Report on an inspection visit to court custody facilities in

London Magistrates' Courts

by HM Chief Inspector of Prisons

17 November–6 December 2025

Contents

Introduction

This report presents findings from our recent inspection of custody facilities in London Magistrates' Courts. Overall, the inspection was disappointing. Fewer than 60% of previous recommendations were fully or partially achieved and only a fifth had been fully achieved. This highlighted persistent systemic challenges that affected detainee welfare and operational efficiency.

The lack of consistent cooperation between leaders and staff from His Majesty's Courts and Tribunals Service (HMCTS), Serco, Prisoner Escort and Custody Services (PECS) and other agencies was causing avoidable delays, poor outcomes for detainees and unnecessary strain on staff. Poor communication, limited understanding of each organisation's priorities and pressures, and unclear roles were hindering effective joint working.

Serco faced major recruitment and retention issues, and staff shortages and delays with vetting directly affected service delivery and contributed to increased operational strain in some of the busiest courts in England. Despite this, custody staff showed professionalism, patience and respect under pressure, but morale was sometimes low due to long working hours.

Chronic underinvestment and complex procurement processes left many custody facilities in a poor condition. Dirty cells, offensive graffiti, poor toilets and a lack of private interview spaces compromised detainee dignity and privacy. Transport arrangements also required urgent attention; tired vehicles, circuitous routes and queuing delays prolonged journeys and delayed court attendance.

Other areas of concern included the limited facilities for detainees with disabilities, underuse of interpreting services and insufficient awareness of neurodivergence. Children in custody received poor care, often locked in cells with long waits for transport and inadequate age-appropriate facilities. Delays in assessments and a lack of secure beds for acutely mentally unwell detainees led to some being remanded to prison, a poor outcome. Release arrangements remained weak, with insufficient support for those needing travel assistance.

Despite these shortcomings, we noted strengths. Custody staff training was generally effective, and many staff managed vulnerable or distressed detainees with commendable skill. The introduction of body-worn cameras was positive. Staff used force rarely and generally proportionately. Safeguarding awareness had improved, and health provision was better than at the last inspection, with improved access to emergency equipment and responsive medical support. In summary, while staff commitment and improved health provision were clear strengths, systemic weaknesses – particularly in facilities, inter-agency cooperation, care for children and the acutely mentally unwell, release arrangements and attention to meeting diverse needs – required urgent and sustained action.

We hope this report will help the responsible agencies to address these issues and improve outcomes for detainees.

Charlie Taylor
HM Chief Inspector of Prisons
January 2026

What needs to improve in London Magistrates' Courts custody

We last inspected court custody in several areas across London in 2016, 2017 and 2021 and raised 74 recommendations and concerns overall, 11 of which were main recommendations and nine of which were key concerns (see Section 6 for a full list).

At this inspection we found that there had been insufficient progress, with only 44 of the recommendations and concerns achieved or partially achieved, including 10 main recommendations and key concerns; those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers. Twenty-eight recommendations and concerns had not been addressed.

During this inspection we identified 14 areas of concern to be addressed by HM Courts and Tribunals Service (HMCTS), the prisoner escort and custody service (PECS) and the escort provider (Serco). 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 seven priority concerns.

1. **Leaders from the three main agencies were not always working effectively together to support consistent delivery of a safe and decent custody provision.**

2. **Not enough attention was given to meeting detainees' individual needs**. Female detainees were not always supervised by female staff. Facilities to support detainees with disabilities were limited, awareness of and provision for neurodiverse needs was low, and staff used telephone interpreting too infrequently to safeguard detainees' welfare.

3. **The main agencies responsible for court custody did not do enough to address the reasons why some detainees were held for longer than necessary.**

4. **Cells were often not clean, and many had ingrained dirt on floors, stains on walls, potential ligature points and graffiti, including some that was offensive.** Toilet facilities were unpleasant and lacked seats and hot water and dispensers for toilet paper and soap.

