Report on an inspection visit
to custody facilities in

Crown Courts, Royal Courts of Justice and immigration and asylum chambers in London

by HM Chief Inspector of Prisons

1–12 June 2026

Contents

Introduction

This report presents findings from our recent inspection of custody facilities in Crown Courts, the Royal Courts of Justice and immigration and asylum chambers in London. The challenges faced in delivering court business while prioritising detainee care, in some of the busiest Crown Courts in England and Wales, cannot be underestimated. It was therefore encouraging to see some positive aspects of this work during the inspection, with some clear improvements since earlier visits. More than three-quarters of our previous concerns were either fully or partially achieved.

Progress was, however, undermined by several significant and persistent weaknesses. Of gravest concern was the continued lack of attention to, and investment in, maintenance and cleaning of custody facilities, which resulted in many detainees being held in poor conditions, including dirty, graffitied cells. Delays across important areas also persisted: detainees often arrived late from prison, many spent longer in custody than necessary, and many had an excessive wait for transfer following conclusion of their cases. A more recent issue meant vetting of Serco staff took far too long. Things were so poor that I took the unusual step of writing to the Minister responsible for courts, the head of the prison service and the head of HMCTS, setting out my concerns.

The children we came across were routinely locked into cells, despite being accompanied by specially trained staff. We also found that agencies did not prioritise checks to make sure detainees were suitable for release, resulting in excessive delays that unnecessarily deprived people of their liberty. It was also concerning that, once released, detainees were rarely given sufficient means to travel all the way home.

There were, however, many positive features. Multi-agency working was cohesive and staffing in custody was generally sufficient. Officers demonstrated a consistent commitment to treating detainees with respect and compassion. Custody staff understood and responded appropriately to individual needs and managed risk and vulnerability well. Detainees were overwhelmingly positive about the care they received. The quality of food had improved, and detainees had more access to distraction materials. There was a good focus on de-escalation, which had undoubtedly led to the very infrequent use of force. The health care provision continued to improve.

We hope this report will help the responsible agencies to build on their successes and further improve the service they provide.

Charlie Taylor
HM Chief Inspector of Prisons
June 2026

What needs to improve in Crown Courts, Royal Courts of Justice and immigration and asylum chambers in London court custody

We last inspected Crown Court custody in London in 2016, 2017 and 2021 and raised 74 recommendations or 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 reasonably good progress and 56 of the 74 concerns or recommendations had been fully or partially addressed, including 13 of the main recommendations and key concerns; those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers. Sixteen concerns and recommendations had not been addressed, and two were no longer relevant.

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

Priority concerns

During this inspection we identified three priority concerns.

1. **Detainees were often delivered late to court, which impacted on court start times and limited or delayed access to legal advisers.**

2. **Leaders in HMCTS had failed to make sure custody facilities were in a decent state.** Many cells were in a very poor state, with ingrained dirt on the floors and offensive graffiti on the walls. Toilet facilities often lacked seats, hot water and dispensers for toilet paper and paper towels. Wooden benches were uncomfortable for lengthy stays.

3. **Children were locked in cells far too often without good reason.**

Key concerns

We identified a further six key concerns.

4. **Leaders across the main agencies were doing too little to address the factors that led to some detainees being held in court custody for longer than necessary.**

5. **Oversight of the use of force was not robust enough.** Body-worn video cameras were under-used, limiting leaders' ability to make sure all force was justified and proportionate.

6. **Safeguarding investigations took too long to complete**. In the sample we saw, the children involved were not always spoken to.

7. **Detainees did not have access to nicotine replacement products.**

8. **Custody staff did not train frequently enough in emergency resuscitation skills to maintain competence.**

9. **On release, detainees were not always given sufficient means to get all the way home.**

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.

About court custody in London

Data supplied by HMCTS and the Custody and Escort Provider

HMCTS cluster
London Crown Courts, Royal Courts of Justice (RCJ)
and immigration and asylum chambers (IACs)

Head of Operations
Grant Morris (Crown Courts)
Michelle Penn (RCJ)
Finola Hayes (IACs)

Geographical area
London

Court custody suites and cell capacity

Central Criminal Court	46 cells
Croydon Crown Court	13 cells
Harrow Crown Court	13 cells
Inner London Crown Court	26 cells
Isleworth Crown Court	21 cells
Kingston-upon-Thames Crown Court	19 cells
Snaresbrook Crown Court	11 cells
Snaresbrook Crown Court Annex	11 cells
Southwark Crown Court	22 cells
Wood Green Crown Court	14 cells
Woolwich Crown Court	22 cells
RCJ	10 cells

