesn't tell me when their last dose of medication was, so if someone comes from police custody and the PER says they've had medication, it's guess work how long we have until they need more."

"I'm not medically trained so I don't really know what the risks are with medication. I just rely on what's written down. When people come from the police it's often a problem as we are working blind."

An electronic version of the PER (ePER) is in development with a view to implementation in 2020. The ePER will have the facility to attach relevant files thus reducing the risk of missing papers/documents.

3.2 Current Court Healthcare Provider (United Safe Care)

United Safe Care (Diagrama) is contracted as the healthcare provider by both GEOAmey and Serco, thus it provides the service nationally, as a subcontract arrangement.

The service operates the following model in both lots; a medical advice line (number) is available to all courts, calls made to the medical advice line are logged and a clinician offers advice over the telephone.

Serco has entered into a further contractual relationship with United Safe Care to provide a First Responder to service the London courts and assess/treat detainees where necessary. The First Responder works Monday-Friday and Saturday am, covering the core operating hours of courts.

In Lots 1, 3 and 4 (GEOAmey) this provision has not been commissioned (over and above the standard offer of the medic line). Consequently, medics generally do not attend courts in Lots 1, 3 and 4 as there is no capacity to allow for this to happen within the timescale that would work for the court.

"When staff are presented with medical emergency they have standard triage which is the deployment of first aid … they are all trained in that. Other than this how effective is the second layer? My biggest worry is the delay (or perceived delay) so we use ambulances. This is a mis direction of NHS resource. We are paying for a service but does it deliver the resilience it needs?"

3.2.1 Calls to the Healthcare Provider

Detailed data was provided by United Safe Care for May and June 2018 and we have used this data to estimate full year data for comparison purposes.

Based on detailed data from May and June 2018, there are an estimated 2010 calls to the medic line in a year nationally. This represents 0.6% of all court footfall over the same period, however the ratio of detainees generating a call to healthcare is four times higher in Lot 2 (where an enhanced healthcare resource

has been established) than is the case across the rest of the country as illustrated below:

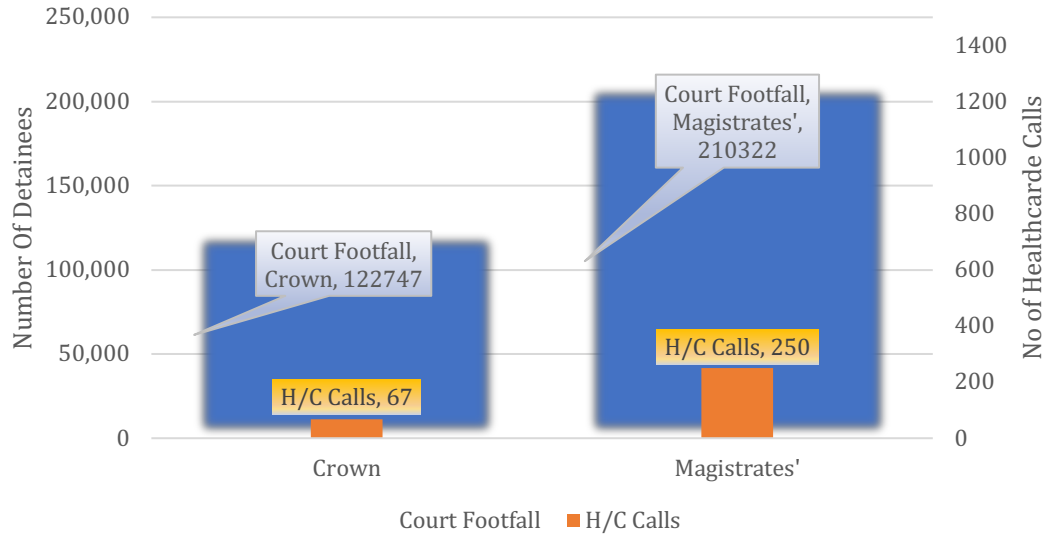
Figure 17 - Detainees in Court Generating Healthcare Call

	GEOAmey (Lots 1, 3 & 4)	Serco (Lot 2)
Total through court custody in 2018	233,777	99,292
Estimated No. health needs calls in a year (2017)	726	1,284
% of Detainees generating a H/C call	**0.31%**	**1.29%**

In contrast to the above, 100% of individuals are seen by a healthcare professional on arrival into a prison, and nationally around 55% of police custody detainees are seen by a healthcare professional (HCP) whilst in custody. In some forces, juveniles are routinely screened by HCPs (thus 100% seen by HCP).

The demand for healthcare is far greater in Magistrates' Court than in Crown Court. Seventy-nine per cent of calls for healthcare originated from Magistrates' Court and just 21% from Crown Courts. When considering this relative to court footfall (63% Magistrates'), the below shows:

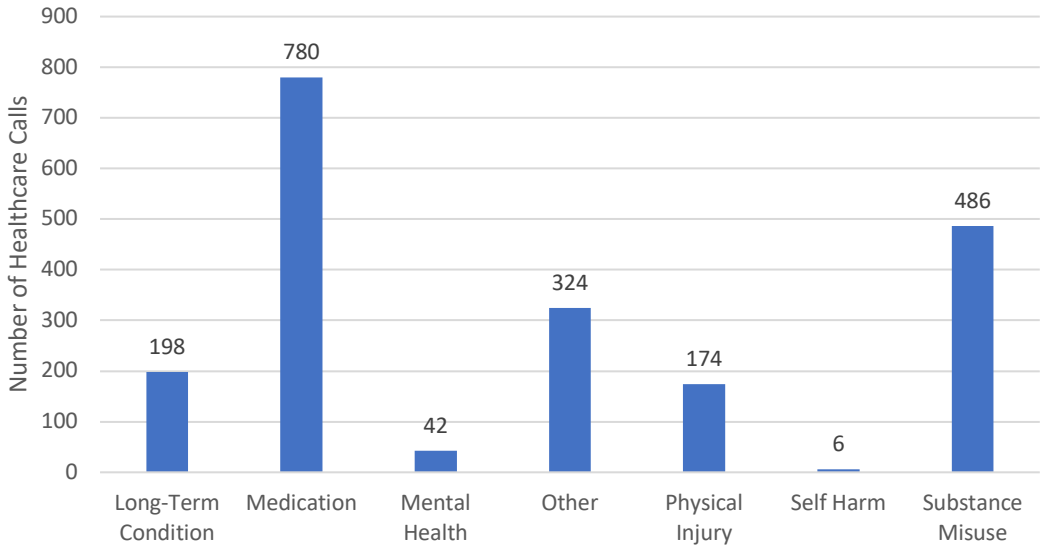
Figure 15 - Relative Volume of Healthcare Calls (Crown & Magistrates') 2017



The reason for healthcare calls from PECS is illustrated below. Medication is by far the most common reason. Note, some categories will be under recorded in the below as categories such as long-term condition and substance misuse are also likely to be medication related to a greater or lesser extent.[5]

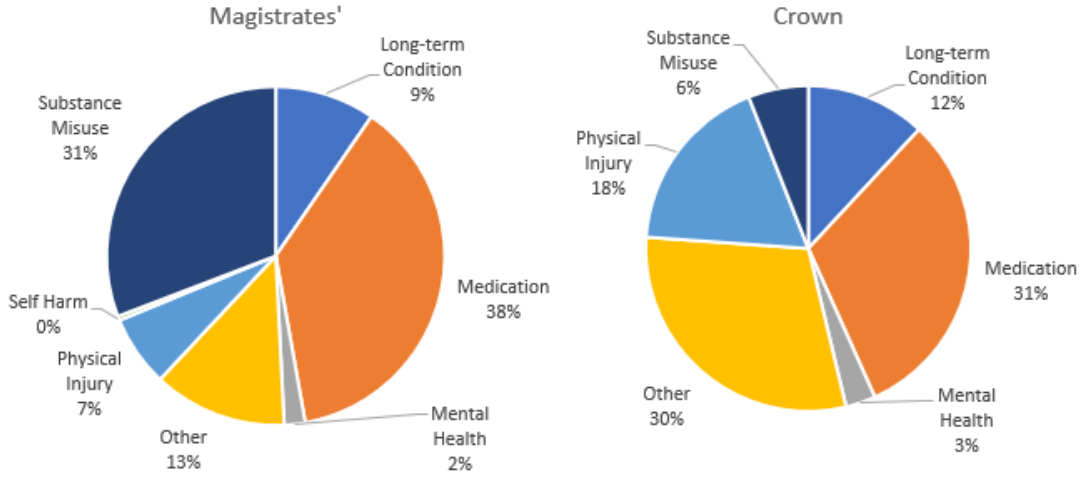
[5] The category of 'other' includes infection (5), stomach pain (<5), feeling faint (<4), chest pains (5), heart problems (<5) headache (<5), vomiting (<5) and various smaller categories assigned to single detainees.

Figure 18 - Reason for Healthcare Calls (National)



The nature of healthcare calls also varies by type of court as is shown in the below illustration. Medication remains the most common reason for healthcare calls in both courts, however substance misuse is a big feature in Magistrates' Courts but less so in Crown. Note that, as most detainees in Crown Court arrive from prison, their health needs should theoretically have been addressed and stabilised there.

Figure 19 - Nature of Calls to Healthcare

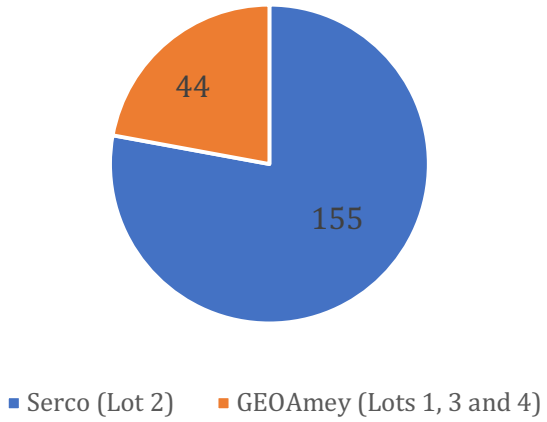


There were only 24 requests for healthcare (nationally) following post restraint in a year. Noting there were 1219 incidents reported by the PECS providers relating to use of force, this means less than 2% of incidents where use of force was involved resulted in a call to healthcare. Note that, in prisons and police custody, a nurse would routinely screen any prisoner following a use of force.

Of all the calls to the healthcare provider, note that in a full year, only 199 resulted in a clinician attending the court. By far the greatest proportion of clinic attendances were in Lot 2 where a more enhanced service has been contracted involving a mobile First Responder. However, note that the footfall in Lot 2

represented just 29% of national court custody footfall in 2017, thus the stark contrast in clinician attendance in Lots 1, 3 and 4 as shown below appears disproportionately low.

Figure 20 - Healthcare Attendances at Court Custody (Total Attendances in 2017)



3.2.2 Medication

Note that medication is *never* provided by either the healthcare provider or via the PECS contractors. There is no 'stock' of common medicines (e.g. paracetamol, ibuprofen) within court custody.

Where medication is (or becomes) necessary, and *not already in the property* of the detainee, this appears to routinely result in A&E attendance.

Where medication comes with the detainee to the court cells and is clearly labelled, PECS staff should offer the detainee the single dose of their medication at the required time. This is often done following a call to the healthcare line for advice, particularly when information on the PER is limited.

> *"A key problem we have is that the PER from Police Custody might say they have got medication but they don't say on the PER when the last dose was which causes a nightmare for us. We can't ring police custody to check as their records aren't accessible once someone leaves their cells."*

> *"We get similar issues with the PER from prisons but it's generally not as bad. When we're not sure about medication and they've come from prison we generally just ring the healthcare team and they tell us."*

Where medication comes into court custody with detainees it is placed in property bags. There are no dedicated medication storage spaces in the court cells and neither is there a temperature-controlled fridge.

> *"We often have insulin which we put in our fridge here with our sandwiches!"*

3.3 Ambulance Service

It was widely reported in our stakeholder consultation (predominantly in the lots served by GEOAmey) that, due to a perception that a clinician via United Safe Care would not attend promptly enough, ambulances are often the first line of call when a healthcare issue arises. It was not possible to obtain specific data from the PECS contractors on the ambulance call-outs however the data in Figure 15 above clearly shows there were 350 hospital escorts/bed watches in 2017 across all lots, which gives an indication. Considering there were only 2010 calls to the healthcare provider during the same period (most of which related to advice on medication), this is a relatively high number of likely ambulance call-outs/A&E attendances.

During site visits the following comments were made:

> *"When we have an issue with someone needing medication for withdrawal or alcohol we always just call an ambulance."*
>
> *There's no question about it, we are using ambulance services inappropriately, but we have no other option."*

There are three ways in which ambulances are used in terms of supporting delivery of court healthcare:

(a) When it is clear that there is a medical emergency that needs an immediate response
(b) When a medical response is needed and there is no confidence that this will be done 'in time' by the current contractor (more common in Lots 1, 2 and 3)
(c) When the current contractor has undertaken a triage and an individual needs immediate medication. In this instance, the process is always to request an ambulance and treatment in hospital.

Points (b) and (c) point towards an unmet need, with the current level of provision resulting in a sometime inappropriate dependency upon the ambulance (and subsequently hospital A&E) services.

It is also observed that, unlike the process in both police custody and prisons, there is no 'triage' process prior to the call-out of an ambulance in courts. In the absence of any health professional, the reality is that ambulances will generally be more readily called than is the case in police custody or prison.

There will always be cases (at all stages of the criminal justice system) where there will be a need to call an ambulance urgently, with no need (on indeed time) to refer to another person/a clinician. However, many of the calls for ambulances will be less 'clear cut' and could arguably be avoided, given implementation of other triage systems (e.g. Custody Early Warning Score – CEWS).

3.3.1 Ambulance Call-Outs by PECS

It was not possible, from the incident reports, to ascertain the actual volume of ambulance call-outs to court custody, however anecdotal evidence suggests this is the first port of call when healthcare issues arise:

> *"If somebody is medically unwell we would call the ambulance service. It sounds heavy handed but we have no other option here."*

> *"I would say we have two ambulance calls each month here. We have little choice as we don't have any other access to healthcare."*

> *"It's hard to say how often we call for ambulances, some months there might be multiple calls in our cells, other months none."*

> *"If somebody needs medication and they don't have it with them (properly labelled) we would call an ambulance and they would need to go to hospital for it as we don't have anything here for them"*

3.3.2 Ambulance Call-Outs by United Safe Care

There was no data available on the number of times United Safe Care recommended an ambulance be called, though anecdotally it was reported that this is not an unusual occurrence:

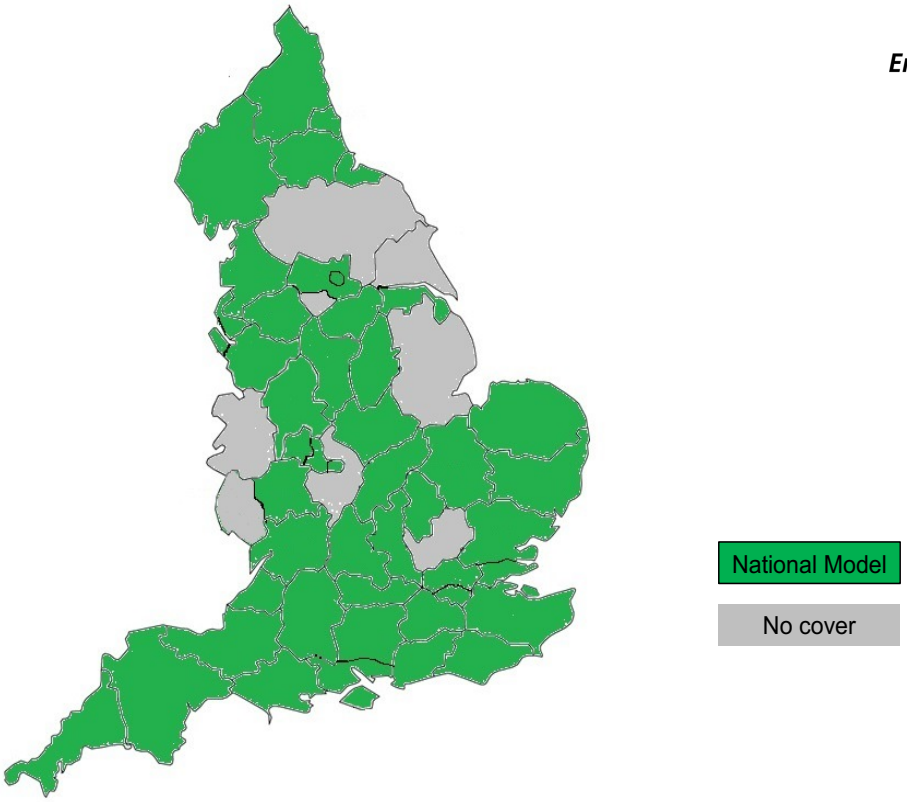
> *"If someone needs to be seen by a clinician we simply can't provide clinicians in the timeframe so an ambulance is the only option where someone needs medical attention."*

3.4 Liaison and Diversion (L&D) Services

Whilst the coverage of L&D services across the country has increased rapidly over the last few years, it should be noted that (a) not all areas of the country are covered by L&D and (b) the extent to which each L&D service works with the courts varies, albeit the national specification is clear that provision of advice should be available to Magistrates' Courts and, more recently, to some of the higher footfall Crown Courts.

