Report on an inspection visit to court custody facilities in

London North, North East and West

by HM Chief Inspector of Prisons

29 May–6 June 2017

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 was the second group of courts to be inspected in the London cluster. The inspection focused on courts in west London and four previously uninspected courts in the north and north east of the cluster. There were eight courts in use that had custody facilities, including two crown courts, and six magistrates' courts. The Prisoner Escort and Custody Services (PECS) arm of HM Prison and Probation Service (HMPPS) had contracted Serco on behalf of HM Courts & Tribunals Service (HMCTS) to provide court custody and escort facilities in the region. The area also included two immigration asylum chambers (IACs) (tribunal centres), for which care of detainees was contracted to be provided by Mitie and Tascor.

We found reasonable and improving working relationships between the key stakeholders involved in the delivery of court custody. Senior managers described a willingness to improve the treatment and conditions of detainees, but their stated intentions were still a considerable way off being realised. Staff mostly dealt patiently and professionally with detainees. HMCTS had an appropriate focus on utilising video link hearings for eligible cases, which reduced the effects that the upheaval of journeys to court could have. Unfortunately, there were few other positive features to comment on following completion of this inspection.

Weaknesses highlighted in the first strand of the cluster inspection in September 2016 still prevailed and a number of outcomes for detainees had, in our view, worsened. The conditions in which detainees were held, including, for example, cell standards and cleanliness, still required significant improvement. The management of the cleaning and maintenance contract had changed but remained ineffective. Where progress had been made, this was too slow and too many detainees and staff had to endure unacceptably poor conditions.

A number of other areas required remedial attention. Too many detainees stayed in court custody for too long. Risks were sometimes not identified and subsequent risk management was on occasion inadequate and compromised detainee safety. Release arrangements did not adequately focus on ensuring detainees always got home safely.

Overall, this was a disappointing inspection. This report provides a number of recommendations for improvement that in particular address issues such as the deployment of staffing resource, the management of risk, the length of time detainees are held, and improvement to the conditions in which people are held. Our hope is that providers and key stakeholders afford more priority to these recommendations than they have in the past, in order that sustained improvement can be delivered.

Peter Clarke CVO OBE QPM July 2017
HM Chief Inspector of Prisons

Section 2. Background and key findings

2.1 This report is part of the programme of inspections of court custody carried out by HM Inspectorate of Prisons. These inspections contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

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

2.3 London North, North East and West court custody suites comprised:

Custody suites	**Number of cells**	**Throughput**
		1 August 2016–31 March 2017
Hendon Magistrates' Court	20	2,228
Willesden Magistrates' Court	25	328
Barkingside Magistrates' Court	14	1,841
Romford Magistrates' Court	6	87
Ealing Magistrates' Court	9	872
Uxbridge Magistrates' Court	15	2,180
Harrow Crown Court	13	1,368
Isleworth Crown Court	22	1,900
		1 January 2017–30 April 2017
Harmondsworth Immigration and Asylum Chamber	Two holding rooms	205
Hatton Cross Immigration and Asylum Chamber	One holding room	301

Leadership, strategy and planning

2.4 HM Courts & Tribunals Service (HMCTS) in London operated as a single cluster. This was the second group of courts in the London cluster to be inspected. Three agencies worked together to deliver court custody services: HMCTS, which had overall responsibility, along with Prisoner Escort and Custody Services (PECS) (part of HM Prison and Probation Service) and Serco, the service provider. Mitie and Tascor were contracted to provide care for detainees held in the immigration asylum chambers (IACs) (tribunal centres). Working

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

relationships between HMCTS, PECS, Serco and the other providers were described to us as reasonable and improving. HMCTS had a clear line management structure for the cluster. HMCTS managers accepted overall responsibility for court and tribunal custody, but did not always make frequent visits to custody facilities.

2.5 Relationships were underpinned by regular formal and informal communication arrangements. The three parties suggested they prioritised detainee care and welfare but their stated intentions were some way from being delivered. We were concerned by the apparent failure to learn lessons and lack of action to address some of the poor findings and recommendations from our 2016 inspection, the first focusing on the London cluster. During this inspection, we found that outcomes for detainees in a number of areas worsened.

