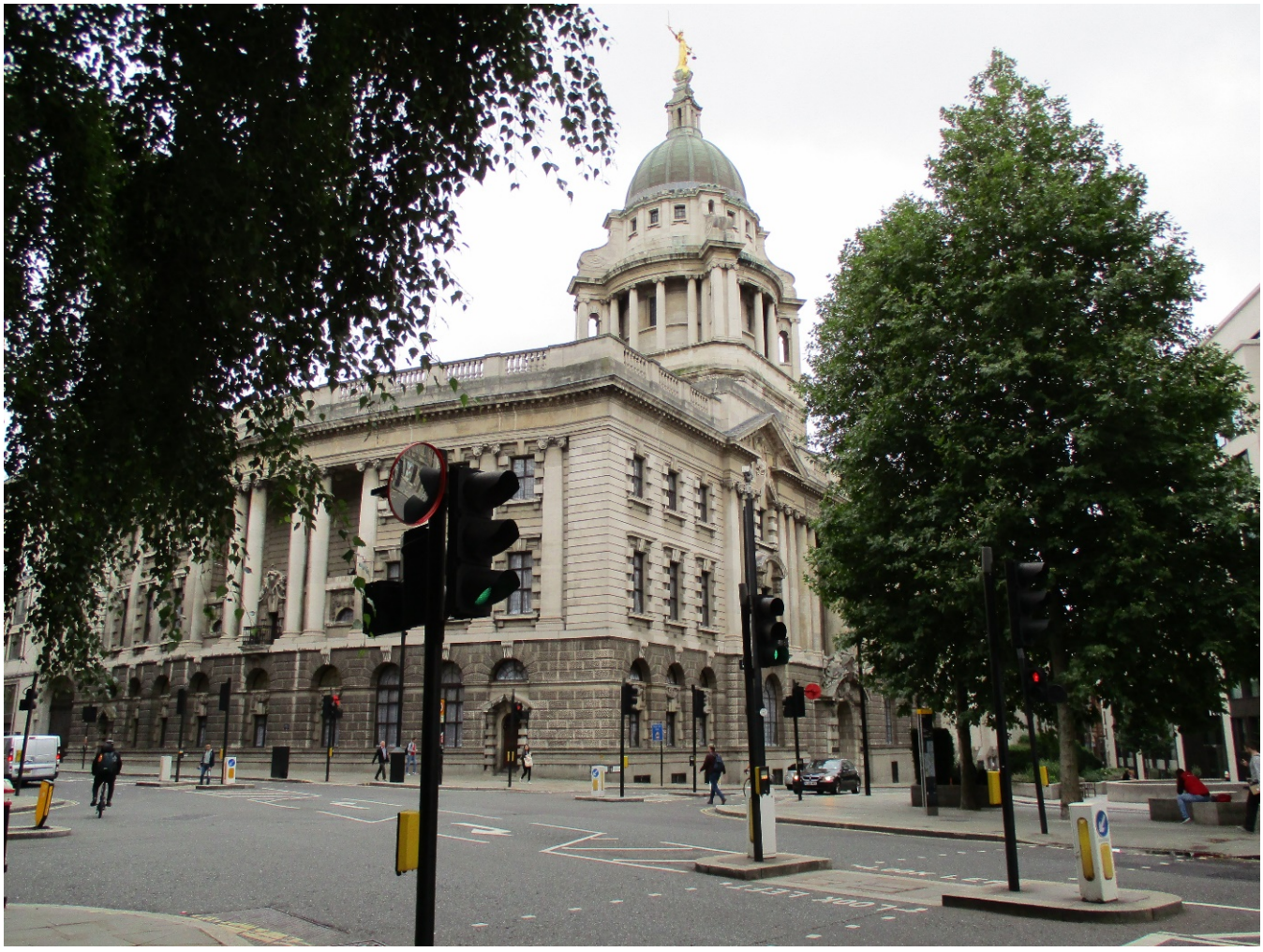
Report on an inspection visit
to court custody facilities in

Central and South London

by HM Chief Inspector of Prisons

28 July – 13 August 2021



Contents

Introduction

This report presents the findings from the last in a series of three inspections of court custody in the London region. It covers the remaining 15 facilities in central and south London which we had not previously visited, including six Crown courts, six magistrates' courts, two immigration asylum chambers (IACs – see Glossary of terms) and, by invitation, the Royal Courts of Justice. Many of these courts were very busy; more than 28,000 detainees had been held in the previous year.

The Prisoner Escort and Custody Service (PECS) arm of HM Prison and Probation Service (HMPPS) had contracted Serco on behalf of HM Courts & Tribunals Service (HMCTS) to provide court custody and escort facilities in the region. Escorts to and detainee care in the IACs were provided by Mitie Care and Custody.

At a strategic level, working relationships between the main stakeholders were superficially constructive, but they were not delivering sufficiently good outcomes for detainees. This report identifies instances of weak leadership, poor oversight, insufficient resourcing and ineffective communication. Data were not being used well enough to identify areas for improvement or monitor the effectiveness of improvement activities.

At an operational level, custody staff remained patient, calm and reassuring with detainees and we witnessed some good attention to meeting detainees' needs. However, acute shortages of Serco staff affected outcomes for detainees, particularly in causing delays.

Some of the concerns that we identified in our previous inspections of London court custody facilities had been resolved. Detainees were no longer handcuffed routinely and approaches to the management of risk and release arrangements were generally better. There was a new and improved fleet of escort vehicles and health services were now more responsive. A new focus on providing in-cell distraction activities was welcome.

However, other issues highlighted in our previous reports were continuing. Conditions in some facilities were poor and many detainees still spent too long in custody. Our recommendations about telephone interpreting for speakers of other languages, safeguarding and women sharing vehicles with men had not been satisfactorily addressed. Disappointingly, the new contracted arrangements for caring for children were not being delivered as well as we have seen in other areas.

Despite some progress, this was a disappointing inspection. More needed to be done, particularly at a strategic level, to enable good outcomes for detainees. We have made 26 recommendations which we hope will aid HMCTS, PECS and Serco to deliver improved outcomes for those in their care.

Charlie Taylor
HM Chief Inspector of Prisons
August 2021

About court custody in London South and Central

Data supplied by HM Courts & Tribunals (HMCTS) London, Prisoner Escort and Custody Service (PECS) and Serco (custody and escort provider).

