

Report on an inspection visit to court custody facilities in

Cambridgeshire and Essex

by HM Chief Inspector of Prisons

6–14 January 2014

Glossary of terms

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Section 1. Introduction

This is the sixth 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 focus on outcomes for detainees in three areas: strategy, individual rights, and treatment and conditions, including health care.

In Cambridgeshire and Essex, there were 11 courts currently in use with custody facilities, including four Crown Courts and seven Magistrates' Courts. Serco Wincanton had been contracted to provide custody and escort operations for HM Courts and Tribunal Service (HMCTS) in the region. There were concerns about low staffing levels in court custody. Although the company had recently recruited more staff, we found evidence that the problem had not been entirely resolved. Poor work practices had become embedded, which adversely affected the care of detainees.

There were good relationships between HMCTS and Serco Wincanton but, as in other regions we have inspected, they had not resulted in effective action being taken to improve outcomes for detainees. There was uncertainty about HMCTS's role in relation to the provision of court custody, and few formal channels through which problems concerning the care of detainees could be resolved. Arrangements for inter-agency collaboration differed between the two counties and overall, leadership was somewhat fragmented.

Care of detainees should have been much better. Staff had received little training in looking after and safeguarding young people; and they had not been briefed about the particular needs of detainees who were members of minority groups. Staff did not inform detainees of their rights in court custody and they sometimes failed to follow basic procedures to safeguard those who were potentially vulnerable.

Problems with the national HMCTS interpreter contract meant that sometimes an interpreter who had been booked for court would fail to turn up. Serco Wincanton had not provided a telephone interpretation service in custody suites. Detainees who could not speak English could be remanded in custody without anyone explaining to them what had happened and where they were being taken.

At most courts, there was excessive graffiti and at some, the toilets lacked privacy. Some cells were cold. Cellular vehicles were dirty, and women and men were often transferred in the same vehicles, providing opportunities for female detainees to be harassed.

In Cambridgeshire and Essex courts, lack of leadership and robust multi-agency forums in which custodial issues could be addressed had allowed problems such as shortages of staff and the limitations of the physical environment to become persistent and pressing. HMCTS and PECS need to clarify their respective responsibilities towards detainees and exercise more scrutiny so that concerns are resolved with greater determination and accountability.

Nick Hardwick
HM Chief Inspector of Prisons

July 2014

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** Cambridgeshire and Essex court custody suites comprised:

Custody suites	Number of cells
Cambridge Magistrates' Court	15
Huntingdon Magistrates' Court	9
Peterborough Magistrates' Court	8
Cambridge Crown Court	12
Peterborough Combined (Crown) Court	6
Basildon Magistrates' Court	7
Chelmsford Magistrates' Court	20
Colchester Magistrates' Court	17
Southend Magistrates' Court	15
Basildon Combined (Crown) Court	9
Chelmsford Crown Court	11

¹ <http://www.justice.gov.uk/inspectorates/hmi-prisons/expectations.htm>

Leadership, strategy and planning

- 2.4** Arrangements for inter-agency work between HM Courts and Tribunals Service (HMCTS) and other agencies differed considerably between Cambridgeshire, where user groups had been abandoned at some courts, and Essex, where most agencies involved in court operations met regularly. No Prisoner Escort and Custody Services (PECS) meetings, involving the court escort and custody contractor, local prisons, HMCTS and the police, had taken place during the previous year in either county. Opportunities to resolve any difficulties between organisations were therefore limited. Senior court custody officers were in regular contact with HMCTS court delivery managers and relationships were positive, but there was a lack of formal structures to resolve problems and in some instances this may have adversely affected detainee care.
- 2.5** In some courts, staffing levels in custody were low. PECS contract managers were aware of the situation and HMCTS managers echoed these concerns. The Ministry of Justice and PECS had made Serco Wincanton, the custody contractor, subject to administrative supervision in response to concerns about their performance, and the company was undertaking a major recruitment and training programme at the time of the inspection.
- 2.6** HMCTS managers had little involvement in Serco Wincanton policy, even though they sometimes had concerns about its implementation. There were examples of HMCTS decisions that had a significant bearing on custody operations not being fully understood by Serco Wincanton staff, such as uncertainty about court cut-off times.
- 2.7** Maintenance and cleaning problems were mostly resolved between senior custody officers (SCOs) and HMCTS delivery managers, although some maintenance problems remained unresolved.
- 2.8** Although all courts had access to video links, detainees were often brought to court for minor procedural hearings and HMCTS were frustrated about the slow progress in developing the use of remote hearings.

Individual rights

- 2.9** Court custody staff were thorough in checking that they had the necessary authority to detain. Most courts supplied warrants of detention promptly. There was a helpful agreement with some of the local prisons, whereby when these warrants were delayed, detainees could be received with a temporary warrant.
- 2.10** At some courts, remand cases were dealt with promptly and concluded in the morning, but at others detainees sometimes waited until the late afternoon for their cases to be heard, for no discernable reason. Vulnerable detainees, including children and young people, were not always prioritised for hearings early in the day. There were also delays in obtaining placement orders from the Youth Justice Board (YJB). This resulted in detainees being held in court custody too long.
- 2.11** Although all custody suites had a notice explaining that detainees would be told of their rights in court custody, at most courts little attempt was made to explain rights or offer written information about them. At some courts there were different versions of detainees' rights in use. Few detainees were given information about how to make a complaint about their treatment in custody.

- 2.12** There was no provision for detainees who could not speak English. There was no access to professional telephone interpreting services, so custody staff relied on court interpreters, when available, or used gestures to communicate with non-English-speaking detainees. This meant that if a non-English-speaking detainee was refused bail, they could be taken to prison without understanding what had happened in court or where they were going.