The current coverage of Liaison and Diversion is illustrated below. It is anticipated that there will be full roll-out by 2020.

Figure 21 - L&D Coverage (2018)



Specifically, in courts, L&D practitioners support Magistrates' Courts (and some of the higher footfall Crown Courts) to promote better identification of vulnerable individuals and ensure those identified are subsequently screened and referred to support services where necessary. **L&D is not a treatment service/intervention in its own right.**

The national specification for L&D services states that all magistrates' courts conducting remand and sentencing business should have a dedicated practitioner on site.

The following data is taken from the most recent publication of the National Minimum Dataset for L&D, which is broken down for adults and youths separately. It specifically considers the number of referrals to L&D from court:

Figure 22 - L&D Data - Referrals from Courts (2017/2018)

	Total Engaged Individuals in L&D Services in Year	Proportion Referred by Courts	Actual Number of Court Referrals per annum
Adults	65,572	4%	2,358
Youths	10,502	0%	35

As a proportion of court custody footfall, the above relates to just under 1% per year. However, this data has limited use for the propose of this HNA because:

- Many individuals will be seen by L&D in court (generally in court cells) who have been referred (and often seen) whilst in police custody, thus the

data does not capture all contacts within court. There are many more individuals seen in court than is reflected in the data set.

- It also potentially includes individuals who are *not* in court custody (e.g. those referred by defence solicitors, legal advisers etc who have walked in/out of the court from the community.

Our site visits suggested a greater involvement of L&D practitioners with court custody detainees than the data suggests, specifically in higher footfall Magistrates' Courts.

> *"We have an L&D practitioner here every day – she spends most of her time with us here in the court cells. If ever she's not here we have a number and they get someone over from Police Custody really quickly."*

In summary, whilst L&D practitioners are a potential resource to support court custody teams, there are a number of very real limitations:

- The role of L&D does not include physical health – other than in a liaison capacity.
- L&D is not a 'treatment' service in its own right but rather a liaison point to ensure timely information is passed on to ensure the service user is fully supported through the process. Thus, where an individual is (or becomes) very mentally unwell in court cells, L&D would not be the end point in terms of meeting that need but should make referrals to the appropriate services (usually within their own NHS Trust).
- The L&D function for court *should* be for *any* court defendants (not exclusively those in court custody). Note that court custody represents a small subset of the total defendants going through Magistrates' Courts each day. It is wrong to assume that a dedicated L&D practitioner in a Magistrates' Court is exclusively there to deal with issues in court custody.
- Despite the existence of a national service specification, there are still local variances in terms of how L&D operates and the extent of the service provided to courts. Some health and justice commissioners, for example, have included KPIs on the proportion of police custody detainees who are screened, but no corresponding KPIs on screenings in court, thus the focus of some L&D services inadvertently shifts towards police custody.

3.4 Chapter Summary

- There are three services which, directly or indirectly, currently contribute to meeting the needs of court custody detainees (adults and juveniles).

- United Safe Care provides a medical service to courts across the country. This involves the provision of an advice line (to a GP) and, in the case of Lot 2, access to a First Responder who will attend the court if necessary. Note this results in inequity of provision across the country.

- Calls to healthcare are far more apparent in Magistrates' Courts (79%) then in Crown Courts (21%). This is unsurprising given such a large proportion of detainees in Crown Court appear from prison, where health needs should already be known and managed.

- Only 0.6% of detainees in court custody generated a call to the healthcare provider in the last year (2010 calls). The proportion was unsurprisingly higher in Lot 2 (1.29%) than in Lot 1 (0.31%) perhaps due to the provision of an enhanced model in Lot 2.

- Calls to the medical advice line are predominantly in relation to medication.

- There were just 199 instances of a clinician actually attending court custody in 2017, 78% of these attendances were in Lot 2 (London), despite Lot 2 holding only 29% of national court custody footfall.

- All the data from the current healthcare provider suggests that actual demand is supressed due to the limited presence/availability of the service (particularly in Lots 1, 3 and 4). Even in Lot 2, the demand for healthcare appears very low considering the likely needs as articulated in the following chapter.

- There were 585 recorded instances nationally of self-harm in court custody in 2017, the highest (standardised) prevalence of self-harm being evident in Lot 3 (East Midlands, Yorkshire & Humber and North East). Note, there were only six calls to healthcare in the same period (nationally) following self-harm.

- There were 1,219 incidents in 2017 relating to use of force, again with the highest standardised prevalence being in Lot 3. There were only 24 requests for healthcare (nationally) following post restraint in a year which means less than 2% of incidents where use of force was involved resulted in a call to healthcare.

- There was a total of 350 bed watches and hospital escorts recorded nationally from court custody.

- Stakeholders in court custody commonly reported using the ambulance service as the first port of call for healthcare issues, including resolving medication. It was not possible to obtain data on ambulance call-outs to each court nationally, however the escort and bed watch data gives some indication.

- Whilst L&D services operate in an increasing number of Magistrates' Courts (and a small selection of higher footfall Crown Courts), their penetration rate into courts remains low, largely because L&D provision has shifted to become more 'front end', identifying individuals before court (e.g. police custody) and then sharing information with relevant professionals along the criminal justice journey (including court).

Chapter Four – The Health Needs of People Detained in Court Cells

Chapter Two considers likely demand in terms of court custody footfall, and Chapter Three considers the resources currently available to meet any presenting health-related needs. This chapter considers the current need and likely subsequent demand for healthcare based on the *known health needs* of individuals in criminal court cells.

4.1 Overview

For the purpose of this chapter, the *type* of court custody (i.e. Magistrates' cells or Crown Court cells) has less relevance than individual health needs. For this reason, data in this chapter is, where relevant, split between the different needs of young people and adults and also males and females, rather than the type of court.

It should, however, be noted that there will likely be more 'met' need in Crown Court cells as the greatest volumes of defendants arrive from prison, where the greatest chances of healthcare needs being met lie. This is evidenced in the data presented in Chapter Three. The majority of defendants in Crown Court cells are generally more stable, less likely to be intoxicated, and more likely to have the correct medication with them. This is evident in the presentations to healthcare to date.

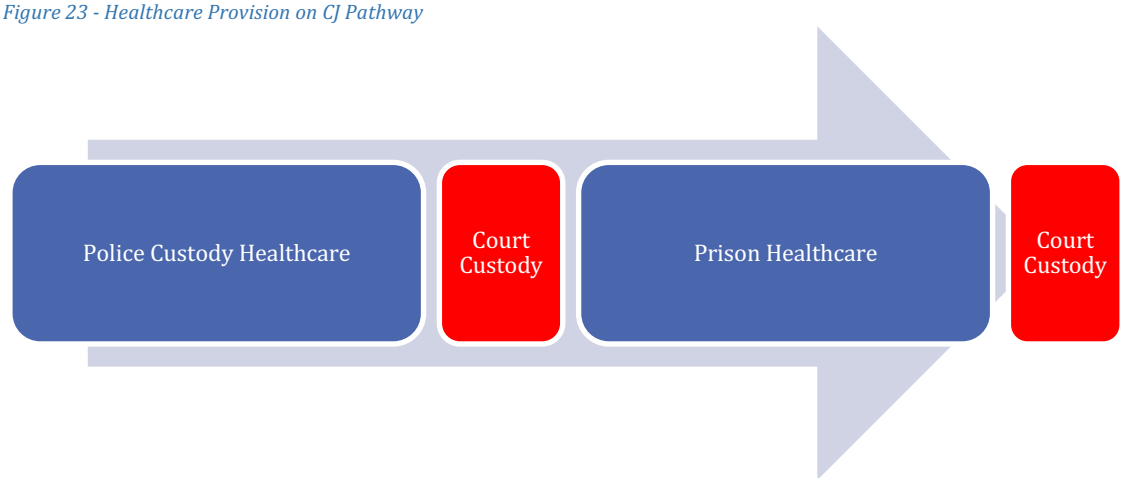
Appendix B is critical to this chapter as it has full details of the process followed, including the full methodology and rationale for the calculations used and rationale. This chapter merely *summarises* the key headline findings from the process followed as outlined in the Appendix.

Whilst there is a very long list of likely health needs of detained individuals, the focus we used, given that this HNA is specifically limited to court custody (which is time limited to a maximum of about eight hours), was around the health needs that are:

- Highest risk
- Most likely to cause problems within the short window of court custody detention

This is a pragmatic approach, reflecting the very temporary nature of the court custody environment and also reflecting that, for the majority of individuals, court custody sits in between well-established healthcare provision along the criminal justice pathway, where health needs should have been previously identified/met as illustrated below, with caution that not all individuals benefit from screening in police custody before court.

Figure 23 - Healthcare Provision on CJ Pathway



4.2 General Population Data (Community Prevalence Estimates)

We looked at various health indicators in different communities. There are varying rates of, for example, asthma and diabetes in different localities. We are conscious that courts serve a subset of each community, usually the most deprived, with the highest levels of morbidity for a range of conditions.

We therefore considered some of the key health-related presentations already described in court settings and chose the following four as key indicators relevant for the purpose of this project:

- Comorbidity and mortality
- Prevalence of individuals on CPA (i.e. diagnosed with severe and enduing mental health)
- Prevalence of opiate and/or crack use
- Rates of alcohol dependency

We took each of the above and considered the prevalence of these in the context of the top five highest footfall, and the bottom five lowest footfall courts in each of the four PECS lots, to see whether there was any correlation/pattern of prevalence in the communities served.

The below illustration shows the highest identified community prevalence of each condition in red, and the lowest in green, with gradings in between. As can be seen, there is a broad pattern of higher rates of poor physical health, poor mental health, and increased prevalence of substance misuse in the localities with higher footfall courts than in the lower ones.

Figure 24 - Community Prevalence Data Matched with Court Footfall

			PHYSICAL HEALTH	MENTAL HEALTH	SUBSTANCE MISUSE	
	Court	Annual Delivered Prisoners	Life Expectancy (Years)	Mental Health Rate of CPA per 100,000 population	Prevalence rate of Opiate and/or Crack Use per 1000 population	Alcohol dependency rate per 1000 population
	England average		79.5	375	8.57	1.48
Top 5 High Footfall Courts from each lot	Manchester Magistrates' Court	7756	74.8	842	11.57	2.35
	Westminster Magistrates' Court	6952	81.1	409	13.18	1.42
	Birmingham Mc Corporation St	6636	77.6	581	13.48	1.66
	Thames Magistrates' Court	5988	77.1	414	13.17	1.55
	Highbury Corner Magistrates' Court	5196	80.5	582	12.38	1.72
	Leeds Magistrates' Court	4499	78	419	10.75	1.74
	Nottingham Magistrates' Court	3924	76.9	148	12.15	2.21
	Camberwell Green Magistrates' Court	3837	78.2	461	9.95	1.84
	Bradford Magistrates' Court	3480	77.5	998	14.24	1.61
	Walsall Magistrates' Court	3365	77.9	379	11.12	1.61
	Sheffield Magistrates' Court	3342	78.7	283	9.76	1.54
	Uxbridge Magistrates' Court	3159	79.9	267	10.46	1.25
	Liverpool Magistrates' Court	3095	76.1	480	15.98	2.99
	Middlesborough Magistrates' Court	2976	76.3	103	24.03	2.57
	Bristol Magistrates' Court	2922	78.3	345	15.43	1.87
	Plymouth Magistrates' Court	1950	78.3	158	12.20	1.58
	Reading Magistrates' Court	1950	78.4	7	12.04	1.36
	Newcastle-Under-Lyme Magistrates' Court	1913	78.9	533	16.36	2.79
	Portsmouth Magistrates' Court	1858	78.2	372	9.98	1.86
	Southampton Magistrates' Court	1622	78.5	433	8.65	1.76
Top 5 Low Footfall Courts from each lot	Barnsley Magistrates' Court	710	77.8	410	12.11	1.89
	Colchester Magistrates' Court	438	79.7	497	6.09	1.08
	City Of London Magistrates' Court	423	77.1	414	13.17	1.55
	Bodmin Magistrates' Court	308	79.5	703	6.36	1.49
	Kidderminster Magistrates' Court	304	78.2	211	7.72	1.57
	Scarborough Magistrates' Court	290	77.9	861	5.30	1.10
	Bury Magistrates' Court	279	78	425	9.81	1.48
	Burnley Magistrates' Court	279	75.7	515	8.96	5.12
	Bath Magistrates' Court	256	80.6	406	8.46	1.16
	Folkestone Magistrates' Court	215	79.2	306	5.50	1.19
	Lancaster Magistrates' Court	197	77.4	439	8.96	1.86
	Salisbury Magistrates' Court	168	80.4	378	4.94	1.00
	Stevenage Magistrates' Court	153	79.6	217	5.68	0.97
	Workington Magistrates' Court	150	78.2	302	8.90	1.86
	King's Lynn Combined Court	146	79.6	131	7.45	1.29
	Beverley Magistrates' Court	132	79.6	556	4.61	1.05
	Bournemouth Magistrates' Court	124	78.6	378	14.47	1.90
	Harrogate Magistrates' Court	123	80.6	372	6.73	1.39
	Northallerton Magistrates' Court	112	81.3	519	5.30	1.10
	Romford Magistrates' Court	104	79.3	350	5.72	1.14

4.3 Data from Criminal Justice Settings

4.3.1 Data from our own Health Needs Assessments

Data was drawn from the following criminal justice settings, based on needs assessments we have undertaken within the last 24 months which included:

- Police custody HNA data (taken from four police force areas)
- Local/remand prison HNA data (taken from 14 remand prisons and two female prisons)
- Secure children's home HNA data (taken from one secure children's home)
- Secure training centre HNA data (taken from two secure training centres)

- YOI HNA data (taken from three young offender institutions)

As detailed in Appendix B, we were able to define a prevalence estimate (in percentage terms) for each health need, based on our previous research. These were then amalgamated to give an estimated *average percentage prevalence* for each health need. It is the estimated *average percentage prevalence* that is used for this chapter.

4.3.2 Data from National Research

Police Custody

Whilst now rather old (dated 2007), and based in a single London custody suite, a well-known research paper described the health needs of individuals presenting to police custody.[6] The research did a full health screen on a random, statistically significant, sample of 201 detainees and was able to give an identified prevalence figure for a large range of physical health conditions, mental health issues and substance misuse issues.