HMCTS cluster
London. This region has been inspected in three stages. The reports of the previous two inspections are available at:
https://www.justiceinspectorates.gov.uk/hmiprisons/inspections?prison-inspection-type=court-custody-facility-inspections&s&location=london

Cluster managers
Alison Aedy (magistrates' courts)
Joanne Towens (Crown courts)
Finola Hayes (tribunals)

Geographical area
Central and South London

Court custody suites and cell capacity
Bexley Magistrates' Court: 8 cells
Bromley Magistrates' Court: 13 cells
Central Criminal Court: 38 cells (including six category A cells)
City of London Magistrates' Court: 10 cells
Croydon Crown Court: 13 cells
Croydon Magistrates' Court: 22 cells
Inner London Crown Court: 26 cells
Kingston-upon-Thames Crown Court: 19 cells
Royal Courts of Justice (inspected by invitation): 10 cells
Southwark Crown Court: 23 cells
Westminster Magistrates' Court: 40 cells
Wimbledon Magistrates' Court: 14 cells
Woolwich Crown Court: 16 cells

Immigration and asylum chambers
Field House: 2 cells
Taylor House: 1 holding room

Annual custody throughput
28,722 detainees (1 June 2020 – 31 May 2021)

Custody and escort provider
Serco for courts
Mitie Care and Custody for immigration and asylum chambers

Custody staffing
13 court custody managers
10 deputy court custody managers
182 prisoner custody officers

Key concerns and recommendations

Key concerns and recommendations identify the issues of most importance to improving outcomes for detainees and are designed to help the main agencies involved in the delivery of court custody to prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

During this inspection we identified some areas of key concern and have made a number of recommendations for HMCTS, the Prisoner Escort and Custody Service (PECS) and the escort provider to address those concerns.

- **Key concern 1:** We observed significant staff shortages at all grades, including court custody managers. Staff said this was not unusual. As a result, we saw staff struggling to offload vehicles promptly, children without enhanced care teams, delays accessing legal representatives, delays in release and some important conversations with detainees being rushed. We were told that delays transporting detainees to prison were also often caused by inadequate staffing. These challenges were compounded when there was either no manager, or no suitably experienced manager, to provide direction and ensure the smooth operation of the suite.

  Recommendation: Sufficient competent staff of appropriate grades should always be deployed in court custody to make sure that facilities run efficiently and detainees are dealt with promptly and respectfully.

- **Key concern 2**: Relationships and communication between the three main agencies responsible for custody were not always effective and did not consistently prioritise good outcomes for detainees. Data concerning the experience of the detainee were not routinely collected or analysed to identify areas for improvement or used sufficiently well to monitor the effectiveness of improvement activities.

  Recommendation: Relationships and communication among the three main agencies responsible for custody should prioritise good outcomes for detainees, including the collection and robust analysis of data to identify areas for improvement and to monitor the effectiveness of improvement activities.

- **Key concern 3:** Women still often travelled in vehicles with men, especially from police stations to court. In a two-week period, more than one-third of female detainees travelled in vehicles with men. We found no evidence that this was exceptional and saw that the screens designed to separate vehicles into two private sections were not routinely used on these occasions. This was unacceptable because it potentially exposed women to verbal abuse.

  Recommendation: Female detainees should always be transported separately from men.

- **Key concern 4:** Most staff were not familiar with telephone interpreting services and they were rarely used. This practice had not improved since our previous inspections in London and had an adverse impact on some detainees.

  Recommendation: Telephone interpreting services should routinely be used with detainees for whom English is a second language when they arrive in custody and at any other time when accuracy is especially important, such as the assessment of risks or needs.

- **Key concern 5:** Some detainees were held in court custody for longer than necessary. The reasons for this included:
  - delays with legal representatives accessing their clients which potentially affected the prompt hearing of their case;
  - cases not always being prioritised;
  - courts often starting later than scheduled;
  - delays with legal representatives receiving court papers from the Crown Prosecution Service;
  - detainees being brought to court in the morning for cases listed in the afternoon;
  - the late or non-attendance of court appointed interpreters; and
  - delays moving detainees to prison once remanded or sentenced.

  Recommendation: Managers should explore and address the reasons for delays to ensure that detainees are held in custody for the shortest possible time.

- **Key concern 6:** Conditions across the estate were often poor. We found extensive and sometimes offensive graffiti in cells, ingrained dirt and potential ligature points in most suites. The arrangements for cleaning and checking cells and other detainee areas were not good enough to ensure a clean, respectful and safe environment.

  Recommendation: Cleaning and maintenance arrangements for custody facilities should ensure that the environment and particularly cells are clean, respectful and safe.

- **Key concern 7:** The care of children was disappointing and did not adequately reflect their innate vulnerability. About 17% of child moves were in cellular vehicles and all the children we saw were locked in cells. Enhanced care officers (ECOs) and dual-badged officers (DBOs) (see Glossary of terms) found it difficult to build relationships with or actively support children in these conditions. Some children did not have a dedicated team of staff looking after them and received a poorer level of care than others. Many children had long waits in court custody, especially for placement orders and for transport to their onward custodial destination.

  Recommendation: Children should receive individualised, age-appropriate care which is focused on building relationships and minimising time in court custody.

- **Key concern 8:** Detainees released by the court who had not originated from a prison were routinely locked in cells in most custody suites to await their release. This often took too long and release procedures were frequently not viewed as a priority. This was highly unusual and unacceptable and unnecessarily denied detainees their liberty.

  Recommendation: Detainees released by the court should not be locked in a cell and should be released promptly.

- **Key concern 9**: Detainees who required governor's authority for release (see Glossary of terms) frequently had to wait for many hours before this was received. Some detainees were returned to the prison to be released from there because authorisation was not received in good time. In both cases, detainees were denied their liberty for too long and we observed a reluctance by Serco staff to escalate this issue to PECS. This has been the case in our last 10 court custody inspections and we consider that one hour is the maximum reasonable wait.

  Recommendation: PECS should work closely with HMPPS and court custody providers to monitor, understand and resolve delays in releasing from court custody detainees who originated from prisons.

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 detainees; 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 two examples of notable positive practice during this visit.

- Staff in a few suites showed understanding of how to support neurodivergent people. This was particularly evident at the Central Criminal Court, where some staff had a good understanding of how to support and communicate with those experiencing such conditions as autism or attention deficit hyperactivity disorder. (See paragraph 3.8.)

- Following consultation with children, boys from HMYOI Feltham could earn 'green cards' for good behaviour while in the custody of Serco in the same way that they could in prison. These allowed children to claim rewards under the YOI incentives and earned privileges scheme so that they were not disadvantaged by attending court. (See paragraph 4.30.)

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 At a strategic level, working arrangements among the three main agencies (HMCTS, PECS and Serco) appeared well developed. They communicated a shared aim to ensure that detainees were kept safe, treated well and held in appropriate conditions. The experienced PECS contract delivery managers had mature working relationships with the key stakeholders. They supervised the contractual arrangements between PECS and Serco through regular performance and contract compliance meetings and visits to custody suites. However, the joint working arrangements were not yet consistently delivering safe and respectful custody.