Treatment and conditions

- 2.13** Few detainees experienced long journeys to and from court in cellular vehicles but women, young people and adult men were regularly carried in the same vehicle, often without a screening partition being used. Some vehicles were dirty and contained graffiti. At one court, we saw two detainees, one of whom had a history of self-harm, left unsupervised on a cellular vehicle. At some courts, detainees were not well protected from being seen by the public while entering and leaving cellular vehicles.
- 2.14** Many courts had whiteboards containing detainees' personal information, where all detainees could view it. Some person escort records (PERs) had confidential medical information attached instead of being sealed in an envelope, and many disclosed confidential information about detainees' medical conditions but did not alert custody staff to the possible risks posed by these conditions.
- 2.15** Several detainees arrived from police stations in Essex wearing bright red tracksuits that had been issued by the police, potentially drawing unnecessary public attention to them.
- 2.16** Although custody staff had good interpersonal skills, were courteous to detainees and we saw some of them reassuring detainees who were upset, many interacted little with them. There was no specific provision for, or staff training in the care of, children and young people, and no named member of staff allocated to their care.
- 2.17** There was little specific provision for detainees with disabilities, or for detainees from other minority groups. Some courts had been designated as suitable for detainees with disabilities but some detainees using a wheelchair had been tried in courtrooms without lift access, necessitating a journey through public areas in handcuffs. Provision for religious observance was inadequate, and staff did not ask detainees on arrival if they had any special needs.
- 2.18** Detainees were provided with hot and cold drinks at regular intervals and microwave meals, in some courts at standard mealtimes and at others more flexibly.
- 2.19** Staffing levels were insufficient. At one court, the absence of a SCO meant that no effective leadership was exercised when problems arose, putting detainees at potential risk. At most courts, custody staff relied on assistance from vehicle crews, many of whom were not familiar with custody suite procedures or facilities. Not all courts had a morning briefing to share information about risks. There was no systematic risk assessment and staff did not adequately establish if detainee had any concerns that might increase their risk whilst in their care. We saw several instances where detainees were potentially placed in unsafe situations due to poor practice. Cell sharing risk assessments were not completed routinely.
- 2.20** All staff received annual training in control and restraint techniques. Use of force was rare, and there were inconsistencies among staff about the procedures for recording it. Detainees were routinely handcuffed, even in secure areas.

- 2.21** Most court cells were clean and in good condition. Staff at all courts carried out daily cell checks, and faults were mostly rectified quickly, but cells were not always checked in between use. Some problems with the physical conditions remained unresolved, such as cold cells at one court, with no effective remedial action taken.
- 2.22** A telephone medical advice service was in place that could also supply a visiting paramedic if required. Some staff were unsure about what it offered but most of those who had used the service were positive about it. Custody staff were qualified in first aid but did not receive refresher training sufficiently regularly. There was no resuscitation equipment in any of the court buildings; staff carried personal resuscitation face shields, but most of these were out of date. Some detainees arrived from police custody without their prescribed medication, and some arrived from prison with medication sealed with clinical records, requiring staff to gain consent from the prison to break the seal before they could administer it.
- 2.23** In Essex courts, mental health professionals were readily accessible and custody staff were positive about the service, but in Cambridgeshire courts mental health professionals were available only in one court. In Essex, most detainees with substance misuse issues were seen in police custody and drug workers also visited the court custody suites as required, but in Cambridgeshire substance misuse staff did not visit the court custody suites. Custody staff had a reasonable awareness of substance misuse and mental health issues but lacked formal training.

Main recommendations

- 2.24** There should be sufficient staff on duty to ensure the safety of detainees, staff and visitors at all times.
- 2.25** A standard risk assessment pro-forma should be completed for each detainee, and staff should be trained in completing it.
- 2.26** Court custody staff should be trained to identify and refer appropriately detainees about whom they have child protection or safeguarding concerns.
- 2.27** Handcuffs should only be used if necessary, justified and proportionate.
- 2.28** Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite.

National issues

- 2.29** 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.
- 2.30** HMCTS should make more use of video link, 'virtual court' facilities and other provisions to reduce the need for detainees to be transported long distances to courts.

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 HMCTS cluster manager had operational oversight of all courts in Cambridgeshire and Essex. Delivery managers were assigned to the Magistrates' and Crown Courts in each county. Their role included the oversight of custody provision in particular courts, and some managed more than one court. In some respects, the two counties were managed as separate entities. For example, inter-agency meetings included court user groups in Essex, but not in Cambridgeshire, where at most courts they were no longer held (see below). The custody contractor, Serco Wincanton, had a structure that was not coterminous with the HMCTS cluster: Cambridgeshire custody operations were linked with Norfolk and Suffolk, whereas Essex was part of another area. Two Serco Wincanton area operations managers supervised custody work, one in Essex and one in Cambridgeshire. The overall structure made it difficult for HMCTS and Serco Wincanton managers to achieve clarity and consistency in managing custody in the two counties.
- 3.2 A criminal justice efficiency group covering all courts in Essex met monthly, and also included active court user groups. The efficiency group included all relevant agencies except health services. However, it was concerned mainly with court processes, and custody was rarely discussed. In most Cambridgeshire courts, there had been no court user group meetings since 2011 because, we were told, some participants did not consider that there was a need for them. In response to this identified problem HMCTS had convened occasional problem-solving groups, but so far these had not addressed custody issues. The frequency of individual HMCTS and contractor meetings had also been increased in Cambridgeshire, but those meetings did not normally involve other relevant organisations. The HMCTS cluster manager had attended Prison Escort and Custody Services (PECS) inter-agency meetings that included the local prisons and other criminal justice agencies, but none had taken place during 2013 in either county. Consequently, there were few opportunities for inter-agency collaboration to improve detainee care, particularly in Cambridgeshire. The capacity for organisations to work together to resolve unanticipated problems in custody was too limited, and we found instances where that may have adversely affected detainee care.
- 3.3 Working relationships between HMCTS and Serco Wincanton managers were mostly positive. The cluster manager met the two Serco Wincanton operations managers regularly to resolve problems informally. However, there was an over-reliance on good relationships to resolve problems. In some courts, custody staff told us that, despite their best efforts, relationships with HMCTS staff were not always productive, and we found examples of important communications not being understood. For example, at one court there was confusion about whether custody cases could be prioritised over hearings involving detainees on bail (see section on individual rights).
- 3.4 In a recent change in policy in Cambridgeshire and Essex, courts could not refuse to remain open for the full business day, in order to help minimise the length of time that detainees spent in police custody. However, this change had not been communicated effectively, and some custody staff gave us incorrect information about court cut-off times.
- 3.5 HMCTS managers had little involvement in Serco Wincanton policy, even though they sometimes had concerns about its implementation. This had occasionally caused difficulty, such as recent concerns among court staff about the large number of applications by custody staff for detainees to be handcuffed in court docks.

