Report on an inspection visit to court custody facilities in

Norfolk and Suffolk

by HM Chief Inspector of Prisons

30 September – 4 October 2013

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Victory House
6th floor
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WC2B 6EX

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Section 1. Introduction

This is the fifth report in a new series of inspections of court custody facilities carried out by HM Inspectorate of Prisons. These inspections contribute to the United Kingdom's response to its international obligation to ensure regular and independent inspection of all places of detention. The inspections look at strategy, individual rights, and treatment and conditions, including health care.

In Norfolk and Suffolk, there were eight courts currently in use with custody facilities, including two Crown Courts and six magistrates' courts. Serco Wincanton had been contracted to provide the custody and escort operations for the HM Courts and Tribunal Service (HMCTS) in the region. Relationships between HMCTS and the contractor were positive, but as in other regions we have inspected, there was uncertainty about the extent and nature of the HMCTS role in relation to the provision of custody facilities. There were few formal channels through which problems concerning the care of detainees in court custody could be resolved.

Issues raised by HMCTS staff and the lay observers had been addressed but not fully resolved. These included the failure of the HMCTS language interpretation provision to supply a suitable service on every occasion. It appeared this had led to the court having to remand detainees in custody because they could not ascertain if the detainee understood or consented to bail conditions. The seriousness of the issue was compounded by the lack of a telephone interpretation service, in the custody suite itself. There was evidence that those detained with little English did not know what was happening to them.

HMCTS staff told us of their concern over low staffing levels in court custody and during the inspection, we observed a shortage of staff at some courts. The contractor had only very recently initiated a recruitment drive to correct the position. It was not clear why this issue had not been resolved earlier through the Prisoner Escort and Contract Services (PECS) contract compliance process. The contractor attempted to manage the situation by moving custody staff from one court to another, but on at least one occasion during the inspection a court custody suite was left without proper supervision while custody officers travelled to it from a neighbouring court.

At most courts, cleanliness was better than we have observed elsewhere, though at two courts physical conditions were poor, with dirty floors and toilets, and much graffiti. At some courts, the temperature of the cells was unsatisfactory and there were no blankets or warm clothes that might have helped mitigate this shortcoming. Some cells were very small, with benches too short for detainees to be able to lie down despite them spending, in some instances, more than eight hours in them.

Custody staff treated detainees courteously and we observed some examples of very good detainee care. For example, custody staff proactively contacted the mental health in-reach service on behalf of detainees who were vulnerable to self-harm. Detainees were positive about the staff and told us they felt well looked-after. However, staff lacked training: they did not know about local safeguarding procedures and they had received no training in looking after young people. They did not properly inform detainees of their rights and entitlements in court custody and they had not been briefed about the particular needs of detainees who were members of minority groups. While custody staff strove to provide a good level of care to vulnerable detainees, they struggled to maintain the mandatory regime of checking every detainee at least once every ten minutes, and recording it. That undermined their capacity to provide an enhanced level of care for the most vulnerable detainees.

In Norfolk and Suffolk courts, standards of detainee care were hampered by shortages of staff, the limitations of the physical environment in some of the courts, and the lack of robust multi-agency forums in which difficulties in court custody could be discussed and resolved. HMCTS and PECS need to clarify their respective responsibilities towards detainees in court custody, and exercise more scrutiny so that concerns are identified and resolved with greater determination and accountability.

Nick Hardwick November 2013
HM Chief Inspector of Prisons

Section 2. Background and key findings

2.1 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.

2.2 The inspections of court custody look at strategy, individual rights, and treatment and conditions, including health care. They are informed by a set of *Expectations for Court Custody*[1] about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.

2.3 Norfolk and Suffolk court custody suites comprised:

Custody suites	**Number of cells**
King's Lynn Magistrates	**5**
Norwich Magistrates	**13**
Norwich Crown	**8**
Ipswich Magistrates	**8**
Ipswich Crown	**9**
Bury St Edmunds Magistrates	**4**
Lowestoft Magistrates	**7**
Great Yarmouth Magistrates	**10**

Leadership, strategy and planning

2.4 Court user groups were the main vehicle for inter-agency work, but at some courts they had not met in the previous six months. Senior court custody officers were in regular contact with HM Courts and Tribunals Service (HMCTS) court delivery managers, and relationships were positive. Nevertheless, the lack of formal structures to resolve problems meant that much-needed improvements in custody had not been achieved at some courts. We were concerned to find low staffing levels in custody - on one occasion we saw a custody officer alone for a short time during a busy period. HMCTS managers echoed our concerns. Serco Wincanton had been contracted by Prisoner Escort and Custody Services (PECS) to provide court custody and escort services and the company was undertaking a major recruitment and training programme at the time of the inspection.

[1] http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm

2.5 We found that HMCTS staff had sometimes been unable to secure the services of interpreters at court. We were told that on occasions, that had led to the court having to remand detainees in custody because they could not ascertain if the detainee understood or consented to bail conditions. This problem was compounded because the custody contractor did not provide a telephone interpreting service, and so staff could not explain to non-English speaking detainees why they were being remanded in custody or where they were being taken.

2.6 The courts had access to video links to prisons, but we were not assured they were fully used. In some cases detainees were brought to court for a few moments' appearance, sometimes for minor matters, when proceedings could have taken place remotely instead.

Individual rights

2.7 We noted several examples of detainees spending long periods in court cells, and we saw one detainee kept in a cell for eight hours for a 10-minute court hearing.

2.8 There were good liaison arrangements with local youth offending teams (YOTs), although we were told that custody staff could sometimes not get a YOT officer on a Saturday when one should have been on call. Staff were critical of the Youth Justice Board (YJB) placement service, which authorised the move of young people to more appropriate custodial facilities. They claimed it was slow to arrange the transfer of young people, who could wait several hours for the YJB to send the placement order to the GEOAmey control centre. [2]

2.9 Custody staff carefully checked the accuracy of incoming and outgoing warrants to establish that detention was lawful. There were no unreasonable delays in receiving warrants from court staff so that detainees could be transferred to prison. Practice when court enforcement officers brought detainees to court for matters such as fine default varied between courts. At some they were allowed to wait in the court instead of being placed in custody unnecessarily, but this did not happen at every court.

2.10 Few custody staff offered detainees suitable information about their rights and entitlements in court custody, and there was little attempt to inform them about how to make complaints.

Treatment and conditions

2.11 Most but not all cellular vehicles were clean. Staff acknowledged that men and women were carried on the same vehicles without the use of a partition, and we had concerns about some unnecessarily long journeys. For example, a detainee arrested in London on a warrant relating to a traffic offence was brought on a three-hour journey to Norwich for a five-minute hearing.

2.12 Sensitive information about detainees was not always properly managed. At some courts, confidential information could be seen when it should not have been, as prison files arriving

[2] A placement order specifies the establishment where the young person will be remanded or held during a custodial sentence. The YJB selects the establishment and sends a placement order to the contractor, who collects the young person from court to take them there.

with detainees were not always sealed in plastic bags; we saw court custody staff looking through them, which was not appropriate.