1.2 Striking the balance between delivering court business and dealing with detainees promptly and effectively was a continuous challenge, particularly in the busier courts, and there were some obvious tensions. Many Serco custody staff were frustrated by the perception that detainees in custody were not routinely prioritised over off-bail detainees (see Glossary of terms). In turn, many HMCTS staff were frustrated by Serco practices which adversely affected court business, such as delaying access to legal representatives. Formal and informal meetings between HMCTS and Serco were well established, but they were not always sufficiently focused on improving outcomes for detainees.

1.3 Concerns that had been identified were not always resolved effectively. Some had persisted since our previous inspections in London, for example, despite repeated escalation, improvements to the estate were sometimes blocked by complicated contractual arrangements and budgetary constraints. Similarly, delays in securing a governor's authority for release were significant and apparently intractable. Joint working among the three agencies was not effective enough.

1.4 As at our previous inspection, Serco had acute staff shortages at all levels. Court custody managers (CCMs) received no specialist training and some custody suites, including the busiest, did not have a consistent CCM or deputy. This lack of management led to a chaotic environment in some suites and affected the smooth running of custody facilities and the development of staff (see key concern 1).

1.5 Initial training for officers was reasonable and more recently employed staff told us that the training included equality and diversity, mental health and safeguarding. However, many established staff said that they received little training other than control and restraint and first aid.

An online catalogue of e-learning training modules only seemed effective in the few courts where CCMs encouraged its use and learning was reinforced with group discussions.

1.6 Serco had published a comprehensive range of policies and protocols for court custody, but we saw many examples where these were not followed consistently.

1.7 We were provided with a range of data in advance of the inspection, some of which had been prepared for the purpose. There was little evidence that the data had been analysed or used to inform organisational learning or to drive improvements for detainees. Managers were, for example, unaware of the extent of the delays in governors authorising release and data on the use of force and the throughput in custody suites were inconsistent (see key concern 2).

1.8 The management of COVID-19 in court custody was subject to risk assessment. However, some requirements, such as cell cleaning, touchpoint cleaning and provision of hand sanitiser, were not implemented consistently.

1.9 Visits to court custody by independent lay observers had ceased during the pandemic and had not yet fully resumed.

1.10 Since our last inspection of the London region, there had been two deaths in custody in the facilities that we inspected: one at Westminster Magistrates' Court and the other at Inner London Crown Court. Both were investigated by the Prisons and Probation Ombudsman who made some recommendations. More attention was now given to excessive temperatures in the cells, but detainees were still not consistently provided with information in a language that they could understand.

1.11 Since the beginning of the pandemic, there had been a significant reduction in throughput at both immigration and asylum chambers (IACs) that we inspected. We saw no detainees in either centre and were told that most hearings were now held via video link.

1.12 The arrangements for care which Mitie described to us were better than those that we had seen in London at previous inspections. Detainees did not spend too much time in the IACs and were rarely locked in a cell at Field House. Detainees were not routinely handcuffed and, if handcuffs were used, they were applied for no longer than necessary. Provision of food and drink appeared adequate as did arrangements to ensure that detainees had the means to travel to their onward destination on release.

1.13 The holding room at Taylor House was large, clean and bright and the two cells at Field House were reasonably clean and well maintained, except for a potential ligature point which had not been identified. The toilets at both sites were clean, but the men's facilities at Field House had no soap and lacked privacy. There was a limited range of magazines in English, otherwise nothing to keep detainees occupied.

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 Arrangements for transfer to court custody were sound and were enhanced by the new fleet of escort vehicles which were safer and more comfortable for detainees. Most vehicles were clean and well equipped. Problems with the retractable steps and doors sticking had resulted in vehicles being taken off the road for repair.

2.2 Most journeys were short, but at Croydon and Westminster Magistrates' Courts, detainees waited at the court for as much as an hour to alight from vehicles. A failure of the IT system at many courts prevented escort staff from recording that detainees had been handed over to custody staff. This created further delays and duplication of effort.

2.3 Person escort records (PERs – see Glossary of terms) contained sufficient information about risks, medication and property.

2.4 Most courts had secure vehicle bays, but there were none at City of London, Croydon and Wimbledon Magistrates' Courts, Inner London Crown Court and the Royal Courts of Justice. At Croydon, City of London and Royal Courts of Justice, detainees were in public view when they alighted from vehicles which compromised detainee privacy.

2.5 Women often still travelled in vehicles with men, especially from police stations to court. During the first two weeks of May 2021, more than a third of women detainees had travelled in vehicles with men, potentially exposing them to verbal abuse. This was unacceptable (see key concern 3). Children were occasionally transported in cellular vehicles (see paragraph 4.26).

Recommendation

2.6 **Detainees should be able to alight from vehicles swiftly on arrival at court.**

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 Detainees were treated with respect across all the custody facilities and we saw examples of exceptional individual care. Staff were welcoming and considerate, but in many suites, particularly in the busy magistrates' courts, they were under pressure and did not have much time to talk to detainees. Nevertheless, staff still took care to identify needs which may not have been immediately obvious, and to spend time reassuring individuals who were anxious or agitated because of delays or uncertainty in the progress of their case.

3.2 Many staff were well acquainted with detainees who had been in court custody before. They treated them appropriately, acknowledging that they knew them but still adhering to proper procedures.

3.3 In almost all suites, white boards with names and risk markers were visible to detainees and other visitors to court custody. Although the risk markers were coded, several detainees knew what they meant. This practice denied detainees their privacy.

Recommendation

3.4 **The names of detainees and individual risk factors should only be displayed in areas where they cannot be seen by detainees or other visitors to court custody.**

Meeting individual and diverse needs

3.5 The diverse staff group remained a great strength in the London region and exemplified positive teamwork and cooperation. Staff gave good practical support to people with diverse needs but often did not have enough training or resources to provide specific and informed care for different groups.

3.6 Women were treated with consideration and a female officer was nearly always assigned to each female detainee. Menstrual care products were always available but the range was too limited in some suites. They were not always stored in a hygienic way and some detainees had to ask for them. Women were still often transported with men (see paragraph 2.5).

3.7 There were hearing loops in several suites. The lifts at Croydon and Westminster Magistrates' Courts were not working and wheelchair users had to travel elsewhere. Other detainees with impaired mobility were still dealt with at these courts. The poor provision for detainees with disabilities or impaired mobility reflected previous inspections of custody facilities in London.

3.8 There were no easy-read versions of key documents such as prisoners' rights and staff did not always ask if detainees could read or write. In a few suites staff were aware of the needs of neurodivergent people, for example at the Central Criminal Court some staff had good awareness and knew how to support and communicate with detainees with autism or attention deficit hyperactivity disorder.