- 3.6** Serco Wincanton employed an SCO at each court, with the exception of Huntingdon Magistrates' Court, where the custody facility was managed by an SCO based at a neighbouring court. Each SCO met the local court delivery manager monthly, and sometimes more often. The cluster manager had recently devised a useful template to formalise these meetings and ensure that actions were progressed. However, at some courts, custody staff told us that the HMCTS delivery manager rarely visited the cells. Serco Wincanton had held meetings with SCOs but these had been irregular, limiting the opportunities for SCOs to share ideas and develop practice.
- 3.7** At most courts, maintenance and cleaning problems were resolved between SCOs and HMCTS delivery managers, and custody staff told us that HMCTS were mostly responsive to maintenance requests. Serco Wincanton discussed these matters with the PECS contract manager at their monthly meetings, although some maintenance problems remained unresolved (see also section on physical conditions).
- 3.8** HMCTS had had concerns about low Serco Wincanton staffing levels, which had resulted in delays in getting detainees to court, and believed that the contract monitoring system did not identify all failures. They had instructed court staff to record such issues and told the HMCTS centre about them. They had also raised their concerns about staffing levels with Serco Wincanton, which, in September 2013, had been made subject to administrative supervision by the Ministry of Justice and PECS owing to concerns about their performance. The company had responded by initiating an extensive recruitment programme that at the time of the inspection was beginning to result in more custody staff being trained and in post. However, the slow response to such concerns risked causing unsatisfactory practices in custody to become embedded, particularly those relating to detainee care and safety (see main recommendation 2.24).
- 3.9** An active Lay Observer² group made monthly visits to all the Cambridgeshire and Essex courts. SCOs and delivery managers discussed the outcome of each visit at their monthly meetings. Most issues raised by Lay Observers were followed up diligently but some, particularly concerning deep cleans and maintenance (see above), were not resolved.
- 3.10** All courts had access to video links but we were not assured that they were fully used, and HMCTS were frustrated about the slow progress in increasing the number of hearings held remotely (see recommendation 2.30). We saw several records of detainees who had been produced at court for minor procedural matters who could probably have been adequately dealt with via video link.

Recommendations

- 3.11** **There should be regular inter-agency forums covering all courts in the cluster, and their remit should include improvements to the care of detainees during escort and in court custody.**
- 3.12** **The length of time that detainees, particularly young people and those who are vulnerable, spend waiting in court cells should be reduced.**

² Lay Observers, established under the Criminal Justice Act 1991, are independent volunteers who check that prisoners escorted by private escort companies in England and Wales are treated decently.

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

Housekeeping points

- 3.14** The rationales for changes to custody policy, including those emanating from HMCTS, should be fully explained to staff.
- 3.15** At all courts, HMCTS managers should regularly visit the cells for which they are responsible so that any problems can be readily understood and resolved.
- 3.16** Serco Wincanton should hold regular meetings with senior custody officers (SCOs), to enable SCOs to share ideas and develop practice.

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 to ensure that they had the necessary authority to detain. At Cambridge Magistrates' Court, we saw a court enforcement officer complete a PER for a detainee he had arrested on warrant on behalf of the court. Custody staff checked the warrant, searched the detainee and then placed them in the court cells. However, there was no arrangement for the enforcement officer to deliver compliant individuals directly to the court room, to avoid unnecessary detention in the cells and the accompanying handcuffing procedures (see section on treatment and conditions). There were no court enforcement officers at the Magistrates' Courts in Essex; the execution of court warrants was the responsibility of the police.
- 4.2** Staff at all courts described a good relationship with their local youth offending team (YOT). All courts had procedures to ensure that YOT staff were aware of all children and young people in the court cells each day, including Saturdays. Although some courts reported delays in YOT workers visiting the court cells, we saw a worker visiting a young person in the court cells at Colchester Magistrates' Court promptly after being contacted by custody staff. There was good communication between custody staff and the YOT worker about potential custodial cases for young people appearing in the youth court that day.
- 4.3** At some courts, we saw remand cases being dealt with promptly and all were concluded in the morning, but this was not the case at Southend, Colchester and Peterborough Magistrates' Courts, where some detainees remained in the court cells until the late afternoon, with no obvious reason for the delay. This was also reflected in the records we reviewed. Court custody staff told us that vulnerable detainees, children and young people were not always prioritised by the court to ensure that they did not remain in court custody too long.
- 4.4** At most courts, we saw detainees being accepted from police custody throughout the day (see section on strategy). Records we reviewed at Southend Magistrates' Court showed that on one day, a detainee had been accepted from police custody at 4.30pm, and we saw a detainee who had come from Clacton police station arriving at Colchester Magistrates' Court at 3.30pm.
- 4.5** At all courts, we frequently saw detainees being brought from prison early in the day, even though their cases were not listed until the afternoon. We also saw records of detainees being transported from prison to the court in the morning, having their cases heard early that morning but not being transported back to prison until after 5pm, due to the lack of availability of escort vehicles. As a result of these practices, detainees spent unnecessarily long periods in court cells. Court custody staff told us that both of these practices were common.
- 4.6** Warrants of detention were received from courts in a timely manner, sometimes within 15 minutes of remand or sentence, enabling them to be checked before onward transport to prison was arranged. At Colchester and Southend Magistrates' Courts, staff told us, and records showed, that warrants sometimes took over two hours to be produced. In an attempt to prevent delays in transporting remanded or sentenced detainees, some local prisons had helpfully agreed to receive new detainees and returning prisoners without

accompanying warrants, provided that court custody staff completed an interim warrant notification and then forwarded the relevant warrant of detention on the next working day.

- 4.7** During the inspection at Chelmsford Crown Court, three detainees whose cases had been heard by 10.30am were not able to be returned to HMP Chelmsford before 1.30pm as the prison reception did not open until that time. We were told that it was prison policy not to accept detainees before 1.30pm on weekdays and to receive them only between 1.30pm and 3pm on Saturdays.
- 4.8** Custody staff and legal representatives told us that there were often delays of up to two hours, especially during the lunchtime period, in securing the authority from prisons to release detainees who had come from prison and then been bailed or released by the court. However, during the inspection we saw the authority received by fax within less than 30 minutes.
- 4.9** Custody staff told us of delays in moving remand or sentenced young people to custodial/secure establishments. They cited delays in receiving placement orders from the YJB, without which young people cannot be moved to more appropriate custodial facilities. They also indicated that young people being taken to a YOI often had long waits to be collected for transportation there. For example, we were told that at Peterborough Magistrates' Court, escorts to Wetherby YOI (a three-hour drive from the court) often did not leave until the early evening – sometimes as late as 8pm. These delays resulted in young people being held for too long in court cells.
- 4.10** Court custody staff in some of the Magistrates' Courts told us that, in exceptional circumstances, they made a telephone call to inform someone of a detainee's whereabouts, and that when they were not able to do this they referred the matter to the detainee's legal representative. One PCO at Southend Magistrates' Court told us that she had contacted the mother of a detainee to alert her to the fact that her son was being taken to a different custodial establishment and not being returned to HMP Chelmsford.
- 4.11** Although there was a notice in each of the custody suites explaining that part of the process of achieving 'Designated Ready and Available for Court Time' (DRACT) was to offer detainees a copy of their rights, this did not happen routinely at all courts. Only at Colchester Magistrates' Court were detainees offered a copy of their rights to read, and at Southend Magistrates' Court a copy was placed on the bench in each cell. Elsewhere, detainees were simply told, '*You know your rights, don't you?*' Detainees' notice of rights was displayed in the main booking-in area in all suites but they were given no time to read it. They were not asked if they were able to read or understand it, and it was produced only in English. We found different versions of the rights at some courts. None of the detainees we spoke to had been advised of their rights by Serco Wincanton staff.
- 4.12** Staff ensured that all detainees had legal representation when they arrived at the custody suite. There were sufficient consultation rooms at all courts except Peterborough Crown Court, where there were only two. This was insufficient, resulting in advocates having to queue. These rooms were also used by custody staff to conduct post-sentence/remand interviews, which further limited their availability. Elsewhere, some consultation rooms were not soundproofed. At Huntingdon Magistrates' Court, two detainees described themselves as 'freeman on the land'. They did not acknowledge the court as a legitimate institution and were not represented by a solicitor. The PCOs dealt with these detainees well during their time in the court cells and provided them with pencil and paper to prepare their defence.
- 4.13** There was no provision for detainees who could not speak English. Court custody staff did not have access to professional telephone interpreting services but told us that they used gestures to communicate with non-English-speaking detainees to ensure that their basic needs were met. At Peterborough Magistrates' Court, we saw a non-English-speaking