2.13 Staff interactions with detainees were courteous, and detainees told us they felt well looked after. While most courts had secure private van docks, at two courts, detainees had to enter and leave cellular vehicles in the street. There was no systematic needs assessment on arrival, although a good cell sharing risk assessment pro forma was used.

2.14 Staff were not trained in how to care for young people and no named member of staff was allocated to their care. Staff were unaware of local authority safeguarding procedures for young people and potentially vulnerable adults.

2.15 There were no cushions, blankets or other provision in the cells for pregnant women or elderly detainees, who might have to spend many hours on hard benches, sometimes in cells that were too small for them to lie down in. Facilities for detainees to undertake religious observance were unsatisfactory. Religious books were rarely held in any suite, but could be obtained from the court, and there were no appropriate Muslim prayer mats.

2.16 Staff kept a small supply of reading materials, which they offered actively. These were mostly old newspapers and magazines, and there was no reading material in foreign languages at any court.

2.17 All detainees were offered drinks on arrival. Ambient microwave meals were available at all courts at lunch time, and for detainees still in court custody late in the afternoon. However, they were of low calorific value and would not be sufficient for detainees involved in a trial lasting more than one day who might miss their evening meal on return to prison. Some detainees, and many staff, told us of their concerns about the size of the food portions and their quality.

2.18 There was a good 'what happens next' leaflet in a range of languages for those going to prison. There was an excellent information booklet from HMP Peterborough at some, but not all, courts.

2.19 The Serco Wincanton computer system prompted staff to check detainees at the required intervals, but these were so frequent that staff struggled to keep up with the cell check regime, particularly at busy times. At some courts, one custody officer would check each detainee while another recorded on the computer that the check had been made. At one court, if the officer making cell checks voiced no concerns, his or her colleague operating the computer assumed that all was well, which is unacceptable.

2.20 There was a good level of care for detainees at risk of self-harm and subject to assessment, care in custody and teamwork (ACCT) case management procedures, and we saw the mental health in-reach team coming to the cells to help two detainees who were at risk of self-harm. Suicide and self-harm warning forms were opened when necessary, but there was no help for vulnerable people being released and no leaflets about support services. Anti-ligature knives were not carried by staff undertaking cell checks but were kept in first aid boxes, which could delay a response in an emergency.

2.21 Staff were able to employ de-escalation techniques, and on the rare occasions that force was used it was well recorded. Searches were undertaken respectfully but not all searches of arrivals were thorough. The routine handcuffing of detainees within secure areas was disproportionate to the risks. At some courts, staff occasionally had to take detainees to the dock through public areas in handcuffs, which was unacceptable.

2.22 Most, but not all, court custody areas were reasonably clean, but there was much graffiti in the cells at Norwich magistrates' court, and Ipswich magistrates had dirty floors, brown

marks on toilet seats and toilet paper on the floor. At Bury St Edmunds magistrates' court, the male toilets were blocked and smelled of sewage. At Norwich Crown court the cells were too hot, and at Bury St Edmunds the female cells were cold; staff told us they could not control the temperature. There was no natural light in the cells at any of the courts. Some cells at Norwich Crown court were very small, but regularly held two or three detainees at busy times. We saw staff respond to cell call bells promptly. Maintenance arrangements worked well at most courts, but most staff who checked cells had little knowledge of how to identify potential ligature points. Toilets provided good privacy except at Ipswich Crown court, where opaque frosting on the window of the disabled toilet had been removed. Toilet paper was provided in the toilets, and all had soap and paper towels.

2.23 Staff were positive about the introduction of a telephone medical advice service, although they were confused about whether it offered only advice or a visiting health professional. All staff had completed first aid at work training, although some were out of date. Each area had first aid kits, but they were inadequate for the custody environment. There were no defibrillators or oxygen.

2.24 Most records we looked at had excessive confidential medical information, but did not always describe the medical risks. The lack of prescribed medication for one detainee was only noticed when he told a member of the inspection team about it. However, when health care interventions were made, staff recorded them well. Staff administered medication safely, but were not familiar with the contractor's relevant protocol. Arrangements for storing medication varied, with some kept with the person escort records (PERs) on custody office desk, which was insecure. We saw several detainees arriving from police custody without prescribed medication that they should have taken while in court custody. The courts had good access to advice on mental health and substance misuse issues, and the mental health court diversion service was effective.

Main recommendations

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

2.26 A standard risk assessment pro forma should be completed for each detainee, and staff should be trained in completing it.

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

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

2.29 There should be a programme of regular deep cleaning, graffiti should be removed and standards of daily cleaning should be improved

2.30 Interpreters should always be obtained when needed in court, and a telephone interpretation service should be available in each custody suite.

National issues

2.31 HMCTS and PECS should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody. Standards should address detainee care and risk assessment, clarify the responsibilities of each organisation for resolving problems, and enable

monitoring of complaints in court custody; and these should be included in the measurement of performance.

2.32 HMCTS should make more use of video link and `virtual court` facilities to reduce the need for detainees to be transported long distances to courts.

2.33 There should be a national body to which detainees who have complained about court custody can appeal if they are dissatisfied with the outcome of their complaint.

Section 3. Leadership, strategy and planning

Expected outcomes:
There is a strategic focus on the care and treatment of those detained, during escort and at the court, to ensure that they are safe, secure and able to participate fully in court proceedings.

3.1 An HM Courts and Tribunals Service (HMCTS) cluster manager had operational oversight of all courts in Norfolk and Suffolk. Delivery managers were assigned to the magistrates' and Crown courts in each county and their role was to maintain a closer oversight of custody provision in their courts.

3.2 Unlike in many other court areas, there had been no recent closures of courts in Norfolk and Suffolk. We were told this was due to the large geographical area covered by each court, although a Crown court at King's Lynn had been 'mothballed'.

3.3 Since 2011, Serco Wincanton had been contracted to provide the Prisoner Escort and Custody Services (PECS) escort and custody operations in the London and South East England regions, together with inter-prison transfers. Many of its senior custody officers (SCOs) and prisoner custody officers (PCOs) had been in post for several years, fulfilling their roles under different contractual arrangements with the previous contractor. The Serco Wincanton area operations manager held regular monthly meetings or audio conferences with SCOs. Director's briefings were occasionally issued, which staff were required to sign to show they had read and understood. However, a recent change in the policy on custody staff carrying anti-ligature knives had been communicated to them via email with no explanation of the rationale for such a significant change. There was no systematic consultation with HMCTS senior managers about such changes, and this did not encourage HMCTS to have any meaningful oversight of practices in their courts' cells.