3.9 Religious books and materials were available at all suites. In several suites religious books such as the Qur'an were not respectfully or tidily stored.

3.10 Most staff had little experience of using telephone interpreting services, although they were aware of the equipment provided. We saw it used on a few occasions, but not in most cases where it was needed. Staff generally relied on informal means of communication until a court appointed interpreter came to the cells, usually with the solicitor. Even then, the interpreter was rarely used for any purpose other than a legal interview. This practice remained unacceptable (see key concern 4).

3.11 The detainee rights leaflet was available in 27 languages. Several suites displayed or issued translated versions of other documents, including the food choices. In two suites, staff had used Google Translate to retrieve some key questions and information in common languages, including Albanian, for which it was often difficult to access telephone interpreting. This was useful but not entirely reliable and was no substitute for accredited interpreting services.

3.12 Staff understood the basic principles of supporting transgender detainees and could describe appropriate engagement with them.

Recommendations

3.13 **All suites should have a freely available, hygienically stored and appropriate range of menstrual care products.**

3.14 **The facilities for detainees with disabilities or impaired mobility should be improved.**

3.15 **There should be easy-read versions of key documents such as the detainee rights leaflet.**

3.16 **Religious books and artefacts should be in good condition and stored with respect and care.**

Risk assessments

3.17 Identification and management of risk were reasonably good. Escort staff shared relevant risk information about detainees with custody staff and staff checked the risk information recorded in the detainee's PER, before placing them in a cell.

3.18 Interactions were positive but often too brief. A basic reception checklist was not used consistently, and detainee responses were not always recorded. A lack of privacy potentially inhibited the disclosure of information about risk and vulnerability (see paragraph 3.3). Risk assessments for detainees received off-bail (see Glossary of terms) were generally more thorough.

3.19 Staff explained how they would ask additional risk assessment questions if they were concerned about a detainee's vulnerability, instability or low mood. Detainees at risk of self-harm or suicide were subject to more frequent observations or constant supervision.

3.20 Staff understood the frequency of checks required on the safety and welfare of detainees. Most of the checks that we observed were carried out as required, but written records were not always accurate. Hand-held devices for recording checks in real time were a welcome innovation, but connectivity issues prevented their use in many facilities.

3.21 The quality of information sharing to ensure that staff knew about the risks relating to detainees in their care varied considerably. There were no verbal briefings at some courts and at others written briefings were not sufficiently informative.

3.22 No detainees were required to share cells at the time of our inspection. Cell call bells were tested every morning and were clearly audible. Detainees who were new to court custody were told how to use the bells on arrival and most bells were answered promptly. All court custody and escort staff carried personal issue anti-ligature knives.

Recommendation

3.23 **Detainees should each receive a systematic assessment of risk on arrival and risks associated with individual detainees should be effectively communicated to all custody staff.**

Individual legal rights

3.24 Staff gave information about rights in custody to most detainees on arrival. Staff told us that they would read the rights document to detainees who needed help with reading. However, they did not always check if such help was needed and our observations indicated that assistance was not always provided when needed (see paragraph 3.8).

3.25 Custody staff did not always ask detainees for the name of their legal representative, but some courts had procedures for advising legal

representatives that their clients had arrived in custody. There were enough consultation rooms to meet demand, but some were not adequately soundproof. Telephone handsets provided an alternative to an in-person meeting. Detainees could keep legal documents about their case and writing materials were available.

3.26 If a detainee wanted to tell a friend or family member where they were, custody staff usually referred the request to the detainee's legal representative. In exceptional circumstances, they made a call on the detainee's behalf. Staff were aware that foreign national detainees had the right to contact their consulate, embassy or high commission.

3.27 There was a strategic commitment to prioritising custody cases through the HMCTS Listings Protocol (see Glossary of terms), but this was not always achieved. A range of other factors contributed to detainees spending longer in custody than strictly necessary, some of which had a cumulative impact.

3.28 Despite liaison between custody staff and HMCTS, it was often unclear why custody cases were not prioritised. Cases were sometimes delayed in the best interest of the detainee, for example while attempts were made to secure accommodation.

3.29 Legal representatives were sometimes refused prompt access to their clients because custody staff could not facilitate access to detainees. This delayed consultations and potentially appearances in court.

3.30 Courts did not always start promptly, and some detainees arrived in the morning even if their case was listed for the afternoon.

3.31 On conclusion of their cases, some detainees experienced lengthy waits to transfer to prison: the longest wait that we identified was almost seven hours. Delays were usually caused by the lack of available vehicles and/or staff. As a result, some detainees had been locked out of prison and held overnight in police stations.

3.32 Legal representatives did not always receive case files in good time from the Crown Prosecution Service. They sometimes also represented multiple clients and often chose to deal with their off-bail clients first, rather than those in custody who should have been prioritised.

3.33 Non-English-speaking detainees were sometimes affected by the late or non-attendance of court-appointed interpreters to assist with their cases. When interpreters failed to turn up, this often led to detainees being remanded to prison, which was potentially unnecessary.

3.34 The key agencies were aware of some of these problems, but not enough was being done to understand or address the reasons for the delays and the unnecessarily extended periods in custody (see key concern 5).

3.35 Once requested by the court, detainees were generally produced without delay.

Complaints

3.36 Most detainees were given information about complaints on arrival but this was only available in English. Court custody staff were aware of the complaints procedure.

3.37 Few complaints were received. Data supplied by Serco showed that only 18 complaints had been submitted in the year ending May 2021. Most complaints were responded to appropriately, but when complaints related to matters outside Serco's control, responses did not always address the issues raised.