2.6 We were pleased that the cleaning and maintenance contract, delivered by Mitie, was now directly managed by HMCTS rather than the Ministry of Justice (MOJ). However, HMCTS were not managing arrangements well enough to ensure arrangements delivered effectively. Most detainees were held in poor conditions.

2.7 Sufficient staff were not always deployed to court custody, too often impacting outcomes for detainees. Serco staff were well trained initially but ongoing training and development was not always adequate.

2.8 HMCTS had a protocol which allowed for court custody cases to be prioritised. Despite this, and sometimes without good reason, we did not always find they were prioritised, even for the most vulnerable. Standard operating procedures, governing the working practices of Serco staff, were not always understood, embedded or effectively implemented, for instance, where adhering to set levels of observation or safeguarding detainees was concerned.

2.9 Lay observers provided regular, proactive and constructive independent scrutiny of custody facilities. Their reports were used to identify and drive some improvements.

2.10 HMCTS had emphasised using video links more effectively. In magistrates' courts, video links for eligible cases were very well used but for a variety of reasons, we were advised they were less well used at crown courts.

2.11 There remained no overarching HMCTS safeguarding protocol setting out how detainees at risk, including children, would be protected from harm, abuse or maltreatment.

2.12 The immigration asylum chambers (tribunal centres) were stark. Detainees held there did not have enough to do to keep them occupied. HMCTS, Mitie and Tascor managers did not provide effective managerial oversight of the care or treatment of detainees held there.

Individual rights

2.13 We were advised that bailiffs, acting on behalf of HMCTS, would on occasion bring detainees into court custody when they should have been taken straight to court. We did not see this happening during the inspection and HMCTS managers assured us it only took place infrequently and subject to a risk assessment, which was appropriate. Youth offending teams supported children who were held in court custody.

2.14 Too frequently, detainees were held in court custody for longer than necessary, which was poor practice. A number of factors contributed to this, including delays waiting for solicitors to attend or for a prison governor's authority to formally release a detainee from prison; and detainees being brought to the crown courts first thing in the morning when their case was

not scheduled until 2pm or later. It was, however, positive that detainees were regularly received at magistrates' courts until 3pm.

2.15 Detainees did not always receive information outlining their rights in court custody. When left in cells, staff did not always point out the information, explain it or clarify if detainees could read or understand it. Rights information was not always issued in foreign languages even when detainees indicated they needed an interpreter.

2.16 Custody staff obtained the details of detainees' legal representatives. There were, however, insufficient legal rooms in some courts and those that existed were not always adequately soundproofed.

2.17 Data we were provided with showed that telephone interpretation services were not widely used. The service would have given several foreign national detainees held during the inspection an understanding of reception, risk management and release processes. It would also have helped staff ensure detainees' welfare and safety were properly considered and appropriately managed.

2.18 Notices outlining the complaints procedure were displayed in all suites, but detainees were not always advised of them. Complaints we inspected had been investigated appropriately.

Treatment and conditions

2.19 Most detainees did not experience unnecessarily long journeys. Cellular vehicles we inspected were generally well equipped, but many were marked with graffiti and not all of them were clean. It was inappropriate that women, children and men sometimes shared transport. Safeguards, such as partitions, were not always available or used if they were, which was poor.

2.20 Detainees were sometimes wrongly left unattended in vehicles. Exceptionally, during a busy period at Uxbridge Magistrates' Court detainees were held in vehicles outside the custody suite during hot weather and without water – one for over an hour – and they did not always receive a drink, which was unacceptable.

2.21 Most vehicle docks were secure and protected detainees from media or public attention. Where there was no secure vehicle dock, staff made sure detainees' privacy was maintained.

2.22 Court custody staff were generally professional and friendly when they interacted with detainees. On a number of occasions, we saw staff taking the initiative to reassure or care for detainees who were in distress or displaying difficult behaviour. However, we also noted that too many staff were distant and waited to be approached by detainees before they spoke with them.