3.4 SCOs and court delivery managers were in regular contact with each other and relationships were cordial, although SCOs at some courts told us that delivery managers rarely visited the custody suite whereas at other courts, the delivery manager would visit the cells each week. The Serco Wincanton area operations manager also had regular contact with the HMCTS cluster manager and the delivery managers. There was a positive 'just pick up the phone' approach, but that had not always brought about necessary improvements, such as better standards of cleaning in some custody suites. HMCTS managers told us that they could raise concerns that could not be resolved informally through the local court user group, although not all courts had a group that met regularly (see also paragraph 3.8). Delivery managers could also raise issues that related to contract compliance, although this procedure was little used and it was unclear what would happen to this information.

3.5 HMCTS managers told us they had sometimes been concerned that there were too few custody staff in some courts. They told us that delivery managers had asked to see what the PECS contract specified about staffing, but it was unclear how their concerns about custody would be addressed, and by whom. We observed low numbers of custody staff on some occasions. Escort staff told us that the demands of the inter-prison transfer system often prevented the contractor from managing the situation by deploying cellular vehicle crews to short-staffed custody suites. Instead, Serco Wincanton temporarily moved PCOs from a neighbouring court to ensure sufficient staff at an understaffed custody suite. However, there were sometimes delays in PCOs arriving, and we observed a PCO who was alone for a short time in a busy custody suite while colleagues travelled there from another court. Serco Wincanton told us it was undertaking a major recruitment and training programme to appoint a further 88 PCOs across the region, and it had recently provided an additional SCO at the busiest magistrates' courts (see main recommendation 2.25).

3.6 The regional PECS contract manager told us that court custody in Norfolk and Suffolk benefited from an experienced and knowledgeable staff, and that there were few problems in delivering the custody and escort function. Serco Wincanton and the PECS contract manager met monthly to monitor contract compliance. However, the meetings were concerned more with security and timely delivery of detainees to court than about detainee care, and participants could recall few instances where detainee care had been discussed.

3.7 Custody staff attended annual refresher training in control and restraint, security and first aid. A few staff were out of date with their first aid refreshers as Serco Wincanton had prioritised security refresher training. We were shown a programme for induction training for newly appointed custody staff, but were unable to establish what training staff currently in post received, other than control and restraint, security and first aid, despite several requests for this information. Staff told us they had not been trained in working with adolescents or in mental health awareness.

3.8 Court user groups were the main channel for strategic inter-agency work. They were in place at every court, but some meetings were infrequent. Minutes from the group meetings that had taken place showed that most of the relevant agencies, including Serco Wincanton, had been represented. However, health services had attended only one group meeting (at Norwich Crown court). We were told that HMCTS managers sometimes consulted with user group members via email to avoid the need to meet, and that meetings were sometimes infrequent because participants had not put forward items for the agenda. Some staff uncertainty about issues such as the removal of handcuffs before detainees entered the dock could have been resolved in court user group meetings.

3.9 There was an active lay observer[3] organisation in the region and all courts received monthly visits. Lay observers were diligent in recording their observations after every visit, supplying a quarterly report to HMCTS and the Serco Wincanton area operations manager, who required the SCO to draw up an action plan for implementing improvements. However, there was no clear process for ensuring HMCTS managers were instrumental in resolving lay observers' concerns, even though some were beyond the control of the SCO, for example the lack of court interpreters (see paragraph 4.12).

3.10 Custody staff were insufficiently aware of safeguarding mechanisms. They told us they would always refer their concerns about vulnerable detainees to a 'responsible person', such as a solicitor, youth offending team (YOT) officer or probation officer, including concerns about the well-being of detainees being released from court. Yet we were also told of occasions when there had been no YOT or probation staff available at court. There was no HMCTS or Serco Wincanton safeguarding policy.

3.11 All courts had access to video links, but we were not assured they were fully used. Custody staff told us of cases where detainees had been brought to court for a few moments' appearance for procedural matters that could have been dealt with by video link (see main recommendation 2.32).

Recommendations

3.12 HMCTS and the PECS contractor should work together to ensure that lay observers' concerns are addressed effectively.

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[3] Independent volunteers who check that detainees escorted by private escort companies in England and Wales are treated decently.

3.13 Inter-agency forums, such as court user groups, should give court custody a higher profile in order to resolve any difficulties.

3.14 There should be clear procedures for safeguarding vulnerable detainees, including those released from court, and custody staff should be briefed about how and when to use them.

Housekeeping points

3.15 The PECS contractor should ensure that the rationales for changes in custody policy and practice are always explained to staff.

3.16 HMCTS managers should visit the cells at the courts for which they are responsible regularly so that any problems can be readily identified and resolved.

Section 4. Individual rights

Expected outcomes:
Detainees are able to obtain legal advice and representation. They can communicate with legal representatives without difficulty.

4.1 Prisoner custody officers (PCOs) at all courts checked warrants, production orders and court lists carefully to ensure that they had the necessary authority to detain.

4.2 We were informed that in some courts, where appropriate, people voluntarily surrendering at court on a warrant or brought there by court enforcement officers (usually for non-payment of fine warrants) were not always taken into court cells and could sit in the court awaiting their case. This prevented unnecessary detention in cells and the accompanying handcuffing procedures (see paragraph 5.46). It was unclear why this approach was not used in all courts in the area.

4.3 Staff at all courts described a good relationship with their local youth offending team (YOT), and instances when they had received help from the YOT when needed. All courts had procedures to ensure that YOT staff were aware of all children and young people in the court cells each day. However, we were told at both Ipswich and Norwich magistrates' courts of occasions when they were unable to locate YOT staff on a Saturday, when someone should have been available.

4.4 Custody staff at most courts told us that courts aimed to deal with cases involving young people and those on remand first, to reduce their time in custody. However, the records we reviewed showed that this was not always the case.

4.5 None of the courts had a set cut-off time, and staff said that this was flexible from day to day, with detainees sometimes accepted after 4pm. This often prevented detainees spending a night in police custody.

4.6 We read records, and observed several instances at both Ipswich and Norwich Crown court, where detainees had been transported from prison to the court early in the morning, even though their cases were not scheduled to be heard until the afternoon. As a result, they spent unnecessarily long periods in court cells. We saw one detainee who had spent eight hours 10 minutes in a small cell for a court hearing that lasted a few minutes.

4.7 Warrants of detention were received from courts in a timely manner, mostly within 30 minutes of remand or sentence, which enabled them to be checked before transport to the prison was arranged. In an attempt to prevent delays in transporting remanded or sentenced detainees, HMPs Norwich and Peterborough had agreed to receive prisoners and new detainees back into prison from all Norfolk courts without accompanying warrants, provided that court custody staff completed an interim warrant notification and forwarded the relevant warrant of detention on the next working day. This was not the case in Suffolk courts. We did not see any undue delays in prisons authorising the release of detainees once they had been released by the court, although some staff said this did occur.