5. **Care for children was not good enough and they were frequently locked in cells without a risk-based justification.**

6. **Not enough was done to make sure acutely mentally unwell detainees in court custody received prompt Mental Health Act assessments and diversion to specialist care and treatment.**

7. **Release arrangements remained weak.** Some detainees were locked inappropriately into cells, release interviews did not always identify immediate concerns, and not all were provided with sufficient means to travel home. Releases for those who originated from prison were often significantly delayed.

Key concerns

We identified a further seven key concerns.

8. **Some detainees waited too long to alight from what were often cold vehicles.**

9. **Whiteboards with information identifying individuals in custody were displayed for detainees to see, which compromised confidentiality.**

10. **Staff were not always briefed comprehensively about detainee risks, and some observation levels were not completed at the required frequency.**

11. **There was too much routine handcuffing and searching of detainees without an individual and dynamic risk assessment.**

12. **The health provider could not access the national patient record system, which meant that practitioners were not always aware of contemporary health contacts and treatment that would have helped mitigate risk.**

13. **Detainees did not have access to nicotine replacement therapy.**

14. **The training of custody staff in resuscitation skills was not frequent enough to maintain their competence**.

Notable positive practice

We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for detainees, and/or particularly original or creative approaches to problem solving.

Inspectors found no examples of notable positive practice during this inspection, which other places may be able to learn from or replicate.

About London Magistrates' Court custody

Data supplied by HMCTS and custody escort provider.

HMCTS cluster
London Magistrates' Courts

Head of Operations, London Magistrates' Courts
Alison Aedy

Geographical area
London

Court custody suites and cell capacity

Barkingside MC	16 cells
Bexleyheath MC	8 cells
Bromley MC	13 cells
City of London MC	10 cells
Croydon MC	22 cells
Ealing MC	9 cells
Highbury Corner MC	37 cells
Romford MC	6 cells
Stratford MC	19 cells
Thames MC	35 cells
Uxbridge MC	15 cells
Westminster MC	40 cells
Willesden MC	25 cells
Wimbledon MC	14 cells

Annual custody throughput
1 October 2024 to 30 September 2025 — 49,381 detainees

Custody and escort provider
Serco

Custody staffing
4 area operations managers
13 court custody managers
6 deputy court custody managers
135.9 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 This inspection was disappointing overall. Leaders had not adequately addressed most key failures identified in previous inspections, many of which persisted and continued to contribute to poor outcomes for detainees. Only a fifth of our previous concerns and recommendations had been fully achieved.

1.2 Custody facilities in London magistrates' courts are among the busiest in the country and require cooperation from a range of agencies to deliver consistently good outcomes for detainees while balancing the demands of judicial business. Leaders from the three main agencies (HMCTS, Serco and PECS), along with others including the police and prisons, met reasonably regularly and claimed a shared focus on detainee welfare. A range of data was collected and analysed but was not always used well enough to improve outcomes for detainees. For example, problems such as late arrivals at court, delays in dealing with detainee cases, low use of telephone interpreting services and delays in onward transportation to prison persisted. Although a huge and complex undertaking, we concluded that, despite their stated aims, leaders were not working together effectively enough to support a consistently safe and decent custody provision.

1.3 Recruitment and retention of custody and escorting staff remained a challenge that Serco worked hard to tackle. This was often affected by some long delays with vetting. This contributed to huge operational strain where shortages left some staff overstretched and increasingly disgruntled. Long hours caused by practices such as late court sittings and redirections for those sentenced or remanded to prison were among their concerns.

1.4 Despite these issues, custody managers generally provided strong direction, and staff maintained a reasonable focus on detainee care. The effectiveness of well-trained custody staff was a real strength, and they often mitigated against shortcomings elsewhere through their respectful treatment of detainees. However, the culture was less positive in a minority of facilities.

