Report on an inspection visit to court custody facilities in

Surrey and Sussex

by HM Chief Inspector of Prisons

12–22 July 2023

Contents

Introduction

This report details findings from an inspection of court custody facilities in Surrey and Sussex. It covers two crown courts, seven magistrates' courts, one combined court and a trial centre.

The prisoner escort and custody services (PECS) arm of HM Prison and Probation Service (HMPPS) contracted Serco on behalf of HM Courts & Tribunals Service (HMCTS) to provide escort and court custody services in the region.

Reasonable progress had been made since our last inspection, with two-thirds of recommendations we made previously having been fully or partially achieved. The main agencies involved in the delivery of court custody worked well together and leaders were aware of the issues that impacted the outcomes for detainees. We were pleased that the conditions in custody facilities had improved and that detainees were positive about their treatment.

There were, however, a number of concerns that required attention. Despite efforts to recruit and retain Serco staff, shortages too often led to detainees arriving late at court and spending longer in custody than necessary and children failing to receive support from specialist staff. The lack of accessible custody facilities for people with disabilities or impaired mobility often meant they were transferred to a location far away from home and arrangements for them to return once cases had been concluded were not always adequate. We could not understand the continued reluctance to make sure interpretation services were used consistently to communicate effectively with detainees whose English was limited, an issue that we have raised before.

We have highlighted three priority concerns and 10 key concerns for leaders to focus on. We hope they will assist HMCTS, PECS and Serco to deliver the required improvements.

Charlie Taylor
HM Chief Inspector of Prisons
August 2023

What needs to improve in Surrey and Sussex court custody

We last inspected court custody in Surrey and Sussex in 2014 and made 41 recommendations overall, nine of which were about areas of key concern (see Section 7 for a full list).

At this inspection we found that there had been reasonably good progress and 20 of the 41 recommendations had been achieved, including four of the recommendations about key areas of concern. Eleven recommendations had not been achieved.

During this inspection we identified areas of concern to be addressed by HM Courts & Tribunals Service (HMCTS), the prisoner escort and custody service (PECS) and the escort provider. All concerns identified here should be addressed and progress tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

During this inspection we identified three priority concerns. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

1. **The lack of Serco staff led to late arrivals at court and delays in transferring detainees to prison at the conclusion of their hearings.** Children were not always accompanied by appropriately trained officers.

2. **Telephone interpretation services were not always used when necessary.**

3. **Detainees with mobility impairments often had onerous journeys to and from the only accessible court in the region.**

Key concerns

We identified a further 10 key concerns.

4. **There were weaknesses in the approach to identifying and managing detainees' risks.** Digital person escort records were not always completed thoroughly, staff were not consistently briefed about risks and some checks were not completed at the required frequency.

5. **A range of factors led to some detainees being held in court custody for longer than necessary.**

6. **Some cells were not clean enough.**

7. **Custody staff's individual statements justifying their use of force against detainees were not always detailed enough and quality assurance was not always sufficiently rigorous.**

8. **Searching and handcuffing some detainees without carrying out an individual risk assessment was disproportionate.**

9. **Activities and distractions for detainees waiting in cells were too limited, particularly for those with neurodiverse needs.**

10. **Detainees did not always have timely access to prescribed medication, particularly those used for symptomatic relief, which potentially had an adverse effect on their health.**

11. **Automated external defibrillators were not always readily available in custody suites, and custody staff did not receive training in basic life support skills frequently enough.**

12. **Many detainees waited too long for a prison governor's authority to be obtained before they could be released.**

13. **On release, detainees, including those with disabilities or impaired mobility, were not always provided with sufficient means to get home.**

Notable positive practice

We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Inspectors found one example of notable positive practice during this inspection.

- Leaders had set up an email service for the custody and escort provider and HM Courts & Tribunals Service to improve communication between the two agencies. This allowed a real-time exchange of information to take place, enabling all parties to be kept up to date with events throughout the day. (See paragraph 3.12.)