4.8 Custody staff at all courts told us of delays in receiving placement orders from the Youth Justice Board (YJB), without which young people cannot be moved to more appropriate custodial facilities. At Norwich magistrates' court we were told of a case where a young person was dealt with by the court at 10.30am but was still in court custody at 3pm waiting for a placement. Such delays were unacceptable as they resulted in young people being held for too long in court cells.

4.9 Many custody staff told us that they were reluctant to contact detainees' friends or family on their behalf to inform them of their whereabouts as they could not be sure of who they were contacting. While such caution may be prudent, some detainees would not be able to ensure someone knows they are in court, particularly if they had been brought to court on a warrant. Staff told us they would notify their legal advisers and ask them to undertake this task.

4.10 We observed varying practices in informing detainees of their rights and entitlements. A rights and entitlements notice was displayed in the main booking-in area in all suites, but detainees were given no time to read it. Most but not all courts had a rights and entitlements leaflet available on request, but detainees were not asked if they were able to read or understand it, and it was produced only in English. Mostly, detainees were told 'you know your rights, don't you', and then placed in a cell, which is not acceptable.

4.11 We observed staff arranging legal visits to detainees efficiently, and several legal advisers told us that they were satisfied with the access and support the staff provided. There were sufficient consultation rooms, although the interview room at Lowestoft was off the main custody office and kitchen and conversations could easily be overheard. Detainees were allowed to keep their legal documents with them, and we observed staff provide them with a pencil and paper to prepare their defence.

4.12 There was poor provision for detainees who could not speak English. Interpreters for court processes seldom attended until later in the morning, and were rarely available to assist custody staff at key times, such as on the arrival of the detainee at the court cells. We were concerned that there were difficulties with interpreters attending court hearings, which had been noted by lay observers six months previously. For example, we observed the failure of the service to provide an interpreter for a Romanian detainee whose English was very poor and was unable to understand the process fully. We were told that on several occasions the court had been unable to grant bail because the interpreter service had failed to supply an interpreter, so the detainee could not confirm their understanding of bail conditions. In that situation a detainee would have to be remanded in custody until a date when an interpreter was available.

4.13 These difficulties were compounded because the custody staff had no access to a telephone interpreting service in the custody suites. Consequently, detainees refused bail could be taken to prison without understanding what had happened in court or where they were going. Serco Wincanton claimed that custody staff would always try to communicate with non-English speakers, but we were not convinced that, in the absence of interpreting services, detainees would sufficiently understand what was happening to them.

4.14 Information about the complaints process was displayed in all the booking-in areas. There was a little information about the complaints process in the prisoner rights' leaflet, but, as stated, this was only in English, however forms were available on request, and staff said they would help detainees to complete these if required. Serco Wincanton told us they had received only one complaint from a detainee, so there was therefore no provision for monitoring complaints and analysing trends. At the time of the inspection, there was no independent body to which detainees unsatisfied with the outcome of a complaint could appeal (see main recommendation 2.33).

Recommendations

4.15 Wherever possible, detainees whose case is listed for the afternoon should not be placed in court custody in the morning.

4.16 HMCTS should liaise with local youth offending teams to ensure that there is coverage on six days a week for young people held in court custody.

4.17 HMCTS should liaise with the Youth Justice Board to reduce delays in transferring young people to more appropriate custodial facilities.

4.18 Detainees should be told about their rights and entitlements on arrival at all courts, including the process for making a complaint, and staff should offer to read or explain the information if necessary.

4.19 Custody staff should ascertain if detainees can read.

4.20 Detainees' rights and entitlements should be available in a range of languages.

4.21 Complaints should be logged and there should be a process for monitoring and analysing any trends.

Housekeeping points

4.22 Court custody staff should ensure that detainees can inform someone of their whereabouts, and check with court staff or legal advisers that it is appropriate for this person to be contacted.

4.23 There should be a private room for legal consultations in the Lowestoft custody suite.

Good practice

4.24 *Court custody staff had reduced the time that detainees waited for transport to prison by arranging for them to be accepted into custody through an interim warrant notification pending the warrant of detention.*

Section 5. Treatment and conditions

Expected outcomes:
Escort staff are made aware of detainees' individual needs, and these needs are met during escort and on arrival. Detainees are treated with respect and their safety is protected by supportive staff who are able to meet their multiple and diverse needs. Detainees are held in a clean and appropriate environment. Detainees are given adequate notice of their transfer, and this is managed sensitively and humanely.

Respect

5.1 With the exception of a van we saw at Ipswich, which was dirty, the cellular vehicles we inspected at the courts were clean and contained first aid kits, anti-ligature knives and cartons of water. There was condensation in a cellular vehicle at Ipswich Magistrates' Court.

5.2 Several vehicles were small three-cell vehicles without the internal partitions sometimes installed to separate men and women. These vans were used regularly to transport men and women on the same journey, which was inappropriate. Staff told us that the PECS contractor always provided a separate minibus when transferring pregnant women, and that young people were always transported separately. However, we saw one van containing two male detainees aged 18 and 15.

5.3 We also saw larger vehicles with partitions, but escort staff were uncertain about the circumstances when the partitions should be used. At Norwich magistrates' court, we observed four men and a woman transported in the same six-cell vehicle with no partition. The woman was seated at the rear and disembarked first, having to walk past the men on board. All detainees were quickly disembarked from vehicles into court buildings.

5.4 Journeys from police custody to court were short, as were those from Norwich prison to Norfolk courts, but we saw some journeys to court that had been lengthy. In one case, a detainee arrested in an inner London borough for non-payment of fine warrant (traffic offence) was transported for a three-hour journey to Norwich magistrates' court for a five-minute hearing and then released to make his way back to London. Custody staff told us that it was very common for detainees to be transported in from all over the country after arrest on non-payment of fine warrants. Although we were informed that there might be legal reasons for this, it was unclear why these cases could not have been dealt with through video link (see main recommendation 2.32).

5.5 Escort staff ensured that all necessary information about detainees accompanied them. Person escort records (PERs) were mostly completed to a reasonable standard and custody staff checked them carefully to ensure all necessary information was recorded. However, a few PERs we examined were of a poor quality – for example, the PER of a detainee received from police custody failed to identify the need for an interpreter. Most PERs received from the police had loose sheets relating to the detainee's risk assessment and medical assessment. The latter should have been in a sealed envelope as it contained confidential information.

5.6 We observed that detainees arriving at court from HMPs Norwich and Peterborough were accompanied by part of their prison files, in case if they were further remanded or sentenced and returned to a different establishment. These prison files were not always securely transferred, and some escort staff carried them unbagged or bagged but not securely sealed. We saw some custody staff reading these files.

5.7 On arrival at court, detainees were mostly disembarked in a private docking area. However, at Bury St Edmunds there was no private vehicle dock, so detainees were transferred from the vehicle in the street and could be observed by the public, which was demeaning. The vehicle dock at King's Lynn could not accommodate larger cellular vehicles and detainees on such vehicles were transferred through a public area (next to a busy café).