2.23 We were advised that none of the courts we inspected were equipped to deal with detainees with disabilities or mobility issues. We saw some staff doing their best to manage detainees with mobility problems, however, overall, the facilities were poor and none of those inspected were properly equipped or adequately adapted to meet the individual needs of disabled detainees.

2.24 All courts had designated areas for holding children, but apart from the separate cell location, there was little specific provision for children and they were treated in the same way as adults. Recently introduced activity boxes for children were available in most suites but were not always offered.

2.25 Although not offered routinely, sanitary products were available in the women's toilets in all courts. Overall staff had limited knowledge or experience of dealing with transgender detainees.

2.26 Religious material was available in all suites, but was generally not stored respectfully. Some staff were sensitive to detainees' needs during Ramadan, but not all staff at every site demonstrated a level of awareness.

2.27 Reading material at most suites was limited and not offered routinely. Food and drinks, in contrast, were offered regularly and in generous amounts. We were not confident, however, that water was always drawn from a suitable source and it was sometimes distributed from unsterilised containers. Some food preparation areas were grubby and equipment was in poor condition.

2.28 There was no formal risk assessment to ensure detainees' risks were effectively identified or managed. Custody managers relied too much on an informal dynamic approach to assessing detainees' risks, which meant risk assessments were not systematic or consistent across the suites. Person escort records (PERs) were mixed. Too many were not detailed enough to ensure that risk management was effective or that detainees received appropriate care.

2.29 Staff briefings did not always take place. We did see some good briefings, but on other occasions staff received no handover briefing at all.

2.30 Cell-sharing risk assessment paperwork was not always completed. Important information was not always considered before detainees were required to share cells, which compromised detainee safety.

2.31 Although most observations of detainees were conducted at the required frequency, it was unacceptable that in some cases, set observation levels were not adhered to or on occasion were recorded inaccurately. Anti-ligature knives were not carried routinely by all staff carrying out custody duties. We sometimes found that no custody officers on cell duties were carrying anti-ligature knives, which potentially compromised detainees' safety. Use of the call bells was not properly explained to detainees, but they generally received a prompt response.

2.32 Searching was not carried out consistently and much of it was unnecessary. Although mostly conducted sensitively, searches were not always carried out privately.

2.33 Despite some reported issues relating to delays in moving detainees to court, most were taken to the dock swiftly. Some courts had insufficient affray alarms on the route up to docks. Mobile alarms were available, but staff did not always carry them.

2.34 Release arrangements were inadequate. Most staff did not focus sufficiently on ensuring detainees, got home safely. Detainees were not routinely asked if they needed any assistance with travel before their release. The travel warrant system was unsuitable and petty cash was not always immediately available.

2.35 Use of force was reasonably low but an incident we witnessed during the inspection, which was not documented, undermined our confidence in the integrity of reporting procedures. Nevertheless, the force staff used on detainees appeared proportionate and reasonable in the circumstances described in the incident reports we inspected and in the incidents we observed. Use of force was mostly documented well. Supporting paperwork generally justified its use and provided details of de-escalation and other techniques used.

2.36 Routinely handcuffing detainees in the secure and controlled custody areas without an individual risk assessment was disproportionate. We saw only limited discretion used when

staff assessed the need to apply handcuffs on vulnerable detainees, such as children and those with mental health problems.

2.37 Conditions across the court custody facilities were generally poor. Many cells were dirty, contained potential ligature points and significant amounts of graffiti (some of which was offensive) and were poorly ventilated. Communal toilets were often dirty, had missing toilet seats and some were not private enough.

2.38 Cleaning and maintenance arrangements were inadequate. During the inspection, the custody suite at Uxbridge Magistrates' Court had not been cleaned for over a week, which was unacceptable.

2.39 Too many defects were not dealt with promptly and many cells were out of use. Reduced cell capacity sometimes meant more detainees than necessary had to share cells, which increased risks.

2.40 Fire evacuation procedures were generally on display and staff were broadly aware of their responsibilities. It was positive that drills or exercises on what to do in the event of a fire were carried out in all the suites in the previous year.