1.5 HMCTS had failed to make sure custody facilities were consistently clean and well maintained. Improvements were blocked by lack of funding, complex procurement and contractual constraints, leaving many facilities substandard. Frequent cell closures for reasons such as poor maintenance made it difficult to accommodate the required detainee numbers at times.

1.6 We were very concerned by the number of acutely mentally unwell people who were often sent to prison for their own safety. There was no cohesive or reliable pathway to divert them to hospital; this required urgent action from local authorities, justice services and the NHS.

1.7 Since our last inspection, two deaths had occurred in Serco vehicles; both were being investigated.

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 Most vehicles we inspected showed wear and tear and were sometimes dirty. Staff did not consistently use partitions to separate women or children from adult men, and vehicles transporting women were not always staffed by female officers.

2.2 Many detainees arrived late to court custody. We were told that delays in prisons and police stations, the use of smaller vehicles, multiple collections, and circuitous routes all contributed to delays with detainees arriving at court (see paragraph 3.10).

2.3 Staff often processed detainees' property first, leaving them waiting unnecessarily in vehicles. When multiple vehicles arrived simultaneously, some detainees waited a long time to alight, often in vans that were cold when engines were turned off.

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 Staff generally engaged politely and respectfully with detainees, although some referred to them by their surname only. We observed staff showing patience, skill and professionalism with detainees who were angry, frustrated, frightened or unwell. However, staff often missed chances to build trust by chatting casually or providing information proactively to structure detainee expectations.

3.2 Some practices compromised detainee privacy. Whiteboards visible in detainee areas often displayed full names of those in custody, and staff usually interviewed detainees in busy areas with multiple officers present, making it hard for detainees to share private information or hear what was being said.

Meeting individual and diverse needs

3.3 Staff did not consistently meet detainees' needs. Facilities for those with disabilities were limited. We were told that three courts complied with the Equality Act, but at one the lift had been out of service for months. Adaptations included accessible toilets and wider cell doors, but cells lacked adjustments such as lowered call bells. Many courtrooms were only accessible via stairs, creating difficulties for detainees with limited mobility. Cells lacked hearing loops. Although legal rights information was available in Braille, it was not explained adequately to detainees who could not read (see paragraph 3.12).

3.4 Staff did not always provide key information in foreign languages or use telephone interpreting effectively to make sure detainees who did not speak English understood their rights and what was happening to them or to check their welfare. In some courts, the lack of quiet spaces and suitable phone equipment made interpreting harder.

3.5 Staff broadly met women detainees' needs, but they were not always supervised by female staff, which made some feel uncomfortable. Ready access to a suitable range of menstrual care products and disposal units was inconsistent.

3.6 Staff checked detainees' religious needs on arrival. Religious items were stored respectfully and provided promptly on request.

3.7 Most staff understood how to care for transgender detainees, an improvement since previous inspections, but they showed less awareness of supporting those who were neurodivergent.

Risk assessments

3.8 Staff identified and managed risk inconsistently. Escort staff generally shared relevant risk information, checked digital person escort records (dPERs, see Glossary) and spoke with detainees. dPERs were often incomplete and lacked detail, including medical information and dates to identify if risks were current or historic (see paragraph 4.16). Custody staff were not consistently briefed about those in their care, including what level of observation they needed, and some staff were unsure of presenting risks. Although they were alert to detainee vulnerabilities and how these changed during custody, some observation checks were cursory, involved no engagement with the detainee and were sometimes not completed at the required frequency.

3.9 When detainees shared cells, staff assessed associated risks. Responses to cell call bells were mostly prompt, and routes to court remained safe, with sufficient working affray alarms in place.