More recently (2010), is some work which compared the actual health needs of those in police custody with those identified by police officers on arrival at the custody suite.[7] This involved a sample of 307 detainees.

Public Health England published a toolkit and guidance for the completion of HNAs in police custody in 2015 (Part 3).[8]

We have used the findings from the above publications to influence our methodology and approach to Section 4.6 onwards. See Appendix B for full methodology.

Prisons

There is a wealth of research data describing the health needs of prisoners. Much of this is summarised or referenced in Part 2 of the PHE toolkit.[9] In some cases, the sources in this document have been superseded by more recent publications. We endeavour to use the most recent and relevant source for estimating the prevalence of each condition.

4.3.3 Data from NDTMS

We used data from NDTMS, specifically filtering local/remand prisons and separating out the data for juveniles, women and men. This is the more reliable

[6] Payne-James *et al* (2007) 'Healthcare issues of detainees in police custody in London, UK', Journal of Forensic and Legal Medicine 17(2010)11-17.

[7] McKinnon and Grubin 'Heath Screening in Police Custody', European Journal of Public Health, Volume 23, issue 3, 1 June 2013, p399-405.

[8] Public Health England (2015) 'Health and Justice health needs assessment guidance: Police custody. Part 3 of the health and justice needs assessment toolkit for prescribed places of detention.

[9] PHE (2014) Health Needs Assessment Toolkit Prescribed Places of Detention: Part 2 Adult Prisons.

indicator of known substance misuse needs of those in treatment in the criminal justice system.

4.4 Range of Health Needs in Scope

As previously discussed, the range of health needs that were determined to be 'in scope' for this HNA was limited to those which have immediate clinical risk. Part of the stakeholder consultation was to devise the list of health needs that would be in scope, alongside a rationale for these. The consultation revealed some very opposing views on what health needs should be considered 'in scope.':

> *"We should only be focussing on the health needs which present a high risk during the time people are in the court cells."*

Some stakeholders argued, during the consultation process, that *all* healthcare needs (including smoking and thus access to nicotine replacement therapy (NRT)) should be 'in scope' as there should be equity across the CJ pathway from prison-court-police.

> *"If we offer screening and NRT in police custody and in prison then how can we justify it not being offered in court custody?"*

In many cases, while some of the health needs in their own right do not present risk in court custody, the reality is that, if left unmanaged, or, in the absence of appropriate medication, those health needs can become clinically risky. For this reason, the following were deemed to be in scope:

Figure 25 - Health Needs in Scope for HNA

Health Need		Risk	Comment
Physical Health	Asthma	High	*If* the condition is treated, the risk is minimal so long as defendants have access to medication at the correct times. In many cases in court settings, our research suggests conditions are often (a) unmanaged and (b) defendants often present to court without the correct medication, thus the risks are increased.
	Coronary Heart Disease (CHD)	High	
	Chronic Obstructive Pulmonary Disease (COPD)	High	
	Diabetes	High	
	Epilepsy	High	
	Hypertension	High	
	Injury (Head)	High	Risk of death.
	Injury (Other)	Medium	Risk ranges from minimal to severe dependent upon injury.
Mental Health	Anxiety	Medium	Relevant for L&D services but potential risk of escalation.
	Depression	Medium	Relevant for L&D services but potential risk of escalation.
	Severe & Enduring Mental Health Problems	High	Risk of onset of florid mental illness.
	Risk of Self-Harm	High	Risk of serious injury/death.
	Risk of Self-Inflicted Death	High	Risk of serious injury/death.

Health Need		Risk	Comment
	Autistic Spectrum Disorder (ASD)	Low/Medium	More relevant for L&D services.
	Learning Disabilities	Low/Medium	More relevant for L&D services.
Substance Misuse	Requiring Alcohol Detox	High	Risk of death for alcohol dependents who are left untreated.
	Acute Intoxication	High	Potential for alcohol withdrawal if alcohol dependent.
	Alcohol Dependent	High	Risk of death for alcohol dependents who are left untreated (e.g. those requiring a detox).
	Drug Dependent	Low/Medium	Whilst low/medium clinical risk, the comfort of these individuals could be greatly increased with the provision of medication to manage withdrawal symptoms.
	Receiving Methadone	Low/Medium	This is a subset of the above. Whilst low/medium clinical risk, the comfort of these individuals could be greatly increased with the provision of medication to manage withdrawal symptoms.
Social Care	Physical Disability	Low/Medium	Whilst outside the scope of the HNA, there are potential health risks associated with social care needs being unmanaged. At present, there is no system or process in court custody for those with social care needs (other than physical adaptations).
	Unable to Manage Medication	Low/Medium	
	Unable to Eat Unaided	Low/Medium	

4.5 Healthcare Needs of Individuals Presenting Off Bail

As evidenced in Chapter Two, not all individuals arrive into court custody from police custody. A sizeable proportion arrive into court off bail or via police vehicles and are arguably at heightened risk because:

(a) They will not have benefit from screening/risk assessment/fitness to detain assessment in police custody
(b) There is increased likelihood of alcohol/substance intoxication as they were not detained immediately prior to court
(c) There is increased likelihood of 'packing', particularly those who anticipate being sent straight to prison
(d) There is increased likelihood of self-ham/suicide for those who did not anticipate being taken into custody (e.g. following Crown Court trials for very serious offences whereby the defendant has never been in the CJ process before, notably historic sex offences or serious motoring offences).

The healthcare needs of this cohort are harder to quantity, not least as they are so variable. Community data on prevalence will be relevant for some (e.g. first-time offenders), whereas CJ data drawn from police/prisons will be relevant for others as, despite coming to court off bail, many individuals are well entrenched in criminal justice systems. As a general observation, health is poorer amongst lower socio-economic groups; offenders are predominantly (though not exclusively) drawn from lower socio-economic groups.

4.6 Physical Health Needs and Prevalence

The following table is a summary of the wealth of data presented in Appendix B. For full details of our methodology and rationale for reaching the below prevalence figures please refer to the Appendix.

Figure 26 - Predicted Physical Health Needs in Court Custody

	Likely Prevalence in Court Custody		
	Men	Women	Juveniles
Asthma	6%	11.5%	14%
CHD	2%	2%	0%
COPD	2%	6%	0%
Diabetes	2.5%	2.5%	0.5%
Epilepsy	2.5%	3%	2%
Hypertension	3.5%	4%	1.5%
Head Injury	3.5%	4%	5.5%
Other Physical Injury	6.5%	7%	14.5%

4.7 Mental Health Needs and Prevalence

The following table is a summary of the wealth of data presented in Appendix B. For full details of our methodology and rationale for reaching the below prevalence figures please refer to the Appendix.

Figure 27 - Predicted Mental Health Needs in Court Custody

	Likely Prevalence in Court Custody		
	Men	Women	Juveniles
Common Mental Health Problems (Anxiety)	24%	43%	16%
Common Mental Health Problems (Depression)	16%	33%	10.5%
Severe & Enduring Mental Health Problems	4%	7%	4%
Self-Harm	14%	31%	28%
Self-Inflicted Deaths (of remand prisoners)	0.09%	0.06%	0.01%
ASD	1%	1%	18%
Learning Disabilities	2.5%	2%	9.5%

4.8 Substance Misuse Needs and Prevalence

The following table is a summary of the wealth of data presented in Appendix B. For full details of our methodology and rationale for reaching the below prevalence figures please refer to the Appendix.

Figure 28 - Predicted Substance Misuse Needs in Court Custody

	Likely Prevalence in Court Custody		
	Men	Women	Juveniles
Requiring Alcohol Detox	7%	9%	0%
Acute Intoxication	6%		

Alcohol Dependent	9%	9%	8%
Drug Dependent	30%	43%	20%
Receiving Methadone	24%	35%	6%

4.9 Social Care Needs and Prevalence

The following table is a summary of the wealth of data presented in Appendix B. For full details of our methodology and rationale for reaching the below prevalence figures please refer to the Appendix.

Figure 29 - Predicted Social Care Needs in Court Custody

	Likely Prevalence in Court Custody		
	Men	Women	Juveniles
Physical Disability	15%	7%	0%
Unable to Manage Medication	1.3%	1.8%	0%
Unable to Eat Unaided	0.1%	0%	0%

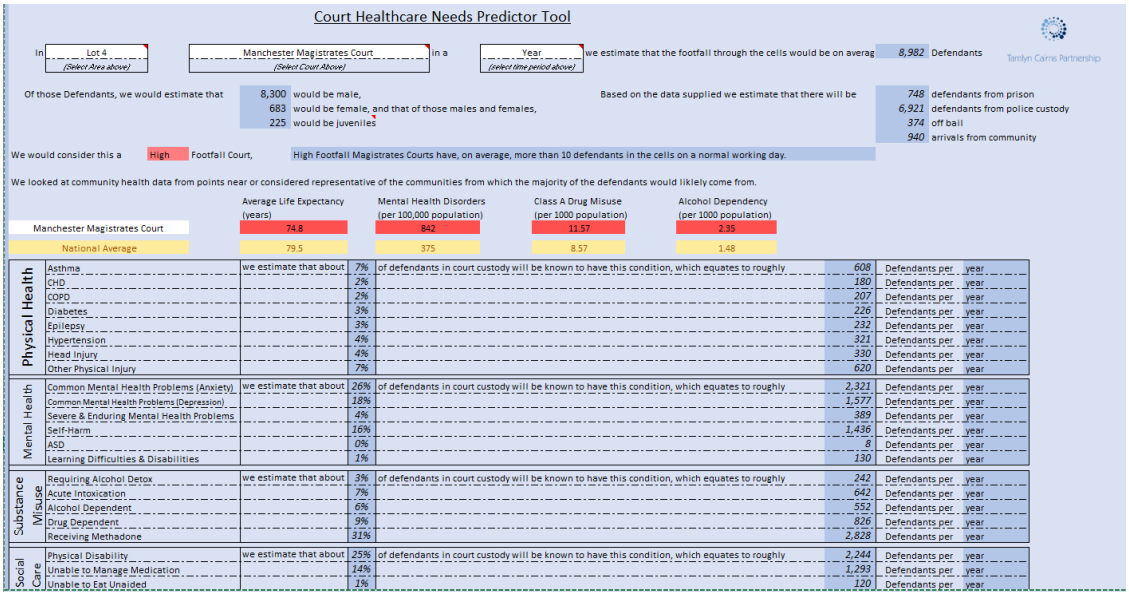
4.10 Predictor Tool

As part of this health needs assessment process, we have developed a predictor tool whereby all the information presented in the report has been amalgamated and categorised to allow readers to 'search' for a specific court, or court type, or group of courts (e.g. all Magistrates' Courts in Lot 3) and understand:

- The likely footfall (based on 2017 footfall data)
- The likely demographic breakdown of that footfall (male, female, adult, juvenile)
- The likely origin of detainees (e.g. off bail, from police custody, from prison)
- The graded community prevalence of related health issues pertinent to court (e.g. mental health, substance misuse, morbidity) as introduced in Section 4.2
- The likely prevalence (in both percentage terms but also actual likely number of detainees) of physical health issues in that court, as introduced in Section 4.6
- The likely prevalence (in both percentage terms but also actual likely number of detainees) of mental health issues in that court, as introduced in Section 4.7
- The likely prevalence (in both percentage terms but also actual likely number of detainees) of substance misuse issues in that court, as introduced in Section 4.8
- The likely prevalence (in both percentage terms but also actual likely number of detainees) of social care issues in that court, as introduced in Section 4.9.

For example, the below is a screenshot of the predictor tool where the end user has searched for Leeds Magistrates' Court and is looking at the likely footfall and needs within a month:

Figure 30 - Worked Example of Predictor Tool (Screenshot)



Court Healthcare Needs Predictor Tool

In Lot 4 (Select Area above) Manchester Magistrates Court (Select Court Above) in a Year (select time period above) we estimate that the footfall through the cells would be on averag 8,982 Defendants

Tamlyn Cairns Partnership

Of those Defendants, we would estimate that 8,300 would be male, 683 would be female, and that of those males and females, 225 would be juveniles

Based on the data supplied we estimate that there will be 748 defendants from prison, 6,921 defendants from police custody, 374 off bail, 940 arrivals from community

We would consider this a High Footfall Court, High Footfall Magistrates Courts have, on average, more than 10 defendants in the cells on a normal working day.

We looked at community health data from points near or considered representative of the communities from which the majority of the defendants would likely come from.

	Average Life Expectancy (years)	Mental Health Disorders (per 100,000 population)	Class A Drug Misuse (per 1000 population)	Alcohol Dependency (per 1000 population)
Manchester Magistrates Court	74.8	842	11.57	2.35
National Average	79.5	375	8.57	1.48

Physical Health	Asthma	we estimate that about	7%	of defendants in court custody will be known to have this condition, which equates to roughly	608	Defendants per year
	CHD		2%		180	Defendants per year
	COPD		2%		207	Defendants per year
	Diabetes		3%		226	Defendants per year
	Epilepsy		3%		232	Defendants per year
	Hypertension		4%		321	Defendants per year
	Head Injury		4%		330	Defendants per year
	Other Physical Injury		7%		620	Defendants per year
Mental Health	Common Mental Health Problems (Anxiety)	we estimate that about	26%	of defendants in court custody will be known to have this condition, which equates to roughly	2,321	Defendants per year
	Common Mental Health Problems (Depression)		18%		1,577	Defendants per year
	Severe & Enduring Mental Health Problems		4%		389	Defendants per year
	Self-Harm		16%		1,436	Defendants per year
	ASD		0%		8	Defendants per year
	Learning Difficulties & Disabilities		1%		130	Defendants per year
Substance Misuse	Requiring Alcohol Detox	we estimate that about	3%	of defendants in court custody will be known to have this condition, which equates to roughly	242	Defendants per year
	Acute Intoxication		7%		642	Defendants per year
	Alcohol Dependent		6%		552	Defendants per year
	Drug Dependent		9%		826	Defendants per year
	Receiving Methadone		31%		2,828	Defendants per year
Social Care	Physical Disability	we estimate that about	25%	of defendants in court custody will be known to have this condition, which equates to roughly	2,244	Defendants per year
	Unable to Manage Medication		14%		1,293	Defendants per year
	Unable to Eat Unaided		1%		120	Defendants per year

4.11 Chapter Summary

- There is a lot of evidence to show health needs are over-represented amongst individuals in the criminal justice system.
- This chapter evidences that there are high levels of health needs in certain populations, which do appear to correlate with the higher footfall courts.
- The needs explored in this chapter are those which specifically pertain to the client group served in court custody, hence a focus on substance misuse and mental health in addition to core long-term conditions.
- In effect, there is a particularly high level of likely health need amongst individuals who present in court custody as summarised within the chapter.

Chapter Five – Conclusions and Recommendations

5.1 Summary of Findings

There are about 350,000 individuals passing through custody in courts across the UK in a year.

The general trend has been a reduction (15%) in court custody detentions over the last three years. Current national priorities and initiatives such as court reform, prison reform, video-link etc. suggest the footfall will continue to decrease.

Of the people going through court custody, the majority (92%) are male. Juveniles represent 3% of all court custody throughput. This has been consistent over the last three years. Custody footfall is greater in Magistrates' Courts (63%) than Crown Courts (37%).