Immigration and asylum chambers holding rooms

Field House Immigration and Asylum Chamber	2 cells
Harmondsworth Immigration and Asylum Chamber	One holding room
Hatton Cross Immigration and Asylum Chamber	One holding room
Taylor House Immigration and Asylum Chamber	One holding room

Annual custody throughput

1 April 2025 to 31 March 2026	29,361 detainees (courts) 1,169 detainees (IACs)

Custody and escort provider
Serco (courts)
Mitie Care & Custody (IACs)

Custody staffing (courts)
4 area operations managers
9 court custody managers
14 deputy court custody managers
238.6 full-time equivalent prisoner custody officers

Custody staffing (IACs)
No permanent staff

Section 1 Leadership and multi-agency relationships

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

1.1 The challenge of managing court business while prioritising detainee care in some of the busiest Crown Courts in England and Wales is substantial and should not be underestimated. It was therefore encouraging that we found areas where outcomes for detainees were positive. We found progress following our earlier visits, with more than three-quarters of previous concerns being fully or partially addressed.

1.2 Agencies worked cohesively and collaboratively to try to deliver court business effectively. Delays in vetting adversely affected Serco staffing levels, although Serco leaders appeared to prioritise court custody staffing, which was broadly sufficient to deliver appropriate care for detainees.

1.3 Leaders collated and regularly discussed data, both to monitor Serco against delivery of its contractual requirements and to drive improvements. Where data caused concern, such as around delays delivering detainees to court, it was used to better understand the issues and take action to address them, although not always successfully.

1.4 Our most significant concern was the poor state of custody facilities (see paragraph 4.1), particularly cells, many of which remained unclean and poorly maintained. Oversight was ineffective and failed to ensure consistent standards. Staff had become inured to the awful condition of many facilities. Some category A cells managed by HMPPS, notably at the Central Criminal Court, were in a particularly poor state.

1.5 Conditions and provision for detainees held in the four IACs had improved. Although two of these were not often used, the number of cases heard at Hatton Cross and Harmondsworth was increasing. Mitie Care & Custody staff provided care across all sites and detainees were well looked after. Release processes were now given more careful attention.

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 Detainees often arrived late to court custody, which delayed or limited access to legal advisers and sometimes affected court start times (see paragraph 1.3). Staff said delays commonly occurred at discharging prisons and along circuitous routes where vehicles stopped to drop detainees off at multiple courts. Although some detainees travelled from outside the area, most made relatively short journeys in reasonably clean, properly equipped vehicles.

2.2 Most sites provided secure vehicle parking, although some could not accommodate larger cellular vehicles. Some detainees therefore alighted in public view, although staff took reasonable steps to protect their privacy and dignity. Detainees generally alighted promptly, although they sometimes had to wait up to an hour when multiple vehicles arrived simultaneously.

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 treated detainees politely and respectfully. The interactions we saw were professional and compassionate. Many detainees attending ongoing trials were well known to staff, who understood their needs and addressed them.

3.2 In many courts, staff compromised detainees' privacy by carrying out initial risk-focused questioning in busy areas where others could overhear. This potentially discouraged detainees from sharing sensitive information that staff needed to know to care for them appropriately.

Meeting individual and diverse needs

3.3 Two courts provided designated custody facilities for detainees with physical disabilities. Both had adapted cells, toilets and legal visit rooms. Access to custody suites and courtrooms was good. The designated cells had wider doors for wheelchair access; however, the hard, uncomfortable benches remained the only available seating.

3.4 Staff rarely used telephone interpreting services, but mitigated this by using court-appointed translators and multilingual staff. Custody staff generally made sure that detainees who spoke little or no English had their rights explained to them in their first language. They could also provide written rights in multiple languages.

3.5 Female staff worked at all sites and generally supervised women in custody. All courts stocked sanitary products, but these were not always readily available and the range was sometimes limited.

3.6 Staff provided religious items promptly on request, stored them respectfully, and demonstrated a good understanding of different religious needs. Many detainees retained their own religious books and other items.

3.7 Custody staff generally understood how to support neurodiverse detainees, and most locations now offered a wider range of distraction materials, including stress relievers. Staff understood reasonably well how to support transgender detainees by addressing, searching and supporting them appropriately in line with their acquired gender.