Lithuanian detainee brought into custody at 8.30am but a court-appointed interpreter did not attend until 3pm. This raised the concern that if a non-English-speaking detainee was refused bail, they could potentially be taken to prison without understanding what had happened in court or where they were going (see main recommendation 2.28).

- 4.14** Information about the right to make a complaint was included in the rights documentation but this was not routinely handed out to detainees and was rarely available in languages other than English. During the inspection, staff at one court were unable to find a Serco Wincanton complaint form, although they found some that had been issued by a previous contractor. At some courts, Prison Service complaints forms were available but were not applicable in court custody. Information about making a complaint was displayed in some courts but the notices contained incorrect information. We were told that few complaints were recorded, so there was no provision for monitoring them and analysing trends.

Recommendations

- 4.15** Detainees whose case is listed for the afternoon should not be placed in court custody in the morning.
- 4.16** Escort vehicles should be available to take detainees to custodial/secure establishments without delay following completion of their court case.
- 4.17** HMCTS should liaise with HMP Chelmsford regarding their hours of operation for receiving prisoners, to reduce delays in transferring remanded or sentenced detainees.
- 4.18** HMCTS should liaise with the Youth Justice Board to reduce delays in transferring young people to more appropriate custodial facilities.
- 4.19** At every court, detainees should be told on their arrival about their rights, including the process for making a complaint, and staff should offer to read or explain them if necessary.
- 4.20** Detainees' notice of rights should be available in a range of languages.
- 4.21** Sufficient comfortable, private and soundproofed interview rooms should be made available at all courts for legal consultations.
- 4.22** Complaints should be logged and there should be a process for monitoring and analysing trends.

Housekeeping points

- 4.23** 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.
- 4.24** Warrants of committal should be produced promptly after a detainee's court case has concluded.

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 Journeys from police custody, local prisons (HMPs Peterborough and Chelmsford) and some London prisons to court were mostly short. None of the detainees we saw arriving at courts had experienced excessively long journeys.
- 5.2 Some of the cellular vehicles we inspected were dirty and contained graffiti. We were told that separate minibuses were always provided by the PECS contractor when transferring pregnant women. Cellular vehicles had first-aid kits containing anti-ligature knives, and drinking water was available. At one court, the cool box carried by the van, which was used to carry sandwiches on longer journeys, was filthy and smelt foul, and contained cups of water and dirty tissues (see Appendix II).
- 5.3 Staff told us that they regularly carried women, young people and adult men in the same vehicle. At Peterborough Crown Court, we saw a six-cell vehicle carrying a woman alongside five male detainees, one of whom was on self-harm monitoring measures, without the screening partition being used. Most escort staff told us that they rarely used the partition, which one described as a 'hassle', or they used it only when conveying young people.
- 5.4 Escort staff ensured that all necessary information about detainees accompanied them to court. Detainees we saw arriving at court from prison were accompanied by part of their prison files, in case they were further remanded or sentenced and returned to a different establishment. Files received from HMP Peterborough were bagged and securely sealed but those from HMP Chelmsford were bagged but not securely sealed.
- 5.5 PERs accompanying detainees from prisons were mostly completed to a reasonable standard but some we examined were of a poor quality; for example, the PER of a foreign national detainee failed to identify that he could not speak any English, and a sex offender's PER was simply endorsed, 'safer custody marker'. Most PERs received from the police contained loose sheets relating to the detainee's risk assessment, charges and other extraneous information which, where relevant, should have been recorded in the PER. In some cases, confidential medical information, which should have been in a sealed envelope, was also attached to the PER (see also section on health). Although most courts had a secure means of disposing of the accompanying documentation that was no longer needed if a detainee was bailed or released, at Basildon Magistrates' Court these items were placed in an open bag, which meant that they could be read by anyone entering the custody office. Court custody staff checked PERs to ensure that all relevant information was transferred to the custody computer system; however, at busy courts (for example, Peterborough Crown Court), these were checked after the detainees had been placed in shared cells (see section on safety).

- 5.6** All courts had secure vehicle bays, with the exception of Basildon Magistrates' Court, which could only accommodate a three-cell escort vehicle. This resulted in detainees being transferred from vehicles in the secure courtyard, where they could be observed by the public. Detainees held in the adjacent Basildon Police Station were walked in handcuffs from the police station to the Magistrates' Court via the police yard and the secure courtyard. At the time of the inspection, the gate into the police yard was faulty, which meant that the yard was unsecured and detainees could be observed by passing members of the public. The police yard and courtyard were overlooked by a multi-storey car park, which left detainees open to media attention and photography.
- 5.7** All detainees were quickly escorted from vehicles to the court building. At Peterborough Crown Court, we saw two male detainees (one of whom was on self-harm monitoring measures), who were travelling onwards to another court, being left unaccompanied on a cellular vehicle while the escort disembarked the vehicle to use the custody suite toilet facilities.
- 5.8** Many courts had a whiteboard containing detainees' information, including their names and cell numbers, sited in the main booking-in area, where all detainees could view it. Some of this information was inaccurate; for example, at two courts detainees were lodged in different cells from those indicated on the whiteboard. It was unclear why these boards were needed, as detainees' details were recorded on the custody computer system and on paper documents.
- 5.9** Custody staff were courteous to detainees and had good interpersonal skills. However, after the initial greeting and placing in a cell, many staff interacted little with detainees, although we saw some staff reassuring those who were upset or frustrated about being held in court cells. At Huntingdon Magistrates' Court, the custody staff were new to this post and, despite having received little training or support in the role, they looked after detainees well.
- 5.10** Neither HMCTS nor Serco Wincanton had a safeguarding policy, and there was no specific provision for, or staff training in the care of, children or young people in the suites, and no named member of staff allocated to their care. At some courts, there was a designated corridor or cell for young people, and at others it was ensured that they were not located in close proximity to adults. Staff were unclear about safeguarding procedures for them and for vulnerable groups. They told us that they would contact their line manager, probation services or another criminal justice agency if they were concerned about a detainee in their care. A member of the mental health team who visited the cells daily at Colchester Magistrates' Court confirmed that she had received several informal referrals from staff voicing concerns about the mental health of detainees in their care (see main recommendation 2.26).
- 5.11** At Basildon, Chelmsford and Colchester Magistrates' Courts, we saw many detainees arriving from local police stations wearing bright red tracksuits. No warm clothing was available for detainees who were cold, but staff retained a small stock of replacement clothing to offer to detainees whose clothing was soiled, although there was no means of laundering it. There were also no blankets or pillows available, so detainees who were pregnant, older or had disabilities had to wait on hard benches, except at Basildon Magistrates' Court, where these items could be accessed through an informal arrangement with staff at the neighbouring police station.