5.8 Some courts had whiteboards with detainees' information, including their name, cell number and, at one court, the fact that the detainee had hepatitis C. This was sited in the main booking-in area, where all detainees could view it, and we observed detainees stopping to read it.

5.9 Most of the staff we met had been employed as court custody officers for a long time and were experienced and committed to their role. Custody staff were very courteous to detainees, using first names when appropriate, and we observed very good interactions with staff reassuring detainees anxious about their court appearance. Detainees told us they felt well looked after.

5.10 In general, court custody suites gave little consideration to meeting the diverse needs of detainees. There was no specific provision for children and young people in the suites and no named member of staff allocated to their care. Staff had received no specific training in caring for children and young people. Staff we spoke to were unclear about safeguarding procedures or the steps to take if a young person or other vulnerable person made an allegation or was otherwise deemed at risk. Staff were aware that there was a young person's cell-sharing risk assessment, which allowed them to consider where young people should be located in the custody suite.

5.11 No courts had any replacement clothing to offer detainees. There were no blankets and no pillows, so pregnant, elderly or disabled detainees had to wait on hard benches. Staff told us they tried to arrange for cases involving such detainees to be listed early in the day to avoid long waits, but this was not always possible. Norwich magistrates' court and Ipswich Crown court were the designated courts for disabled detainees in the area. Some custody suites had signs that a hearing loop was available in the building, but none could be located. None of the courts had information in Braille.

5.12 Female detainees were located separately but were not routinely asked if they were pregnant. All courts had feminine hygiene products available, but these were not routinely offered to female detainees, although some courts had a notice on the female corridor or in the toilet cubicle.

5.13 Detainees were not asked about religious observance, dietary requirements or any other needs. We observed a detainee at Norwich magistrates' court requesting that he be allowed to have his own Qur'an from his property, and this was handled respectfully, with the book handed over once his property had been appropriately searched in his presence. Bury St Edmunds and King's Lynn had Bibles for detainees, but no religious books were available in custody suites elsewhere, although staff were aware that they were available from the courtrooms. Small carpet samples were available for use by Muslim detainees as prayer mats, which was disrespectful. All courts had compasses to determine the direction of Mecca, although staff said they could be unreliable.

5.14 Staff were unaware of any policy on searching transgender detainees, although some correctly indicated that they would ask the detainee how they would like to be cared for. Court custody staff said that they would appreciate some guidance on this topic.

5.15 Some court custody staff had brought in old newspapers and magazines for detainees, and we saw staff actively handing these out to detainees at most courts. There was no reading

material in any foreign languages, easy-read format or, except at Bury St Edmunds, specifically suitable for young people.

5.16 All courts provided hot and cold drinks to detainees on arrival and at regular intervals. Detainees were given a choice of microwave meals at standard mealtimes, although some meals were slightly out of date. Some had a low calorific content that would not sustain detainees coming to court each day for a trial, particularly if in doing so they missed the evening meal at the prison. While some PCOs said that they were not permitted to give more than one meal to a detainee per session, others stated that they had flexibility. Most detainees we spoke to, and many staff, had concerns about the size of the meals available and their quality. Most courts indicated they would give detainees a hot microwave meal before they returned to prison in the evening if they had a lengthy journey. Food preparation areas, except for Ipswich magistrates, were clean and hygienic, but the microwave ovens at Ipswich Crown court and Norwich magistrates' court were unclean.

Recommendations

5.17 Cellular vehicles should be clean, properly ventilated, and free of graffiti.

5.18 Adult men, women and young people should not be carried in the same escort vehicle.

5.19 Detainees should be transferred from cellular vehicles to the court cells in privacy.

5.20 All staff should receive diversity training.

5.21 Young people in court custody should be supported by a named staff member trained to work with young people.

5.22 All courts should have hearing loops and Braille versions of key information for detainees.

5.23 Every court cell area should have a copy of the holy books of the main religions, a suitable prayer mat, which is respectfully stored, and a reliable means of determining the direction of Mecca.

5.24 All courts should have a stock of appropriate reading materials, including some suitable for young people and non-English speakers.

5.25 Food offered to detainees should be of adequate quality and calorific content to sustain them for the duration of their stay, and food preparation areas and equipment should be clean.

5.26 The PECS contractor should produce a policy setting out the correct approach to caring for transgender detainees and ensure that staff implement it.

Housekeeping points

5.27 Confidential information about detainees on whiteboards and in documents should be out of public view.

5.28 Serco should liaise with the Norfolk and the Suffolk constabularies to discuss the quality and transfer of information and completion of person escort records (PERs) for detainees.

5.29 Cellular vehicles should be clean and tidy.

5.30 Staff should make regular checks on the food for detainees and discard any that is out of date.

5.31 Staff should routinely inform all female detainees of the availability of feminine hygiene packs.

Safety

5.32 We observed SCOs directing morning staff briefings about detainees coming into custody to highlight any warning markers and confirm staff duties. The SCOs told us that any changes to policy or practice were passed on during these briefings, and that expectation was confirmed by Serco Wincanton. While potentially an effective way of ensuring that staff were kept informed, they did not always take place at every court.

5.33 We had concerns about staffing levels during our inspection. For example, we sometimes saw just one officer available in the custody suite as others were on escort duties elsewhere (see paragraph 3.5). In one suite staff told us, `sometimes we get caught out, with often just two here'.

5.34 There was no systematic risk assessment for detainees when they arrived in court custody (see main recommendation 2.26). Staff reviewed each detainee's documentation on arrival but did not spend any time with them to find out if there were any concerns that had not previously been identified. Where there were identified risks, staff asked detainees relevant general questions about their well-being and opened suicide and self-harm warning forms when necessary. Staff told us that if a detainee was identified as at risk of self-harm, for example if they were subject to assessment, care in custody and teamwork (ACCT) case management, they would consider allowing them to share a cell with another detainee. In this case, they completed and documented a cell sharing risk assessment for both detainees. We also saw the mental health in-reach team going to the cells to help two detainees who were at risk of self-harm.

5.35 We saw some staff make efforts to question detainees about vulnerabilities and care for them accordingly. For example, at Norwich magistrates' court, the SCO contacted the drug worker for a detainee on a daily controlled drugs prescription and likely to receive a custodial sentence and requested that they alert the prison to his medication needs, which they agreed to do.

5.36 All detainees were searched on arrival, but not always thoroughly, for example we saw one detainee at Ipswich Crown court who did not have the hood of his jacket checked. Rub-down searches were frequent in many suites, such as every time a detainee attended and returned from a legal visit or from the toilet and the courtroom, which was disproportionate.

5.37 Where possible, staff tried to place detainees in a single cell, but at busy times this was not always possible. All staff were aware of the cell sharing risk assessment form, which they completed when it was necessary for detainees to share a cell.