Risk assessments

3.8 Staff identified and managed risk reasonably well. Arrangements for detainees arriving off-bail (see Glossary) were thorough. Escort staff shared relevant risk information, but some digital person escort records (dPERs, see Glossary) lacked detail.

3.9 Most custody staff were adequately briefed on risks posed by those in their care. They remained alert and responded well to detainees' vulnerabilities and changes in mood and demeanour over time. Appropriate observation levels were set and generally completed as required.

3.10 Detainees rarely needed to share cells. The required risk assessments were usually completed appropriately when needed. Routes to court were safe, and there were sufficient working affray alarms. Cell call bells were audible and usually responded to promptly.

Individual legal rights

3.11 Information on detainees' rights was available in cells, although it was sometimes in poor condition. However, rights were rarely explained to detainees, particularly those who did not read or write well or were new to custody in a Crown Court.

3.12 Staff managed legal consultations appropriately, supervised them discreetly, and avoided unnecessary delays when detainees were called to attend court.

3.13 Hearings for detainees who arrived late (see paragraph 2.1) were sometimes postponed, which was a wasted journey to court. We were also concerned that some detainees continued to spend longer in court custody than necessary. Detainees were often brought to court in the morning for hearings scheduled for the afternoon. After hearings, many detainees waited a long time for transfer to prison. Some detainees who arrived from prison and were released by the court remained in custody for excessive periods while awaiting a governor's authority to release (see Glossary) (see paragraph 5.4).

Complaints

3.14 Complaints about detainees' treatment and conditions in custody were rare, and when received were managed appropriately. Information about the complaints procedure was readily available to detainees but not always clearly explained.

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.