Individual legal rights

3.10 Since the previous inspections, there was now a better focus on trying to prioritise vulnerable detainees, including women and children, for court listing and appearance. Despite this, many still spent longer in custody than necessary due to late delivery to court (see paragraph 2.2), limited cell capacity that led to detainees being held back in police custody, delays in handling cases, delayed legal consultations often caused by late electronic case papers, interpreter non-attendance and long waits for prison transfers (see paragraph 5.4). In other cases, the reasons for delay were unclear. These issues had persisted from previous inspections, yet leaders from the three main agencies had still not done enough to make sure that detainees were dealt with promptly.

3.11 Courts now accepted additional detainees from the police later in the day, which helped reduce their overall custody time.

3.12 Rights information was available in cells, but staff rarely explained it, even to detainees who could not read or had difficulty understanding (see paragraph 3.3).

3.13 Some custody facilities lacked enough consultation rooms. While some rooms were not soundproofed, staff supervised them discreetly. Most detainees were moved to court promptly when requested.

Complaints

3.14 Custody staff did not always explain the complaints procedure clearly. Notices in custody facilities contained outdated information. Detainee complaints were rare, but responses were not always comprehensive.

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 facilities remained in poor condition even though leaders had had significant notice of this inspection. Cleaning schedules were ineffective, and staff often failed to complete daily checks thoroughly or report defects. During the inspection, multiple cells were deemed unfit for use, which limited cell capacity, particularly in busier facilities.

4.2 Communal areas were generally clean, but many cells were dirty, with ingrained dirt on floors, stains on walls, extensive and sometimes offensive graffiti, little natural light and some potential ligature points. Cells were uncomfortable for long stays, offering only a hard bench for detainees to sit on. Leaders responded promptly to our findings and assured action to address our concerns.

Stains on bench and cell walls

Examples of graffiti

Damaged floor and hard bench

4.3 Staff were familiar with emergency evacuation procedures, and practised drills regularly.

Use of force

4.4 It was positive that staff had used force against only a small proportion of detainees. Staff we spoke to described a strong focus on de-escalating challenging situations, and force was almost always used as a last resort. Documentation showed that force was generally low level, necessary and proportionate. The introduction of body-worn video cameras was positive and supported better quality assurance. Oversight had improved and had led to firm action when poor practice was identified. However, oversight remained inconsistent and did not routinely include camera footage reviews; some cases that we looked at revealed that learning had been missed when paperwork alone had been reviewed.

4.5 The approach to handcuffing and searching was disappointing. It was inconsistent and too often routine in some facilities, appearing unnecessary and frequently lacking dynamic and individualised risk assessment to support it.

Detainee care

4.6 Detainees overwhelmingly said they felt cared for during their time in court custody. Staff offered them drinks on arrival and throughout the day. Most dietary needs were met, but ready meals were poor quality, although leaders had advanced plans to improve them. Courts were generally flexible, providing food when detainees were hungry rather than waiting for set mealtimes.

4.7 Distraction activities were available but not always well promoted or explained. In-cell packs with puzzles were offered inconsistently. Reading material varied by location, with few options that were in other languages, easy-read formats or suitable for children. Stock relied on staff donations or free newspapers. Most cells had chalkboards, and there were games, colouring books and stress relievers, though these were rarely given out as staff often assumed these were only for children or detainees at risk of self-harm on constant supervision.

4.8 Toilet facilities were often poor. Few toilets had seats, some sinks lacked hot water, and toilet paper and soap were not always stored hygienically. Staff supervised discreetly, but it was inappropriate that male staff supervised women detainees, which made some feel uncomfortable (see paragraph 3.5).

Toilet at Wimbledon with no seat or toilet paper dispenser

Safeguarding

4.9 We were more confident than in previous inspections that staff identified and supported detainees at risk of harm. Safeguarding managers were well known, and their contact details were easily accessible. Most staff spoke confidently about situations for which they would make referrals and described actions they had taken to prevent harm. However, a few staff, including some escort staff, still lacked a clear understanding of their responsibilities.

Children

4.10 Care of children remained inadequate, with little improvement since our previous inspections. In the previous six months, about 60% of children arriving from police custody were transported in cellular vehicles, often with adults.