About court custody in Surrey and Sussex

Data supplied by HMCTS and PECS contractor

HMCTS cluster	Surrey and Sussex
Cluster manager	Dave Manning
Geographical area	Counties of Surrey and Sussex
Court custody suites and cell capacity	
Brighton Combined Court	12 cells
Chichester Nightingale Crown Court	6 cells
Crawley Magistrates' Court	6 cells
Guildford Crown Court	8 cells
Guildford Magistrates' Court	5 cells
Hastings Magistrates' Court	5 cells
Horsham Magistrates' Court	8 cells
Hove Trial Centre	10 cells
Lewes Combined Court	14 cells
Staines Magistrates' Court	7 cells
Worthing Magistrates' Court	8 cells
Annual custody throughput	7,329 detainees
Custody and escort provider	Serco
Custody staffing	One area operations manager 10 court custody managers One deputy court custody manager 57.2 prisoner custody officers

Section 1 Leadership and multi-agency relationships

Expected outcomes: There is a shared strategic focus on custody, including the care and treatment of all those detained, during escort and at the court, to ensure the well-being of detainees.

1.1 The main agencies involved in the delivery of court custody worked effectively together. Leaders were focused on detainees' welfare and had fully or partially achieved almost three quarters of the recommendations made at the last inspection.

1.2 Despite efforts to recruit and retain custody staff, there were too few officers in post. While this rarely affected the care provided to adults in custody it sometimes affected children (see paragraph 4.11) and frequently affected the efficiency of court cases and the length of time some people remained in detention (see paragraphs 2.1, 3.11 and 5.4).

1.3 Leaders monitored a wide range of data. While they focused on many areas where outcomes for detainees fell below the required standard, follow-up action to address them was sometimes too limited. For example, leaders did not make sure telephone interpretation was always used when it was needed (see paragraph 3.3).

1.4 Leaders welcomed external scrutiny from lay observers and were often responsive to the issues they raised.

Section 2 Transfer to court custody

Expected outcomes: Escort staff are aware of detainees' individual needs, and these needs are met during escort.

2.1 Our biggest concern was that too many detainees arrived late at court. This was often because not enough escort staff were available, requiring circuitous and/or long journeys to collect detainees from numerous locations before delivering them to court (see paragraphs 1.2, 3.11 and 5.4).

2.2 Detainees were transferred to court in clean, safe and well-equipped vehicles. Women and children continued to share vehicles with adult men too frequently. While this was generally offset by the use of screens, which separated them to an extent, in some cases, they were not used, and detainees were not adequately safeguarded.

2.3 Most courts had a secure vehicle bay that was not overlooked. However, in the few where there was no secure area for detainees to alight from their dignity and privacy were not adequately protected. Detainees generally got off vehicles quickly. We saw people arriving from police custody who were poorly dressed in dirty clothing.

2.4 Digital person escort records (see Glossary) did not always include sufficient detail concerning detainees' risks (see paragraph 3.7), and handovers between escort and custody staff were often minimal.

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

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

Respect

3.1 Custody staff welcomed newly arrived detainees and often greeted them warmly. Staff showed kindness and compassion and their interactions were respectful, polite and patient.

3.2 Reception procedures were often rushed and lacked privacy. Detainees were rarely offered the opportunity to speak to a member of staff separately. This meant they did not get a chance to share sensitive information or concerns, which could have helped staff to better look after them.

Meeting individual and diverse needs

3.3 Staff were generally responsive to detainees' individual needs. However, those who spoke little or no English often received a lower standard of care than others because staff did not always use telephone interpretation when it was required, even for health-related matters (see paragraph 1.3).

3.4 Only one court in the region, Crawley MC, had any adaptations for detainees with mobility impairments. Some detainees therefore had to make unacceptably long and onerous journeys to get there and back (see paragraph 5.3). Courts had no distraction activities suitable for detainees with neurodivergent conditions, except in a few facilities where staff provided them personally (see paragraphs 4.6), when they were used to very good effect.

3.5 Women detainees were held separately from men and received good support. Menstrual care products were freely available, but replacement underwear was not always individually wrapped. Most staff were aware of the policy for supporting transgender detainees.

3.6 All courts had a suitable range of religious items, which were generally stored respectfully and were offered to detainees routinely. However, too many staff could not identify the direction of prayer for Muslims.

Risk assessments

3.7 There were weaknesses in the courts' approach to identifying and managing detainees' risks. There was no thorough assessment of risks on arrival, and staff were not always comprehensively briefed about those in their care. While staff were aware of factors that might have affected presenting risks, some checks were cursory. The majority were carried out at the required frequency, but some records were not accurate. (See paragraph 2.4).