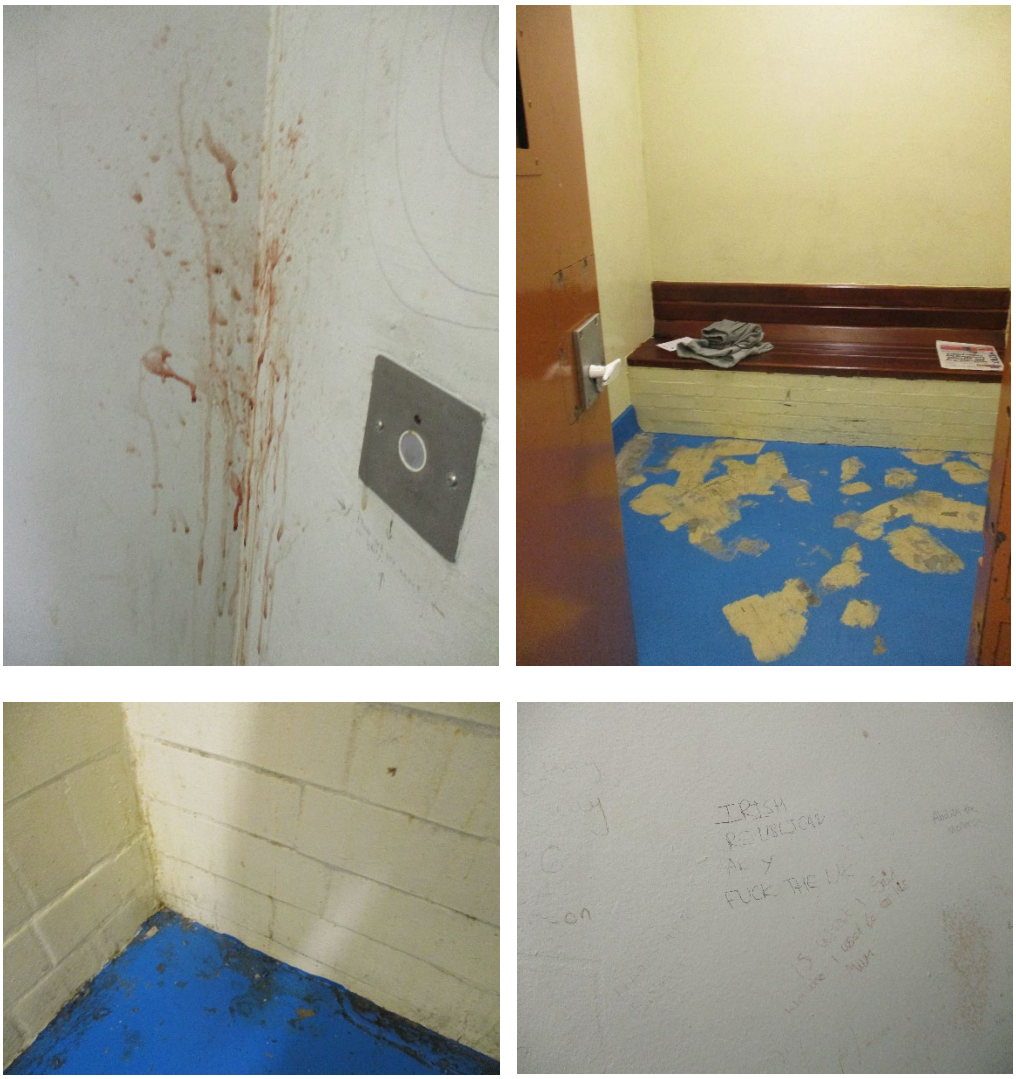
Physical environment

4.1 Too many custody facilities were in poor condition, despite advance notice of the inspection. The custody estate varied considerably but many facilities suffered from inadequate oversight (see paragraph 1.4).

4.2 Many cells were substandard. Staff had become inured to the poor conditions and accepted low standards. Cleaning arrangements were ineffective, and left ingrained dirt, stained walls, debris, and widespread graffiti, including offensive and gang-related material. Inspectors also identified potential ligature points in some facilities. All cells continued to have only uncomfortable wooden benches for seating, which were unsuitable for long stays.

Ingrained dirt at Snaresbrook Crown Court (left) and Southwark Crown Court (right)

4.3 HMPPS managed designated facilities for category A prisoners in a small number of courts. Cleaning and maintenance arrangements were either non-existent or ineffective. Conditions were especially poor at the Central Criminal Court, where most cells were filthy and covered in graffiti.



Damage to cells in Central Criminal Court. Clockwise from top left: stains on walls; damage to floor in a cell; graffiti; ingrained dirt.

4.4 Toilets were often unpleasant, malodorous, and in poor condition. They sometimes lacked privacy, though staff mitigated this through discreet supervision. Many toilets lacked seats, hot water and hygienic dispensers for toilet paper and paper towels.

Toilets at Wood Green Crown Court (top), Snaresbrook Crown Court (bottom left) and cells for category A prisoners at Woolwich Crown Court (bottom right)

4.5 We provided HMCTS with a report detailing our findings and this was responded to comprehensively, with a commitment to improving the environments in custody facilities.

4.6 Staff understood emergency evacuation procedures and practised them regularly.

Use of force

4.7 Staff were properly focused on de-escalation and used force infrequently and as a last resort, including with children. Fewer than 0.003% of detainees experienced force in the last year.

4.8 Handcuffing and searching were now more proportionate. However, individual risk assessments were rarely carried out when handcuffs were used when alighting from vehicles or moving around the custody facility.

4.9 It was positive that body-worn cameras had been introduced. However, limited availability and inconsistent use reduced their effectiveness; some staff failed to activate them promptly or at all when required. While much force was low level, our reviews of incidents found a lack of control and poor techniques, sometimes exacerbated by limited direction from managers. Post-incident paperwork often lacked sufficient detail to justify the use of force.

4.10 There was some oversight of use of force incidents, but it was not robust enough and was not resulting in sustained change to address identified weaknesses.

Detainee care

4.11 Detainees overwhelmingly told inspectors that custody staff treated and cared for them well. The range and quality of food had improved significantly. Detainees were offered snacks such as fruit pots, crisps and biscuits, along with a good range of microwave meals, pot noodles and soup at all courts. The introduction of sandwiches was popular with detainees but these were not yet available everywhere. The range of drinks had also increased, and they were routinely offered on arrival and at mealtimes, and throughout the day on request.

4.12 The range of distraction materials had improved to include a range of fidget items, stress-relievers and games, but it was disappointing that these were not yet readily offered to detainees. Other items, such as books, newspapers and printed puzzles, were provided more often. Some custody facilities had chalkboards in cells, but many were heavily graffitied and staff rarely offered chalk.

Safeguarding

4.13 Safeguarding was clearly promoted and custody staff knew how to contact the dedicated safeguarding team for support when needed. Inspectors were given some good examples of when custody staff had identified concerns, and appropriately supported vulnerable adults in court and after release.

4.14 Safeguarding was discussed at several meetings and was given appropriate emphasis. The experienced, dedicated team provided reasonable oversight.

4.15 Only two safeguarding cases were referred to the local authority in the last year; both involved children. Investigations were thorough but took too long to complete and did not always include the child's voice.

