Report on an inspection of court custody facilities in

London North and East

by HM Chief Inspector of Prisons

5–14 September 2016

Glossary of terms

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Section 1. Introduction

This is a report in a 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 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.

This is the first in a series of reports concerning court custody across the London cluster. We inspected custody facilities at seven courts, including three crown courts and four magistrates' courts in North and East London.

Working relationships among the agencies responsible for delivering the court custody provision were reasonable. However, provision was severely hampered by ineffective delivery of the cleaning and maintenance contract for which none of the agencies was directly responsible. Some investment in the estate was required to address the unacceptable conditions we found for detainees and staff.

The diverse and generally well-trained staff group was a strength. Custody staff dealt with detainees professionally and sensitively and on the whole paid good attention to their welfare needs during their court custody.

A range of shortcomings were identified throughout the inspection. A number of factors, including delays in obtaining warrants, contributed to detainees spending unduly long periods in court custody. The routine application of handcuffs in the physically secure court custody facilities was unnecessary and disproportionate. We had concerns about the legitimacy of some techniques used to restrain refractory or non-compliant detainees. Release arrangements were not always focused on securing a safe release for all detainees.

Our most serious concerns related to the approach to risk management. There was no effective formal assessment of detainees' risks on arrival to ensure they were identified and managed. Across the facilities we were particularly concerned that observation levels, including those for the most vulnerable, were not always conducted as required, despite some records suggesting they were. This criticism of the provider was highlighted elsewhere and was also raised following a death in custody at Thames Magistrates' Court in April 2015.

Overall this was a mixed inspection. Despite the diversity of the well-trained staff group, we have some significant concerns about safety, risk management, care for the most vulnerable detainees and the physical environment in court custody facilities across North and East London. We have made a number of recommendations to improve the safety and care of people detained in court custody.

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November 2016

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 The table below outlines the courts, number of cells and the throughput of each custody suite:

Custody suites	**Number of cells**	**Throughput** January 2016 – July 2016
Highbury Corner Magistrates' Court	32	3,672
Thames Magistrates' Court	35	4,080
Tottenham Magistrates' Court	13	55
Stratford Magistrates' Court	22	367
Snaresbrook Crown Court	11	1,915
Snaresbrook Crown Court Annexe	11	727
Wood Green Crown Court	14	1,712

Leadership, strategy and planning

2.4 HM Courts & Tribunals Service (HMCTS) in London operated as a cluster with two strands, one for magistrates' courts and one for crown courts. We focused on courts in the North and East of the cluster during this inspection. Two HMCTS cluster managers were responsible for these courts, among others in the rest of the London cluster, and they delegated responsibility to four HMCTS operations managers. Six HMCTS delivery managers supported them, each of whom was separately responsible for the crown and magistrates' courts we inspected. Prisoner Escort and Custody Services (PECS), part of the National Offender Management Service, commissioned Serco to manage court custody and provide escort services on behalf of HMCTS in London.

2.5 Formal meeting structures between key stakeholders were in place and there was adequate focus on the treatment of detainees in court custody. HMCTS took ownership of court

[1] http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/inspection-criteria/

custody facilities and attempted to resolve issues when advised. Court delivery managers and accommodation liaison staff visited court custody suites regularly. Minutes of meetings and lay observer reports indicated that most custody suites were in a poor state and had been for a considerable time. At the time of the inspection, many were dirty, damaged and covered with graffiti. HMCTS was not directly responsible for the contract for cleaning and maintenance, which was managed through a Ministry of Justice contract delivered by a contractor, Mitie. Despite reporting issues and escalation initiatives where necessary, defects and shortfalls were not always addressed. We did not accept that the explanation of ineffective contract management was a satisfactory answer to the long-term problem of poor conditions.

2.6 The staff group were from diverse backgrounds and we regarded this as a strength. Although levels of staffing for court custody facilities were generally adequate, we were concerned by the deployment of some staff, particularly those acting as gaolers in the cell areas of the custody suites. We were concerned that in the busier custody suites gaolers were overwhelmed and were sometimes unable to conduct cell checks at the required frequency. Serco was committed to delivering ongoing training for its staff, including equality and diversity.

2.7 Lay observers[2] visited court custody facilities regularly. The reports they produced highlighted issues in the court custody suites and were thorough. HMCTS, PECS and Serco were aware of their concerns.

2.8 Monthly meetings between PECS and Serco focused predominantly on contract compliance, but matters concerning detainees' care and welfare were also raised. Outcomes of audits conducted by the PECS contract delivery manager were not always circulated widely enough.

2.9 The use of virtual courts or prison video link to hear eligible cases without the need to transport prisoners to court was very low in crown courts and underused in most magistrates' courts. We were advised that the infrastructure across London did not support the wider use of video link.

2.10 There was no HMCTS safeguarding policy or protocol. Serco had its own standard operating procedure and had recently introduced some safeguarding awareness training, but court custody staff did not always know how to report a safeguarding concern if one arose.

Individual rights

2.11 Court enforcement officers who executed court warrants rarely brought detainees in to court custody, which was commendable.

2.12 Youth offending teams engaged proactively with children detained in court custody, but it was disappointing that cases involving children were not always prioritised.

2.13 A number of factors contributed to too many detainees being held in court custody for unnecessarily long periods. These included delays in the attendance of duty solicitors and court-appointed interpreters, unacceptable delays in obtaining warrants, detainees brought from prison early in the morning to crown courts when their cases were not listed until the afternoon, and lengthy delays before courts received the authority to release detainees who had been held in prison. Although most detainees were moved from court relatively quickly,

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

we found some excessive delays. However, vehicles were generally available at lunchtime to move crown court detainees back to prison, which reduced the time they had to spend in court custody.

2.14 Leaflets containing details of detainees' rights in custody and the local complaints process were routinely placed in cells, which was good. However, custody staff did not always check that the detainee could read or understand the information. Information about detainees' rights was readily available in a number of languages but staff did not always hand it out to detainees. We saw queues at Thames Magistrates' Court but access to legal representatives was good elsewhere. Arrangements for legal visits were satisfactory, with the exception of Highbury Corner Magistrates' Court where interview rooms were located on the secure cell corridors which were not always well controlled and which consequently presented some risks to visitors.