3.8 Cell call bells were answered promptly, and all staff now carried anti-ligature knives. Routes to court were safe, but there were issues with some affray alarms.

Individual legal rights

3.9 Custody staff did not always make sure detainees were aware of their rights while in court custody.

3.10 There were generally sufficient rooms for private, or at least discreetly supervised, legal consultations, but it remained inappropriate to lock professional visitors in some of the rooms with detainees. (See also paragraph 4.16.)

3.11 A range of factors contributed to some detainees spending longer in custody than necessary. They included: detainees arriving late, which potentially delayed their hearings; cell capacity not always meeting demand; custody courts starting late and long waiting times to see legal representatives, which was sometimes linked to delays in receiving electronic case papers. There were also other factors such as: the non-attendance of court-appointed interpreters; detainees arriving in the morning for afternoon listings; and some long waits to move detainees to prison once their hearings had concluded (see paragraphs 1.2, 2.1 and 5.4).

3.12 Leaders had introduced an email service for the custody and escort provider and HM Courts & Tribunals Service, to improve communication between the two agencies. This allowed a real-time exchange of information to take place, so all parties were fully informed of events throughout the day. The arrangement meant, for example, custody staff could advise others when a case might need to be prioritised (see Notable positive practice).

Complaints

3.13 Complaints were received infrequently – only one complaint had been submitted in the previous 12 months.

3.14 While detainees were given information about complaints on arrival, it was not always explained well enough. Custody staff had a reasonable awareness of the procedures but were less confident when dealing with confidential complaints.

Section 4 In the custody cell, safeguarding and health care

Expected outcomes: Detainees are held in a safe and clean environment in which their safety is protected at all points during custody.

Physical environment

4.1 Physical conditions had improved. While communal areas were mostly reasonable, some needed redecoration. Cell cleaning arrangements were, however, not always sufficient. Too many cells had grubby floors and walls. Some facilities failed to manage graffiti well, but, overall, relatively few cells were significantly affected, and little of it was offensive. Few cells had natural light and we found potential ligature points in most facilities. The comprehensive report illustrating our findings that we provided to HM Courts & Tribunals Service during the inspection received an appropriate response. Custody staff were aware of the emergency evacuation procedures.

Use of force

4.2 Custody staff defused and de-escalated tense situations well and avoided the use of force where possible. While force had only been used against detainees 32 times in the year to June 2023, it was a concern that more than a fifth of those occurrences involved children.

4.3 Most documentation accounting for incidents indicated that the force used was generally low level and proportionate to the risk posed. However, some situations appeared protracted and poorly controlled. Too many of custody staff's individual statements to account for the use of force lacked sufficient detail. Quality assurance processes had not led to consistent improvements in the standard of documentation.

4.4 The position on handcuffing and searching was undoubtedly better than at the last inspection. The current guidance was, however, confusing and led to inconsistent practices and we found instances that were neither individually risk assessed nor proportionate. For example, detainees were routinely handcuffed when leaving a vehicle in a locked courtyard, which was two steps from the entrance to the custody facility.

Distance between vehicle and custody entrance where detainees were routinely handcuffed

Detainee care

4.5 Detainees we spoke to told us they received very good care. They were offered a drink on arrival and regularly throughout their stay. While food catered for differing dietary and cultural needs, it was of poor quality, but was provided on request. Petty cash was available to buy alternatives to meet detainees' individual needs, such as those requiring a Kosher diet.

4.6 Detainees had too little to do while waiting in the cells, particularly those with neurodiverse needs and detainees whose first language was not English. Staff in some facilities had bought their own stress-relieving equipment, such as fidget toys and stress balls, which were used to good effect and which detainees appreciated. (See paragraph 3.4.)

4.7 Distraction packs, including puzzles, were offered, but reading material consisted of old, tatty newspapers and magazines, and a small selection of books. Chalkboards and a compendium of games were available in most facilities, but chalks were not offered frequently, and the games were rarely used.

4.8 The location of toilet facilities on corridors with low saloon doors was not ideal, but they were supervised discreetly to maintain privacy. Toilets generally did not have seats but most had toilet paper, hand towels and soap in dispensers, and there was ready access to a bin.

Safeguarding

4.9 Custody staffs' understanding of safeguarding had improved since our previous inspection, but it needed to be reinforced in some courts. Staff generally knew the names and contact details of the safeguarding managers, and most could recognise situations that might need to be reported.