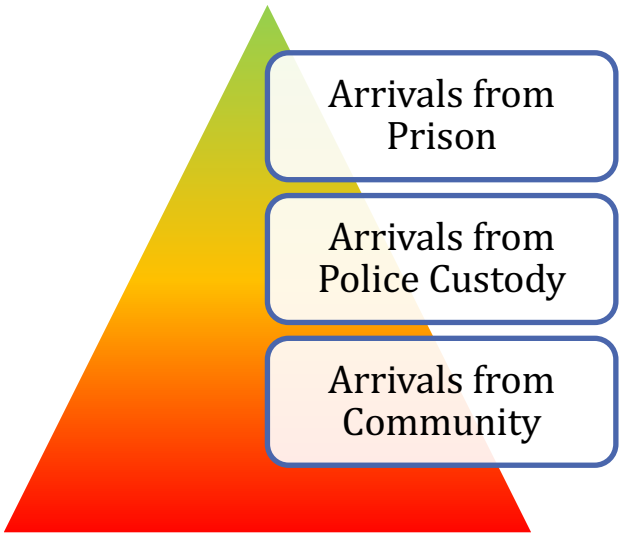
Individuals arrive into court custody by one of the following means:

Figure 31 - Arrivals into Court Custody

	Arrivals in Magistrates' Court Custody	Arrivals in Crown Court Custody
From community (off bail court appearance)	3.7%	12.9%
From community (brought by police vehicle (e.g. warrants, breach of bail)	10.1%	1.6%
From police custody (PECS transport)	74.2%	4.6%
From prison (PECS transport)	12.0%	80.9%

The 'risk' associated with detainees is partly dependent upon how they got to court custody; those arriving into custody from prison will largely be stable and any health needs will likely have been identified and be managed. Those arriving from the community may be under the influence of drugs/alcohol, withdrawing from drugs/alcohol, suffering head injuries etc. Some may have been seen in police custody, others may not have even passed through police custody.

Figure 32 - Health Risks vs Origin of Detainees



The report considers the footfall of both Magistrates' and Crown Court custody cells and categorises each court as 'high, medium or low footfall.'

Chapter Three considers current resources available to meet the needs of detainees in Court Custody, noting the inequity of provision in Lots 1,3 and 4 in comparison to the enhanced offer which has been commissioned in Lot 2. Inequity aside, the current provision doe little more than scratching the surface in terms of meeting needs.

Furthermore, Chapter Four considers community prevalence of relevant health needs (e.g. comorbidity, severe and enduring mental health, and substance misuse) and maps this prevalence against the highest and lowest footfall courts, showing a correlation.

Whilst it is accepted that prevalence does not equal need and need does not automatically correlate to service demand, we have calculated the following likely prevalence of relevant health needs for individuals in court custody. Note that this is based on the likely prevalence that would be identified by a comprehensive health screen/provision. The actual real prevalence will be higher.

Figure 33 - Likely Prevalence of Key Health Conditions in Court Custody

		Male Detainees	Female Detainees	Juvenile Detainees
Physical Health	Asthma	6%	8.5%	14%
	CHD	2%	2%	0%
	COPD	2%	6%	0%
	Diabetes	2%	2.5%	0.5%
	Epilepsy	2.5%	3%	2%
	Hypertension	4%	4%	1%
	Head Injury	2%	1%	9%
	Other Physical Injury	8%	8%	21%

Mental Health	Anxiety	24%	43%	16%
	Depression	16%	33%	36%
	Severe & Enduring MH	4%	7%	4%
	Self-Harm	14%	31%	28%
	Self-Inflicted Death	0.09%	0.06%	0.01%
	ASD	1%	1%	18%
	Learning Disabilities	2.5%	2%	9.5%
Substance Misuse	Requiring Alcohol Detox	7%	9%	0%
	Acute Intoxication		6%	
	Alcohol Dependent	9%	9%	8%
	Drug Dependent	30%	43%	20%
	Receiving Methadone	24%	35%	6%
Social Care	Physical Disability	15%	7%	0%
	Unable to Manage Medication	1.3%	1.8%	0%
	Unable to Eat Unaided	0.1%	0%	0%

The data supplied by the current healthcare contractor for the courts (United Safe Care) shows a clear and likely unmet need, with only 0.6% of court custody detainees generating a healthcare call in 2017. Note that the demand for healthcare is greater from Magistrates' Court custody than Crown Court custody (even after standardising the data to take account of the different footfall in each).

There are a number of barriers to the current effective delivery of healthcare in court custody including:

- Poor quality of information on the PER
- Confusion over the contractual requirement of PECS to give (detainees own) medication
- At strategic level, the lack of a single commissioning structure across the health and justice pathway creates additional challenges. Whilst NHS England has commissioning responsibility for L&D and secure settings (including SCH, STC and YOIs), the commissioning responsibility for police custody healthcare to date still falls with individual police force areas. This means neither PECS nor NHS England has influence over healthcare in police custody which can directly impact on the health of individuals in court
- Lack of a defined commissioning plan and budget for court custody healthcare.

Unsurprisingly, given the limited provision of healthcare, there is a dependency upon ambulance services in the court cells. In the absence of robust data on ambulance call-outs to court, our only means of qualifying this statement is via our experience in looking at ambulance call-outs to both police custody and prisons. As a general principle, the number of individual detainees in police custody and prisons is significantly higher than those in court, plus the detention time (in prison) is significantly longer than the short few hours individuals are

held in court cells. Despite this, the volume of calls for ambulances for court detainees (versus police custody and prison) appears disproportionately high.

5.2 Conclusions and Recommendations

There is, without doubt, a high level of need amongst detainees in court custody across both Magistrates' and Crown Courts, albeit, as the HNA demonstrates, the need is most acute and most likely to be unmet in the Magistrates' Court cells.

The actual level of need is masked by a number of factors:

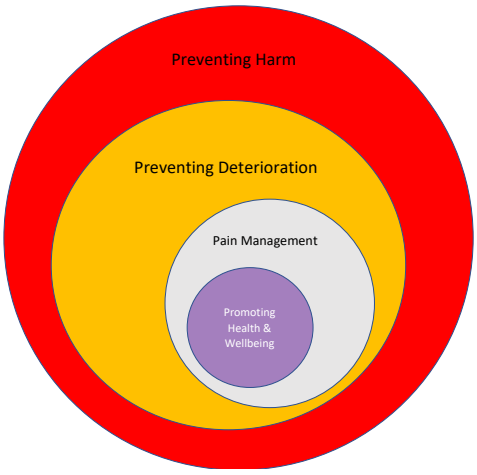
- The lack of health screening in court custody (including basic screens that could be done by non-clinical staff)
- The limited current healthcare service (particularly in Lots 1, 3 and 4) resulting in anything other than life threatening issues being suppressed/delayed until individuals leave court custody (e.g. to return to prison).

The result of the above means that any of the following happen:

- The health needs of detainees are unrecognised
- The health needs of detainees are known/recognised but are not managed (e.g. there is no access to medication). This *can* mean a deterioration of health conditions.
- There is a reliance on ambulance service and A&E to meet health needs, which, given a more robust in-house service could be more appropriately met within the court
- Detainees are either (a) released to the community or (b) returned to prison more quickly (following adjudication) in an attempt to avoid the need escalating and becoming more risky while in the police cells.

There are a number of ways in which these health needs could be met, however the approach will be influenced by the *type* of healthcare provision stakeholders wish to see in courts. As a minimum, it would be to manage immediate risk and prevent deaths in custody, at the other end of the spectrum it may be to ensure a full NHS-type care pathway across the whole of the criminal justice system with equity of provision, regardless of where a detainee is located (police custody, court, prison). The latter is more complex, not least because NHS England does not currently have commissioning responsibility for healthcare in the police custody estate.

Figure 34 - Understanding the Purpose of Court Healthcare



In the absence of a dedicated and commissioned healthcare service within the court, there are a number of recommendations below which could be implemented at minimal cost and at maximum speed (and included in the new PECS4 contract) that would improve the current situation, even if only temporarily. Longer-term commissioned solutions are considered in the separate document.

5.2.1 Managing the Needs of Detainees Withdrawing from Substances

Almost universally, staff working in court custody (particularly in Magistrates' Courts) said the biggest health need was those withdrawing from drugs/alcohol. There was a lack of awareness of the clinical risks associated with alcohol withdrawal for individuals who are alcohol dependent.

Recommendation 1 – All PECS staff should be trained in the use of the Custody Early Warning Score (CEWS) to improve the robustness of identification of the needs of those withdrawing from drugs and/or alcohol.

Staff also reported instances involving ambulance call-outs in response to individuals (generally detainees off bail) who may have overdosed on opiates.

Recommendation 2 – Explore the viability of naloxone (an emergency opiate antagonist for overdose) being available in Magistrates' Court custody, alongside appropriate training for PECS staff in its use.

It was clear, through the consultation process for the HNA, that the flow of information from police custody via the PER relating to substance misusers who had been medicated whilst in police custody was poor. Information was very limited, leaving non-clinicians (i.e. PECS staff) in the dark about likely clinical risk.

Recommendation 3 – The new version of the PER should include a requirement to state the time of the last dose of medication given *and the approximate time the next dose may be required.*

5.2.2 Managing the Needs of Detainees with Learning Difficulties and Disabilities

There is ample evidence given in the HNA that a sizeable proportion of individuals, both adults and juveniles, are in court custody who will likely have learning difficulties and, to a lesser extent, a diagnosed learning disability. The same also applies for other conditions such as autistic spectrum disorders (ASD), whilst not a learning difficulty.

It is acknowledged this is a very real issue for PECS staff and it was consistently raised by stakeholders as a health need which should be within the scope of this project.

Arguable, however, these are not 'health needs' as such, but more needs which need to be understood and, where relevant, information shared with appropriate staff members (e.g. L&D practitioners in the courts). This is primarily a training issue for existing staff rather than a health need in its own right.

Recommendation 4 – PECS staff should be trained in the management of detainees with special needs which should include learning difficulties, learning disabilities, ASD, ADHD and traumatic brain injury. The purpose of this is to ensure that episodes of detention are managed in the best way possible to minimise adverse consequences.

5.2.3 Clarifying Access to Medication

Access to medication was a recurrent theme during our site visits and stakeholder consultation. It is clear that there is an inconsistent approach, nationally, regionally and even within the same court buildings, and this needs clarifying.

In some cases, access to medication should be straight forward where it has been prescribed for the detainee, is correctly labelled as such and is in the property of the detainee. However, prisoners in local/remand prisons frequently reported not being given access to their medication in their property while at court, despite it being prescribed and labelled by the prison and included on the PER.

Recommendation 5 – The new PECS4 contract should explicitly state the requirement for PECS staff to (a) transport medication with prisoners where it is necessary and (b) *routinely* make that medication available to detainees at the time stated on the PER.

5.2.4 Long-Term Conditions (LTCs)

As evidenced in Chapter Three, there is a high prevalence of LTCs within the detainee population, noting that many LTCs have a higher prevalence in lower socio-economic groups. In Crown Court cells, where detainees arrive from

prisons, it is generally the case that needs in relation to LTCs are-well managed and, if necessary, medication accompanies the detainee to court.

In Magistrates' Court cells, however, these needs are often unknown. Left untreated, even for the short periods of time detainees are in court cells, some LTCs can present a very high clinical risk

5.2.5 Social Care

As noted in Appendix B, the social care needs of prisoners have become more firmly on the radar as a consequence of the ageing prison population and the increasing number of convictions of older people for historic sex offences.

Whilst the Commissioner agreed this was out of scope for this particular project, the reality is that defendants in court custody will increasingly present with social care needs which may need management, albeit not by a healthcare service.

Arguably, where social care needs are left unmet, there are risks to health (e.g. an individual who is unable to feed themselves and has a long journey to/from court in addition to seven hours in court cells).

Recommendation 7 – Discussions should be undertaken between NHS England and PECS regarding how best to (a) identify the social care needs of people in court and (b) how these needs will be met given the new PECS contract and the possible development of court healthcare.

5.2.6 Improving Information on the PER

The report notes significant issues with the quality, and sometimes accuracy, of information included on the PER. Noting that the PER is *always* generated before a defendant is placed in a court custody cell, it is within the 'gift' of PECS contractors to query poor (or missing) information at the point of detainee handover.

Recommendation 8 – PECS contractors should pay closer attention to the notes on health needs, specifically including medication requirements, and be fully satisfied that they have all the correct information *before* accepting the detainee.

5.3 Next Steps/Future Commissioning Models

Please see supporting document outlining potential models of delivery for court custody.

Note that, even if a future 'gold-standard' NHS-commissioned healthcare service was to be agreed, the recommendations in this section would still be relevant.

Claire Cairns
October 2018

Appendix A – List of Interviewees

The following people were consulted, some formally, some informally as part of the HNA process:

Name	Role	Organisation
Ivan Trethewey	National L&D and Police Healthcare Team	NHSE England (National Team)
Tim Coates	Head of PECS	HMPPS
Mark Howell	Operational Advisor (PECS)	HMPPS
Julie Dhuny	Commissioning Lead	NHS England (North Region)
Paula Bray	Head of Contracted Services	HMCTS
Tony Hirst	National Guidance Lead	HMCTS
Peter Masters	Head of Professional Standards	Serco
Brent Davison	Chief Inspector (Chair of National Police Custody Board)	Devon & Cornwall Police
Jeanne Trotter	Criminal Justice Programme Lead	OPCC Durham Constabulary
Lucia Saiger-Burns	Director of Rehabilitation – Tees & Wear Prison Group	HMPPS
Shane Newcome	Operations Manager	United Safe Care –Diagrama Foundation
Steve Allen	Business Lead	GEOAmey
Neil Winter	Incident Manager	Serco
Barry Bailey	Contract Delivery Manager	PECS
Vicki Stones	Delivery Manager	HMCTS (Leeds)
Colin Cohern	First Responder Emergency Care	United Safe Care –Diagrama Foundation
Tracey Bagley	Legal Team Manager (Leeds Magistrates' Court)	HMCTS
Caroline Allott	Court Custody Manager	GEOAmey (Leeds Magistrates' Court)
Fred Kiyagon	Deputy Court Custody Manager	GEOAmey (Leeds Crown Court)
Wayne Hodges	PER Lead – Security, Order and Counter Terrorism Directorate	HMPPS
Paul Smith	ePER National Lead	HMPPS
Lauren Mundy	Performance & Development Manager	Lincolnshire Action Trust (SPARK)
Keiron Duncan	Custody Officer (Exeter Crown Court)	GEOAmey
Nichola Chambers	Custody Officer (Exeter Crown Court)	GEOAmey
Tracy Rutter	Custody Manager (Teesside Magistrates' Court)	GEOAmey
Chris Partridge	Custody Manager (Exeter Magistrates' Court)	GEOAmey

With thanks to the following stakeholders who also provided guidance and expertise around some specific areas of the work:

- Marian Bullivant – L&D Team Manager
- Sandy Gilbert – Health & Justice Commissioner
- Tracy Wilson – Health & Justice Commissioner
- Inspector Samantha Strange – Police Custody
- Alan Grant – Custody Healthcare Manager
- Dr Lux Parimelalagan – Clinician (Prison)
- Annie Cunningham – L&D Practitioner
- Rupert Bailie – HMPPS
- Sadie Canning-Dosser – L&D Practitioner
- Kirsty Simpson – L&D Practitioner
- Jon Bashford – Consultant
- Julie Dhuny – Health & Justice Commissioner
- Dr Tania Claxton, FME
- Dr Vis Reddy, FME
- Dr Meng Aw-Yong, FME
- Debbie Kewley – Police Custody Inspector
- Marilyn Read – Health & Justice Commissioner

Appendix B – Methodology for Prevalence Calculations

The following shows, in full, the methodology we have applied in calculating likely prevalence of each health condition within court custody. The purpose of this is to supplement Chapter Four with robust evidence/rationale.

Key to this is the difference between the *predicted* (i.e. theoretical) prevalence of conditions, against the *observed* prevalence (real life taken from our health needs assessments across the CJ system nationally). We base our estimations for court prevalence on the *observed prevalence*, as this is the closest demographic we have to inform the needs of court custody detainees.