- 5.12** Some courts across the area had been designated as suitable for detainees with disabilities and had adapted toilets, a cell with a widened door and access to the court via lifts. However, staff at Peterborough Crown Court told us of a recent case where a detainee in a wheelchair had been tried in a courtroom without lift access. This had necessitated the detainee being taken through a public area into the courtroom, where they had sat in the main area of the courtroom as their wheelchair could not access the dock. At Chelmsford Crown Court, we were told of instances where detainees with disabilities, wearing handcuffs, had had to be taken through public areas to gain access to courtrooms. There were no hearing loops available in the cell areas and none of the courts had information in Braille.
- 5.13** All courts, with the exception of Southend Magistrates' Court, had a separate women's corridor. However, at Peterborough Crown Court, a man charged with a sexual offence who was deemed vulnerable was placed in the women's corridor, in an adjoining cell to a female detainee which was not appropriate. Female detainees were not routinely asked if they were pregnant or offered feminine hygiene products, although in some courts there were notices advertising their availability in the toilets and the women's corridor.
- 5.14** Detainees were not asked about religious observance, dietary requirements or any other needs on arrival at court. Some courts had prayer mats but others simply had a square of carpet which custody staff had been told could be used as a prayer mat. Some custody suites had access to a compass to determine the direction of Mecca but no religious texts were available, other than a copy of the Bible at a few locations. Most custody staff indicated that they would access the courtroom religious books if these were required.
- 5.15** Staff were unaware of any policy on searching transgender detainees but at some courts they had had experience of this and recalled asking the detainee how they would like to be cared for, which was appropriate practice. At other courts, staff told us that searches would be conducted by a female PCO as they are authorised to search detainees of both genders.
- 5.16** At all courts, arrangements for securing detainees' property were satisfactory. On a busy day at Peterborough Crown Court, none of the seals of the property bags arriving with detainees from prison were cross-checked with the individual PERs until after all 12 detainees had been lodged in their cells.
- 5.17** Custody staff at all courts had brought in old newspapers and magazines to keep detainees occupied, and we saw them handing these out. At Basildon Crown Court, staff brought in free newspapers from the railway station when they could. There was no reading material in languages other than English, in easy-read format or suitable for young people. When self-harm issues were identified, staff ensured that staples were removed from reading materials before issue.
- 5.18** All courts provided hot and cold drinks to detainees on arrival and at regular intervals. They were given a choice of microwave meals at standard mealtimes at Colchester Magistrates' and Basildon Crown Courts but there was more flexibility at all other courts, depending on when the detainee had last eaten. The meals had a low calorific content, and at some courts there was little choice for vegetarians. Custody staff recognised that the portions were small and told us they would offer more than one if a detainee requested another. All courts gave detainees a hot microwave meal if they were still in the court cells at 4pm as it was likely that they would miss their evening meal in prison. Food preparation areas were clean but the microwave ovens at a number of courts were not.

Recommendations

- 5.19 Cellular vehicles should be clean inside and free of graffiti.**
- 5.20 Adult men, women and young people should not be carried in the same escort vehicle.**
- 5.21 Serco Wincanton should liaise with local prisons, Cambridgeshire Constabulary and Essex Police to discuss the transfer of information and completion of person escort records (PERs) for detainees. PERs should clearly identify the health risks for each detainee, while ensuring that confidentiality is appropriately maintained.**
- 5.22 Detainees should be transferred from cellular vehicles and neighbouring police stations to the court cells in privacy.**
- 5.23 Detainees should not be left unaccompanied on cellular vehicles.**
- 5.24 All staff should receive diversity and equality training that includes how to care for young people.**
- 5.25 Young people in court should be supported by a named staff member who is appropriately trained.**
- 5.26 All court cells should have hearing loops and Braille versions of key information for detainees.**
- 5.27 All courts 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.**
- 5.28 The PECS contractor should produce a policy setting out the correct approach to caring for transgender detainees and ensure that staff implement it.**
- 5.29 All courts should have a stock of appropriate reading materials, including some suitable for young people and non-English speakers.**
- 5.30 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 kept clean.**

Housekeeping points

- 5.31 Cool boxes on cellular vehicles should be kept clean at all times.**
- 5.32 Secure confidential waste arrangements should be introduced at Basildon Magistrates' Court.**
- 5.33 Confidential information about detainees on whiteboards should be accurate and sited out of the view of detainees.**
- 5.34 Police services should not send detainees to court in distinctive clothing that might publicly identify them as having been in police custody.**
- 5.35 Mattresses and blankets or warm clothing should be available for all detainees.**

- 5.36** Detainees' property should be checked against accompanying documentation to ensure that it is all in order, before detainees are placed in cells.
- 5.37** Staff should routinely inform all female detainees of the availability of feminine hygiene packs.