5.38 Staff at all courts told us that the standard level of observation for all detainees was 10-minute cell visits, with five-minute checks for those who were vulnerable. They said that such frequent checks were onerous, particularly when they were busy, though they

understood the need to ensure the safety of detainees. The Serco escort recording system (SERS) flashed up on the computer when a check was due. We observed staff struggling to keep up with the system's demands to make and record checks. When the suite was busy, staff constantly entered details of checks, legal visits and court attendance, but the system required them continuously to enter more. We believed that this resulted in cursory checks or errors.

5.39 Sometimes when there was no feedback from the PCO making the cell check, staff updating the SERS interpreted this as meaning that all was well, without the PCO verbally confirming this. For example, at one court we saw that the SERS operator had not been informed that a detainee was in court for approximately 20 minutes and only advised when the detainee was returned to the custody suite, yet the detainee had been recorded on SERS as subject to 10-minute checks, although he was not in his cell. Some staff told us that observation levels could not be downgraded or upgraded once recorded on the SERS, but other staff were able to demonstrate that these could be changed if a detainee's risk levels altered.

5.40 Staff did not carry anti-ligature knives. These were kept in sealed first-aid boxes, which could have delayed access when an urgent intervention was required.

5.41 Social or domestic visits were not facilitated, unless directed by the court.

5.42 Staff had not received any training in safeguarding children and vulnerable adults. They said they would approach staff from the YOT, probation or social services informally to seek additional support for such detainees, but their availability could not always be relied upon. At Norwich magistrates' court, we were told of a case involving a vulnerable adult on remand in prison who indicated difficulties with other detainees. As a result, court custody staff contacted his social worker, who attended and spoke with the detainee to calm him down. They submitted a security information report to make the prison aware of the situation and address it. If the social worker had not been available, it is doubtful if custody staff would have had sufficient knowledge of safeguarding to make such an effective intervention (see main recommendation 2.27).

5.43 There were no significant delays in transferring detainees from the cells to the courtroom. Routes to courts were secure, with most courts equipped with alarms in the corridors and on the stairs to the dock. Where these did not exist, personal alarms were provided to staff.

5.44 At Norwich magistrates' court we were told that detainees could sometimes be remanded or sentenced in court five, which involved conveying them through a public area in handcuffs, although the route was usually cleared beforehand. However, at Norwich Crown court detainees attending the family court were taken in handcuffs through a public area, which was not cleared.

5.45 Staff received annual refresher training in control and restraint. All use of force, other than routine handcuffing, was recorded on a form, which was sent to Serco Wincanton managers. The forms we looked at were completed thoroughly, and mainly described low levels of force to get detainees into cells. Staff at all courts said they used de-escalation techniques and resorted to force only rarely if persuasion failed. Records confirmed that force was used infrequently, and that where it was, detainees were asked if they wished to see a health care practitioner.

5.46 Detainees were routinely handcuffed when entering and leaving cellular vehicles, in cell area corridors and on the route to the courtrooms, even though they were all within the secure area of the custody suite. We were informed, and saw, that almost all detainees were handcuffed irrespective of gender, age, previous history, compliance or nature of the offence. This routine use of handcuffing was frequently unnecessary and disproportionate. However, we saw staff at Bury St Edmunds use their discretion for handcuffing detainees to the

courtroom, where the narrow staircase into the dock could have been dangerous. We also saw a detainee with walking difficulties taken to another court without handcuffs. These examples show that in reality, staff did occasionally exercise some discretion about handcuffing, and it would be better if it was recognised. There was also inconsistency about when handcuffs were removed. In magistrates' courts, detainees were taken into the dock of the court before handcuffs were removed, whereas in Crown courts they were always removed before entering the dock (see main recommendation 2.28).

5.47 If a detainee was remanded or sentenced, court custody staff ensured that risk information was passed on to the prison through a printout of the electronic PER from the SERS. They also completed an HM Prison Service personal record form and, if required, a suicide/self-harm warning form.

5.48 All courts had copies of generic 'what happens next' information on what newly remanded or sentenced detainees could expect in prison, which was available in a range of languages. Some courts had copies of a very informative booklet detailing what happens in the first 24 hours of arriving at HMP Peterborough, which was available in several languages.

5.49 None of the custody suites had any information leaflets about local support organisations for potentially vulnerable detainees. No formal pre-release risk assessment was completed for detainees being released.

5.50 All courts could supply travel warrants and cash for trains and bus fares for detainees being released, and we saw such warrants and cash provided to detainees who said they had no other means of travelling home.

Recommendations

5.51 Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits.

5.52 The outcome of cell visits should be communicated to the PCO updating SERS and records should properly reflect this.

5.53 Every court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages.

Housekeeping points

5.54 Rub-down searches in secure areas should not be routine.

5.55 Vulnerable detainees should be able to have social visits in exceptional circumstances.

Physical conditions

5.56 Staff in most courts carried out daily checks of the cells, which included checking that call bells were functioning and that no property had been left or secreted. There were also more thorough weekly health and safety inspections, with an action plan for any maintenance issues that needed to be reported and rectified. The area operations manager conducted an annual audit in line with Serco Wincanton's standard operating procedures. Staff reported

that faults were mostly rectified quickly, depending on their nature and the availability of spare parts. On one day during the inspection, the men's toilets at Bury St Edmunds were blocked and the cell block area smelled of sewage. Staff had reported this and it had been resolved on the next day that we visited. We were concerned about potential ligature points in some cells, and staff acknowledged this was not something they covered during their daily checks.

5.57 Some cells were too small for long periods of detention. At Norwich Crown court, although a larger cell was available, one detainee was kept in a cell approximately nine feet by four feet for eight hours, with a wooden bench that was too short to lie down on. Staff told us that at busy times up to three detainees had to share small cells such as this. This was unacceptable. There was no natural light in cells at any of the courts.

5.58 Many custody facilities were clean and in a good condition, although there was much graffiti on doors and wooden benches. Contract cleaners cleaned most courts in the evening. Toilet areas were private, properly equipped and clean. At Norwich Crown court we saw offensive graffiti that staff said had been there for 15 years. At Lowestoft magistrates, one cell had been out of use for many weeks as the floor was breaking up.

5.59 Norwich and Ipswich magistrates' courts were the exceptions. The Norwich custody area was dirty and required a deep clean. One cell had a brown substance sticking to the ceiling. There were large amounts of graffiti on all the benches and doors, some dating back to 1998. We were told that the custody area rarely got a thorough clean on Saturdays, despite detainees and staff using the facilities then. At Ipswich, the cells and toilets were dirty, with dirty residue on the cell floors, brown marks on toilet seats and toilet paper on the floor. There was some graffiti on bed plinths and walls. There were peeling sharp flakes of paint on the cell floors. The staff kitchen, where detainees' drinks and meals were prepared, was grubby and in need of refurbishment. The suite needed a deep clean (see main recommendation 2.29).