2.41 United Safe Care provided health advice, which staff accessed over the phone. Health professionals could also attend the custody suites if required. Custody staff were aware of the health provider's services and told us they found them helpful. Some courts used them regularly.

2.42 Custody staff were generally up to date with their first aid training. The triennial updates for first aid training were, however, too infrequent to maintain staff's competency. Automated external defibrillators were not available in custody suites. First aid boxes were generally fit for use and contained sufficient stocks.

2.43 PERs did not always include all relevant health information, which potentially put detainees at risk. Medication received from the police was generally stapled to the PER and was not always stored securely. Staff were confident about administering medicines appropriately. Custody staff did not always cooperate with or support the court mental health liaison and diversion nursing staff who visited the suites.

Main concerns and recommendations

2.44 **Concern:** During the inspection, we were advised that staffing was often running significantly short. We saw staff in some courts struggle to conduct even routine tasks, such as initial risk assessments and cell-sharing risk assessments.

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

2.45 **Concern:** Detainees were held in court custody for longer than necessary because of: the late attendance of legal representatives; delayed transfer warrants; detainees being transported to crown courts too early; waiting for governors' authority to formally release detainees; and detainees not being moved to prison promptly after being remanded or sentenced. Detainees' arrival in court custody was also delayed as they were held for longer than necessary in police custody due to a shortage of available court cells.

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

2.46 **Concern:** There was no formal risk assessment to ensure risks were effectively identified and managed. Cell-sharing risk assessment paperwork was not always completed. Set observation levels used to check detainee safety and welfare were not always adhered to, which was inherently risky.

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

2.47 **Concern:** Release arrangements were inadequate and most staff did not focus enough on ensuring detainees, including the most vulnerable, got home safely. Travel warrants could not be used on the underground or buses, which often meant people had to walk significant distances to get a train. Support leaflets were not offered routinely on release.

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

2.48 **Concern:** Handcuffs were applied to detainees routinely even in secure and controlled custody areas without an individual risk assessment, which was disproportionate.

Recommendation: Handcuffs should only be used if justified and proportionate.

2.49 **Concern:** Conditions across the court custody facilities were poor. Too many cells and communal areas were dirty, had potential ligature points and excessive graffiti. Defects were not resolved promptly enough and the cleaning contract was ineffective.

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

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 single cluster. This was the second in a series of inspections to cover all court custody facilities in the London cluster. Three agencies worked together to deliver court custody services: HMCTS, which had overall responsibility, along with Prisoner Escort and Custody Services (PECS) (part of HM Prison and Probation Service) and Serco, who was the service provider. We were told working relationships between the agencies were reasonable and improving. Two HMCTS cluster managers, supported by three operations managers, were responsible for managing courts across the area of the cluster that we inspected, which included two crown and six magistrates' courts. Eleven HMCTS court delivery managers were directly responsible for the day-to-day running of the eight courts we inspected. An HMCTS cluster manager and court delivery manager were also responsible for the two immigration asylum chambers (IACs) (tribunal centres) in the area. Court managers had regular contact with Serco staff, particularly when there were problems affecting court custody operations. HMCTS had a clear line management structure for the cluster. HMCTS managers accepted responsibility for court custody but visited the facilities relatively infrequently.

3.2 PECS commissioned Serco to manage court custody and provide escort services on behalf of HMCTS in London. Serco's regional operations manager was responsible for overseeing the delivery of the contract for court custody and escort services. Eight court custody managers and 15 deputy court custody managers employed by Serco reported to two court operations managers. The contractual arrangement between PECS and Serco was supervised by a PECS contract delivery manager. Relevant issues were not always escalated to PECS, such as delays in receiving formal authority to release detainees from prison.

3.3 Formal and informal meeting structures between the three key stakeholders were well developed. Minutes from meetings and strategic interviews reflected a reasonable focus on detainee care and welfare. However, we found gaps in the stated strategic intentions and the operational reality. Some of the recurring issues had an adverse impact on the treatment of detainees and the conditions they were held in. Many of them also featured significantly in our first inspection in September 2016. It was evident that managers had been slow to learn lessons and take action to address issues raised previously and in some respects, we found outcomes for detainees during this inspection had deteriorated.