Safety

- 5.38** We saw variable practices in relation to staff briefings. At some courts, SCOs convened morning staff briefings about detainees coming into custody, to highlight any warning markers and confirm staff duties. Elsewhere, the briefing did not include any issues about detainees, focusing mainly on where staff would be deployed and details of any changes to company policy.
- 5.39** During the inspection, we had concerns about staffing levels. One day at Peterborough Crown Court there was no SCO or deputy SCO on duty. Staffing comprised three Crown Court PCOs, supplemented by two PCOs from another court and four vehicle crew members. When problems arose, no effective leadership was exercised, putting detainees at potential risk. Although there appeared to be sufficient staff to care for detainees during the inspection, at most courts custody staff relied on assistance from vehicle crews, some of whom did not know the custody suites or their facilities sufficiently well; for example, staff at one court were not able to operate the closed-circuit television (CCTV) system, rendering it ineffective in monitoring a vulnerable detainee. At Huntingdon Magistrates' Court, which was open just two days each week, only two PCOs were employed as permanent staff in the custody suite. They needed to be supported by two vehicle crew members and there was no SCO; it was unclear who had responsibility for the running of the custody suite (see main recommendation 2.24).
- 5.40** When detainees arrived at the court, court custody staff did not complete a systematic risk assessment but simply noted the warning markers highlighted on the accompanying documents (see main recommendation 2.25). Other than responding to obvious vulnerabilities, such as medical issues, staff did not routinely interact with detainees on their arrival to determine how they were and any potential concerns that might arise while they were in their care. In contrast staff understood the process of supporting detainees who were subject to self-harm monitoring arrangements.
- 5.41** At Colchester Magistrates' Court, we saw staff showing good care for a vulnerable detainee. They placed him in an observation cell (glass fronted) as he was unwell and potentially at risk of having a seizure, and they interacted with him during the cell visits. They also alerted the court clerk to his poor health, to see if his case could be dealt with as early as possible.
- 5.42** Not all detainees were searched on arrival. Staff told us that those arriving from prison and transferred by Serco Wincanton were not searched when they arrived at the court and we confirmed this to be the case at most courts. All other detainees were searched on arrival and this was conducted respectfully. Rub-down searches at some courts were conducted randomly when detainees returned from a legal visit, the toilet or the courtroom, which was proportionate.
- 5.43** Cell sharing risk assessments were not completed routinely and we saw several cases where detainees were placed in cells with others, without a risk assessment being considered. At one court, we were told that staff were 'too busy' to complete cell sharing risk assessments when a detainee with self-harm issues was placed in a cell with a detainee suffering from attention-deficit hyperactive disorder. At another, when we asked why no cell sharing risk assessment had been completed for two detainees sharing a cell, staff completed a cell sharing risk assessment for one of them but not for the other.

- 5.44** Staff at all courts told us that the standard level of observation for all detainees was cell visits at 10-minute intervals, with checks every five minutes for those who were vulnerable. Staff at most courts made regular checks of the cells but this tended to be a cursory view through the cell door, with no physical interaction with detainees, and these checks were not always communicated to the PCO adding information to the custody computer system. At Southend Magistrates' and Basildon Crown Courts, there was good exchange of information about the detainee between this PCO and the member of staff conducting cell visits. The cells at Colchester Magistrates' Court were spread out and detainees were located in different corridors, depending on age and gender. All the cells were monitored by CCTV and staff relied on this as a means of checking on detainees. However, some staff made additional, irregular visits to the cells to make physical checks.
- 5.45** At a few courts, staff on cell duties carried anti-ligature knives on their person, whereas elsewhere these were kept in a drawer, in the first-aid kit or in the key safe. These latter practices would delay access to the knives if required in an emergency. Staff were unaware of company policy on this subject.
- 5.46** Social and domestic visits were not facilitated, unless directed by the court, which was not satisfactory, particularly for vulnerable detainees.
- 5.47** There were no significant delays in transferring detainees from the cells to the courtroom. Routes to courts were secure, with all courts equipped with affray alarms in the docks, corridors and on the stairs to the dock, with the exception of Cambridge Magistrates' Court, where the affray alarms were positioned only at the top and bottom of two flights of stairs leading to the dock.
- 5.48** All staff had received annual training in control and restraint techniques, which included training in particular techniques for use with pregnant women and young people. Staff told us that they would initially use communication skills in an attempt to de-escalate any potentially volatile situation. Staff told us that they rarely had to use force. There were inconsistencies among staff concerning the correct form to use to record use of force but they all said that this would be sent to Serco Wincanton managers.
- 5.49** 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 (see main recommendation 2.27). However, we saw some discretion exercised at a number of courts, where detainees were not handcuffed between the cells, toilets and legal visits. At all the courts, handcuffs were removed before detainees were taken into the dock. Those who were bailed or acquitted were allowed to return to the cell area for release without the use of handcuffs.
- 5.50** 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 custody computer system. They also completed an HM Prison Service personal record form and, if required, a suicide/self-harm warning form.
- 5.51** All courts had copies of 'what happens next' documentation, providing generic information about what to expect in prison for newly remanded or sentenced detainees. This was available in a range of languages on the company intranet site. Some courts offered a booklet, in a range of languages, providing detailed information for prisoners about the first 24 hours at HMP Peterborough. We saw staff at one court completing an HM Prison Service personal record form for a detainee entering prison for the first time, without providing any information about what would happen on arrival at prison.

- 5.52** No formal pre-release risk assessment was completed for detainees being released, and none of the custody suites had any information leaflets about local support organisations for potentially vulnerable detainees.
- 5.53** All courts provided travel warrants for trains but not all had petty cash available for bus fares.

Recommendations

- 5.54** Cell sharing risk assessments should be completed for all detainees subject to sharing, before this takes place.
- 5.55** The outcome of cell visits should be communicated to the prisoner custody officer updating the custody computer system, and records should reflect this.
- 5.56** When closed-circuit television is in use, it should be used in addition to, not as a substitute for, cell visits.
- 5.57** Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits.
- 5.58** Each court should have information leaflets about local support organisations and local custodial establishments, and they should be available in a range of languages.

Housekeeping point

- 5.59** Vulnerable detainees should be able to receive social visits in exceptional circumstances.

Physical conditions

- 5.60** Most court cells were clean and in good condition, with the exception of Southend and Cambridge Magistrates' Courts (see Appendix II) and Basildon Crown Court, which were dirty and had graffiti on the benches and doors. At Peterborough Magistrates' Court, the cells had recently been repainted but not the communal or toilet areas, the latter having a large amount of graffiti, some of it offensive, on the walls (see Appendix II). Staff told us that this had been reported on many occasions but still not rectified.
- 5.61** Staff at all courts carried out daily checks of the cells, which included checking that the call bells were functioning and that no property had been left or secreted. However, cells were not always checked between occupancies. For example, at Chelmsford Magistrates' Court we saw a detainee being placed in a cell which contained confidential documents relating to the previous detainee's court case, including their name and address, charge details and drug testing results; these documents were only removed from the cell at our suggestion. Staff told us that faults were mostly rectified quickly, although this was dependent on the nature of the fault and the availability of spare parts. For example, the cells at Chelmsford Crown Court were cold and, despite meetings between the SCO and the court manager, no effective remedial action had been taken.

- 5.62** Contract cleaners cleaned most courts in the evening or first thing in the morning. A good service was available from an external contractor to clean up spills of bodily fluid but staff indicated that these services were rarely needed. There was no natural light in cells at any of the courts.
- 5.63** All courts had clear fire evacuation procedures, with which staff were familiar. At some courts there was documentary evidence to confirm that drills had taken place.
- 5.64** Staff did not routinely explain the use of cell call bells to detainees, although most detainees we spoke to knew what they were for. At most courts, staff promptly answered cell call bells but at Chelmsford Magistrates' Court, the cell call bell buzzer did not work.
- 5.65** At all courts detainees were able to use a toilet in a cell corridor in privacy. However, at Colchester and Cambridge Magistrates' Courts, the toilets in some of the corridors had half doors, which did not afford sufficient privacy (see Appendix II). We saw an open soiled bin in the women's toilet at Cambridge Magistrates' Court (see Appendix II). Toilet paper, hand-washing facilities and a good supply of soap, paper towels and hand dryers were readily available in all toilets.