2.15 Telephone interpreting facilities were available in all the courts. Staff were confident in their use but we were not sure that interpretation was always used to check on the detainee's welfare or assess and manage risk. Arrangements for dealing with detainees' complaints were good, but detainees were not routinely told on arrival that there was a complaints procedure.

Treatment and conditions

2.16 Most of the cellular vehicles that we inspected were reasonably clean but were covered with graffiti. Children were transported on the same vehicles as adults, which was unacceptable. Anti-ligature knives were not readily accessible on vehicles, posing a potential risk to the safety of detainees. Most vehicle docks were secure and protected detainees from media or public attention. Where there was no secure vehicle dock, arrangements to maintain detainees' privacy and dignity were good.

2.17 Court custody staff interacted with detainees in a professional and friendly manner. We observed many occasions when staff reassured and cared for detainees who were in distress or anxious about their time in court custody.

2.18 The diversity of the custody staff group was a strength. We were confident that most custody staff considered individual needs while applying custody procedures. Despite a confusing and outdated protocol on the treatment of transgender detainees, staff knew how to look after transgender detainees and spoke respectfully about them.

2.19 We were informed that none of the court custody facilities that we inspected complied with the Disability Discrimination Act. Adaptations for detainees with disabilities were limited: hearing loops were provided during the week of the inspection but staff were not confident in their use. There was no information in Braille or easy-read format. We were reassured that most staff did their best to ensure the individual needs of detainees with disabilities or mobility issues were considered.

2.20 There was no specific provision for children apart from a separate cell location in most suites. Custody suites did not have appropriate reading material or enhanced observations for children. All court custody facilities had a wide range of religious material covering the main faiths and notices across the suites advised detainees of their availability.

2.21 There was limited access to reading material. Staff provided some, including newspapers that we saw being issued to detainees. The provision of drinks was good across most courts, although at Thames Magistrates' Court we saw excessive delays in issuing drinks on some mornings. Only low nutritional value microwave meals were provided in all courts. Meals

were issued at mealtimes and at other times on request, which was good to see. Unsterilised disposable water bottles were used daily to provide detainees with chilled water, which was insanitary.

2.22 Staff briefings were good at crown courts and at Stratford Magistrates' Court where they focused on detainees' risks and welfare. Briefings at other courts were poor, if they happened at all, and we were not confident that all staff received the briefing.

2.23 A formal risk assessment was being piloted in the crown courts and the less busy Stratford Magistrates' Court, which was positive. However, we felt that the risk assessment was unworkable in its current format. At other courts there was no formal risk assessment process that collated all the information about detainees so that they could be managed as safely as possible. Detainees sometimes had to share cells and the cell-sharing risk assessment was not always completed before co-location. We found a number of cases when it was not completed at all.

2.24 Following the death in custody at Thames Magistrates' Court in April 2015, it was concerning that not enough attention had been given to ensuring full compliance with recommendations made by the coroner to prevent future deaths.

2.25 We had many serious concerns about adherence to set levels of observation. In the busier magistrates' courts, there was no systematic approach to completing checks at the required frequency. We were particularly concerned that checks on the most vulnerable detainees requiring higher levels of observation were not always undertaken. Furthermore, records did not always reflect the actual visits the detainee received. The person conducting the checks did not always carry an anti-ligature knife which potentially compromised the safety of the detainee.

2.26 Arrangements for releasing detainees safely were inadequate. There was no formal pre-release risk assessment. Staff at most courts did not determine if detainees had the means to get home and did not routinely offer travel warrants or bus fares. However, we did see one vulnerable detainee being provided with the taxi fare to ensure he got home safely. Support leaflets were not offered consistently, if at all.

2.27 We were confident that staff de-escalated most challenging situations and that they only used force as a last resort. We were confident that use of force incidents were reliably reported with one notable exception, which Serco advised us they had investigated following an external complaint. Records reflected clear justification for the use of force but otherwise lacked detail about the techniques used to move and re-locate detainees. Handcuffs were routinely applied, even on children and where court custody facilities were secure, without a robust and individual risk assessment to justify their use. We saw some discretion used in applying handcuffs to detainees with mobility issues, which was positive.

2.28 Conditions in the court custody suites were very poor. Some courts had been without heating and hot water for a significant time. On numerous occasions during the inspection cells were out of action because of damage and graffiti or for cleaning. This reduced the capacity of cell blocks and increased the necessity for cell sharing, which greatly increased risk. Thames and Highbury Corner Magistrates' Courts and Snaresbrook Crown Court were by far the worst: cells were covered with graffiti, some of which was racist and offensive, they were often damaged and they were dirty. Stratford and Tottenham Magistrates' Courts were better but still contained offensive graffiti and needed redecoration. Conditions at Wood Green Crown Court were the best among the courts that we inspected. Overall, cleaning and maintenance arrangements were inadequate.

2.29 United Safe Care provided health advice, which staff could access by telephone. Medical practitioners could also attend court custody suites if necessary. Staff were aware of the full

range of services that United Safe Care provided and told us the service was responsive and helpful.

2.30 All custody staff received first aid training during induction and three-yearly updates. We were concerned that this was not frequent enough to maintain adequate staff skills.

2.31 Medication was not stored securely. Staff were confident to issue medication in an appropriate manner.

2.32 There was very good support from the diversion and liaison schemes for detainees with mental health and substance misuse problems.

Main recommendations

2.33 HMCTS, PECS and the escort and custody contractor should investigate the reasons for the prolonged periods that detainees, including children, spend in court custody cells. Measures should be put in place to ensure detainees have their cases prioritised where possible and are transferred and released without delay.

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

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

2.36 Use of force records should describe the techniques used in all use of force incidents. Only approved techniques should be used. Handcuffs should only be used if justified and proportionate.