The sources for the **predicted prevalence** are as follows:

- National police custody research, specifically Payne-James (2007)[10] and McKinnon and Grubin (2013)[11]
- PHE (Birmingham) Toolkit for HNAs in prescribed places of detention (prisons)[12]

The predicted prevalence describes the true prevalence of a condition where all patients are assessed. The findings in our police and prison HNAs describe the *observed* prevalence amongst the populations; this acknowledges that in every health condition, to a greater or lesser degree, there will be people who, for a range of reasons, do not disclose their condition to healthcare.

The sources for our **observed prevalence** (all dated within the last 18 months) include:

- NDTMS data, filtered by male prison (locals), female prison, and YOIs
- MOJ Safety in Custody Statistics[13]
- Our raw data from police custody HNAs in four police force areas across the country
- Our raw data from remand/local male prison HNAs from 14 remand prisons across the country
- Our raw data from HNA in a secure children's home in the north
- Our raw data from HNAs in two secure training centres in the south of England
- Our raw data from HNAs in three YOIs across the country.

This part of the report is split into the following sections, reflecting the categories of health needs covered in the HNA:

[10] Payne-James *et al.* (2007) 'Healthcare issues of detainees in police custody in London, UK', Journal of Forensic and Legal Medicine 17(2010)11-17.

[11] McKinnon and Grubin (2013) 'Heath Screening in Police Custody', European Journal of Public Health, Volume 23, issue 3, 1 June 2013, p399-405.

[12] PHE (2014) Health Needs Assessment Toolkit Prescribed Places of Detention: Part 2 Adult Prisons.

[13] Ministry of Justice (2018) Safety in Custody Statistics – Summary Tables (self-harm and assaults to March 2018. Deaths in prison custody to June 2018.

- Physical Health
- Mental Health
- Substance Misuse
- Social Care

The prevalence of many health conditions is gender and/or age-correlated, thus most data sets are split between men, women, and juveniles to reflect this.

Physical Health

Asthma

Unlike other chronic conditions, asthma is more prevalent in younger age groups; it is the most common chronic condition in children. Research indicates that prevalence may be decreasing over time.[14]

The estimated prevalence of asthma amongst prisoners has historically always been based on the community rate and is consistent (albeit now very old). However, of interest is that in a study in police custody suites in London, 14% of all police detainees screened had asthma, suggesting a higher prevalence amongst offenders than in the general community.

The rate identified in our police HNAs (3%) is unsurprisingly low as this reflects that there is no routine screening for asthma in police custody, the only individuals recorded will be those who come to the attention of police custody healthcare.

In prisons the rate is higher, given the more robust screening process in reception of all prisoners and subsequent NHS commissioned healthcare services.

For our estimate, we have taken the mid-point between the rates we have observed in our previous research (i.e. police custody HNAs, prison, and YO HNAs).

We therefore estimate the likely prevalence of asthma (as seen in the court) to be 6% (males), 11.5% (females) and 14% (juveniles):

Figure 35 - Asthma Prevalence Estimates

	Predicted Prevalence				Observed Prevalence in CJ Settings		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police	National Estimated Prevalence		Our Police HNAs	Our Prison HNAs	

[14] Simpson, C.R. and Sheikh, A. (2010) 'Trends in the Epidemiology of Asthma in England: A National Study of 333,294 Patients'. *Journal of the Royal Society of Medicine.* 103/3: 98-106; also Simpson and Sheikh (2014) 'Trends in the Prevalence of Asthma'. *Chest.* 145/2: 219-225.

		Custody Research	Amongst Prisoners			
Male	5%	14%	5%	3%	9%	**6%**
Women	6%		6%		20%	**11.5%**
Juveniles	7%		7%		9-19%	**14%**

Coronary Heart Disease (CHD)

For registered GP patients, the all-age prevalence of CHD in England is 3.4% for males and females. The England prevalence for hypertension is 13.5%.[15] These figures are lower than the overall prevalence, because not all those with the conditions have this registered with a GP.

A variety of factors, including high rates of smoking, combine to mean that in contrast to the general population, prisoners are at heightened risk of cardiovascular disease.[16]

The prevalence of CHD is highly age-correlated and is lower in women than in men. In addition, the British Heart Foundation reports that CHD is 2.9 times more prevalent in men from the lowest socioeconomic group compared to the highest.

We have observed a rate of 2% in adults in both our police and prison HNAs.

We therefore estimate the prevalence of CHD (as seen in the court) to be 2% (males and females) and 0% (juveniles):

Figure 36 - CHD Prevalence Estimates

	Predicted Prevalence			Observed Prevalence in CJ Settings		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Research	National Estimated Prevalence Amongst Prisoners	Our Police HNAs	Our Prison HNAs	
Male	5.7%	2%	5.7%	2%	2%	**2%**
Women	3.5%		3.5%		2%	**2%**
Juveniles	0.1%				0%	**0%**

[15] British Heart Foundation (2012) *Coronary Heart Disease Statistics 2012 Edition.* Table 2.19 England data for 2010/11.

[16] Aries, E. (2013) *Cardiovascular risk factors among prisoners: an integrative review.*

Chronic Obstructive Pulmonary Disease

COPD is a term that includes a number of conditions, including chronic bronchitis and emphysema.

The community data shows that COPD is highly age correlated. A British Medical Journal (BMJ) article in 2011 suggests that community figures are an underestimate.[17]

Smoking tobacco is seen as the major risk factor[18] and, as noted elsewhere in this report, smoking rates are high amongst prisoners. Also, there are anecdotal concerns of an increasing prevalence amongst drug users who heeded the message not to inject and instead have been smoking drugs, sometimes for many years.

We expect that the population of the court custody suites will most closely resemble the population from the prison HNAs we have carried out.

We therefore estimate the prevalence of COPD (as seen in the court) to be 2% (males), 6% (females) and 0% (juveniles):

Figure 37 - COPD Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	4.5%	-	5%		-	2%	**2%**
Women	2.8%		3%			6%	**6%**
Juveniles	<1%		<1%			0%	**0%**

Diabetes

The prevalence of diabetes is increasing year on year, PHE projects that this trend will continue.[19] Diabetes prevalence strongly correlates with increasing age. The PHE HNA National Toolkit states that diabetes could be between two and eight times as prevalent in prisons compared to the community.[20] The rates of type 2 diabetes are reported to be 1.8 times as great in the most deprived quintile compared to the least.[21] The rate of diabetes in the community is now described as 9.6% of males and 7.6% of females and continues to rise. There has been no recent study in UK prisons, but a study amongst American prisoners suggested 4.8% prevalence.[22]

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[17] Snell, N. *et al.* (2016) *Epidemiology of chronic obstructive pulmonary disease (COPD) in the uk: findings from the british lung foundation's 'respiratory health of the nation' project.*

[18] WHO Factsheet (2017) *Chronic Obstructive Pulmonary Disease (COPD).*

[19] PHE (2016) *Diabetes Prevalence Model.*

[20] Marshall, T. *et al.* (2000) *Health care in prisons: A health care needs assessment*. University of Birmingham.

[21] NHS Digital (2012) Health Survey for England 2011, Chapter 4.

[22] American Diabetes Association: Diabetes Management in Correctional Institutions. Vol. 37, Supplement 1, Jan 2014.

We would not expect demand to equal prevalence or incidence. The prevalence figure includes both non-insulin dependent, and insulin dependent diabetes. The diabetes service is used more by insulin dependent patients than other patients with diabetes; though non-insulin dependent patients should also receive planned care.

National data indicates that 10% of those with diabetes have insulin dependent diabetes (type 1) and that 90% have non-insulin dependent diabetes (type 2).[23] The link between diabetes and deprivation is only associated with type 2, which is influenced by lifestyle issues.

Diabetes is almost twice as prevalent in Asian and black ethnic groups, compared to white (for both genders, 15.2% compared to 8.0%).

For our estimate, we have taken the mid-point between the actual rates we have observed in our police and prison HNAs, but have used only the prison HNA rate for juveniles as the police HNA data did not differentiate between juveniles and adults.

We therefore estimate the prevalence of diabetes (as seen in the court) to be 2.5% (males), 2.5% (females) and 0.5% (juveniles):

Figure 38 - Diabetes Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	9.1%	5%	9.1%		2%	3%	**2.5%**
Women	7.3%		7.3%			3%	**2.5%**
Juveniles	0.8%		0.8%			0.5%	**0.5%**

Epilepsy

Identified rates of epilepsy are usually well above the predicted prevalence; this is down to misdiagnosis in childhood that never leaves the systems.

There is a potential for prisoners to be misdiagnosed with epilepsy, as evidenced in an audit of healthcare in prisoners of one UK prison. The diagnoses of epilepsy were reviewed in 19 of the 26 cases identified, and of those, only 11 were believed to have epilepsy after the review. It is interesting to note that in this study, 38.4% of prisoners reported that their seizures developed within 12 months of beginning significant substance misuse, and a number of the prisoners also identified substance abuse as a cause for further seizures.[24]

[23] Diabetes in the UK (2012) *Key Statistics on Diabetes*.

[24] Tittensor *et al.* (2008) Audit of healthcare provision for UK prisoners with suspected epilepsy.

We believe that that the prevalence in court custody will be in between the observed values in our previous research.

We therefore estimate the prevalence of epilepsy (as seen in the court) to be 2.5% (males), 3% (females) and 2% (juveniles):

Figure 39 - Epilepsy Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	1.2%	4%	1.2%		2%	3%	**2.5%**
Women						4%	**3%**
Juveniles						2%	**2%**

Hypertension

Hypertension is another highly age-correlated condition.

Many patients with hypertension can manage their care themselves and good outcomes can depend on the patient attending to this. Lifestyle choices significantly impact on risk, and the following are examples of steps that can be taken to reduce risk: discontinuing smoking, making healthier food choices, increasing aerobic exercise, and moderating alcohol consumption.

The prevalence rate in England for hypertension is 13.5%.[25]

However, we believe the figure will more closely resemble that seen in prison and police custody and so have used the midpoint of the values observed in our previous research.

We therefore estimate the prevalence of hypertension (as seen in the court) to be 4% (males), 4% (females) and 1% (juveniles):

Figure 40 - Hypertension Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Academic Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	7%	5%	7%		2%	5%	**3.5%**
Women	8%		8%			6%	**4%**
Juveniles	0%		0%			1%	**1.5%**

Head Injury

[25] British Heart Foundation (2012) *Coronary Heart Disease Statistics 2012 Edition.* Table 2.19 England data for 2010/11.

Our data on head injuries and physical injuries is not gender specific, though anecdotally males are more likely to suffer head injuries than females.

Head injury doubles a person's risk of going on to experience mental health problems.[26] A French study postulates to a link between head injury and the high rate of epilepsy amongst offenders. [27]

In a national study, 9% of detainees who were routinely screened on arrival at police custody had a head injury. The data from our police HNAs suggests 2% prevalence of head injury.

When we examined our data from secure training centres, 9% of children had a head injury.

We have taken a midpoint between the two rates we have observed in our previous research.

We therefore estimate the prevalence of head injury (as seen in the court) to be 3.5% (males), 4% (females) and 5.5% (juveniles):

Figure 41 - Head Injury Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Academic Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	-	9%	-		2%	5%	**3.5%**
Women						6%	**4%**
Juveniles						9%	**5.5%**

Other Physical Injury

Physical injuries (other than head injuries) occur more frequently than head injuries. Our data on head injuries and physical injuries is not gender specific, though anecdotally males are more likely to suffer physical injuries than females.

National police custody data sets suggest 15% prevalence of any other physical injury, whereas our police custody HNAs show 8%.

When we examine our data from secure training centres, 21% of children had a physical injury.

For our estimate we have taken the mid-point between the rates we have observed in our previous research (i.e. police custody HNAs, prison and YO HNAs).

[26] Parsonage, M. (2016) *Traumatic Brain injury and offending.*

[27] Waiter, L. *et al.* (2016) *Prevalence of traumatic brain injury and epilepsy among prisoners in France: Results of the Fleury TBI Study.*

We therefore estimate the prevalence of other physical injury (as seen in the court) to be 6.5% (males), 7% (females) and 14.5% (juveniles):

Figure 42 - Other Physical Injury Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Academic Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	-	15%	-		8%	5%	**6.5%**
Women						6%	**7%**
Juveniles						21%	**14.5%**

Mental Health

Common Mental Health Issues

The following table is taken from the work by Singleton *et al.*[28] These estimates are for adults of all ages; one person can have more than one condition. Across every condition, the prevalence is greater amongst prisoners than the general population, and greater amongst remand prisoners than sentenced.

Figure 43 - Prevalence of Common Mental Health Conditions

	Male			Female		
	Community	Remand	Sentenced	Community	Remand	Sentenced
Worry	17%	58%	42%	23%	67%	58%
Depression	8%	56%	33%	11%	64%	51%
Irritability	19%	43%	35%	25%	51%	43%
Depressive ideas	7%	38%	20%	11%	57%	39%
Concentration/ forgetfulness	6%	34%	23%	10%	53%	38%
Anxiety	8%	33%	21%	11%	64%	51%
Obsessions	7%	30%	22%	11%	42%	32%
Somatic symptoms	5%	24%	16%	12%	35%	24%
Compulsions	5%	24%	15%	10%	40%	30%
Phobias	3%	20%	13%	8%	25%	18%
Worry about physical health	4%	22%	16%	5%	25%	23%
Panic	2%	18%	8%	3%	26%	15%
PTSD		5%	3%		9%	5%

This study describes prevalence. National studies estimate that a considerable proportion of people with mental health problems go undiagnosed and do not

[28] Singleton, N. *et al.* (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. ONS and DH. [2] McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). Mental health and wellbeing in England: Adult psychiatric morbidity survey 2014. Leeds: NHS digital.

seek help.[29] For this project, our estimates focus only on those who might present to services.

Prison screening for mental health issues is more accurate than in police custody and so we will use the rate observed in our prison HNAs for depression and anxiety.

We therefore estimate the prevalence of anxiety problems (as seen in the court) to be 24% (males), 43% (females) and 16% (juveniles):

Figure 44 - Common Mental Health Prevalence Estimates (Anxiety)

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Academic Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	7.8%	10%	33%		10%	24%	**24%**
Women	10.5%		64%			43%	**43%**
Juveniles	2.3%		36%			29%	**16%**

We therefore estimate the prevalence of depression (as seen in the court) to be 16% (males), 33% (females) and 36% (juveniles):

Figure 45 - Common Mental Health Prevalence Estimates (Depression)

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Academic Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	8%	10%	56%		10%	16%	**16%**
Women	11%		64%			33%	**33%**
Juveniles	2%		36%			10.5%	**10.5%**

Severe and Enduring Mental Health Problems

As above, for the adults we have used the prison HNA rate, as we believe prison mental health screening to be more rigorous than that in police custody. For juveniles, we have two data points, one from YOIs and the other from STCs and so we have taken the midpoint between the two values.

We therefore estimate the prevalence of severe and enduring mental health issues (as seen in the court) to be 4% (males), 7% (females) and 3.4% (juveniles):

[29] Sainsbury Centre for Mental Health (2003) *Primary Solutions: An independent policy review on the development of primary care mental health services.*

Figure 46 - Severe & Enduring Mental Health Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates[30]	National Police Custody Academic Research	National Estimated Prevalence Amongst Prisoners (psychosis)		Our Police HNAs	Our Prison HNAs	
Male	0.7%	11%	14.2%		2%	6%	**4%**
Women	0.7%		9.9%			12%	**7%**
Juveniles	0%		0%			1-6%	**4%**

Risk of Self-Harm/Suicide

Self-harm is common in secure settings due to the combined increased risks from mental ill-health and being incarcerated.[31]

According to the MOJ, prisoners are 8.6 times more likely to take their own lives than members of the general population.[32]

Within prisons, the Prisons and Probation Ombudsman (PPO) says the most vulnerable groups include[33]:

- those who have recently been incarcerated
- life or indeterminate sentence prisoners
- those with an offence against a family member or someone they were close to
- prisoners with mental health issues
- prisoners with substance misuse and withdrawal
- those with a history of self-harm

Women comprise only around 5% of the prison population, yet women consistently make up a higher proportion of prisoners who take their own lives.