Recommendation

- 5.66** **A programme of regular deep cleaning should be put in place and graffiti should be removed.**

Housekeeping points

- 5.67** A suitable temperature should be maintained in all cells.
- 5.68** Cell call bell buzzers should function and staff should explain the use of call bells to detainees.
- 5.69** Toilets should afford sufficient privacy.

Health

- 5.70** Custody staff established health concerns with detainees on arrival. Taylormade provided telephone medical advice and a health services professional visited if required. Basildon, Cambridge and Colchester Magistrates' Courts had made 86% of the 50 calls to Taylormade between July and December 2013, and five courts had made no calls. Notices advising staff how to contact Taylormade were displayed clearly in each suite. Staff were aware of the provision but some were unsure of the services offered. Most of the staff who had used the service were positive about it. However, a few reported excessive waiting times for a visit; although the average wait was only 55 minutes, we found one instance where the requested visit had been cancelled when a health professional had not attended after over three hours. Staff telephoned the emergency services when necessary, and response times were reported to be good.

- 5.71** All staff were qualified in first aid and received updates every three years; however, with the low level of reported incidents, the training was too infrequent to maintain adequate skill levels. There was no automated external defibrillator, oxygen or suction in any of the court buildings, and in the event of an emergency this would delay the appropriate response. All staff carried personal resuscitation face shields but most were out of date, although we were told that replacements had been ordered. The first-aid kit in each suite was inadequate for predictable emergencies such as heart attacks, major self-harm and scalds, and most contained some out-of-date stock, despite weekly documented checks.
- 5.72** Most PER forms we examined included excessive medical-in-confidence information, such as medical diagnosis, and did not clarify the health risk that this generated, which made it difficult for custody staff to provide effective care (see recommendation 5.21). Health interventions were consistently recorded on the PER form.
- 5.73** Some detainees arrived from police custody or prison with medication, accompanied by clear instructions, which staff administered and recorded on the PER at the relevant times. However, staff reported, and we saw, that detainees often arrived from police custody without their prescribed medication. Although custody staff attempted to expedite court and transfer processes to enable detainees to access their medication post-release or in prison, the lack of prescribed medication was unacceptable. At Chelmsford Magistrates' and Crown Courts, staff told us that detainees regularly arrived from prison with medication sealed with clinical records, which caused delays in administration. We saw custody staff appropriately call the health care department at the sending prison to gain consent to break the seal and clarify drug administration instructions. Staff we spoke to demonstrated a good understanding of safe drug administration, and appropriately sought advice from the sending establishment or Taylormade for medication concerns. However, the Serco Wincanton medical policy was out of date and required review. Medication in some suites was stored unsecured with the PERs.
- 5.74** In Essex courts, there was good daily access to mental health professionals, and custody staff were positive about the service. However, mental health practitioners told us that the lack of an agreed process for Mental Health Act 1983 assessments had resulted in some detainees being inappropriately remanded to prison. In Cambridgeshire courts, mental health professionals were available only in Peterborough Magistrates' Court, as part of a pilot project. In both counties, young people received mental health support through the youth justice team.
- 5.75** Custody staff we spoke to demonstrated reasonable awareness of mental health issues but said that they would welcome formal mental health awareness training to identify and manage mental illness more effectively.
- 5.76** In Essex, most detainees with substance misuse issues were seen in police custody and drug workers also visited the court custody suites as required. In Cambridgeshire, substance misuse staff did not visit the court custody suites and we were told that court custody staff had never needed to refer any detainees. Custody staff had a reasonable awareness of substance misuse issues but lacked any formal training.

Recommendations

- 5.77** All staff should receive annual updates in first aid that is appropriate for the environment, to maintain an adequate skill level.
- 5.78** 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.
- 5.79** All detainees who require prescribed medications while in court custody should have access to them.
- 5.80** All detainees should have access to mental health support at all times that the courts are open. There should be clear process agreed with the courts and mental health trusts for the provision of Mental Health Act assessments.
- 5.81** Court custody staff should receive regular training to identify, support and appropriately refer detainees who may be experiencing mental health- or substance use-related problems.

Housekeeping points

- 5.82** All staff should be fully aware of the service provided by the current medical provider.
- 5.83** Detainees' medication should be stored securely in all court suites.
- 5.84** The Serco Wincanton medical policy should be reviewed.

Section 6. Summary of recommendations

Main recommendations

- 6.1** There should be sufficient staff on duty to ensure the safety of detainees, staff and visitors at all times. (2.24)
- 6.2** A standard risk assessment pro-forma should be completed for each detainee, and staff should be trained in completing it. (2.25)
- 6.3** Court custody staff should be trained to identify and refer appropriately detainees about whom they have child protection or safeguarding concerns. (2.26)
- 6.4** Handcuffs should only be used if necessary, justified and proportionate. (2.27)
- 6.5** Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite. (2.28)

National issues

- 6.6** 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. (2.29)
- 6.7** HMCTS should make more use of video link, 'virtual court' facilities and other provisions to reduce the need for detainees to be transported long distances to courts. (2.30)

Recommendations

Leadership, strategy and planning

- 6.8** There should be regular inter-agency forums covering all courts in the cluster, and their remit should include improvements to the care of detainees during escort and in court custody. (3.11)
- 6.9** The length of time that detainees, particularly young people and those who are vulnerable, spend waiting in court cells should be reduced. (3.12)
- 6.10** There should be clear procedures for safeguarding vulnerable detainees, including those released from court, and custody staff should be briefed about how to use them. (3.13)

Individual rights

- 6.11** Detainees whose case is listed for the afternoon should not be placed in court custody in the morning. (4.15)

- 6.12** Escort vehicles should be available to take detainees to custodial/secure establishments without delay following completion of their court case. (4.16)
- 6.13** HMCTS should liaise with HMP Chelmsford regarding their hours of operation for receiving prisoners, to reduce delays in transferring remanded or sentenced detainees. (4.17)
- 6.14** HMCTS should liaise with the Youth Justice Board to reduce delays in transferring young people to more appropriate custodial facilities. (4.18)
- 6.15** At every court, detainees should be told on their arrival about their rights, including the process for making a complaint, and staff should offer to read or explain them if necessary. (4.19)
- 6.16** Detainees' notice of rights should be available in a range of languages. (4.20)
- 6.17** Sufficient comfortable, private and soundproofed interview rooms should be made available at all courts for legal consultations. (4.21)
- 6.18** Complaints should be logged and there should be a process for monitoring and analysing trends. (4.22)