2.37 Outstanding repairs across the court custody suites should be completed as a matter of urgency. All offensive graffiti should be removed immediately. The current cleaning regime should be significantly improved to ensure that all cells, toilets and communal areas are cleaned each day to an acceptable standard.

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 HM Courts & Tribunals Service (HMCTS) in London operated as a cluster with two strands, one for magistrates' courts and one for crown courts. We inspected court facilities in North and East London which were led by two HMCTS cluster managers and four operations managers. Six delivery managers supported them, each of whom was separately responsible for the crown and magistrates' courts that we inspected. The delivery managers took charge of running the courts. They had regular contact with Serco staff, particularly if there were problems affecting court custody operations. HMCTS had a clear line management structure for the cluster to deal with any significant issues.

3.2 Prisoner Escort and Custody Services (PECS), part of the National Offender Management Service, commissioned Serco to manage court custody and provide escort services in London. Serco's regional operations manager was responsible for overseeing the delivery of the contract for court custody escort services. Six court custody managers and nine deputy court custody managers employed by Serco reported to the court operations manager. The contractual arrangement between PECS and Serco was supervised by a PECS contract delivery manager.

3.3 We were not confident that Serco escalated all issues of concern to PECS as required, for example when HMP Pentonville advised a deputy court custody manager at 10am on a Saturday during the inspection that their reception would not be open to admit detainees until 1.30pm, this issue was not escalated to PECS and a number of detainees were held in court custody for longer than necessary.

3.4 Strategic meetings between Serco, HMCTS and PECS took place regularly. Minutes and interviews indicated that the agencies were focused on the care and welfare of detainees held in court custody. However, some issues were repeatedly raised, including the poor environment in most court custody suites, frequently with little progress in addressing them. We were not confident that all issues were reported to these strategic meetings, for example we were told repeatedly of frequent delays in issuing warrants and we found significant evidence to support this. This had been a historic issue that HMCTS believed to be resolved. Serco had not raised what was in fact an ongoing issue at the most recent meeting.

3.5 Working relationships between HMCTS and the court contractor Serco were professional. HMCTS accommodation liaison staff and court delivery managers visited court custody suites regularly. HMCTS operations managers were aware of most issues affecting the care and welfare of detainees. They acknowledged that physical conditions in some facilities were poor and escalated most of their concerns appropriately to the responsible contractor, Mitie. HMCTS were frustrated at the lack of action by the cleaning and maintenance contractor, Mitie, to remedy reported faults and defects. Serco staff attended HMCTS daily team briefings infrequently at magistrates' courts but more regularly at crown courts. Daily communication between court and custody staff was generally by telephone.

3.6 Despite an understanding by Serco staff of how to report cleaning or maintenance issues and how to escalate them, we were not confident that defects were always reported or escalated if required. Staff had become inured to dirt, graffiti and damage and we repeatedly found conditions that were disrespectful and some that were wholly unacceptable. HMCTS

were bound by, but not responsible for, a Ministry of Justice estates contract with Mitie to provide cleaning and maintenance services for the whole courthouse, including court custody facilities. They told us of their frustration that the contract was not delivered effectively and that, despite their best efforts, some faults and defects remained unaddressed for significant periods. Lack of funding was often cited as the reason for delays in undertaking work. Many cells contained substantial amounts of graffiti, most of which was racist and offensive. Throughout the inspection we came across cells that were out of action because of graffiti, damage or for cleaning and this reduced the capacity of custody suites to an unacceptable level. Lay observers and staff from Serco and PECS had repeatedly raised concerns about the poor environment. While we acknowledged that HMCTS did not own the contract, this did not excuse the unacceptable and disrespectful conditions we found in most court custody facilities.

3.7 The judiciary were responsible for listing court cases and following the inspection we were advised that there was a HMCTS listings framework for prioritising court custody cases. Observations during the inspection assured us that Serco staff alerted court staff when vulnerable detainees were in custody. We saw evidence that cases were sometimes prioritised.

3.8 We were advised that court user groups only took place every six months at the crown courts. Attendance was often poor and minutes did not reflect a focus on the care and welfare of detainees in court custody.

3.9 The staff group was diverse and representative of the community it served and we considered this a strength. Staffing for court custody facilities was generally adequate but we were concerned by the deployment of some staff, particularly those responsible for gaoler duties in the sometimes chaotic and busier custody suites in Thames and Highbury Corner Magistrates' Courts. Gaoler duties included completing cell checks, particularly on vulnerable detainees at stated frequencies. These were not always completed as required and some gaolers were sometimes overwhelmed by the number of detainees they dealt with (see paragraphs 5.26 and 5.27). Serco was committed to delivering staff training. Staff received annual refresher training in control and restraint and the 'essentials' package, which covered topics such as equality and diversity. Safeguarding awareness training had also been introduced in the essentials package, which was positive. The first aid refresher training was delivered every three years which was not frequent enough to maintain good awareness.

3.10 Serco issued a range of standard operating procedures (SOPs), but we were not confident that these were always communicated effectively to operational staff or monitored for compliance. For example, the SOP 'Prisoner Welfare at Court' (no. 054) set out revised levels of observation which had made checks at five-minute intervals obsolete. Despite this, many staff still used five-minute observations for vulnerable detainees or those at risk, which was inappropriate and, in most cases we observed, not achieved.

3.11 Lay observers visited all court custody suites in the courts that we inspected. Their reports were thorough and appropriately focused on conditions for detainees. HMCTS, PECS and Serco managers were familiar with lay observers' reports and told us they found them helpful. These reports repeatedly highlighted concerns about the physical conditions in some courts, including the lack of heating and hot water in some.

3.12 The PECS contract delivery manager convened monthly performance/contract compliance meetings with Serco. Detainee care and welfare issues, such as the low use of interpreting services, lack of variety in meals and promotion of the availability of religious items, were raised on an ad hoc basis. Concerns about the physical conditions in most courts were raised regularly. The contract delivery manager conducted 'safe, secure, decent and compliant' audits in each court custody facility, but reports of these audits were sent only to Serco. Most court custody staff we spoke to were not aware of the action plans arising from

the audits. We were not confident that court staff were properly briefed on the outcome of audits, even when improvements were needed.