We observed that 23% of children in our secure training centre HNAs had a history of self-harm.

Whilst we have a wealth of data on self-harm from our HNAs, there is a robust MOJ national data set which is regularly updated covering all prisons and YOIs and we have used this to define prevalence of self-harm. Note that it specifically relates to the prison environment (not police custody).

We therefore estimate the prevalence of self-harm (as seen in the court) to be 14% (males), 31% (females) and 28% (juveniles):

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[30] DH (2016) Adult Psychiatric Morbidity Survey (2014) Chapter 5 tables tab 5.1 Psychotic disorders in the last year.

[31] Royal College of Psychiatrists (2010) *Self-Harm, Suicide and Risk: Helping People who Self-Harm. Final Report of a Working Group*.

[32] MOJ (2017) *Safety in Custody Statistics Bulletin, England and Wales, Deaths in prison custody to December 2016, Assaults and Self-Harm to September 2016.*

[33] PPO (2014) *Learning the lessons from PPO Investigations. Risk factors in self- inflicted deaths in prisons*.

Figure 47 - Risk of Self-Harm Prevalence Estimates

	Predicted Prevalence		Actual Prevalence	**Our Estimated Prevalence for Court**
	National Community Estimates		MOJ Safer Custody Data	
Male	5.7%		14%	14%
Women	8.9%		31%	31%
Juveniles	17.5%		28%	28%

Using the same MOJ national data set, we estimate the prevalence of self-inflicted death (as seen in the court) to be 0.09% (males), 0.06% (females) and 0.01% (juveniles):

Figure 48 - Risk of Self-Inflicted Death Prevalence Estimates

	Predicted Prevalence		Actual Prevalence	**Our Estimated Prevalence for Court**
	National Community Estimates		MOJ Safer Custody Data	
Male	0.015%		0.09%	0.09%
Women	0.005%		0.06%	0.06%
Juveniles	0.006%		0.01%	0.01%

Autistic Spectrum Disorders

Whilst often bundled alongside learning disabilities,[34] autistic spectrum disorder is quite distinct.

The 2014 Adult Psychiatric Morbidity Survey estimated a UK prevalence rate of 0.8% for all adults, predominantly men; a rate of 1.5% for men nationally. The study noted:

> *Rates may be different in specific adult populations, such as among people who are homeless or living in prison. Rates were higher in men and in those without educational qualifications.*[35]

There is a lack of data on the prevalence of children and young people in the youth justice system with autism spectrum conditions. Prevalence among children in general is now thought to be 1 in 100, and higher amongst males.

For adults, we have observed rates in prison HNAs, while for juveniles we have observed rates from both STC and YOI HNAs (range 7-29%) and so have used the mid-point between them.

[34] See for example HM Inspectorates of Prisons and Probation (2015) *A joint inspection of the treatment of offenders with learning disabilities within the criminal justice system.*

[35] McManus, S. *et al.* (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital.

We therefore estimate the prevalence of ASD (as seen in the court) to be 1% (males), 1% (females) and 18% (juveniles):

Figure 49 - ASD Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Academic Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	1.5%	N/A	1.5%		N/A	1%	**1%**
Women	0.8%		0.8%			1%	**1%**
Juveniles	1.6%		0.6%			7 - 29%	**18%**

Learning Difficulties and Disabilities

Learning difficulty is a broad term, learning difficulties are not a health issue, but may be considered a social care issue. The *No One Knows* report estimates that 20-30% of offenders have learning difficulties or disabilities that interfere with their ability to cope within the criminal justice system.[36]

Learning disability is a more restricted definition:

> *[A] learning disability is defined by three criteria: an IQ score of less than 70; significant difficulties with everyday tasks; and onset prior to adulthood.*[37]

It is estimated that between 2 and 10% of offenders have a learning disability.[38]

We have taken the midpoint between the two values observed in our previous research in prison and police HNAs for adult men and women. However, for juveniles we have taken the midpoint between STCs and YOI HNAs (range 2-17%).

We therefore estimate the prevalence of learning disability issues (as seen in the court) to be 2.5% (males), 2% (females) and 9.5% (juveniles):

Figure 50 - Learning Disability Prevalence Estimates

	Predicted Prevalence				Observed Prevalence		**Our Estimated Prevalence for Court**
	National Community Estimates	National Police Custody Academic Research	National Estimated Prevalence Amongst Prisoners		Our Police HNAs	Our Prison HNAs	
Male	4.4%	3%	7%		2%	3%	**2.5%**
Women						2%	**2%**
Juveniles						2-17%	**9.5%**

[36] Prison Reform Trust (2007) *No One Knows: The Prevalence and Associated Needs of Offenders with Learning Difficulties and Learning Disabilities*.

[37] Hughes, N. *et al.* (2012) *Nobody made the connection: The prevalence of neurodisability in young people who offend.*

[38] DH (2015) *Equal Access, Equal Care; Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities*.

Substance Misuse Needs

Requiring Alcohol Detoxification

NDTMS tells us the percentage of people entering prisons (in this case we restricted it to local prisons, women's prisons and YOIs) who commenced an alcohol detox. This is updated quarterly and is (a) the most up to date data and (b) understood to be the most reliable indicator for the prison estate. It is based on all prisons, and broken down by prison type so we can be certain this is a robust data set.

Drug Dependent

NDTMS tells us the percentage of people entering prisons (in this case we restricted it to local prisons, women's prisons and YOIs) who commenced drug treatment programmes (regardless of treatment modality i.e. clinical/non-clinical). This is updated quarterly and is (a) the most up to date data and (b) understood to be the most reliable indicator for the prison estate. It is based on all prisons, and broken down by prison type so we can be certain this is a robust data set.

Acute Intoxication

The only data source we were able to use for this was our data from police custody health needs assessments showing the snapshot percentage of detainees who entered police custody under the influence of alcohol. Note that many defendants arrive at the court from the community before their detention in court cells, thus there is the potential for people to be acutely intoxicated in court cells.

Receiving Methadone

NDTMS tells us the percentage of people entering prisons (in this case we restricted it to local prisons, women's prisons and YOIs) who commenced opiate substitution treatment (OST). This is updated quarterly and is (a) the most up to date data and (b) understood to be the most reliable indicator for the prison estate. It is based on all prisons, and broken down by prison type, so we can be certain this is a robust data set.

From the above, the following is applied for our predictions in relation to substance misuse:

Figure 51 - Predicted Substance Misuse Needs in Court Custody

	Likely Prevalence in Court Custody		
	Men	Women	Juveniles
Requiring Alcohol Detox	7%	9%	0%
Acute Intoxication	6%		
Alcohol Dependent	9%	9%	8%
Drug Dependent	30%	43%	20%
Receiving Methadone	24%	35%	6%

Social Care Needs

The three areas explored in social care needs relate to the three data points which we have routinely gathered as part of our prison HNA process (in both male and female prisons). The prevalence assumptions we make are entirely based on the rates we have found in local/remand prisons and YOIs.

There are no community estimates which are of relevance and no national research to act as a further anchor point.

Subsequently the following is applied for our predictions:

Figure 52 - Predicted Social Care Needs in Court Custody

	Likely Prevalence in Court Custody		
	Men	Women	Juveniles
Physical Disability	15%	7%	0%
Unable to Manage Medication	1.3%	1.8%	0%
Unable to Eat Unaided	0.1%	0%	0%

Appendix C – PER

PERSON ESCORT RECORD FORM

PER

NOT FOR RELEASE – (Full Reason To Be Entered)	Tick if applicable
CARE PLAN ENCLOSED *(Police Use)*	
SELF HARM WARNING FORM ENCLOSED *(Contractor Use)*	
Assessment, Care in Custody & Teamwork (ACCT) ENCLOSED *(HMPS Use)*	

PHOTO
(If Available)

Surname .....

Forename .....

Prison No .....

Date of Travel .....

BQ009a - 9/2009

PROTECT - PERSONAL
PERSON ESCORT RECORD FORM
RISK INDICATOR

PERSON/DETAINEE IF NOT FOR RELEASE - TICK		REASON			
FROM		TO		DATE OF TRAVEL	/ /
SURNAME				NUMBER	
FORENAME				DOB	
ALIASES				RELIGION	

MALE		FEMALE		ETHNIC CODE		UNDER18		D.Y.O		P.o.P.O.	

(POLICE USE ONLY) PNC WARNING SIGNALS (IF YES, SEE DETAILS OF RISK BELOW)	YES	NO

PNC ID		CRO NO		NATIONALITY (UKBA ONLY)	

OFFENCE/CHARGE				If further information needs to be added, tick here and include on the Record of Events page.			
PREVIOUS CUSTODIAL HISTORY	POLICE	YES	NO	PRISON	YES	NO	

If no risk is known, tick the 'No Known Risk' box and sign to confirm at the bottom of the Form. The details of risk provided on this form Complete the Risk Indicator in accordance with the Guidance Notes on the opposite page.

No Known Risk

RISK	DETAILS OF CURRENT & RELEVANT RISK	INITIAL IF RISK CHANGED
SUICIDE/SELF HARM		
AT RISK OF PHYSICAL OR VERBAL ABUSE		
VIOLENCE/ RISK TO OTHERS		
ESCAPER/CAT A RESTRICTED STATUS		
DRUGS/ALCOHOL		
HOSTAGE TAKER		
CONCEALS WEAPONS OR OTHER ITEMS		
STALKER/HARASSER/ INTIMIDATION		
RACIAL/HOMOPHOBIC MOTIVATION		
SEX OFFENCE		
COMMUNICATION/ LANGUAGE DIFFICULTIES		
OTHER (SPECIFY)		

NAME		SIGNED		DATE		TIME	

If more than one person is completing both sections of the Risk Indicator, initial here and sign at the bottom.

HEALTH RISKS	CONTACT NUMBER FOR HEALTH QUESTIONS	

RISK	DETAILS OF CURRENT & RELEVANT RISK	TICK IF NO KNOWN RISK	INITIAL IF RISK CHANGED
HEALTH – MEDICAL			
HEALTH – MENTAL			

NAME		SIGNED		DATE		TIME	

This section is required if more than one person has completed the Risk Indicator section above

NAME		SIGNED		DATE		TIME	

RISK INDICATOR GUIDANCE NOTES

PROTECTIVE MARKING - The level of protection provided for assets marked **PROTECT** should promote discretion in order to prevent unauthorised access.

PERSON/DETAINEE IF NOT FOR RELEASE - TICK must be ticked if an individual is not for release, and a full reason must be given.

NUMBER - Refers to the unique number that a particular agency gives to an individual.

ETHNIC CODE - The following codes will be used: **Nationality** to be used by UKBA

A1	Asian or Asian British Indian	M3	Mixed White & Asian
A2	Asian or Asian British Pakistani	M9	Mixed other
A3	Asian or Asian British Bangladeshi	NS	Not stated
A9	Asian other	O1	Chinese
B1	Black or Black Caribbean	O9	Any other
B2	Black or Black British African	W1	White British
B9	Black other	W2	White Irish
M1	Mixed White & Black Caribbean	W9	White Other
M2	Mixed White & Black African		

P.o.P.O. /D.Y.O - If the individual is a Prolific and Other Priority Offender, or a Deter Cohort Young Offender this box must be ticked.

P.N.C. ID WARNING SIGNALS - Is for police use only. Delete either Yes or No. Relevant risk must be recorded in the appropriate boxes.

PNC ID – PNC ID number to be entered.

CRO NO – Criminal Records Office number to be entered.

NATIONALITY - UKBA only to fill this section.

OFFENCE - Include the Offence. If further information is required, tick the box and include it on the Record of Events page.

PREVIOUS CUSTODIAL HISTORY - Delete either Yes or No on every occasion.

If a known risk exists, it must be recorded in line with the guidance below.

If no known risk exists, a tick must be placed in the **NO KNOWN RISK** box.

SUICIDE/SELF HARM	To be completed if the person : ▪ has or has attempted to self-harm. ▪ is at known risk of self-harm (e.g. has threatened self-harm / on open ACCT Plan) ▪ has recently been at risk of self-harm (e.g. post-closure phase of ACCT Plan / PNC suicide/self-harm warning marker in last six months) ▪ gives other reason to indicate at risk of self-harm (e.g. has killed or seriously injured a family member / unexpected recall / bizarre behaviour or other signs of mental disorder / withdrawal from drugs/alcohol) ▪ becomes at risk during this custody (e.g. receives unexpected remand / long sentence) It must be recorded which of the above (or other reason) is relevant, along with details.
AT RISK OF PHYSICAL OR VERBAL ABUSE	Consideration must be given to the nature of the charge or offence or if there is any history of bullying or intelligence of threats against the individual. Press interest may also place the individual at risk.
VIOLENCE/RISK TO OTHERS	To be completed if there is any relevant history of violence, actual or threatened. Reference must be made to risks to specific groups such as women, children, and minority ethnic groups, Police/Prison/Private Contractors or any other Criminal Justice Agency. Specific reference must also be made to any risks they may pose to others, particularly if placed into shared cellular accommodation (the Cell Sharing Risk Assessment must be consulted if available).
ESCAPER/CAT 'A' RESTRICTED STATUS	To be completed if: ▪ Categorised Cat 'A' or potential Cat 'A,' Restricted Status ▪ The individual is from prison and on the 'E' list. ▪ There is relevant history of escape attempts ▪ Intelligence suggests an escape attempt is likely
DRUGS/ALCOHOL	To be completed if there is a history or intelligence of the individual attempting or actually trafficking drugs/alcohol into secure establishments. (This is **not** to be completed if the individual is drug or alcohol dependent - this will be recorded in the **Health Risk Section**).
HOSTAGE TAKER	To be completed if there is an actual history or a relevant threat of a hostage situation.
CONCEALS WEAPONS/DRUGS OR OTHER ITEMS	To be completed if there is intelligence to suggest that there is the possibility of concealed weapons or items with the individual:
STALKER/HARASSER/ INTIMIDATION	To be completed if the individual has a Restraining Order or a Civil Injunction against them or intelligence to suggest that the individual will attempt to harass or intimidate witnesses, co-defendants or other specific individuals. Prison staff must ensure that information recorded here is passed to the relevant person on the day of arrival.
RACIAL/HOMOPHOBIC MOTIVATION	To be completed if the offence or charge is homophobic or racially motivated, or there is a history of.
SEX OFFENCE	To be completed if the offence or charge is of a sexual nature offences (excluding prostitution offences - except where the charge is the procurement of others into prostitution
COMMUNICATION/LANGUAGE DIFFICULTIES	To be completed if any barriers to verbal communication exist. This is to include any issues regarding foreign language and literacy requirements and will relate to those who are visually or hearing impaired.
OTHER (SPECIFY)	To be completed if there is any relevant information that is not covered above.
HEALTH – MEDICAL	To be completed if there is any current and relevant medical health risk. All medical holds including those on Drug Maintenance Programmes should be highlighted '*return to the discharging establishment*' **(HMPS)**. A contact number for health care must be given in the box provided in the event that more information becomes necessary.
HEALTH – MENTAL	To be completed if there is any current and relevant risk mental health risk. A contact number for health care must be given in the box provided in the event that more information becomes necessary.

A **health contact number** must be given so that questions or clarification relating to health matters can be made.

There are two places where signatures are required. This reflects the fact that the form may be completed by more than one person.
If one person is completing the form then the first section can be initialled and the signature may be completed at the bottom of the form.
The time and date must be recorded as the time and date that the relevant section of the form was completed.

If a risk changes after completion of the form, consideration must be given to completing a new form. If this is considered impracticable or unnecessary then the **'INITIAL IF RISK CHANGED'** must be initialled, a statement made in the relevant risk box and an entry made on the **'HISTORY AND RECORD OF DETENTION AND ESCORT EVENTS'** form.