Children

4.16 Some children travelled long distances to attend hearings, which meant very early starts for them. They often arrived late, which left them little time to prepare for court or engage with legal representatives.

4.17 Children always travelled in appropriate vehicles, with specially trained staff, and were not escorted with adults. On arrival, children were prioritised and there were few delays in returning them to custody when their cases were complete.

4.18 At some, particularly busier, courts, children were routinely locked in cells, which was inappropriate. While we appreciate that risks need to be managed, we were not assured that alternatives were always thoroughly explored or kept under review.

4.19 Inspectors also saw staff supervising children without cell keys, which introduced unnecessary risk and meant the supervising staff could not respond immediately to any issues or requests made.

Health

4.20 IPRS Aeromed (the contracted health care provider) set proportionate, clinically responsive standards for detainee care. Since the last inspection, they have continued to improve the support they provide. All areas now had automated external defibrillators (AEDs), and custody staff could now administer simple pain relief with approval from the health care provider. Designated staff also now carried naloxone nasal spray for opiate overdoses.

4.21 Detainees presented little acute clinical risk. Staff accurately identified most risk markers and treatment needs through dPERs (see Glossary) and used prison health and custody contacts for clarification if needed.

4.22 Risks, however, occasionally arose from new arrivals who arrived off-bail (see Glossary) or were delivered directly by the police. Staff described a responsive service that promptly dispatched paramedic support, including for alcohol withdrawal.

4.23 Governance and oversight were robust. IPRS Aeromed delivered well-structured induction and training to build practitioners' capability. Custody staff felt able to respond to medical emergencies. However, first aid refresher training occurred only every three years, which was insufficient to maintain competence and confidence, particularly in emergency resuscitation skills.

4.24 Medicines were secured and fridges were used appropriately for insulin. IPRS Aeromed clinicians authorised routine prescribed medicines so that detainees received essential treatment in custody.

Detainees had no access to nicotine replacement products, which caused unnecessary distress, particularly during long and potentially stressful trials.

4.25 Mental health liaison and diversion practitioners were based at all sites. They mainly supported court proceedings. While they also responded to queries from custody staff and requests from detainees, this was ad hoc and custody staff told us support was not always readily available when needed.

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 Detainees generally received reasonable support on being remanded or sentenced to prison, including being provided with relevant information.

5.2 Staff appropriately provided local support leaflets for those being released, which included information about issues such as homelessness. We were, however, concerned that those released were rarely given sufficient means to travel all the way home. Staff focused on returning detainees to their nearest train station, which could be a significant distance from home. The courts preferred to issue travel warrants, but these could only be used if the driver allowed it, and could not be exchanged for tickets in unstaffed underground stations. Some detainees were given cash for travel cards, but the amount provided was inconsistent and often insufficient. Positively, taxis were arranged for the most vulnerable detainees.

5.3 During the inspection, many detainees whose cases were completed waited too long in custody before transfer to prison, unnecessarily extending their stay in dirty, uncomfortable cells (see paragraph 3.13).

5.4 We recognise the need for thorough checks to make sure detainees released by the court on current cases have no outstanding matters requiring ongoing detention. However, detainees often experienced excessive waits while relevant checks were completed. We were told that delays in recording/logging case outcomes frequently prevented originating prisons from completing their checks promptly. As a result, most detainees waited a minimum of three hours for release. Data showed that some waited over five hours or were returned to prison. In too many cases, this amounted to an excessive deprivation of liberty, a concern that has persisted from previous inspections.

Section 6 Progress on concerns from the last report

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

London North and 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.
Partially 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.
Partially 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.
Partially 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.
No longer relevant

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.
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.
Partially achieved

Disposable water bottles should not be reused to store and serve water.
Achieved

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.
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.
Not 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.
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.
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**.**
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.
Partially 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.
Partially 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.
Partially achieved

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.
Achieved

Suitable arrangements should be in place at all court custody facilities to ensure that the needs of detainees with disabilities can be met**.**
Partially 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.
Partially achieved

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

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

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

Central and South London – 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.
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.
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.
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) 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.
Partially 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.
Achieved

Key concern: Detainees who required governor's authority for release (see Glossary) 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.
Not achieved

Recommendations

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

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

Detainees should be offered reading materials in a range of common languages and accessible formats.
Partially 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.
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
David Foot	Inspector
Fiona Shearlaw	Inspector
Steve Eley	Health inspector

Appendix II Glossary

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

Digital person escort record (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.

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.

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.

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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