3.13 PECS was advised of all reports of use of force in court custody and sampled a random selection of these reports. Serco's figures indicated that there had been 43 incidents involving force between January and July 2016. With one exception, which Serco had investigated following an external complaint, we were reasonably confident that reporting processes were reliable (see paragraph 5.39).

3.14 The use of virtual courts and prison video link were intended to avoid prisoners having to attend court. Use of prison video link for eligible cases was very low in crown courts and some magistrates' courts, although slightly better at Thames Magistrates' Court. The infrastructure to support wider use of virtual courts and prison video link hearings was described as inadequate by HMCTS.

3.15 There was no HMCTS safeguarding policy or protocol describing how detainees at risk, including children, would be protected from harm, abuse or mistreatment. Serco had its own standard operating procedure on safeguarding and had introduced some awareness training. However, staff were not always aware of their responsibilities or how to report a safeguarding concern if one arose.

Recommendations

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

3.17 The use of prison video link should be increased for eligible cases.

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

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 We observed custody officers checking the warrants and documentation that accompanied each detainee to ensure that they had the correct authority to detain them.

4.2 HMCTS operations managers told us that court enforcement officers (CEOs), who executed warrants on behalf of the court, could deliver compliant individuals directly to the court room. This avoided unnecessary detention in the court custody suites. Court custody staff confirmed that they rarely received detainees from CEOs and, when they did, it was usually because of the individual's behaviour or a health concern.

4.3 Custody staff at all courts we visited said they had a good relationship with their local youth offending service (YOS). We observed that YOS staff contacted court custody daily, including Saturdays, and attended when a child was detained in the court cells so that their needs, risks and circumstances were presented to the court. We saw children detained whose cases were not always prioritised to reduce the time they spent in the cells. We reviewed records across all the courts which showed that children were frequently held for over six hours before they appeared in court. In one case at Highbury Corner Magistrates' Court, a child had to wait 8 hours 46 minutes before appearing in court, which was unsatisfactory.

4.4 Staff told us of historic delays in obtaining placement orders (which determine where children under 18 should be held securely) from the Youth Justice Board. They said that placement orders were now obtained between one and two hours after a child was remanded or sentenced. Such delays prevented prompt booking of transport to take children to secure accommodation, leading to further delays. In records that we reviewed we found several cases of children not leaving court custody for transportation to secure accommodation until after 7pm, with the latest leaving at 9.26pm, which was unacceptable.

4.5 We saw remand cases being dealt with promptly at most courts, but we identified a number of significant delays in the attendance of duty solicitors and court-appointed interpreters. In one case at Stratford Magistrates' Court, the duty solicitor had been delayed at another court and did not attend at the court cells to visit a number of detainees until after lunch. At Highbury Corner Magistrates' Court, a Bulgarian detainee was remanded in custody for an additional night as an interpreter failed to attend the court, which was inappropriate (see paragraph 4.14).

4.6 National guidance stated that a detention warrant should be produced within 30 minutes of a court hearing or appearance: this was achieved in most cases at all the crown courts we inspected. However, there were routine waits of more than an hour in magistrates' courts which delayed transport being organised and lengthened detainees' stay in court custody cells. We reviewed records which indicated numerous delays of four, five and six hours waiting for warrants to be produced. Such delays evidenced poor practice.

4.7 HMCTS had negotiated with local prisons for detainees returning to prison to be accepted on an existing warrant provided their status remained unchanged. If the detainee's status had changed, for example if they had been sentenced and were no longer remanded, a new warrant was required. Custody staff said that this new arrangement was working well as it reduced the volume of requests for warrants and helped to organise transport for returning detainees more quickly. It was good to see that detainees whose cases had been heard at

crown courts were returned to prison at lunchtime when transportation was available and we found few excessive delays in moving adult detainees at the end of the working day.

4.8 Long periods in court custody were also caused by other factors. It was common practice at the crown courts for detainees to be brought from prison early in the day, even though their cases were not listed until the afternoon. We found evidence of this in records that we reviewed. It was also common for detainees who had been bailed or acquitted, but previously remanded in custody, to wait for long periods before their originating prison authorised their release. We saw one detainee at Highbury Corner Magistrates' Court who was released by the court but returned to his cell while it took a further 2 hours 38 minutes to secure the authority to release him from the prison.

4.9 Custody staff told us they had started to experience significant delays in receiving the authority to release detainees who were subject to licence conditions. Records at Snaresbrook Crown Court Annexe showed that one detainee had been released by the court at 10.38am and returned to his cell. Court custody staff sent the necessary paperwork to the prison promptly, but the licence was not received at the court until 5.20pm and the detainee was not released until 5.30pm. Such delays were unacceptable.

4.10 Detainees in police custody were accepted by the magistrates' courts as long as the court was sitting and there was capacity to hear the cases. Custody staff advised us it was the clerk of the courts' decision to accept a detainee in these circumstances and that detainees were accepted throughout the day, occasionally as late as 3.30pm. Records showed that detainees had been accepted as late as 2.48pm. We saw a detainee being accepted at 12.20pm on a Saturday at Thames Magistrates' Court, which meant they did not have to be held in police custody over the weekend.

4.11 Court custody staff in the magistrates' courts told us that if a detainee wanted to tell somebody where they were, this was referred to the detainee's legal representative.

4.12 Printed copies of rights and complaints information were placed in cells before a detainee's arrival, although this did not happen one day at Thames Magistrates' Court. Custody staff did not always explain this information or check that detainees were able to read and understand it. At one crown court, we saw a detainee tell the cells officer that he could not read or write and no effort was made to read the rights documentation to him, in contrast to another crown court where the cells officer read the document to a detainee. The rights and complaints information was readily available in a number of languages, but staff did not always issue this to detainees.