5.60 The court custody suite at Bury St Edmunds, although superficially clean, required further cleaning in the communal areas. Low ceilings and exposed pipes were covered in warning hazard tape, some of which had graffiti that should have been removed. Some cells were very cold, which was not satisfactory given that there were no blankets or clothing to offer detainees feeling cold. By contrast, some cells at Norwich Crown court were too hot. Staff told us they could not control the temperature in any of the custody suites.

5.61 All courts had clear fire evacuation procedures, which were clearly displayed, and with which staff were familiar. There was documentary evidence of recent fire drills.

5.62 Staff did not routinely explain the use of cell call bells to detainees, although most with whom we spoke knew what they were for. Staff responded to call bells promptly. At Ipswich magistrates, the call bells did not activate an audible alarm.

5.63 At all courts detainees were able to use a toilet in a cell corridor in privacy, other than at Ipswich Crown court where the opaque frosting has been removed from the window of the disabled toilet. Toilet paper was readily available in all toilets, as well as handwashing facilities and a good supply of soap and paper towels.

Recommendation

5.64 The court custody estate should be checked daily for ligature points and any found immediately rectified.

Housekeeping points

5.65 A suitable temperature should be maintained in all cells.

5.66 Mattresses and blankets or warm clothing should be available for detainees.

5.67 There should be a fire evacuation drill for court custody staff at Norwich magistrates' court.

5.68 Staff should explain call bells to detainees, and the call bell panel at Ipswich magistrates' court should have an audible signal.

Health care

5.69 Custody staff identified any health concerns for detainees on their arrival. Taylor-Made became Serco's medical services provider in April 2013, and provided telephone advice and a visiting health care professional if required. Staff could also contact the ambulance service in urgent situations, and response times were reported to be good. Five of the nine calls to Taylor-Made in the six months to October 2013 were medication related. Notices advising staff how to contact Taylor-Made were clearly displayed in each suite. Staff we spoke to were aware of and positive about the service, although most believed it offered telephone advice only - we spoke to one detainee who had been incorrectly advised by custody staff that it was not possible to treat his reported migraine at the suite.

5.70 All staff had completed a first aid at work qualification, although some were out of date with this, which was being addressed. Staff received updates every three years, but required annual training specific to the environment to maintain an adequate skill level. There was no automated external defibrillator (AED), oxygen or suction in any of the courts. We were told that someone from an adjacent building had attended one court with an AED when a detainee had collapsed. The first aid kit in each suite contained an anti-ligature knife and basic supplies, but the equipment was inadequate for predictable emergencies, such as heart attacks, major self-harm and scalds. Most kits had some out-of-date stock, despite weekly documented checks.

5.71 Most of the PERs we examined included excessive confidential medical information, such as medical conditions, but did not clarify their health risk. For example, one PER recorded that a detainee was on a substance misuse programme and received unnamed medication, but his risk of alcohol withdrawal fits was not specified and the medication prescribed by the prison to prevent these was not supplied, although it was due while he was at court. These issues were only identified when the detainee raised concerns about his lack of medication with the inspection team, and custody staff took appropriate action when we informed them.

5.72 In Ipswich magistrates' court, open PERs with confidential medical information were visible to all non-custodial staff, which was unacceptable. Health interventions were consistently recorded on the PERs.

5.73 Some detainees arrived from police custody or prison with medication with clear administration instructions, which staff administered and recorded on the PER at the relevant times. Staff sought advice appropriately from the sending establishment or Taylor-Made for medication concerns. Staff we spoke to understood safe drug administration, but most were unaware of the Serco drug administration policy and their practice, while safe, did not match it. Medication in some suites was stored unsecured with the PERs on the custody office desk, which risked possible loss.

5.74 Staff reported, and we observed, that detainees often arrived from police custody without medication that required administration while at court. Although they attempted to speed up court and transfer processes to enable detainees to access their medication post release or in prison, the lack of prescribed medication was unacceptable.

5.75 Heat-sensitive medication was stored in the kitchen fridge in each suite, but there was no assurance that it was stored correctly as temperatures were not recorded.

5.76 Mental health professionals from Norfolk and Suffolk Foundation Trust provided advice to the courts and access to further mental health assessment and treatments as appropriate. Staff at all suites reported very good access to telephone advice and staff visits for mental health issues, plus effective active communication from the mental health team about its patients attending court. However, this support was only available on weekdays and staff were unsure what to do at the weekend. We observed prompt attendance by a mental health nurse to a detainee at Ipswich magistrates' court following referral by custody staff. Staff at both Norwich courts were positive about the benefits of having a mental health nurse based at Norwich magistrates. Young detainees with mental health needs referred by custody staff received an initial assessment from the mental health team before they were referred to specialist services.

5.77 Custody staff we spoke to demonstrated reasonable awareness of mental health issues but said they would welcome formal mental health awareness training to identify and manage mental illness more effectively.

5.78 Staff at all suites were positive about the substance misuse services. Westminster Drug Project and Norfolk Recovery Partnership provided support in all the police custody and court suites. Most detainees were seen in police custody, but drug workers also visited or telephoned the court custody suites as required. Many detainees with substance misuse problems were already attending drug services, and new clients were offered individualised community support. Custody staff had reasonable awareness of substance misuse issues but no formal training. Clean needles and harm minimisation advice and supplies were available from local drug services. Young detainees with substance misuse needs were signposted to specialist services and YOT workers.

Recommendations

5.79 All staff should hold a current first aid qualification and receive annual updates to maintain an adequate skill level.

5.80 First aid kits should contain sufficient in-date equipment to manage all predictable incidents, including an automated external defibrillator and equipment to maintain an airway, which staff are trained to use.

5.81 Person escort records should not be accessible by non-custody staff and should clearly identify the health risks for each detainee, while maintaining confidentiality appropriately.

5.82 All detainees who require prescribed medications while in court custody should have access to it.

5.83 Mental health liaison and diversion schemes should be available to detainees at all times that the courts are open.

5.84 Court custody staff should receive regular training to identify, support and refer appropriately detainees experiencing mental health or substance misuse-related problems.

Housekeeping points

5.85 All staff should be fully aware of the service provided by the current medical provider.

5.86 Detainees' medication should be stored securely in all court suites.

5.87 All custody staff should be familiar with and adhere to the Serco medical standing operating procedure, including the handling of medication.

5.88 Maximum and minimum temperatures should be recorded daily for refrigerators used to store detainees' medication to ensure that heat-sensitive items are stored within the 2–8°C range. Corrective action should be taken where necessary and monitored by senior staff.