Treatment and conditions

- 6.19** Cellular vehicles should be clean inside and free of graffiti. (5.19)
- 6.20** Adult men, women and young people should not be carried in the same escort vehicle. (5.20)
- 6.21** Serco Wincanton should liaise with local prisons, Cambridgeshire Constabulary and Essex Police to discuss the transfer of information and completion of person escort records (PERs) for detainees. PERs should clearly identify the health risks for each detainee, while ensuring that confidentiality is appropriately maintained. (5.21)
- 6.22** Detainees should be transferred from cellular vehicles and neighbouring police stations to the court cells in privacy. (5.22)
- 6.23** Detainees should not be left unaccompanied on cellular vehicles. (5.23)
- 6.24** All staff should receive diversity and equality training that includes how to care for young people. (5.24)
- 6.25** Young people in court should be supported by a named staff member who is appropriately trained. (5.25)
- 6.26** All court cells should have hearing loops and Braille versions of key information for detainees. (5.26)
- 6.27** All courts 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. (5.27)
- 6.28** The PECS contractor should produce a policy setting out the correct approach to caring for transgender detainees and ensure that staff implement it. (5.28)

- 6.29** All courts should have a stock of appropriate reading materials, including some suitable for young people and non-English speakers. (5.29)
- 6.30** 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 kept clean. (5.30)
- 6.31** Cell sharing risk assessments should be completed for all detainees subject to sharing, before this takes place. (5.54)
- 6.32** The outcome of cell visits should be communicated to the prisoner custody officer updating the custody computer system, and records should reflect this. (5.55)
- 6.33** When closed-circuit television is in use, it should be used in addition to, not as a substitute for, cell visits. (5.56)
- 6.34** Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits. (5.57)
- 6.35** Each court should have information leaflets about local support organisations and local custodial establishments, and they should be available in a range of languages. (5.58)
- 6.36** A programme of regular deep cleaning should be put in place and graffiti should be removed. (5.66)
- 6.37** All staff should receive annual updates in first aid that is appropriate for the environment, to maintain an adequate skill level. (5.77)
- 6.38** 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. (5.78)
- 6.39** All detainees who require prescribed medications while in court custody should have access to them. (5.79)
- 6.40** All detainees should have access to mental health support at all times that the courts are open. There should be clear process agreed with the courts and mental health trusts for the provision of Mental Health Act assessments. (5.80)
- 6.41** Court custody staff should receive regular training to identify, support and appropriately refer detainees who may be experiencing mental health- or substance use-related problems. (5.81)

Housekeeping points

Leadership, strategy and planning

- 6.42** The rationales for changes to custody policy, including those emanating from HMCTS, should be fully explained to staff. (3.14)
- 6.43** At all courts, HMCTS managers should regularly visit the cells for which they are responsible so that any problems can be readily understood and resolved. (3.15)

- 6.44** Serco Wincanton should hold regular meetings with senior custody officers (SCOs), to enable SCOs to share ideas and develop practice. (3.16)

Individual rights

- 6.45** 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)
- 6.46** Warrants of committal should be produced promptly after a detainee's court case has concluded. (4.24)

Treatment and conditions

- 6.47** Cool boxes on cellular vehicles should be kept clean at all times. (5.31)
- 6.48** Secure confidential waste arrangements should be introduced at Basildon Magistrates' Court. (5.32)
- 6.49** Confidential information about detainees on whiteboards should be accurate and sited out of the view of detainees. (5.33)
- 6.50** Police services should not send detainees to court in distinctive clothing that might publicly identify them as having been in police custody. (5.34)
- 6.51** Mattresses and blankets or warm clothing should be available for all detainees. (5.35)
- 6.52** Detainees' property should be checked against accompanying documentation to ensure that it is all in order, before detainees are placed in cells. (5.36)
- 6.53** Staff should routinely inform all female detainees of the availability of feminine hygiene packs. (5.37)
- 6.54** Vulnerable detainees should be able to receive social visits in exceptional circumstances. (5.59)
- 6.55** A suitable temperature should be maintained in all cells. (5.67)
- 6.56** Cell call bell buzzers should function and staff should explain the use of call bells to detainees. (5.68)
- 6.57** Toilets should afford sufficient privacy. (5.69)
- 6.58** All staff should be fully aware of the service provided by the current medical provider. (5.82)
- 6.59** Detainees' medication should be stored securely in all court suites. (5.83)
- 6.60** The Serco Wincanton medical policy should be reviewed. (5.84)

Section 7. Appendices

Appendix I: Inspection team

Peter Dunn	Team leader
Elizabeth Tysoe	Team leader (shadowing)
Gary Boughen	Inspector
Vinnett Percy	Inspector
Fiona Shearlaw	Inspector
Majella Pearce	Health services inspector

Appendix II: Photographs

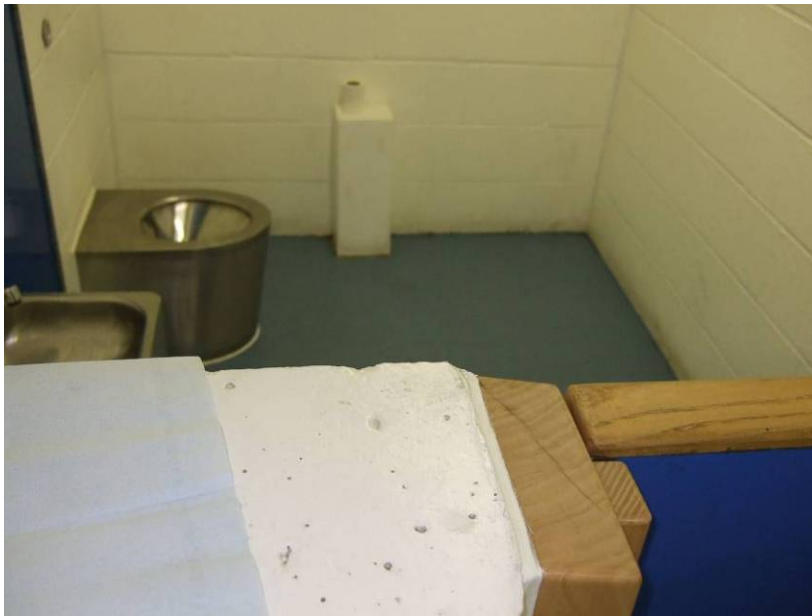
Filthy cellular vehicle cool box.



Stains on the cell walls and floors at Cambridge Magistrates' Court.



Lack of privacy in the toilets at Cambridge Magistrates' Court.



Dirty rubbish bin in women's toilet at Cambridge Magistrates' Court.



Detainee toilet area off the cell corridor at Peterborough Magistrates Court.