4.13 Custody staff at all the courts asked detainees when they arrived who their legal representative was. Legal representatives were allowed access to detainees in suitable interview rooms, although queues to gain access to these rooms were common at Thames Magistrates' Court. The interview rooms at Highbury Corner Magistrates' Court were sited within the secure cell corridors, which presented a clear risk to legal representatives as detainees had free movement on the corridors to use the toilets. Detainees at all courts were allowed to keep legal documents with them.

4.14 Custody staff in all courts knew how to use the telephone interpreting service and hands-free telephone handsets were available to facilitate access to the service. Staff were very positive about the service, although data supplied by Serco showed that the service was underused, with only five calls logged in the last three months. We saw several foreign national detainees in court custody who would have benefited from the interpreting service to enquire about their welfare, manage risks and aid understanding of the judicial process. The Bulgarian detainee referred to in paragraph 4.5 did not appear in court until the late afternoon (see paragraph 4.5). He was clearly upset and confused that he could not

communicate with anybody, but it was only after he was remanded overnight that the telephone interpreting service was used to explain to him what had happened.

4.15 Data provided by Serco showed that only one complaint had been received during the previous six months across all court custody suites in the area. This complaint was currently under investigation. Detainees were advised of the complaints procedure through the rights and complaints documentation placed in their cells. This was, however, not routinely explained and was not accessible to detainees who did not read (see paragraph 4.12). Notices about the complaints procedure were displayed in all the custody suites, in most cases in the main reception areas where detainees did not have time to read them. Staff were aware of the complaints process and we saw one detainee at Highbury Corner Magistrates' Court issued with a complaint form and a stamped addressed envelope to complain about damage to his mobile phone, which he said had happened during his transfer to court on an escort vehicle. Custody staff did not know if detainees could appeal to an independent body if they were unsatisfied with the outcome of a complaint. This information was not available in any of the complaints documentation.

Recommendations

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

4.17 HMCTS should investigate the siting of suitable private interview rooms outside the secure cell corridors at Highbury Corner Magistrates' Court.

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

4.19 All detainees should be informed of the complaints process.

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 Most of the cellular vehicles that we inspected were reasonably clean but were covered with graffiti. We saw children being transported with adults and records showed that this was common practice. This was unacceptable. Anti-ligature knives were not readily accessible on vehicles, which posed a potential risk to the safety of detainees.

5.2 There were very few long journeys; most detainees arrived at court from local police custody suites and prisons. On arrival at courts, detainees disembarked promptly from vehicles, although at a Saturday court several cellular vehicles arrived at the same time and the last detainee waited 48 minutes in the vehicle to be taken into the custody suite, which was unsatisfactory. Most vehicle docks were secure and protected detainees from media or public attention. If there was no secure vehicle dock, staff tried to ensure that detainees' privacy and dignity were maintained.

5.3 All necessary information accompanied detainees arriving from police stations or prisons. Detainees' details were checked and their identity confirmed. One day at Thames Magistrates' Court the process for receiving 37 detainees was disorganised and haphazard. Some detainees' identity was checked by the member of staff reviewing the person escort record and some by the staff member collating solicitors' details, while other detainees just pointed to their names on the wipe clean board. There was poor oversight and management of this procedure.

5.4 Throughout the inspection we noted friendly and considerate interactions between prisoner custody officers and detainees. We observed many occasions when custody staff calmed and cared for detainees who were distressed or anxious about their case.

5.5 A diverse group of custody staff largely reflected the population of detainees coming into court custody, which was a real strength. It was good to see custody staff using their cultural understanding and language skills to communicate with detainees and provide reassurance. Most staff had received diversity and equality training. We were confident that most custody staff applied custody procedures while considering the individual needs of detainees. Despite a confusing and outdated protocol on the treatment of transgender detainees, staff knew how to look after transgender detainees and spoke respectfully about them.

5.6 We were told that none of the court custody facilities in the courts we inspected complied with the Disability Discrimination Act. Adaptations for detainees with disabilities were limited: hearing loops were provided during the week of the inspection but staff were not confident to use them. There was no information in Braille or easy-read format. Some staff did their best to consider the individual needs of detainees with disabilities or mobility issues.

5.7 There was no specific provision for children apart from a separate cell location in most suites. There was no appropriate reading material or enhanced observations for children.

An activity box containing puzzles was provided during the inspection but we did not see this being offered to the children we saw in court custody. Staff were not sufficiently aware of safeguarding procedures (see paragraph 5.30).

5.8 All court custody facilities had a wide range of religious material covering the main faiths, and notices across the suites advised detainees of their availability. At Snaresbrook Crown Court there was a separate space for detainees to pray, which was commendable, particularly as many detainees had to share a cell.

5.9 Most courts had separate corridors or cells for women and staff ensured that women were held separately while in custody. Women were not routinely advised that feminine hygiene products were available in the suites.

5.10 The court custody suites did not have a stock of blankets for detainees who found the wooden benches uncomfortable. Those with disabilities, older detainees and women who were pregnant were particularly affected by having to wait on uncomfortable seats, sometimes for a long time.

5.11 There was no reading material for detainees, some of whom spent all day in court cells with nothing to do. Court custody staff had brought in a limited selection of books and newspapers and we saw staff handing out newspapers to some detainees. There were no publications in languages other than English. Arrangements for securing detainees' property were adequate at all courts except Thames and Highbury Corner Magistrates' Courts. The property cupboard at Highbury Corner was left unlocked on a number of occasions. At Thames Court the property cupboard was full and detainees' property was left strewn on the floor until it was removed to a back office some time later. This was poor, inconsiderate practice.

5.12 Drinks were provided on arrival and on request, which was good. However, at Thames Magistrates' Court on one day during the inspection, detainees had to wait nearly two hours after arrival for drinks to be served. At some courts, staff were inexplicably reluctant to offer coffee to detainees because of the perceived effects of caffeine on their behaviour. Serco managers did not know that staff were taking this course of action.