3.4 Serco staff understood how to report cleaning and maintenance issues, of which there were many. Relevant concerns were generally escalated to HMCTS. However, we were advised and saw that staff had become desensitised to low standards and that escalation processes were not always followed. The environment across the court custody estate was overwhelmingly poor. Since the last inspection, responsibility for the cleaning and maintenance contract, delivered by Mitie, was now held directly by HMCTS. Despite this, we saw little, if any, improvement and we found conditions across the court custody estate unacceptable. Defects, including some significant damage, were left unaddressed for long periods and cleaning arrangements were often poor (see paragraph 5.36 and main recommendation 2.49). As with previous inspections the court custody estate continued to suffer from a lack of investment.

3.5 An HMCTS listings protocol had been designed to allow for court custody cases to be prioritised. We saw Serco staff asking for cases to be prioritised for a variety of reasons,

particularly for detainees identified as vulnerable. However, we found that requests were not always met, sometimes without apparent reason.

3.6 Minutes we received showed that court user groups met infrequently at the crown courts and rarely, if ever, at magistrates' courts. Attendance by the key stakeholders involved in court custody provision was poor and there was little or no focus on specific issues facing court custody.

3.7 We were extremely concerned by the apparent and sometimes acute lack of staff in many of the courts we inspected. Shortages were sometimes managed adequately, for example, through staff goodwill, but this often meant cutting corners on safety procedures, which posed a risk. Court custody managers regularly advised us that they only had half the required number of staff. On a Saturday during the inspection, Uxbridge Magistrates' Court expected 16 detainees but there were only two staff on duty at the beginning of the day. As a result, many procedures, including risk assessments and management procedures, were not conducted thoroughly, compromising detainee and staff safety (see paragraph 5.20). In general, staff from vehicles were relied on too often to supplement court custody staffing levels, but this often did little to alleviate the problem. (See main recommendation 2.44.)

3.8 Court custody staff received comprehensive initial training. However, the commitment to ongoing training and development was inadequate and we found some staff ill-prepared to deal with all the issues they had to manage during their day-to-day work. The triennial first-aid refresher training being delivered was not sufficient to maintain staff's skills (see paragraph 5.39).

3.9 Serco issued a range of standard operating procedures (SOPs) to provide staff with guidance on carrying out their duties. We were concerned that they were not always communicated effectively to staff and staff feedback was not sought to ensure they understood and complied with them. Guidance concerning safeguarding (see paragraph 5.8) and observation levels (see paragraph 5.23) was issued but understanding and implementation were variable.

3.10 The PECS contract delivery manager convened monthly performance and contract compliance meetings with Serco. Detainee care and the physical conditions in most courts were raised frequently there (see also section on physical conditions and main recommendation 2.49). The PECS contract delivery manager conducted 'safe, secure, decent and compliant' audits in each court custody facility. Reports from the audits were useful but not circulated widely enough.

3.11 PECS was advised of all use of force and sampled a selection of associated paperwork. While we believed that most staff would have reported any use of force and submitted required documentation to justify their actions, we did observe a staff member using force but failing to report it until we raised the matter with Serco managers (see paragraph 5.31).

3.12 A small but extremely proactive group of lay observers made regular visits to the court custody facilities. They produced reports that focused appropriately on detainees' treatment and the conditions they were held in. Many of the reports supported our findings during the inspection and although they were being used to drive forward some improvements, they continued to reflect HMCTS' inertia in addressing some of the longstanding problems with the physical environment.

3.13 HMCTS was committed to increasing the use of video links for eligible cases, which was positive and reduced the negative effect on detainees of having to be transported to court. The use of video links was generally very good, particularly at magistrates' courts, which were now using them more frequently. For a variety of reasons, it was not yet as well used in crown courts. For example, we were told that, despite cases being eligible to appear in

court via video link, some judges and legal representatives insisted on detainees being presented in court.