Recommendation

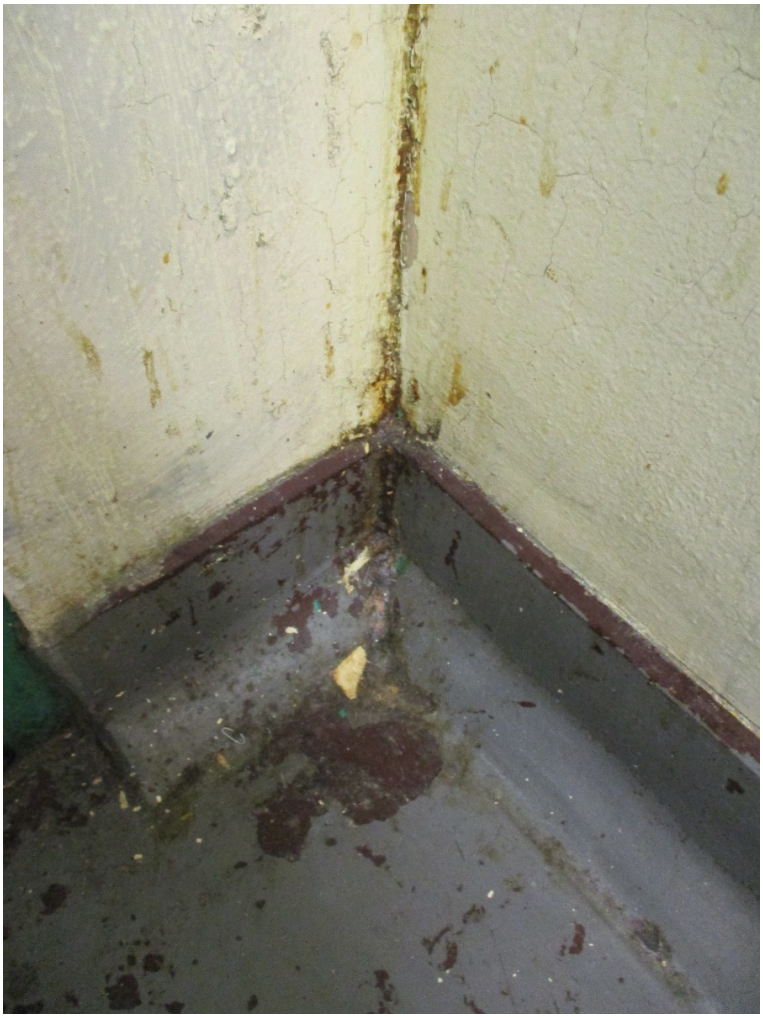
3.38 **Detainees should be given comprehensive and accurate information about the complaints process in their own language.**

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

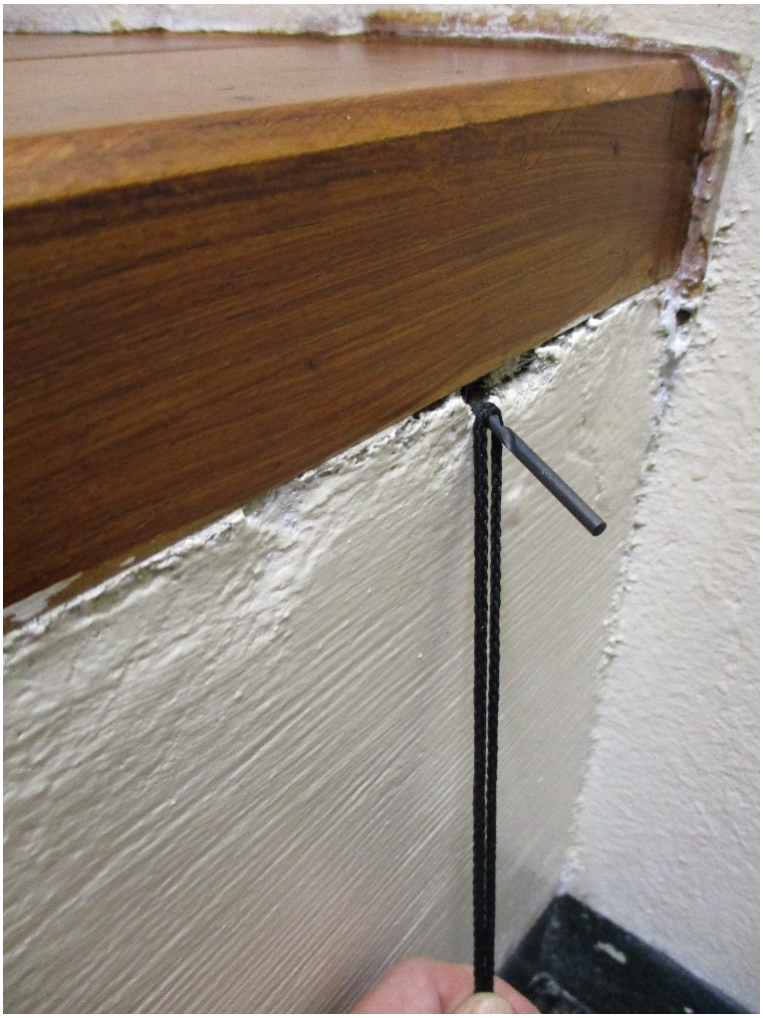
4.1 Most custody suites looked neglected, shabby and grubby in both staff and detainee areas. Routine cleaning, particularly of cell walls, had not prevented dirt from building up over time. Conditions were usually better in the quieter courts. However, some significant defects were long-standing (such as no tiles on the wall of the women's toilet at Croydon Crown Court) and managers were unclear if or when they would be remedied.



Dirty cell at Southwark Crown Court

4.2 Although staff signed off daily cell checks and should have logged defects, we found many unreported issues which suggested that the

checks were inadequate. In the busier courts, some cells remained in use despite offensive graffiti, which was disrespectful. We found potential ligature points in every custody facility, generally caused by ill-fitting doors or the lack of sealant around benches and observation panels (see key concern 6). We provided a separate, illustrative report of these findings.



Potential ligature point under a bench at Croydon Magistrates' Court

4.3 Routes to court were safe with enough affray alarms and they did not pass through public areas. Staff knew the fire evacuation plans but did not practise them with detainees regularly enough. The contractor for specialist cleaning of body fluids was responsive and effective.

4.4 Staff were aware of cell temperatures and were familiar with the policy for managing excessive heat. Managers had placed some cells out of use at the Central Criminal Court for this reason. The fabric of this court was the responsibility of the City of London Corporation rather than HMCTS. Elsewhere, detainees complained of being too cool and staff said that in winter some cells were very cold.

4.5 Each court had 'touchpoint cleaning' at least twice a day to reduce the risk of COVID-19 transmission, but this was usually cursory.

Use of force

4.6 There had been 46 recorded incidents of use of force in the previous 12 months, including four involving MMPR (see Glossary of terms) on children. This was not excessive. At the Royal Courts of Justice and at City of London Magistrates' Court, no force had been used during this period. Most incidents were relatively low level, often when detainees refused to leave the dock or to board transport. There was good evidence of the use of de-escalation techniques to try to avoid the use of force.

4.7 Most staff had had up-to-date control and restraint (C&R) training. In the sample of documents that we reviewed relating to incidents of restraint, most statements were of reasonable quality and some were good. In some cases, there was not enough detail about the kind of hold or restraint that staff had applied.

4.8 Some anomalies in the data and documentation supplied to us suggested that governance was not yet robust enough. We found records of a few incidents which had not been included in the data we received and observed an incident where force was used but no documentation had been completed to justify it. We were therefore not confident that all incidents involving use of force (including guiding holds) had been properly recorded. However, managers had taken robust action in one case where excessive force had been used.