5.13 All courts had ambient microwave meals of low nutritional value. Food preparation areas were generally clean and appropriately located and meals were issued at standard mealtimes and at other times on request, which was good to see. We were concerned that unsterilised disposable water bottles were being used repeatedly to chill water to dispense to detainees, posing a health risk.

Recommendations

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

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

5.16 Detainees' property should be securely stored.

5.17 All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers, which should be routinely offered to detainees.

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

Safety

5.19 Custody staff at all courts should have received an early morning briefing on changes in policy or procedure and on the risks or vulnerabilities of those who would be detained. Most staff briefings were good at the crown courts and at Stratford Magistrates' Court. They appropriately focused on risk and vulnerability and the court custody managers identified any detainee with medical issues that needed additional monitoring. At other courts the briefings were poorly delivered, if at all. Not all staff were present and there was no focus even when there was important information about detainees that needed to be shared with staff.

5.20 A new risk assessment form was being piloted in the crown courts and the less busy Stratford Magistrates' Court which brought together all sources of information and outlined how the detainee would be managed in custody. This was a positive initiative, although the draft form was too long, the questions were intrusive and it was not properly focused. Staff struggled to complete it with detainees in a timely manner. At other courts there was no systematic risk assessment process to manage detainees as safely as possible. Custody staff across the courts reviewed the person escort record (PER) and we observed some staff interviewing detainees with self-harm warning markers to find out how they were feeling. This was not done at all courts and the outcome of the interviews was not always recorded on the PER or the computer database, Serco electronic recording system (SERS).

5.21 We reviewed PERs accompanying detainees transferring from local police custody suites, some of which contained far too much loose information, such as risk assessments and non-confidential medical information. The quality of the PERs was variable. Too many from both police and prisons were completed poorly and did not contain enough information on which to base risk assessments (see paragraphs 5.56 and 5.57).

5.22 Detainees at some of the busier magistrates' courts and Snaresbrook Crown Court were often required to share cells. Cell-sharing risk assessments (CSRAs) were not completed for all occupants before they were co-located. On one day at Thames Magistrates' Court 18 detainees were sharing cells but only three CSRAs had been completed. A number of cells at this court were frequently out of use and custody staff did not routinely ask detainees if they objected to sharing a cell (see paragraph 5.45). When detainees were taken to the cell block, some refused to share and staff changed their location or coerced them to share. This caused considerable disruption to the detainees and staff. Inconsistent completion of the CSRA was potentially unsafe and did not comply with Serco operating procedures. Staff needed further training and guidance on the importance of completing the CSRA correctly.

5.23 We had some serious concerns across the spectrum of risk assessment and management, particularly at Thames and Highbury Corner Magistrates' Courts.

5.24 A detainee had died from natural causes in the court custody suite at Thames Magistrates' Court in April 2015. A coroner's regulation 28 report to prevent future deaths in court custody was issued to Serco in March 2016 with 'matters of concern' for the court contractor to respond to. An action plan was produced detailing safeguards that had been put in place to improve practice and to ensure that observations conducted by court custody staff were complied with and correctly recorded, and that detainees were held in a safe environment.

5.25 Despite this, we had many concerns. The levels of observation were appropriately set for most detainees, but at some courts staff still used five-minute observations which had been withdrawn from practice some months previously (see paragraph 3.10). This raised questions

about how important information was shared with staff and how compliance with operational instructions was supervised and monitored.

5.26 In the busier magistrates' courts, there was no systematic approach to ensuring that checks were completed at the specified frequency. Court custody staff were required to complete a cell visits check sheet every time they visited a cell which was used to update detainees' records. On one morning at Thames Magistrates' Court the cell visit check sheet had not been completed between the hours of 9am and 2pm. We had observed some detainees being visited during that time, but we were not confident that all detainees were visited at the required frequency. This presented a significant risk and was a concern.

5.27 The cell visits check sheets that we reviewed at all courts did not always reflect actual visits to the detainee. We were particularly concerned that checks on the most vulnerable detainees requiring higher levels of observation, every 15 minutes, were not always undertaken. We were told of at least two detainees who were on constant watch who were not monitored constantly at Thames and Highbury Corner Magistrates' Courts.

5.28 During the staff briefing, court custody staff were told who was carrying the anti-ligature knife; this was usually the cells officer at all courts. At least one anti-ligature knife was available in all custody suites. Cell visits were not always undertaken by the same member of staff and the anti-ligature knife was not always carried or handed over to the person conducting the checks. This compromised detainee safety.

5.29 There were no significant delays in presenting detainees at court. There were generally sufficient affray alarms in the area to summon assistance. Arrangements for releasing detainees safely were inadequate. There was no systematic pre-release risk assessment. All courts had stocks of rail warrants and petty cash but detainees were not routinely asked how they were getting home and if they had the means. Staff did not always offer travel warrants or provide money to meet transport costs. However, we did observe that the court custody manager at Snaresbrook Crown Court ensured that a vulnerable detainee was given money to take a taxi home.

5.30 Very few staff understood that they had a duty to refer detainees if they had concerns about them leaving court custody. Some staff knew they had to contact their line manager, youth offending service or probation, but most were unfamiliar with internal avenues, such as the Serco safeguarding manager.

5.31 Detainees were not routinely offered information about general support services despite leaflets being available at some courts. Staff at Wood Green Crown and Highbury Corner Magistrates' Courts knew of local homeless shelters and other support services and were able to offer informal advice.

5.32 Detainees remanded or sentenced to prisons were offered a 'What happens next?' leaflet and there was information about the local prisons to which detainees were transferred.

5.33 When a detainee was remanded or sentenced to prison, court custody staff ensured that the PER was updated with relevant information about risks that had been identified in custody. Where suicide or self-harm concerns were apparent, they also completed a separate form. Court custody staff were required to print a copy of the electronic record of the detainee's time in court custody and send it with the PER. This was not being done at Thames or Highbury Corner Magistrates' Courts.