4.11 Nearly all the children we observed were locked in cells without a risk-based justification, even when accompanied by a three-person enhanced care officer (ECO, see Glossary) team. Some ECOs lacked enthusiasm for the care of children, and some regular court staff were reluctant to provide care because they were not trained to look after children as 'dual-badged' officers (DBO, see Glossary). Three custody suites had designated rooms for children's care, but all were only partly refurbished, one was very small, and none were used during our inspection.

4.12 Youth offending team (YOT) workers engaged well with court staff and supported children appropriately, including during release. However, about a third of children remanded in custody waited over three hours for onward transport, and a shortage of secure placements in the London area meant that some also had very long journeys to and from court.

Health

4.13 Oversight of health care was sound. Stakeholder meeting minutes showed providers were held accountable, clinical incidents were reported and contract breaches explored. Plans to improve detainee care were also considered.

4.14 Health provision had improved since our last inspections, including ready access to an automated external defibrillator (AED) and simple pain relief, and custody managers now carried naloxone (a drug to manage substance misuse overdose) to allow immediate response to opiate overdoses.

4.15 Detainees received more responsive medical support, reducing clinical risk. Telephone advice was accessible and backed by prompt paramedic visits, including treatment for alcohol withdrawal. Staff induction, training and competency frameworks assured that health care professionals were well-equipped to meet detainee needs.

4.16 Health information was not always complete on dPERs, which created risk (see paragraph 3.8). While staff felt confident handling urgent issues, emergency resuscitation refresher training was only every three years, which was insufficient. Other health training, such as in mental health and substance misuse, was mostly limited to managers.

4.17 Medicines were generally stored securely and protocols ensured that essential medication could be administered. However, Aeromed (the health provider) could not access the national SystmOne clinical IT system, preventing checks on live prescriptions, which could have mitigated risk. There were no arrangements for detainees experiencing nicotine withdrawal.

4.18 Mental health support was available in all locations, often through embedded liaison and diversion practitioners. Support was mostly good, and relationships between custody staff and mental health professionals were positive. Increasingly, detainees were remanded to custody pending Mental Health Act assessments, leading to prolonged, inappropriate custody rather than diversion. A shortage of mental health beds and pathways meant some very unwell detainees were sent to prison instead of receiving proper care.

4.19 Support for detainees with drug or alcohol problems was inconsistent. Some locations offered strong help, but most only signposted them to community services.

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 Progress on previous concerns was poor, and release arrangements remained weak.

5.2 Staff sometimes locked detainees back into cells while they waited to be released, which was inappropriate. Pre-release risk assessments varied in quality and sometimes missed immediate concerns. Most courts provided local support leaflets, but we were not assured that homeless detainees always received adequate help, which was a missed opportunity.

5.3 Detainees were rarely given sufficient means to get them all the way home. Travel warrants were given out readily but could not be used on buses, and the nearest train stations were not always staffed to allow them to be exchanged for tickets. Only a minority of custody facilities provided cash for bus fares, but this was no longer suitable as London buses did not accept cash. Some detainees did not know the local area around the court and staff often failed to give directions to the train station. Taxis were arranged for the most vulnerable people, but these often took a long time to arrive.

5.4 Many detainees waited a long time in custody before transfer to prison or another setting, extending their stay unnecessarily (see paragraph 3.10).

5.5 Data indicated that the average release time for detainees who originated from prison was just over two hours, but some waited much longer for a prison governor or manager to authorise release (see Glossary). During the inspection, one detainee waited almost six hours, which was an excessive deprivation of liberty.

Section 6 Progress on concerns and recommendations from previous reports

The following is a list of the concerns and recommendations raised in previous reports from London court custody inspections.