4.9 In five courts staff routinely used handcuffs when removing detainees from vehicles because the area where they alighted was not secure (see paragraph 2.4). However, at the Royal Courts of Justice, Inner London Crown Court and Wimbledon and Croydon Magistrates' Courts, staff routinely left the handcuffs on until the detainee was placed in a cell, which was unnecessary.

4.10 The teams responsible for escorting children carried waist restraint belts designed to be used in non-cellular vehicles if necessary. We were told that these had not been used in the past year.

Recommendation

4.11 **Handcuffs should only be used when justified by an individual risk assessment and for no longer than is strictly necessary.**

Detainee care

4.12 Some detainees went out of their way to tell us how well they had been treated and some contrasted the helpful behaviour of custody staff with the formality of the rest of the process that they had experienced.

4.13 Food and hot drinks or water were offered at any time. A few courts served meals at set times, which did not always meet detainees' needs. At Westminster Magistrates' Court, large numbers of meals were served at once and towards the end of service the food and drinks were barely warm. Microwaveable meals were the only food

available, with no fresh food, sandwiches or snacks that are often provided in other custody suites visited. Food preparation areas were clean, but some microwaves were dirty inside and containers of sugar and coffee were sometimes left uncovered all day.

4.14 Chalk boards in cells provided a distraction activity and were a good innovation, but chalk was not always offered.

4.15 Boxes of games and puzzles, including resource packs produced by the charity 'Recoop', were available in all courts but were not always offered.

4.16 There were a few books in English for adults in every suite, but they were not offered consistently. These books had been brought in by staff and did not reflect the range of ages and backgrounds among detainees. This provision had not been improved since previous inspections of the London region. Some staff brought in free newspapers, which was good, but again they were not offered consistently.

4.17 A few of the toilets were not private enough, often because they were located on busy corridors with low stable-type doors. Several were stained or cracked, toilet paper was left unhygienically on the toilet bowl in many places and there were often no paper towels. At Wimbledon Magistrates' Court, most of the taps produced no water at all.

Unscreened toilet at Inner London Crown Court

4.18 No clothing was available in any suite, except for a few plimsolls. Several detainees went to court in ill-fitting police-issue tracksuits or were released without appropriate clothes.

Recommendations

4.19 **The range of food in custody suites should be improved and foodstuffs should be properly stored at all times.**

4.20 **Detainees should be offered reading materials in a range of common languages and accessible formats.**

4.21 **Detainees should be able to use the toilet in private and have access to hygienically stored toilet paper and hand towels.**

Safeguarding

4.22 There was still no HMCTS safeguarding policy, but Serco had comprehensive policies for adults and children. Most regular court custody staff now had a basic understanding of safeguarding in terms of promoting welfare, but few described it as protection from harm. The majority knew the safeguarding officers by name, could locate their telephone numbers immediately and were confident about contacting them. Awareness was greater when managers had led team discussions about safeguarding and we encountered staff who could describe behaviours which might indicate that a detainee had been trafficked.

4.23 A significant number of staff, especially those who primarily worked on vehicles, still lacked understanding of their safeguarding responsibilities. One officer told us that safeguarding was a security process and another said that they would advise a child alleging abuse to tell someone they trusted.

4.24 We usually hear of recent cases involving safeguarding concerns during court custody inspections but, despite the high throughput, this was not the case during this inspection. We could not be confident that potential harm was being identified or appropriate action taken.

Recommendation

4.25 **All staff, including HMCTS staff, should understand their safeguarding obligations and how to exercise them.**

Children

4.26 Each child should now receive care from a dedicated enhanced care team. They should be held in a holding room rather than a cell and should not travel in a cellular vehicle. However, many of the children we saw during this inspection received care that was barely different from that offered to adults.

4.27 During the four weeks to 9 July 2021, 33 children had been held in court custody on 71 occasions. All the children whom we saw were locked in a cell, usually with a tablet computer for entertainment. Staff could not engage or observe easily because of the locked cell door and their role was limited to answering cell call bells or conducting welfare checks, rather than building relationships. Only at Inner London Crown

Court had a room been identified for use by children, but staff said that it would be used only for very young children. The large number of children on trial at the Central Criminal Court presented an undeniable logistical challenge for Serco.

4.28 During May 2021, 17% of child moves had taken place in cellular vehicles. These children were denied the opportunity to talk to enhanced care team staff or to sleep comfortably during their journey. At court children were sometimes cared for by prisoner custody officers or enhanced care officers (ECOs) and dual-badged officers (DBOs, see Glossary of terms) from other teams, and received less consistent care than others as a result. There were not always enough tablet computers or snacks for children who were not accompanied by a dedicated team.

4.29 Children often spent too long in court custody and there was little evidence that their cases were prioritised. At the end of hearings, there were frequently long waits for placement orders, even when the child was expected to return to the placement from which they had travelled. These were sometimes followed by waits for transport. For example, a child arrived at Bromley Magistrates' Court at 9.20am, went to court at 3.22pm, waited until 5pm for a placement order and then waited until 9.56pm to leave court because of a lack of vehicles and/or staff (see key concern 7).

4.30 Children from HMYOI Feltham could earn 'green cards' for good behaviour while in the custody of Serco as they could in prison, which was positive. These allowed children to claim rewards under the YOI incentives and earned privileges scheme.

Health

4.31 The physical health care services for detainees were informed by a health needs analysis commissioned by NHS England and provided by IPRS Aeromed. Liaison and Diversion (L&D) services were delivered by specialist mental health and social care providers across the region and overseen by NHS England specialist commissioners.

4.32 Clinical governance processes were well established and systems and policies were in place to ensure that core professional standards were met. Clinical activity was monitored well. L&D staff worked closely with community agencies which ensured that access to services was well coordinated and focused on detainee needs and diversion from custody where appropriate. All L&D teams had robust clinical governance processes and held regular inter-agency meetings to review activity and generate service improvement.

4.33 The paramedics and L&D practitioners were professional, with clear competencies, and they prioritised detainee welfare. Training and supervision arrangements were good.

4.34 Custody staff knew how to access physical health advice through the dedicated telephone helpline and valued the prompt and expert

service. There were about 70 calls to the service each month of which slightly more than a quarter required the attendance of paramedics. Westminster Magistrates' Court accounted for most of these calls.

4.35 Custody staff felt that the service met most of the needs that they observed. We were told that detainees could speak to a health professional on the phone. However, most communication was channelled through custody staff which limited confidentiality and could inhibit an accurate assessment.

4.36 All off-bail detainees received a separate health risk assessment to enable the immediate identification of concerns, but we did not see this in practice. If required, paramedics were dispatched to the suites to undertake a health assessment within a four-hour window, but most contacts took place within two hours. Examinations were generally conducted in cells. We saw no evidence of joint working or routine engagement between Aeromed and L&D service providers and some opportunities to coordinate care had been missed.