Recommendations

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

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

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

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

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

Use of force

5.39 Across the six courts inspected, there had been 43 incidents of use of force between 1 January and 31 July 2016. We were reasonably confident that all use of force was reported with one notable exception, which Serco advised us they had investigated following an external complaint. All staff received annual refresher training in control and restraint techniques. We observed staff de-escalating challenging situations and we were confident they only used force as a last resort. The standard of the completed use of force forms that we reviewed was only adequate. Justification for the use of force was recorded, but details of the techniques used to move and re-locate detainees were lacking.

5.40 Handcuffs were routinely applied, even on children and where court custody facilities were secure, without a robust and individual risk assessment to justify their use. We saw discretion being used in applying handcuffs to detainees with mobility problems, which was good.

5.41 Searching practices that we observed were proportionate. Detainees arriving from prisons did not have a further search on arrival at court. Detainees were not given frequent rub-down searches after using the toilet or seeing their legal advisers, which was commendable.

Physical conditions

5.42 Conditions in the court custody suites were unacceptable. Conditions at Snaresbrook Crown Court, Thames and Highbury Corner Magistrates' Courts were by far the worst: they were disrespectful and indecent, cells and toilet areas were covered with graffiti, some of which was racist and offensive, and they were dirty (see photographs in Appendix II). They required immediate remedial action and ongoing maintenance, redecoration and repair to ensure that detainees were held in clean and decent environments. Tottenham and Stratford Magistrates' Courts were better but still contained offensive graffiti and were in a poor decorative state. In contrast, Wood Green Crown Court was clean, light and well maintained.

5.43 The checking of cells was a difficult task at some suites because of the poor conditions, particularly at Snaresbrook Crown Court and Thames and Highbury Corner Magistrates' Courts. Court custody staff were required to check the custody suites to ensure that cells were fit for occupancy, there was no fresh graffiti and cell bells were working. They did not

always focus on potential ligature points or try to limit the risks they posed. An example at the time of the inspection was a large hole in the bench of one of the cells at Highbury Corner Magistrates' Court which was a potential ligature point. The cell was taken out of use when the hole was pointed out by an inspector but was operational the next day with no repair to the hole or thorough risk assessment of any detainee placed in the cell (see photograph in Appendix II). It was evident that court custody staff had become inured to the dirt, graffiti and damage in the cells (see paragraph 3.6).

5.44 There was a system for reporting basic maintenance defects to the responsible contractor but documents that we reviewed showed that, while court custody staff had reported many defects over the previous 12 months, there was no timescale for remedying the defects and the reporting sheet merely recorded that the issues were 'ongoing'. During the inspection, 10 cells at Thames Magistrates' Court were placed out of use, five requiring specialist cleaning and five with maintenance problems that had been reported several months previously with no indication of when repairs would be completed. This reduced the capacity of cell blocks and increased the necessity for cell sharing, which was unacceptable (see paragraph 5.22).

5.45 There were concerns at Snaresbrook Crown Court about the temperature in the cells. During the summer, the cells were very hot with no ventilation and were often occupied by three or four detainees. In the winter, cells were cold because of a boiler defect. Similarly, at Thames Magistrates' Court the lay observers had reported that the men's cells were cold and detainees were complaining about the temperature.

5.46 Lay observers attended the court custody suites regularly and reported on the conditions, highlighting concerns about the dirt, heating, drainage and overall conditions of the suites. This produced very little action. We were not confident that all issues were reported by Serco or escalated. The reporting and escalation process was ineffective and unresponsive and the lack of action caused court custody staff significant frustration (see paragraph 3.6).

5.47 The graffiti across all the custody suites was excessive, degrading and offensive. Immediate action was needed to remove graffiti of a racist, sexist, homophobic and islamophobic nature. We were advised by court staff that some of the cells had been deep cleaned some weeks previously, and we had not seen the custody suites at their worst.

5.48 The cleaning regime was poor, despite the attendance of cleaners at the suites. Paper, food and dirt remained in the communal areas, in the cells and on the walls. Improvement was needed, not only in the cell areas and toilets, but in areas occupied by staff.

5.49 The toilets at all the court custody suites were generally in need of repair and deep cleaning. Wall tiles needed replacing, hot water was not available in all the suites (Snaresbrook Crown Court Annexe and Stratford Magistrates' Court) and soap and hand towels were not consistently available. Mitie was slow to repair faults with toilets, and during the inspection staff covered the drains at Thames Magistrates' Court with paper to prevent the pungent smell from emanating around the corridors. Staff toilets at this court had needed repair for three weeks and staff had had to hand in their keys and use toilets elsewhere in the court. All of this was unacceptable.

5.50 Staff were aware of fire evacuation procedures, which were clearly displayed. At some suites, staff discussed response to a fire evacuation during the staff briefing, and practice emergency evacuation drills had taken place.

5.51 We saw some staff explain the cell call bell to detainees, particularly when they were new to custody, but this did not always happen. We observed cell bells receiving a prompt response.

Health

5.52 Custody staff identified health concerns for detainees on their arrival. United Safe Care had been contracted as medical services provider in July 2015, and provided telephone advice and a visiting health care professional if required. Staff contacted the ambulance service in urgent situations, and response times were said to be good. Details of how to contact the medical services provider were clearly displayed in each suite, but some were out of date. Staff we spoke to were very positive about the service, which was well used. We reviewed records supplied to us by the company which showed that they had been contacted by the courts 25 times in July 2016. Paramedics had attended most of the calls and in only two cases had advice been given. We saw representatives of United Safe Care and the ambulance service attend at a number of the court custody suites to treat detainees and their response times were appropriate.

5.53 All staff had completed a first aid at work qualification and received updates every three years, which was not enough to maintain an adequate skill level specific to the environment. Many staff had not used or practised these skills and there was no on-site resuscitation equipment, suction, oxygen or automated external defibrillators (AEDs). The basic first aid kits in most suites had different contents and were not routinely checked. In some cases, they contained out-of-date stock. We were told that all staff were issued on appointment with a first aid pouch which was carried on their belt. We found that many staff did not carry these and some contained out-of-date items.