London North and North East – 5 to 14 September 2016

Main recommendations

HMCTS, PECS and the escort and custody contractor should investigate the reasons for the prolonged periods that detainees, including children, spend in court custody cells. Measures should be put in place to ensure detainees have their cases prioritised where possible and are transferred and released without delay.
Not achieved

There should be a comprehensive review of custody operations to address some of the failures identified during the inspection. All custody procedures should be monitored to ensure that they are understood, consistently implemented and adhered to. Management and oversight of the custody suites should be improved to ensure the safe detention of detainees.
Partially achieved

Staff should complete a standard risk assessment for each detainee and receive training to do this. Cell-sharing risk assessments should be completed for all detainees before sharing takes place.
Achieved

Use of force records should describe the techniques used in all use of force incidents. Only approved techniques should be used. Handcuffs should only be used if justified and proportionate.
Not achieved

Outstanding repairs across the court custody suites should be completed as a matter of urgency. All offensive graffiti should be removed immediately. The current cleaning regime should be significantly improved to ensure that all cells, toilets and communal areas are cleaned each day to an acceptable standard.
Not achieved

Recommendations

Leadership, strategy and planning

Serco should escalate all relevant cleaning, maintenance and contractual issues concerning the care of detainees with HMCTS or PECS.
Achieved

The use of prison video link should be increased for eligible cases.
No longer relevant

There should be a safeguarding policy and all staff should be made aware of safeguarding procedures for children and adults at risk.
Achieved

Individual rights

Detainees whose case is listed for the afternoon should not be placed in court custody in the morning.
Not achieved

HMCTS should investigate the siting of suitable private interview rooms outside the secure cell corridors at Highbury Corner Magistrates' Court.
Not achieved

Telephone interpreting services should be used as necessary to check on the welfare, risk management and understanding of foreign national detainees.
Partially achieved

All detainees should be informed of the complaints process.
Not achieved

Treatment and conditions

Cellular vehicles should be free of graffiti and men and women and children should be transported in separate escort vehicles.
Partially achieved

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

Detainees' property should be securely stored.
Achieved

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

Disposable water bottles should not be reused to store and serve water.
No longer relevant

All custody staff should receive a comprehensive briefing at the start of duty focused on risk management and the care of vulnerable detainees.
Partially achieved

Set levels of observation should always be adhered to and accurately recorded.
Partially achieved

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

Pre-release risk arrangements should be improved. Custody staff should check if detainees have any immediate needs or concerns that should be addressed before they leave custody.
Partially achieved

Staff should provide detainees with information about local support organisations.
Achieved

Custody staff should be appropriately trained in: emergency response skills, including the use of automated external defibrillators, with annual refresher training; mental health awareness; and drugs and alcohol awareness.
Partially achieved

First aid equipment in custody areas should include sufficient up-to-date kit, including basic equipment to maintain an airway and automated external defibrillators.
Partially achieved

Person escort records should identify the detainee's health risks while maintaining appropriate confidentiality. All inadequately completed PERs should be fully completed and captured on the incident reporting system and the information should be formally escalated to the sending establishment.
Partially achieved

London North, North East and West – 29 May to 6 June 2017

Main recommendations

Adequate staff should always be deployed in court custody to ensure that all necessary duties can be undertaken and that detainees are looked after and kept safe at all times.
Partially achieved

HMCTS, PECS and the escort and custody contractor should investigate the reasons for prolonged periods that detainees, including children, spend in court custody cells. Measures should be put in place to ensure detainees have their cases prioritised where possible and are transferred and released without delay.
Not achieved

Measures to identify and manage detainees' risks should be applied consistently. Staff should complete a standard risk assessment for each detainee. Cell-sharing risk assessments should be completed for all detainees before they share a cell. Set levels of observation should be adhered to.
Achieved

Release planning and arrangements should be improved to ensure all detainees, particularly the most vulnerable, are able to get home safely.
Partially achieved