4.37 Five different providers worked in the courts in partnership (Oxleas NHS Foundation Trust, South-west London & St George's Mental Health NHS Trust, South London and Maudsley NHS Foundation Trust, Central & North-west London NHS Foundation Trust and Together for Mental Well-being). The L&D teams delivered comprehensive and well-established levels of support to detainees using an 'all vulnerabilities' approach.

4.38 Specialist assessment and support were embedded in all magistrates' courts and delivered through a coordinated, multi-agency approach. Timely professional advice facilitated more effective decision making in court. This included diversion and out-reach from custody using strong links with local authorities, charities and specialist substance and alcohol misuse services. L&D input into the Crown courts was more specialised and focused on supporting court decision making. In some settings this contribution was still developing but consistent cover was scheduled to be in place in all Crown courts by September 2021 once recruitment had been finalised. The Central Criminal Court offered a strong model for these developments and we also saw an innovative scheme there to prepare children attending lengthy trials.

4.39 Only a few custody staff had completed mental health awareness training, except at Southwark Crown Court where most had completed it. Custody staff had completed first aid training and knew what to do in the event of a medical emergency, but training was only delivered every three years which was not enough to ensure that skills were retained. No staff had undertaken additional health training such as Custody Early Warning Scores (CEWS – see Glossary of terms), although at Southwark Crown Court we saw examples of health-related desk top exercises. At Woolwich Crown Court and in some other settings, the automated external defibrillators (AEDs) were located too far from the custody suite.

4.40 Health practitioners kept records of their contacts and clinical input and appropriately shared information based on risk with prisons and police custody if required. Information such as medication requirements was included in the PER.

4.41 Custody staff did not administer medication but arrangements appeared to work well to facilitate access for detainees to existing prescriptions once authorised by IPRS Aeromed or indicated in the PER. Detainees could also hold certain medications such as salbutamol and GTN sprays (used to treat angina). Simple remedies such as paracetamol and antihistamines could only be administered by a paramedic who had seen the detainee. This seemed unnecessarily restrictive and delayed treatment. There was no provision of symptomatic relief for alcohol or drug withdrawal, nor access to nicotine replacement products. This was a shortcoming in the service profile and a potential risk. Medication was stored in detainees' individual property. No stock medication or over-the-counter medicines were stored on site.

Recommendations

4.42 **Custody staff should attend an annual first aid refresher session and mental health awareness training.**

4.43 **Custody staff should be able to access an automated external defibrillator rapidly in the event of an emergency.**

4.44 **Detainees should be able to access simple over-the-counter remedies in a timely fashion and paramedics should have more scope to support detainees experiencing signs of withdrawal from drugs or alcohol.**

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 Staff took reasonable care to ensure that detainees were transferred or released safely when they had finished in court, but there were frequently too many delays.

5.2 In all but two suites, detainees who had not originated from a prison and who were released by the court were locked in a cell for up to an hour before being allowed to leave. This practice was highly unusual. Some courts lacked suitable holding rooms for this purpose. Staff attributed these delays to other calls on staff time and failed to realise that they were depriving people of their liberty with no good reason (see key concern 8).

5.3 Serving prisoners who had been released by the court subject to governor's authority for release frequently had long waits. We observed waits of more than four hours and detainees being returned to prison when they were due for immediate release. It was unclear why senior Serco staff seemed reluctant to escalate such cases to PECS (see key concern 9).

5.4 Staff consistently gave detainees leaflets on release which contained information about local services. There were different versions for adults, with tailored leaflets for women and children. 'What happens next?' leaflets were given to those sent to prison. In a few suites there were introductory information sheets for specific prisons.

5.5 A private conversation took place in some courts before release, but in most there was a quick discussion at the desk, with no privacy, focused on whether the detainee had somewhere to go and the means to get there. In almost all suites, travel warrants were given to detainees who needed them, which was an improvement on our previous inspections in London. Face masks were offered before release.

Recommendation

5.6 **Staff should conduct good quality pre-release risk assessments in the presence of the detainee and in private.**

Section 6 Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

6.1 Key concern 1: We observed significant staff shortages at all grades, including court custody managers. Staff said this was not unusual. As a result, we saw staff struggling to offload vehicles promptly, children without enhanced care teams, delays accessing legal representatives, delays in release and some important conversations with detainees being rushed. We were told that delays transporting detainees to prison were also often caused by inadequate staffing. These challenges were compounded when there was either no manager, or no suitably experienced manager, to provide direction and ensure the smooth operation of the suite.

Recommendation: Sufficient competent staff of appropriate grades should always be deployed in court custody to make sure that facilities run efficiently and detainees are dealt with promptly and respectfully. (To HMCTS, PECS and Serco)

6.2 Key concern 2: Relationships and communication between the three main agencies responsible for custody were not always effective and did not consistently prioritise good outcomes for detainees. Data concerning the experience of the detainee were not routinely collected or analysed to identify areas for improvement or used sufficiently well to monitor the effectiveness of improvement activities.

Recommendation: Relationships and communication among the three main agencies responsible for custody should prioritise good outcomes for detainees, including the collection and robust analysis of data to identify areas for improvement and to monitor the effectiveness of improvement activities. (To HMCTS, PECS and Serco)

6.3 Key concern 3: Women still often travelled in vehicles with men, especially from police stations to court. In a two-week period, more than one-third of female detainees travelled in vehicles with men. We found no evidence that this was exceptional and saw that the screens designed to separate vehicles into two private sections were not routinely used on these occasions. This was unacceptable because it potentially exposed women to verbal abuse.

Recommendation: Female detainees should always be transported separately from men. (To HMCTS, PECS and Serco)

6.4 Key concern 4: Most staff were not familiar with telephone interpreting services and they were rarely used. This practice had not improved

since our previous inspections in London and had an adverse impact on some detainees.

Recommendation: Telephone interpreting services should routinely be used with detainees for whom English is a second language when they arrive in custody and at any other time when accuracy is especially important, such as the assessment of risks or needs. (To HMCTS, PECS and Serco)

6.5 Key concern 5: Some detainees were held in court custody for longer than necessary. The reasons for this included:

- delays with legal representatives accessing their clients which potentially affected the prompt hearing of their case;
- cases not always being prioritised;
- courts often starting later than scheduled;
- delays with legal representatives receiving court papers from the Crown Prosecution Service;
- detainees being brought to court in the morning for cases listed in the afternoon;
- the late or non-attendance of court appointed interpreters; and
- delays moving detainees to prison once remanded or sentenced.

Recommendation: Managers should explore and address the reasons for delays to ensure that detainees are held in custody for the shortest possible time. (To HMCTS, PECS and Serco)

6.6 Key concern 6: Conditions across the estate were often poor. We found extensive and sometimes offensive graffiti in cells, ingrained dirt and potential ligature points in most suites. The arrangements for cleaning and checking cells and other detainee areas were not good enough to ensure a clean, respectful and safe environment.