Children

4.10 Arrangements for children in court custody were reasonable overall. Children were not usually locked in cells and were held either in a separate cell area or a consultation room.

4.11 Specially trained teams had additional resources for children, but the staff were not always available, particularly for those arriving from police stations. In these situations, custody staff did their best with limited resources. Some children still experienced delays in being transferred to secure custody facilities because they were waiting either for a placement order or transport (see paragraph 1.2).

Health

4.12 Custody staff were familiar with the process for accessing the telephone health advice service and used it to support detainee care.

4.13 Although detainees had no prompt access to simple interventions, such as basic pain relief, they could obtain their own prescribed medication once it had been validated by the health care provider. However, they were not always given immediate access to medication for ongoing conditions, such as inhalers to relieve the symptoms of asthma, which was unacceptable.

4.14 Some custody staff had been trained in the use of naloxone (a drug used to counter the effects of an opiate overdose) but not all were confident in its use.

4.15 Although they were available in all court buildings, automated external defibrillators were often some distance from the custody facilities, which meant there would be a delay in deploying them in an emergency. It posed a further significant risk that some did not work, had chest pads that were out of date and were not serviced regularly. Custody staff did not receive an appropriate annual training update in basic life support skills, which presented further risks.

4.16 Liaison and diversion services had embedded practitioners in many of the magistrates' courts but were not always visible or readily accessible in custody suites. It was not appropriate that clinical staff had no private space to compile confidential reports or that they were locked into consultation rooms with detainees (see paragraph 3.10). While custody staff had still not received training in mental health or substance misuse, they knew they had to contact the liaison and diversion teams if issues were brought to their attention.

Section 5 Release and transfer from court custody

Expected outcomes: Detainees are released or transferred from court custody promptly and safely.

Release and transfer arrangements

5.1 Custody staff appropriately focused on releasing people safely. Information sharing with other relevant agencies was good if issues of concern, such as homelessness or suicidal thoughts, were highlighted. Leaflets containing helpful information about local and national sources of support were provided routinely.

5.2 Some people experienced unnecessary delays before they were released. While this mostly affected those requiring a governor's authority to release (see Glossary), others were also sometimes affected. Those waiting for the prison to authorise their release were locked in a cell, often for hours when they were essentially free. While this was often the fault of the originating prison, some HM Courts & Tribunals Service staff contributed to delays by failing to communicate the outcome of cases promptly enough to allow the prison to complete the necessary checks in a timely way.

5.3 On occasion, those without the means to travel home were not always provided with sufficient assistance. There was an overreliance on issuing rail warrants, which only allowed people to travel by train to their nearest railway station, often a considerable distance from their final destination. The situation for detainees with disabilities and/or mobility issues who were released from Crawley MC was often worse. While they were generally provided with a taxi to the local train station, they were expected to navigate their onward journey, which could be lengthy, without any assistance (see also paragraph 3.4).

5.4 The shortage of Serco staff meant that once they were remanded or sentenced to prison, detainees were not always transferred promptly and some experienced lengthy delays (see paragraphs 1.2, 2.1 and 3.11). Detainees were rarely given information about where they were going or what to expect on arrival.

Section 6 Progress on recommendations from the last report

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

Main recommendations

HMCTS should work with all the organisations involved in court custody and escort operations to identify the pressures following the centralisation programme, and put in place a multiagency action plan to resolve the difficulties.
Achieved

Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite and used as necessary.
Not achieved

Court custody staff should be trained to identify and refer appropriately detainees about whom they have child protection or safeguarding concerns.
Achieved

Staff should complete a standard risk assessment form for each detainee, and be trained to do this.
Partially achieved

There should be sufficient staff on duty at all times to ensure the safety of detainees, staff and visitors.
Achieved

Handcuffs should only be used if necessary, justified and proportionate.
Partially achieved

Person escort records should contain sufficient accurate, legible risk information and health care advice to inform risk assessment and facilitate the care of detainees; and they should be clearly signed.
Partially achieved

National issues

HMCTS and Prison Escort and Custody Services should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody. Standards should address detainee care and risk assessment, clarify the responsibilities of each organisation for resolving problems, and enable complaints in court custody to be monitored. Complaints should be included in the measurement of performance.
Achieved

Prisoner Escort and Custody Services should revise the escort contract arrangements to eliminate the practice of transferring men, women and children in the same cellular vehicle.
Not achieved