Section 6. Summary of recommendations

Main recommendation

To HM Courts and Tribunals Service

6.1 There should be a programme of regular deep cleaning, graffiti should be removed and standards of daily cleaning should be improved. (2.29)

National issues

To HM Courts and Tribunals Service

6.2 HMCTS should establish agreed standards in staff training, treatment and conditions, which should cover areas such as risk assessments and monitoring of complaints in court custody; these should be included in the measurement of performance. (2.31)

6.3 HMCTS should make more use of video link and `virtual court` facilities to reduce the need for detainees to be transported long distances to courts. (2.32)

6.4 There should be a national body to which detainees who have complained about court custody can appeal if they are dissatisfied with the outcome of their complaint. (2.33)

Recommendations

To Prisoner Escort and Custody Services

Background and key findings

6.5 There should be sufficient staff on duty to ensure the safety of detainees, staff and visitors at all times. (2.25)

6.6 A standard risk assessment pro forma should be completed for each detainee, and staff should be trained in completing it. (2.26)

6.7 Court custody staff should be trained to identify and refer appropriately detainees about whom they have child protection or safeguarding concerns. (2.27)

6.8 Handcuffs should only be used if necessary, justified and proportionate. (2.28)

6.9 Interpreters should always be obtained when needed in court, and a telephone interpretation service should be available in each custody suite. (2.30)

Leadership, strategy and planning

6.10 HMCTS and the PECS contractor should work together to ensure that lay observers' concerns are addressed effectively. (3.12)

6.11 Inter-agency forums, such as court user groups, should give court custody a higher profile in order to resolve any difficulties. (3.13)

6.12 There should be clear procedures for safeguarding vulnerable detainees, including those released from court, and custody staff should be briefed about how and when to use them. (3.14)

Individual rights

6.13 Wherever possible, detainees whose case is listed for the afternoon should not be placed in court custody in the morning. (4.15)

6.14 Detainees should be told about their rights and entitlements on arrival at all courts, including the process for making a complaint, and staff should offer to read or explain the information if necessary. (4.18)

Treatment and conditions

6.15 Cellular vehicles should be clean, properly ventilated, and free of graffiti. (5.17)

6.16 Adult men, women and young people should not be carried in the same escort vehicle. (5.18).

6.17 The PECS contractor should produce a policy setting out the correct approach to caring for transgender detainees and ensure that staff implement it. (5.26)

Recommendations

To HM Courts and Tribunals Service

Individual rights

6.18 HMCTS should liaise with local youth offending teams to ensure that there is coverage on six days a week for young people held in court custody. (4.16)

6.19 HMCTS should liaise with the Youth Justice Board to reduce delays in transferring young people to more appropriate custodial facilities. (4.17)

6.20 Custody staff should ascertain if detainees can read. (4.19)

6.21 Detainees' rights and entitlements should be available in a range of languages. (4.20)

6.22 Complaints should be logged and there should be a process for monitoring and analysing any trends. (4.21)

Treatment and conditions

6.23 Detainees should be transferred from cellular vehicles to the court cells in privacy. (5.19)

6.24 All staff should receive diversity training. (5.20)

6.25 Young people in court custody should be supported by a named staff member trained to work with young people. (5.21)

6.26 All courts should have hearing loops and Braille versions of key information for detainees. (5.22)

6.27 Every court cell area should have a copy of the holy books of the main religions, a suitable prayer mat, which is respectfully stored, and a reliable means of determining the direction of Mecca. (5.23)

6.28 All courts should have a stock of appropriate reading materials, including some suitable for young people and non-English speakers. (5.24)

6.29 Food offered to detainees should be of adequate quality and calorific content to sustain them for the duration of their stay, and food preparation areas and equipment should be clean. (5.25)

6.30 Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits. (5.51)

6.31 The outcome of cell visits should be communicated to the PCO updating SERS and records should properly reflect this. (5.52)

6.32 Every court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages. (5.53)

6.33 The court custody estate should be checked daily for ligature points and any found immediately rectified. (5.64)

6.34 All staff should hold a current first aid qualification and receive annual updates to maintain an adequate skill level. (5.79)

6.35 First aid kits should contain sufficient in-date equipment to manage all predictable incidents, including an automated external defibrillator and equipment to maintain an airway, which staff are trained to use. (5.80)

6.36 Person escort records should not be accessible by non-custody staff and should clearly identify the health risks for each detainee, while maintaining confidentiality appropriately. (5.81)

6.37 All detainees who require prescribed medications while in court custody should have access to it. (5.82)

6.38 Mental health liaison and diversion schemes should be available to detainees at all times that the courts are open. (5.83)

6.39 Court custody staff should receive regular training to identify, support and refer appropriately detainees experiencing mental health or substance misuse-related problems. (5.84)

Housekeeping points

To Prisoner Escort and Custody Services

6.40 The PECS contractor should ensure that the rationales for changes in custody policy and practice are always explained to staff. (3.15)

6.41 Cellular vehicles should be clean and tidy. (5.29)

Housekeeping point

To PECS and HMCTS

6.42 Serco should liaise with the Norfolk and the Suffolk constabularies to discuss the quality and transfer of information and completion of person escort records (PERs) for detainees. (5.28)

Housekeeping points

To HM Courts and Tribunals Service

Leadership, strategy and planning

6.43 HMCTS managers should visit the cells at the courts for which they are responsible regularly so that any problems can be readily identified and resolved. (3.16)

Individual rights

6.44 Court custody staff should ensure that detainees can inform someone of their whereabouts, and check with court staff or legal advisers that it is appropriate for this person to be contacted. (4.22)

6.45 There should be a private soundproofed room for legal consultations in the Lowestoft custody suite. (4.23)

Treatment and conditions

6.46 Confidential information about detainees on whiteboards and in documents should be out of public view. (5.27)

6.47 Staff should make regular checks on the food for detainees and discard any that is out of date. (5.30)

6.48 Staff should routinely inform all female detainees of the availability of feminine hygiene packs. (5.31)

6.49 Rub-down searches in secure areas should not be routine. (5.54)

6.50 Vulnerable detainees should be able to have social visits in exceptional circumstances. (5.55)

6.51 A suitable temperature should be maintained in all cells. (5.65)

6.52 Mattresses and blankets or warm clothing should be available for detainees. (5.66)

6.53 There should be a fire evacuation drill for court custody staff at Norwich magistrates' court. (5.67)

6.54 Staff should explain call bells to detainees, and the call bell panel at Ipswich magistrates' court should have an audible signal. (5.68)

6.55 All staff should be fully aware of the service provided by the current medical provider. (5.85)

6.56 Detainees' medication should be stored securely in all court suites. (5.86)

6.57 All custody staff should be familiar with and adhere to the Serco medical standing operating procedure, including the handling of medication. (5.87)

6.58 Maximum and minimum temperatures should be recorded daily for refrigerators used to store detainees' medication to ensure that heat-sensitive items are stored within the 2–8°C range. Corrective action should be taken where necessary and monitored by senior staff. (5.88)

Good practice

6.59 Court custody staff had reduced the time that detainees waited for transport to prison by arranging for them to be accepted into custody through an interim warrant notification pending the warrant of detention. (4.24)

Section 7. Appendices

Appendix I: Inspection team

Peter Dunn	Team leader
Gary Boughen	Inspector
Vinnett Pearcy	Inspector
Fiona Shearlaw	Inspector
Majella Pearce	Health services inspector