Recommendation: Cleaning and maintenance arrangements for custody facilities should ensure that the environment and particularly cells are clean, respectful and safe. (To HMCTS, PECS and Serco)

6.7 Key concern 7: The care of children was disappointing and did not adequately reflect their innate vulnerability. About 17% of child moves were in cellular vehicles and all the children we saw were locked in cells. Enhanced care officers (ECOs) and dual-badged officers (DBOs) (see Glossary of terms) found it difficult to build relationships with or actively support children in these conditions. Some children did not have a dedicated team of staff looking after them and received a poorer level of care than others. Many children had long waits in court custody, especially for placement orders and for transport to their onward custodial destination.

Recommendation: Children should receive individualised, age-appropriate care which is focused on building relationships and minimising time in court custody. (To HMCTS, PECS and Serco)

6.8 Key concern 8: Detainees released by the court who had not originated from a prison were routinely locked in cells in most custody suites to await their release. This often took too long and release procedures were frequently not viewed as a priority. This was highly unusual and unacceptable and unnecessarily denied detainees their liberty.

Recommendation: Detainees released by the court should not be locked in a cell and should be released promptly. (To HMCTS, PECS and Serco)

6.9 Key concern 9: Detainees who required governor's authority for release (see Glossary of terms) frequently had to wait for many hours before this was received. Some detainees were returned to the prison to be released from there because authorisation was not received in good time. In both cases, detainees were denied their liberty for too long and we observed a reluctance by Serco staff to escalate this issue to PECS. This has been the case in our last 10 court custody inspections and we consider that one hour is the maximum reasonable wait.

Recommendation: PECS should work closely with HMPPS and court custody providers to monitor, understand and resolve delays in releasing from court custody detainees who originated from prisons. (To HMCTS, PECS and Serco)

Recommendations

6.10 Recommendation 2.6: Detainees should be able to alight from vehicles swiftly on arrival at court. (To HMCTS, PECS and Serco)

6.11 Recommendation 3.4: The names of detainees and individual risk factors should only be displayed in areas where they cannot be seen by detainees or other visitors to court custody. (To HMCTS, PECS and Serco)

6.12 Recommendation 3.13: All suites should have a freely available, hygienically stored and appropriate range of menstrual care products. (To HMCTS, PECS and Serco)

6.13 Recommendation 3.14: The facilities for detainees with disabilities or impaired mobility should be improved. (To HMCTS, PECS and Serco)

6.14 Recommendation 3.15: There should be easy-read versions of key documents such as the detainee rights leaflet. (To HMCTS, PECS and Serco)

6.15 Recommendation 3.16: Religious books and artefacts should be in good condition and stored with respect and care. (To HMCTS, PECS and Serco)

6.16 Recommendation 3.23: Detainees should each receive a systematic assessment of risk on arrival and risks associated with individual detainees should be effectively communicated to all custody staff. (To HMCTS, PECS and Serco)

6.17 Recommendation 3.38: Detainees should be given comprehensive and accurate information about the complaints process in their own language. (To HMCTS, PECS and Serco)

6.18 Recommendation 4.11: Handcuffs should only be used when justified by an individual risk assessment and for no longer than is strictly necessary. (To HMCTS, PECS and Serco)

6.19 Recommendation 4.19: The range of food in custody suites should be improved and foodstuffs should be properly stored at all times. (To HMCTS, PECS and Serco)

6.20 Recommendation 4.20: Detainees should be offered reading materials in a range of common languages and accessible formats. (To HMCTS, PECS and Serco)

6.21 Recommendation 4.21: Detainees should be able to use the toilet in private and have access to hygienically stored toilet paper and hand towels. (To HMCTS, PECS and Serco)

6.22 Recommendation 4.25: All staff, including HMCTS staff, should understand their safeguarding obligations and how to exercise them. (To HMCTS, PECS and Serco)

6.23 Recommendation 4.42: Custody staff should attend an annual first aid refresher session and mental health awareness training. (To HMCTS, PECS and Serco)

6.24 Recommendation 4.43: Custody staff should be able to access an automated external defibrillator rapidly in the event of an emergency. (To HMCTS, PECS and Serco)

6.25 Recommendation 4.44: Detainees should be able to access simple over-the-counter remedies in a timely fashion and paramedics should have more scope to support detainees experiencing signs of withdrawal from drugs or alcohol. (To HMCTS, PECS and Serco)

6.26 Recommendation 5.6: Staff should conduct good quality pre-release risk assessments in the presence of the detainee and in private**.** (To HMCTS, PECS and Serco)

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 one of the following:

Key concerns and recommendations: identify the issues of most importance to improving outcomes for detainees and are designed to help HMCTS, the prisoner escort and custody service (PECS) and the escort provider prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

Recommendations: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

Examples of notable positive practice: 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 detainees; 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
Steve Eley	Health care inspector
Jeanette Hall	Inspector
Martin Kettle	Inspector
Fiona Shearlaw	Inspector

Appendix II Glossary of terms

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. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Custody Early Warning Score (CEWS)
An adapted version of a health care physiological scoring system for use in custody aimed at identifying detainee health need and reducing morbidity.

Dual-badged officers (DBOs)
Officers who work in custody and who additionally undertake specific training, including MMPR, to work with children.

Enhanced care officers (ECOs)
Officers who only work with and escort children. They undertake specific training, including MMPR, to provide an enhanced level of care and support. They are deployed from a central resource and remain with children throughout their stay in custody.

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.

HMCTS Listings Protocol
The listing of cases to be heard in courts is a judicial function. There is a protocol between the judiciary and HMCTS which sets out the priorities for the listing of cases. The first priority refers to all custody cases including: overnight custody cases from police stations (including arrest warrants and breach of bail cases), productions from prisons and sentencing cases.

Immigration asylum chamber (IAC)
Immigration asylum chambers, otherwise known as tribunal centres, handle appeals against Home Office decisions concerning permission to stay in the UK, deportation from the UK and entry clearance to the UK. They also take applications for immigration bail for people being held by the Home Office on immigration matters.

Minimising and managing physical restraint (MMPR)
A behaviour management and restraint system, aiming to provide secure estate staff with the ability to recognise young people's behaviour, use de-escalation and diversion strategies and apply behaviour management techniques to minimise the use of restraint. See:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/456672/minimising-managing-physical-restraint.pdf

Off-bail
A person is received ‘off-bail’ into court custody directly from the courtroom when they are on bail for offences and have not been detained in custody but are subsequently remanded into custody or given a custodial sentence.

Person escort record (PER)
The PER 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.

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