PROTECT - PERSONAL

ESCORT HANDOVER DETAILS

Complete the Escort Handover Details in accordance with the Guidance Notes on the opposite page

NUMBER		SURNAME	

ESCORT DETAILS		PRESCRIBED MEDICATION	YES	NO
At each point where a person/detainee is handed over or received both the dispatching and receiving contact telephone numbers must be completed on the form.		WITH ESCORT		WITH PERSON/DETAINEE	
		NAME		SIGNATURE	
ORIGINATING LOCATION	PHONE NO.	It is not essential to list medication below. Refer to Guidance opposite for instructions.		
TO (ESCORT/COURT/PRISON/POLICE STATION, ETC)	PHONE NO.		
TO (ESCORT/COURT/PRISON/POLICE STATION, ETC)	PHONE NO.		
TO (ESCORT/COURT/PRISON/POLICE STATION, ETC)	PHONE NO.		
TO (ESCORT/COURT/PRISON/POLICE STATION, ETC)	PHONE NO.		

FORMS ENCLOSED

ACCT / RECENT ACCT	Y	QUANTITY	REMAND TIME CALCULATION	Y	QUANTITY
SUICIDE/SELF-HARM WARNING FORM	Y	QUANTITY	PNC PRINTOUT	Y	QUANTITY
CELL SHARING RISK ASSESSMENT	Y	QUANTITY	MEDICAL ASSESSMENT / CARE PLAN	Y	QUANTITY
F2050 CORE RECORD	Y	QUANTITY	CONFIDENTIAL MEDICAL DOCUMENTS	Y	QUANTITY
F2052A HISTORY SHEET	Y	QUANTITY	POLICE RISK ASSESSMENT FORM	Y	QUANTITY
PROPERTY CARD	Y	QUANTITY	IMMIGRATION DETENTION AUTHORITY (IS91)	Y	QUANTITY
CATEGORISATION DOCUMENTATION	Y	QUANTITY	DEPORTATION ORDER	Y	QUANTITY
RESTRAINTS APPLICATION FORM	Y	QUANTITY	WARRANT	Y	QUANTITY
OTHER ATTACHED (PLEASE SPECIFY)				Y	QUANTITY

PROPERTY & CASH

CODE	SEAL NO.	OUT	IN	CASH AMOUNT		SEAL NO.	OUT	IN
				£				
				OTHER				
				OTHER				
				OTHER				
				OTHER				
				OTHER				
				OTHER				

PROPERTY RETAINED	YES	NO	RETAINING ORGANISATION	

RECORD OF HANDOVER (See Guidance Notes)

Record and confirm any changes to property or cash on the Record Of Events.

Sign to say that the correct person/detainee is being handed over and that the property and cash described above is complete and accurate at the time of each handover. Contractor staff will only sign for an intact bag against seal number. The risks have been handed over and understood by the Receiving Officer.

DISPATCHING OFFICER	I.D.	SIGNATURE	RECEIVING OFFICER	I.D.	SIGNATURE	TIME	DATE	INITIAL IF ENTRY MADE ON R.O.E.

Escort Handover Details Guidance Notes

NUMBER - SURNAME - These details must be taken from the Risk Indicator and are included again here for quick reference.

ESCORT DETAILS		
At each point where a person/detainee is handed over or received both the dispatching and receiving contact telephone numbers must be completed on the form.		It is a requirement for both the Dispatching and Receiving agencies to give a contact number. This is so that contact can be made to clarify information or to communicate new information. Escort Contractors will use their Control Room number.
ORIGINATING LOCATION	PHONE NO.	
TO (ESCORT/COURT/PRISON/POLICE STATION, ETC)	PHONE NO.	
TO (ESCORT/COURT/PRISON/POLICE STATION, ETC)	PHONE NO.	
TO (ESCORT/COURT/PRISON/POLICE STATION, ETC)	PHONE NO.	
TO (ESCORT/COURT/PRISON/POLICE STATION, ETC)	PHONE NO.	

PRESCRIBED MEDICATION		YES	NO	Please circle "YES or NO" in order to indicate if the person has prescribed medication. If "no" is circled, a name and signature is still required. If medication is accompanying the person/detainee then the appropriate box must be ticked and the name and signature of the member of staff must be completed. Note that it is not essential to list the medication but space is provided for agencies to list it if they choose to. **Prison staff will not routinely list medication, but Primary Care Trust (PCT) will provide their name and signature if medication accompanies the person.**
WITH ESCORT		WITH PERSON/DETAINEE		
NAME		SIGNATURE		
It is not essential to list medication below. Refer to Guidance opposite for instructions.				

FORMS ENCLOSED
Where specific forms exist they must also be handed over to the receiving agency, with the relevant "Y" circled, **and the quantity of each form handed over recorded.** This is to help ensure that documents are accounted for.

PROPERTY & CASH
The receiving officer is responsible for ensuring that the seal number is correct and that the bag and seal are intact. Should there be any discrepancy then this is to be detailed on the 'HISTORY AND RECORD OF DETENTION AND ESCORT EVENTS' form. The 'OUT' and 'IN' boxes should be ticked to confirm the property has been handed over at the start of the escort and received at the end. The following Codes are used: ▪ 'V' = Valuables ▪ 'SP' = Stored Property ▪ 'IP' = In Possession ▪ 'C' = Cash ▪ 'D' = Documentation Property Retained denotes any organisation which withholds property. The YES or NO box should be circled accordingly. If yes, state the organisation which has retained the property. An entry should then be made on the record of events page.

RECORD OF HANDOVER
All individuals that complete this section are to ensure that the 'Dispatching Officer' and 'Receiving Officer' details are legible. The section containing the heading 'I.D.' requires the epaulette or ID number of the 'Dispatching Officer' and 'Receiving Officer' if applicable. 'INITIAL IF ENTRY MADE ON RECORD OF EVENTS'– If there are any discrepancies in the Property & Cash the Dispatching officer is to initial following the entry that has been made on the 'HISTORY AND RECORD OF DETENTION AND ESCORT EVENTS' The Receiving Officer is signing for the following: ▪ The correct person/detainee is being received. ▪ The property and cash described are complete and accurate at the time of the handover. Contractor staff will only sign for an intact bag against seal number. ▪ Additional forms and documents as listed on the PER. ▪ The risks associated with the person are understood.

PROTECT - PERSONAL

HISTORY AND RECORD OF DETENTION AND ESCORT EVENTS

SHEET NUMBER	1

NUMBER		SURNAME	

Complete the History and Record of Detention and Escort Events in accordance with the Guidance Notes on the opposite page

TIME	DETAILS		NAME	SIGNED	SEC
	Correctly Identified	Y/N			
	Searched (State Level)	Y/N			
	Escort Fully Verbally Briefed (Including Risks)	Y/N			
	Searched by Contractor (State Level)	Y/N			

REFER TO THE RISK INDICATOR FOR KNOWN RISKS

The PER Form must accompany the person/detainee to the Health Screening process

HISTORY AND RECORD OF DETENTION AND ESCORT EVENTS GUIDANCE NOTES

SHEET NUMBER - This must be sequential so that receiving agencies can read through the additional sheets in the correct order.

NUMBER – **SURNAME -** These details must be taken from the Risk Indicator and are included again here for quick reference.

TIME - The time must be completed for every entry.

DETAILS - Details of the event must be clear and unambiguous.

NAME - The name of the officer completing any entry must be legible (Print Name).

SIGNED - Signature of the officer completing the entry.

SEC - See below for the Significant Event Codes.

correctly identified **Searched (State Level)** **Escort verbally briefed (including risks)**	This section is for Prison use only. Include details of the level of search given.	
searched by contractor (state level)	**This section is for contractor use only.**	**Y/N**

Use the following **Significant Event Codes** to highlight lines that contain important information to be handed over.

Significant Events may be suicide attempts, self-harm, escapes, violence, drugs, although this list is not exclusive. Refer to the Significant Events Codes below.

A New risks identified during the escort or detention or old risks that have been re-presented
B First Aid administered/Unplanned Urgent Treatments
C Incapacitant Spray/Device used
D Meals taken or offered
E Change of Status
F Any apparent injuries
G Use of batons
H Other significant events

Prison Reception Staff must refer to this document to obtain information relating to risk and use it to inform the Cell-Sharing Risk Assessment, ACCT, OASys and MAPPA processes.

PROTECT - PERSONAL

HISTORY AND RECORD OF DETENTION AND ESCORT EVENTS

SHEET NUMBER	2

NUMBER		SURNAME	

Complete the History and Record of Detention and Escort Events in accordance with the Guidance Notes on the opposite page

TIME	DETAILS	NAME	SIGNED	SEC

In the event all the available rows are used go to a continuation booklet

RELEASE AT COURT

I certify that all the relevant checks have been made with clearance given as shown:

Agency	Establishment	Name	Authority to Release	Remarks

Release Authorised by SCO/IC	Name		Signature	
Release Countersigned by	Name		Signature	

STATEMENT OF RECEIPT OF PROPERTY

I certify that I have received all the contents of property bag numbers shown below, and am completely satisfied

1)	2)	3)	4)	5)
6)	7)	8)	9)	10)

Name (Print)		Signature	

REFER TO THE RISK INDICATOR FOR KNOWN RISKS

The PER Form must accompany the person/detainee to the Health Screening process

HISTORY AND RECORD OF DETENTION AND ESCORT EVENTS GUIDANCE NOTES

SHEET NUMBER- This must be sequential so that receiving agencies can read through the additional sheets in the correct order.

NUMBER - These details must be taken from the Risk Indicator and are included again here for quick reference.

TIME - The time must be completed for every entry.

DETAILS - Details of the event must be clear and unambiguous.

NAME - The name of the officer completing any entry must be legible (Print Name).

SIGNED - Signature of the officer completing the entry.

SEC - See below for the Significant Event Codes.

RELEASE AT COURT – when a person is released at court the release should be recorded using this section. Any checks that need to be made to authorise the release should be recorded in the boxes shown, as follows:

AGENCY - Court, Prison, Police or Other (Please state)

ESTABLISHMENT - Name of the authorising establishment

NAME - Name of the person authorising, or refusing, the release

AUTHORITY TO RELEASE - "Yes" or "No"

REMARKS – Any further information in corroboration of the decision

RELEASE AUTHORISED BY SCO/IC – The Senior Custody Officer will ensure all checks have been carried out by contacting the relevant agency or establishment and obtaining both a contact name and level of authority. These details must then be entered onto the form together with any related remarks. Having confirmed the release has been authorised, the Senior Custody Officer must then print and sign their name in the relevant boxes.

RELEASE COUNTERSIGNED - A second officer should check the documentation and the release information, and then print their name and sign in the relevant boxes.

STATEMENT OF RECEIPT OF PROPERTY - If a person is being released and has property held in your possession then they should acknowledge the return of their property using this section. The corresponding bag seal numbers should be copied across from the Property and Cash section, and the person being released should print their name and sign in the relevant boxes.

Use the following **Significant Event Codes** to highlight lines that contains important information to be handed over.

Significant Events may be suicide attempts, self-harm, escapes, violence, drugs, although this list is not exclusive. Refer to the Significant Events Codes below.

A New risks identified during the escort or detention or old risks that have been re-presented
B First Aid administered/Unplanned Urgent Treatments
C Incapacitant Spray/Device used
D Meals offered and taken or refused.
E Change of Status
F Any apparent injuries
G Use of batons
H Other significant events

Prison Reception Staff must refer to this document to obtain information relating to risk and use it to inform the Cell-Sharing Risk Assessment, ACCT, OASys and MAPPA processes.

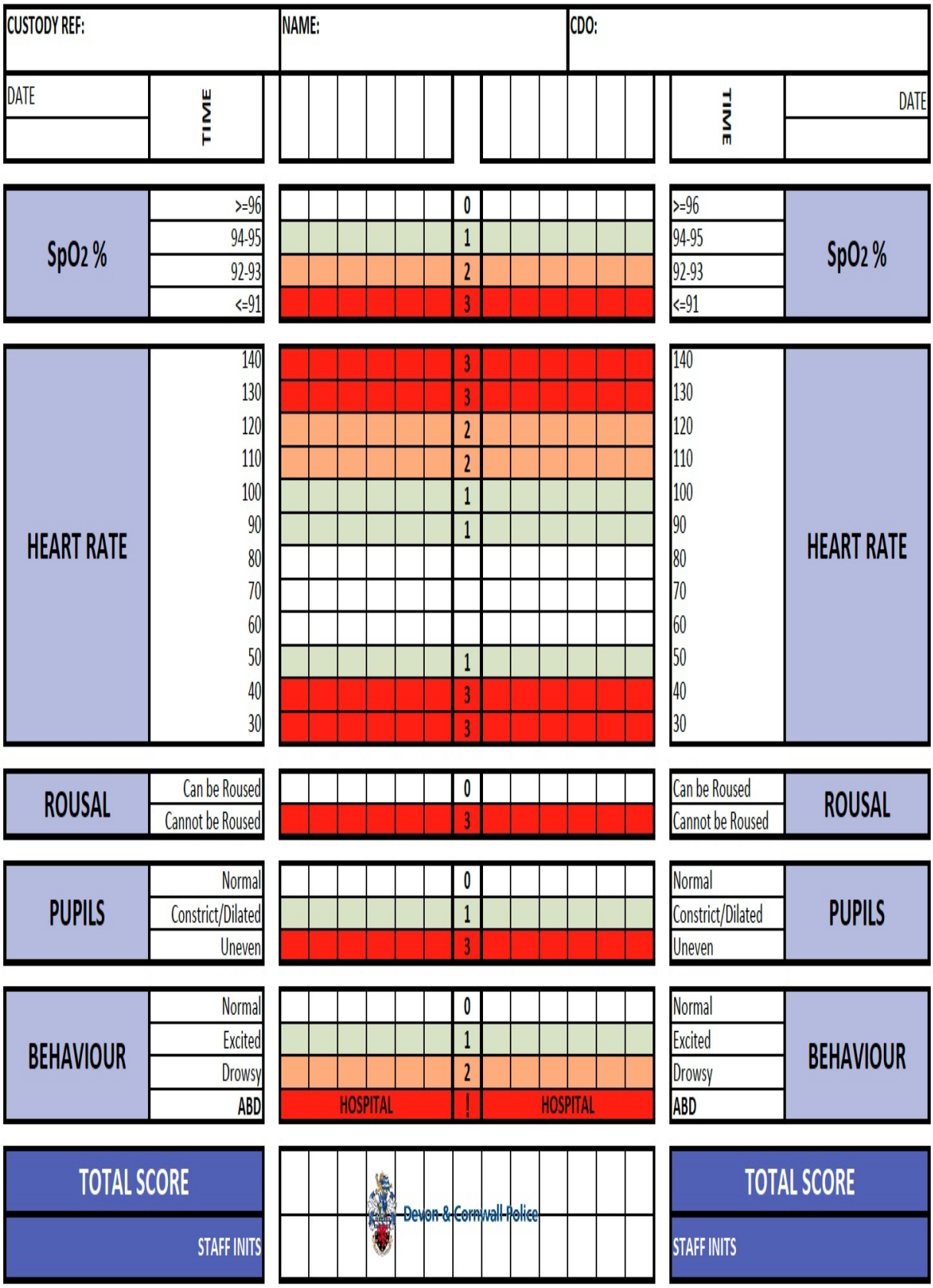
Appendix D – Magistrates' Courts by Volume Category