Handcuffs should only be used if justified and proportionate.
Not achieved

The court custody environment should be improved. Outstanding repairs across the court custody suites should be completed as a matter of urgency. All offensive graffiti should be removed immediately. The current cleaning regime should be significantly improved to ensure that all cells, toilets and communal areas are cleaned every day to an acceptable standard.
Not achieved

Recommendations

Leadership, strategy and planning

There should be an HMCTS safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and adults at risk.
Achieved

Conditions, including the environment, provision of activities and support offered on release, should be improved for detainees held in the IACs [immigration asylum chambers].
Not applicable

Individual rights

All detainees should be informed of their rights while in court custody in a language and format they understand.
Partially achieved

HMCTS should ensure all interview rooms are in an appropriate location and are soundproofed to ensure confidentiality.
Achieved

Telephone interpreting services should be used as necessary to check on the welfare of foreign national detainees and to ensure their risks are appropriately managed and they understand what is happening to them.
Partially achieved

All detainees should be informed of the complaints process.
Not achieved

Treatment and conditions

Cellular vehicles should be free of graffiti and men, women and children should be transported in separate escort vehicles.
Partially achieved

Suitable arrangements should be in place at all court custody facilities to ensure that the needs of detainees with disabilities can be met.
Not achieved

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

Kitchen areas within court custody should all be clean and properly maintained.
Partially achieved

Disposable water bottles should not be reused to store or serve water.
Not achieved

All custody staff should receive a comprehensive briefing at the start of duty focusing on risk management and the care of vulnerable detainees.
Partially achieved

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

Custody staff should receive annual first aid refresher training to maintain their skills. They should have access to regularly checked equipment, including an AED [automated external defibrillator].
Partially achieved

PERs should identify detainees' health risks, while maintaining appropriate confidentiality. All inadequately completed PERs should be completed in full and captured on the incident reporting system. The information should be formally escalated to the sending prison or police force. [PERs are now dPERS, see Glossary.]
Partially achieved

Detainees should have prompt access to mental health services, including assessments and transfers to health facilities.
Achieved

Custody staff should have regular mental health and substance misuse awareness training.
Not achieved

London Central and South – 28 July to 13 August 2021

Key concerns and recommendations

Key concern: 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.
Partially achieved

Key concern: 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.
Partially achieved

Key concern: 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.
Not achieved

Key concern: 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.
Partially achieved

Key concern: 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.
Not achieved

Key concern: 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.
Not achieved

Key concern: 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.
Not achieved

Key concern: 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.
Partially achieved

Key concern: 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.
Partially achieved

Recommendations

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

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.
Not achieved

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

The facilities for detainees with disabilities or impaired mobility should be improved.
Not achieved

There should be easy-read versions of key documents such as the detainee rights leaflet.
Not achieved

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

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.
Partially achieved

Detainees should be given comprehensive and accurate information about the complaints process in their own language.
Not achieved

Handcuffs should only be used when justified by an individual risk assessment and for no longer than is strictly necessary.
Not achieved

The range of food in custody suites should be improved and foodstuffs should be properly stored at all times.
Not achieved

Detainees should be offered reading materials in a range of common languages and accessible formats.
Not achieved

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

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

Custody staff should attend an annual first aid refresher session and mental health awareness training.
Not achieved

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

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.
Achieved

Staff should conduct good quality pre-release risk assessments in the presence of the detainee and in private.
Partially 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 Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk), 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 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
Jeanette Hall	Inspector
Natalie Heeks	Inspector
Angela Johnson	Inspector
Fiona Shearlaw	Inspector
Stephen Eley	Health and social care 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 (dPER)
The PER is the key document for making sure that information about the risks 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 electronic form agreed with and used by all agencies involved in the movement of detained people.

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 in minimising and managing physical restraint (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 from court custody detainees who have originated from a prison if directed by the court. The process involves checking that there are no other reasons that the detainee should be returned to prison, and providing any licence conditions applicable to them on release.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

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