5.54 Custody officers relied on information on the person escort record (PER) and from detainees, but health issues were not always fully identified on the PER, for example a detainee who arrived at court on crutches and in a partial cast was simply recorded as having a 'bad ankle'. We observed a large number of loose sheets containing information about medical consultations, medicines administered and risk assessments attached to the PERs, rather than recorded on them.

5.55 Some detainees arrived from police custody or prison with their prescribed medication and instructions, which staff handed to detainees for self-administration and recorded on the PER at relevant times. In one case the detainee arrived with prescribed medication but no record in the PER of why the medication was required. Court custody staff accepted the detainee's explanation that he required the medication for his epilepsy but no check was made with the relevant police station to clarify the health needs of the detainee. Medications were on occasion stored unsecured with the PERs in the custody suite offices, with the risk of them being mislaid. Staff were aware of the requirements for safe drug administration.

5.56 Detainees were allowed to keep their asthma inhalers with them in their cells. They were not allowed to keep angina sprays (to relieve heart pain or tightness), insulin pens or blood sugar testing equipment, which were stored in the custody suite offices and were accessible if required. We saw a detainee being allowed access to his blood sugar testing equipment, which was appropriate. We did not see any formal risk assessments of the retention of medicines by detainees.

5.57 Detainees with mental health difficulties were identified and assessed before arriving from prison or police custody. Well established court and liaison diversion services were available at most magistrates' courts five days a week, with a more limited service at the crown courts. At Thames and Highbury Corner Magistrates' Courts, specialist mental health practitioners were available two days a week and custody staff knew whom to contact for support in their absence. Across all courts, not all custody staff had received mental health awareness training.

5.58 Detainees with substance misuse problems had usually been seen in police custody or at the transferring prison. Specialist substance misuse workers provided comprehensive coverage and a routine presence across all the magistrates' courts, where a number of different agencies provided support based on where the detainee lived. Custody staff demonstrated a reasonable understanding of drugs and alcohol issues and most were familiar with the risks associated with alcohol withdrawal. However, they lacked formal training in drug- and alcohol-related risks.

Recommendations

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

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

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

Section 6. Summary of recommendations

Main recommendations

6.1 HMCTS, PECS and the escort and custody contractor should investigate the reasons for the prolonged periods that detainees, including children, spend in court custody cells. Measures should be put in place to ensure detainees have their cases prioritised where possible and are transferred and released without delay. (2.33)

6.2 There should be a comprehensive review of custody operations to address some of the failures identified during the inspection. All custody procedures should be monitored to ensure that they are understood, consistently implemented and adhered to. Management and oversight of the custody suites should be improved to ensure the safe detention of detainees. (2.34)

6.3 Staff should complete a standard risk assessment for each detainee and receive training to do this. Cell-sharing risk assessments should be completed for all detainees before sharing takes place. (2.35)

6.4 Use of force records should describe the techniques used in all use of force incidents. Only approved techniques should be used. Handcuffs should only be used if justified and proportionate. (2.36)

6.5 Outstanding repairs across the court custody suites should be completed as a matter of urgency. All offensive graffiti should be removed immediately. The current cleaning regime should be significantly improved to ensure that all cells, toilets and communal areas are cleaned each day to an acceptable standard. (2.37)

Recommendations

Leadership, strategy and planning

6.6 Serco should escalate all relevant cleaning, maintenance and contractual issues concerning the care of detainees with HMCTS or PECS. (3.16)

6.7 The use of prison video link should be increased for eligible cases. (3.17)

6.8 There should be a safeguarding policy and all staff should be made aware of safeguarding procedures for children and adults at risk. (3.18)

Individual rights

6.9 Detainees whose case is listed for the afternoon should not be placed in court custody in the morning. (4.16)

6.10 HMCTS should investigate the siting of suitable private interview rooms outside the secure cell corridors at Highbury Corner Magistrates' Court. (4.17)

6.11 Telephone interpreting services should be used as necessary to check on the welfare, risk management and understanding of foreign national detainees. (4.18)

6.12 All detainees should be informed of the complaints process. (4.19)

Treatment and conditions

6.13 Cellular vehicles should be free of graffiti and men and women and children should be transported in separate escort vehicles. (5.14)

6.14 Serco should produce a policy, in line with police and Prison Service guidance, on the correct approach to caring for transgender detainees, and ensure that staff implement it. (5.15)

6.15 Detainees' property should be securely stored. (5.16)

6.16 All courts should have a stock of appropriate reading material, including some suitable for children and non-English speakers, which should be routinely offered to detainees. (5.17)

6.17 Disposable water bottles should not be reused to store and serve water. (5.18)

6.18 All custody staff should receive a comprehensive briefing at the start of duty focused on risk management and the care of vulnerable detainees. (5.34)

6.19 Set levels of observation should always be adhered to and accurately recorded. (5.35)

6.20 Staff undertaking observations and cell visits should carry anti-ligature knives at all times. (5.36)

6.21 Pre-release risk arrangements should be improved. Custody staff should check if detainees have any immediate needs or concerns that should be addressed before they leave custody. (5.37)

6.22 Staff should provide detainees with information about local support organisations. (5.38)

6.23 Custody staff should be appropriately trained in: emergency response skills, including the use of automated external defibrillators, with annual refresher training; mental health awareness; and drugs and alcohol awareness. (5.61)

6.24 First aid equipment in custody areas should include sufficient up-to-date kit, including basic equipment to maintain an airway and automated external defibrillators. (5.62)

6.25 Person escort records should identify the detainee's health risks while maintaining appropriate confidentiality. All inadequately completed PERs should be fully completed and captured on the incident reporting system and the information should be formally escalated to the sending establishment. (5.63)

Section 7. Appendices

Appendix I: Inspection team

Kellie Reeve	Lead Inspector
Ian MacFadyen	Inspector
Vinnett Pearcy	Inspector
Fiona Shearlaw	Inspector

Appendix II: Photographs

A cell at Highbury Magistrates Court with a large hole – a potential ligature point

Graffiti in cells at Thames Magistrates Court