Recommendations

There should be regular interagency forums covering all courts in the cluster, and their remit should include improvements in the care of detainees during escort and in court custody.
Achieved

Quality assurance processes should be more effective in encompassing key elements of detainee care and rights during escort and court custody.
Achieved

HMCTS and PECS should liaise with the Youth Justice Board to reduce delays in transferring children to secure training centres.
Achieved

Escort vehicles should be available to take detainees to custodial establishments as soon after the completion of their court case as possible.
Not achieved

HMCTS should liaise with local prisons about their hours for receiving prisoners at weekends and, in all applicable cases, obtain the prison's authority to release detainees promptly, directly from court.
Not achieved

Detainees should not be held in custody without lawful authority to detain.
Achieved

All courts should offer all detainees information, in a range of languages, about their rights, including the process for making a complaint, and staff should offer to read or explain the information if necessary.
Achieved

There should be sufficient comfortable and private consultation rooms at all courts.
Not achieved

Visitors to the court cells should not be locked in interview rooms with detainees.
Not achieved

Cellular vehicles should be clean and free of graffiti, with readily accessible anti-ligature knives.
Achieved

Adult men, women and children should not be carried in the same escort vehicle, and detainees should be transferred from cellular vehicles to the court cells out of public view.
Not achieved

Custody officers should receive sufficient training to meet the diverse needs of detainees held in court custody.
Achieved

All court custody suites should have a copy of the holy books of the main religions, a suitable prayer mat that is respectfully stored, and a reliable means of determining the direction of Mecca.
Partially achieved

All court custody suites should have hearing loops as well as Braille versions of key information.
Partially achieved

GEOAmey should produce a policy, in line with police and Prison Service guidance, setting out the correct approach to caring for transgender detainees, and ensure that staff implement it.
Achieved

Children in court custody should be supported by a specifically trained named staff member.
Achieved

All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers.
Not achieved

There should be a small stock of mattresses and blankets or warm clothing for detainees who are elderly, pregnant or disabled.
Not achieved

Cell sharing risk assessments should be completed for all detainees before they share a cell.
Achieved

Staff should record the outcome of all cell visits accurately in the detention log.
Partially achieved

Staff undertaking observations and cell visits should carry anti-ligature knives at all times.
Achieved

Custody staff should check whether detainees being released have any immediate needs or concerns that should be addressed before they leave custody.
Achieved

Each court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages for detainees leaving custody.
Achieved

A programme of regular deep cleaning, graffiti removal and cell repairs should be implemented immediately.
Partially achieved

All detainees should be able to use the toilet in privacy, and toilets should be kept in a hygienic state.
Not achieved

All court custody suites should be maintained at a comfortable temperature.
Achieved

GEOAmey should monitor the health contract to ensure that it performs as agreed.
Achieved

All staff should receive first aid training that is appropriate to maintain competency.
Partially achieved

First aid kits should contain sufficient in-date equipment to manage all predictable incidents, including an automated external defibrillator and equipment to maintain an airway.
Achieved

All detainees who require prescribed medications while in court custody should have access to them.
Partially achieved

All detainees should have access to mental health and substance misuse support at all times that the courts are open.
Partially achieved

Court custody staff should receive regular training to identify, support and refer appropriately detainees experiencing mental health or substance misuse problems.
Not achieved

Appendix I About our inspections and reports

This report is part of the programme of inspections of court custody carried out by HM Inspectorate of Prisons. These inspections contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

The inspections of court custody look at leadership and multi-agency relationships; transfer to court custody; reception processes, individuals needs and legal rights; safeguarding and health care; and release and transfer from court custody. They are informed by a set of *Expectations for Court Custody*, available at http://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/court-custody-expectations, about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.

Four key sources of evidence are used by inspectors: observation; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for detainees. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which HMCTS, the prisoner escort and custody service (PECS) should attend to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Inspection team

This inspection was carried out by:

Kellie Reeve	Team leader
David Foot	Inspector
Jeanette Hall	Inspector
Fiona Shearlaw	Inspector
Nadia Syed	Inspector
Sarah Goodwin	Health inspector

Appendix II Glossary

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

Digital person escort record
The digital person escort record is the key document for ensuring that information about the risked posed by detainees on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody. It is a standard form agreed with and used by all agencies involved in the movement of detained people.

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

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