Lot 1 (South West, South East)	Lot 2 (London, East)	Lot 3 (East Mids, Yorks & Humber, North East)	Lot 4 (North West, West Midlands, Wales)
High Footfall			
Bristol Magistrates'Court	Westminster Magistrates' Court	Leeds Magistrates'Court	Manchester Magistrates'Court
	Thames Magistrates' Court	Bradford Magistrates'Court	Birmingham Mc Corporation St
	Highbury Corner Magistrates' Court	Nottingham Magistrates'Court	Liverpool Magistrates'Court
	Camberwell Green Magistrates' Court	Middlesborough Magistrates'Court	Cardiff Magistrates'Court
	Uxbridge Magistrates' Court	Sheffield Magistrates'Court	Walsall Magistrates'Court
	Hendon Magistrates' Court	Leicester Magistrates'Court	Newcastle-Under-Lyme Magistrates'Court
	Wimbledon Magistrates' Court	Derby Magistrates'Court	Bootle Magistrates'Court
	Barkingside Magistrates' Court	Bedlington Magistrates'Court	
	Hatfield Remand Court	South Shields Magistrates'Court	
	Chelmsford Magistrates' Court	Lincoln Magistrates'Court	
Medium Footfall			
Reading Magistrates'Court	Bromley Magistrates' Court	Kingston-Upon-Hull Magistrates'Court	Newport
Southampton Magistrates'Court	Croydon Magistrates' Court	Doncaster Magistrates'Court	Dudley Magistrates'Court
Portsmouth Magistrates'Court	Norwich Magistrates' Court	Northampton Magistrates'Court	Blackburn Magistrates'Court
Plymouth Magistrates'Court	Luton Magistrates' Court	Grimsby Magistrates'Court	Merthyr Tydfil Combined Court
Poole Magistrates'Court	Hammersmith Magistrates' Court		Preston Magistrates'Court
Brighton Combined Court			Coventry Magistrates'Court
Staines Magistrates'Court			Blackpool Magistrates'Court
Crawley Magistrates'Court			Chester Magistrates'Court
			Warrington Combined Court
			Leamington Spa Magistrates'Court
			Swansea Magistrates'Court
Low Footfall			
Oxford Magistrates'Court	Peterborough Magistrates' Court	Newton Aycliffe Magistrates'Court	Cannock Magistrates'Court
Cheltenham Magistrates'Court	Ealing Magistrates' Court	York Magistrates'Court	Worcester Magistrates'Court
Basingstoke Magistrates'Court	Cambridge Magistrates' Court	Newcastle-Upon-Tyne Sat Magistrates'Court	Crewe Magistrates'Court
Swindon Magistrates'Court	Basildon Magistrates' Court	Mansfield Magistrates'Court	Telford Magistrates'Court
High Wycombe Magistrates'Court	Ipswich Magistrates' Court	Huddersfield Magistrates'Court	Ashton-Under-Lyne Magistrates'Court
Milton Keynes Magistrates'Court	Bexleyheath Magistrates' Court	North Shields Magistrates'Court	Llandudno Magistrates'Court
Hastings Magistrates'Court	Newham Stratford Magistrates' Court	Chesterfield Magistrates'Court	Birkenhead Magistrates'Court
Slough Magistrates'Court	Willesden Magistrates' Court	Peterlee Magistrates'Court	Carlisle Magistrates'Court
Exeter And Wonford Magistrates'Court	St. Albans Magistrates' Court	Barnsley Magistrates'Court	Wrexham Magistrates'Court
Taunton Magistrates'Court	Huntingdon Law Courts	Scarborough Magistrates'Court	Wigan Magistrates'Court
Maidstone Magistrates'Court	Southend Combined Court	Harrogate Magistrates'Court	Redditch Magistrates'Court
Banbury Magistrates'Court	Colchester Magistrates' Court	Beverley Magistrates'Court	Llanelli Magistrates'Court
Guildford Magistrates'Court	City of London Magistrates' Court	Northallerton Magistrates'Court	Bolton Combined Court
Truro Magistrates'Court	Stevenage Magistrates' Court	Wellingborough Magistrates'Court	Barrow In Furness Combined Court
Canterbury Magistrates'Court	King's Lynn Combined Court	Loughborough Magistrates'Court	Stockport Magistrates'Court
Chatham Magistrates'Court	Romford Magistrates' Court	Boston Magistrates'Court	Wolverhampton Magistrates'Court
North Somerset Magistrates'Court	Great Yarmouth Magistrates' Court	Hartlepool Magistrates'Court	Hereford Magistrates'Court
Weymouth Magistrates'Court	Hertford Magistrates' Court	Bridlington Magistrates'Court	Caernarfon Combined Court
Yeovil Magistrates'Court		Skipton Magistrates'Court	Mold Combined Court
Bodmin Magistrates'Court		Berwick-Upon-Tweed Magistrates'Court	Kidderminster Magistrates'Court
Margate Magistrates'Court		Penrith Magistrates'Court	Bury Magistrates'Court
Newport Iow			Burnley Magistrates'Court
Bath Magistrates'Court			Lancaster Magistrates'Court
Folkestone Magistrates'Court			Workington Magistrates'Court
Salisbury Magistrates'Court			Haverfordwest Combined Court
Bournemouth Magistrates'Court			Birmingham Yc Newton St
Chippenham Magistrates'Court			Aberystwyth Magistrates'Court
Sevenoaks Magistrates'Court			Welshpool Magistrates'Court
Worthing Magistrates'Court			Runcorn Magistrates'Court
Horsham Magistrates'Court			Cwmbran Magistrates'Court
Barnstaple Magistrates'Court			Kendal Magistrates'Court
Torbay Magistrates'Court			Holyhead Magistrates'Court
Newton Abbot Magistrates'Court			Nuneaton Magistrates'Court
Dartford Magistrates'Court			Liverpool Youth Court
Aldershot Magistrates'Court			Llandrindod Wells Magistrates'Court
Maidenhead Magistrates'Court			

Appendix E – Crown Courts by Volume Category

	Lot 1 (South West, South East)	Lot 2 (London, East)	Lot 3 (East Mids, Yorks & Humber, North East)	Lot 4 (North West, West Midlands, Wales)
High	Maidstone Crown Court	Central Criminal Court	Leeds Crown Court	Manchester Crown Square Crown Court
		Snaresbrook Crown Court		Birmingham Crown Court
Med	Bristol Crown Court	Isleworth Crown Court	Newcastle-Upon-Tyne Quayside Crown Court	Preston Crown Court
	Oxford Crown Court	Kingston-upon-Thames Crown Court	Nottingham Crown Court	Liverpool Crown Court
		Inner London Crown Court	Sheffield Crown Court	Manchester Minshull St Crown Court
		Woolwich Crown Court		
		Harrow Crown Court		
		Blackfriars Crown Court		
		Southwark Crown Court	Leicester Crown Court	Cardiff Crown Court
		Wood Green Crown Court	Bradford Crown Court	Wolverhampton Crown Court
		Luton Crown Court	Teesside Crown Court	Leamington Spa Crown Court
		Snaresbrook Crown Court (annex)	Kingston-Upon-Hull Crown Court	
		St. Albans Crown Court		
		Chelmsford Crown Court		
	Canterbury Crown Court	Norwich Crown Court	Derby Crown Court	Chester Crown Court
	Hove Crown Court	Cambridge Crown Court	Lincoln Crown Court	Swansea Crown Court
	Reading Crown Court	Basildon Crown Court	Great Grimsby Crown Court	Newport
	Exeter Crown Court	Ipswich Crown Court	York Crown Court	Birmingham Annex Crown Court
	Bournemouth Crown Court	Peterborough Crown Court	Durham Crown Court	Stoke-On-Trent Crown Court
	Southampton Crown Court	Croydon Crown Court	Northampton Crown Court	Mold Combined Court
	Lewes Crown Court	Court of Appeal Criminal Division Crown Court	Doncaster Crown Court	Bolton Combined Court
	Guildford Crown Court		Newcastle-Upon-Tyne Crown Court	Stafford Crown Court
	Winchester Crown Court			Worcester Crown Court
	Portsmouth Crown Court			Merthyr Tydfil Combined Court
Low	Plymouth Crown Court			Burnley Crown Court
	Gloucester Crown Court			Caernarfon Combined Court
	Brighton Combined Court			Preston Sessions House Crown Court
	Swindon Crown Court			Shrewsbury Crown Court
	Truro Crown Court			Wolverhampton Magistrates Court
	Aylesbury Crown Court			Warrington Combined Court
	Taunton Crown Court			Hereford Crown Court
	Salisbury Crown Court			Coventry Crown Court
	Amersham Crown Court			Carlisle Crown Court
	Newport Iow			Barrow In Furness Combined Court
	Reading Crown Sitting At Reading Magistrates			Haverfordwest Combined Court
				Preston Lancaster Crown Court
				Carmarthen Crown Court

Appendix F – Custody Early Warning Score (CEWS)



Appendix G – NHS England Regions Showing Criminal Justice Settings

Tamlyn Cairns Partnership

NHS England North Region

	Police Forces (L&D)	Magistrates' Courts	Crown Courts	Prisons
North West	Greater Manchester Cheshire Merseyside Lancashire	Ashton Thameside Bolton Bury Manchester Macclesfield Oldham Sale (Trafford) Stockport Wigan Birkenhead (Wirral) Bootle Blackburn Blackpool Burnley Chester Chorley Crewe Liverpool Youth Liverpool City Ormskirk Preston Runcorn	Bolton Manchester Crown Square Manchester Minshull St Burnley Chester Liverpool Combined Preston Preston Sessions Warrington	Buckley Hall Garth Forest Bank **(L)** Hindley Manchester **(L)** Risley Thorn Cross Wymott Lancaster Farms Altcourse (L) Kirkham Kennet Liverpool (L) Preston (L) Styal (L)
North East & Cumbria	Cumbria Cleveland Durham Northumbria	Bedlington Berwick Consett Gateshead Hartlepool Middlesbrough Newcastle Newton Aycliffe North Shields Peterlee South Shields Sunderland	Carlisle Combined Barrow in Furness Lancaster Durham Newcastle Combined Newcastle Moot Hall Teesside Combined	Haverigg Deerbolt Durham **(L)** Frankland Holme House **(L)** Kirklevington Low Newton **(L)** Northumberland
Yorkshire & Humber	North Yorkshire South Yorkshire West Yorkshire Humberside	Barnsley Beverley Bradford Bridlington Doncaster Grimsby Halifax Harrogate Huddersfield Hull Leeds Northallerton Rotherham Scarborough Scunthorpe Sheffield Wakefield York	Bradford Doncaster Grimsby Hull Leeds Sheffield York	Askham Grange Doncaster **(L)** Full Sutton Hull **(L)** Humber Leeds **(L)** Lindholme Hatfield Moorland New Hall **(L)** Wakefield Wealstun Wetherby **(L)**

NHS England South Region

Tamlyn Cairns Partnership

	Police Forces (L&D)	Magistrates Courts	Crown Courts	Prisons
South West	Avon & Somerset	Bath	Bristol	Ashfield
	Devon & Cornwall	Bodmin	Exeter	Bristol **(L)**
	Dorset	Bristol	Gloucester	Channings Wood
	Gloucestershire	Cheltenham	Plymouth	Dartmoor
		Exeter	Taunton	Eastwood Park **(L)**
		Plymouth	Truro	Erlestoke
		Taunton		Exeter **(L)**
		Truro		Guys Marsh
		Worle/WSM/North S'set		Leyhill
		Yeovil		Portland
South Central	Thames Valley	Aylesbury	Amersham	Aylesbury
	Hampshire	Banbury	Aylesbury	Bullingdon **(L)**
	Wiltshire	High Wycombe	Bournemouth	Grendon
		Maidenhead	Oxford	Springhill
		Milton Keynes	Reading	Huntercombe
		Portsmouth	Newport IOW)	Woodhill **(L)**
		Poole	Portsmouth	Winchester **(L)**
		Southampton	Salisbury	Isle of Wight **(L)**
		Swindon	Southampton	
		Aldershot	Swindon	
		Basingstoke	Winchester	
		Newbury		
		Oxford		
		Reading		
		Slough		
		Weymouth		
South East	Kent	Brighton	Hove	Bronzefield **(L)**
	Surrey	Crawley	Lewes	Downview
	Sussex	Hastings	Canterbury	High Down **(L)**
		Horsham	Maidstone	Send
		Worthing	Guildford	Coldingley
		Sevenoaks		Downview
		Maidstone		Maidstone
		Eastbourne		Rochester
		Medway/Chatham		Elmley **(L)**
		Canterbury		Cookham Wood
		Folkestone		Swaleside & Standford Hill
		Thanet/Margate		East Sutton Park
		Guildford		Blantyre House
		Staines		Ford
				Lewes **(L)**

NHS England London Region

Tamlyn Cairns Partnership

	Police Forces (L&D)	Magistrates Courts	Crown Courts	Prisons
London	City of London Metropolitan	Barkingside (Redbridge) Bexleyheath Bromley Camberwell Green City of London Croydon Ealing Feltham Greenwich Hammersmith Hendon Highbury Corner Richmond Romford (Havering) Stratford (Newham) Thames Tottenham (Enfield) Uxbridge Westminster Willesden (Brent) Wimbledon	Blackfriars Central Criminal COACD – RCJ Croydon Harrow Inner London Isleworth Kingston Snaresbrook Southwark Wood Green Woolwich	Belmarsh **(L)** Brixton Feltham **(L)** Holloway **(L)** Isis Pentonville **(L)** Thameside **(L)** Wandsworth **(L)** Wormwood Scrubs **(L)**

NHS England Midlands and East Region

Tamlyn Cairns Partnership

	Police Forces (L&D)	Magistrates Courts	Crown Courts	Prisons
West Midlands	Staffordshire	Burton	Birmingham	Brinsford **(L)**
	West Midlands	Cannock	Birmingham Annexe	Dovegate **(L)**
	West Mercia	Dudley	Coventry	Drake Hall
		Shrewsbury	Hereford	Featherstone
		Stoke	Worcester	Oakwood
		Telford	WJC	Stafford
		Walsall	Shrewsbury	Stoke Heath **(L)**
		Warley	Stafford	Swinfen Hall
		Wolverhampton	Stoke	Werrington **(L)**
		Birmingham Youth	Wolverhampton	Birmingham (L)
		Birmingham		Hewell (L)
		Coventry		Swinfen Hall
		Hereford		
		Kidderminster		
		Redditch		
		Worcester		
		Nuneaton		
East Midlands	Leicestershire	Loughborough	Leicester	Foston Hall **(L)**
	Northamptonshire	Northampton	Northampton	Gartree
	Lincolnshire	Wellingborough	Derby	Glen Parva **(L)**
	Derbyshire	Corby	Lincoln	Leicester **(L)**
	Nottinghamshire	Hinckley	Nottingham	Onley
		Kettering		Rye Hill
		Leicester		Sudbury
		Chesterfield		Lincoln **(L)**
		Derby		Long Lartin
		Nottingham		North Sea Camp
		Mansfield		Nottingham **(L)**
		Lincoln		Lowdham Grange
		Boston		Ranby
		Grantham		Stocken
		Skegness		Whatton
		Spalding		
East of England	Bedfordshire	Basildon	Basildon	Bedford **(L)**
	Cambridgeshire	Bedford	Bury St Edmunds	Blundeston
	Essex	Bury St Edmunds	Cambridge	Bullwood Hall
	Hertfordshire	Cambridge	Chelmsford	Bure
	Norfolk	Chelmsford	Huntingdon	Chelmsford **(L)**
	Suffolk	Colchester	Ipswich	Highpoint
		Great Yarmouth	Kings Lynn	Hollesley Bay
		Hatfield	Luton	Littlehey
		Huntingdon	Norwich	The Mount
		Ipswich	Peterborough	Norwich **(L)**
		Kings Lynn	Southend	Peterborough **(L)**
		Lowestoft	St Albans	Warren Hill
		Luton		Wayland
		Norwich		Whitemoor
		Peterborough		
		St Albans		
		Southend		
		Stevenage		