3.14 There continued to be no HMCTS safeguarding policy or protocol that set out how detainees at risk, including children, would be protected from harm, abuse or maltreatment. Serco had its own guidance on safeguarding and we were informed that specific awareness training continued to be rolled out. However, as with numerous other areas of the operation, staff were not always aware of their responsibilities and did not always know how to report a safeguarding concern if one arose (see paragraph 5.8).

3.15 There were two immigration asylum chambers (IACs), otherwise known as tribunal centres, in the cluster. The IACs handled appeals against Home Office decisions concerning permission to stay in the UK, deportation from the UK and entry clearance to the UK as well as applications for immigration bail for people being held by the Home Office on immigration matters. Arrangements for detainees held in the IACs were not good enough. Tascor, a privately contracted company, was responsible for transporting detainees to Hatton Cross IAC and for supervising them during their stay. Mitie was contracted to run Heathrow Immigration Removal Centre and its staff were responsible for detainees at Harmondsworth IAC. The holding rooms at both facilities were austere and at Harmondsworth, the fabric and furniture were badly damaged. Other than a limited range of magazines at Hatton Cross, there was little else to keep detainees occupied during their time in the holding rooms. The provision of food and drinks at both centres was adequate. There were no formal arrangements to ensure that detainees were released safely from Hatton Cross. HMCTS managers told us they were not responsible for detainees who were released. Detainees who were released did not receive money or travel warrants to ensure they could get home safely, or any leaflets outlining where they could go for support. Arrangements at Harmondsworth were better, as detainees were released from the neighbouring immigration removal centre and appropriate release plans put in place.

Recommendations

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

3.17 Conditions, including the environment, provision of activities and support offered on release, should be improved for detainees held in the IACs.

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 Custody staff advised us that court enforcement officers or bailiffs, who executed warrants on behalf of the court, could deliver compliant individuals directly to the court but on occasion brought them into court custody. We did not see this happening during our inspection and HM Courts & Tribunals Service (HMCTS) managers assured us that this only took place infrequently and subject to a risk assessment based on the individual's behaviour or a health concern, which was appropriate.

4.2 Custody staff at all the courts inspected said they had a good relationship with their local youth offending service (YOS). We observed that arrangements were in place to ensure YOS staff were contacted when a child was in the court cells, including on Saturdays. YOS staff attended so that children's needs, risks and circumstances could be presented to the court. The children we saw being detained had their cases prioritised to reduce the amount of time they spent in the cells, but in records we reviewed it was apparent that this was not always the case. At Uxbridge Magistrates' Court, we found that one child waited in custody for seven hours and 39 minutes before they appeared in court. We also found that once sentenced or remanded, children were not always moved to secure accommodation promptly, for example, one child waited just over seven hours before being transferred, which was too long. (See also paragraph 4.6.)

4.3 We saw remand cases being dealt with promptly at most courts, but we identified that detainees were too often held in court custody for longer than necessary for a number of reasons. Many of these reasons were beyond the control of HMCTS. There were, however, some cases where detainees experienced excessive delays before being taken to court. We could establish no appropriate reason for the delays in some of these cases. At one court, we observed a delay of one day because a nominated solicitor did not attend the court cells until the afternoon and at another court the duty solicitor was nominated to deal with 10 separate cases, which delayed proceedings until a colleague stepped in to assist. In records we reviewed, there were numerous examples across the courts of solicitors only visiting their clients after midday, which meant they could not attend court in the morning. Solicitors informed us that they regularly found it difficult to access legal papers relating to their clients' cases, which delayed their consultations, all of which contributed to detainees being held in court custody for longer than necessary (see main recommendation 2.45).

4.4 National guidance states that a detention warrant should be produced within 30 minutes of a court hearing or appearance: this was achieved in most cases at the crown courts we inspected. Elsewhere, we observed routine waits of between 40 minutes and more than an hour, which delayed transport being organised and lengthened detainees' stay in court custody cells. Records we reviewed also indicated numerous delays of between 40 minutes and up to three hours and eight minutes waiting for warrants to be produced. (See main recommendation 2.45.)

4.5 Long delays 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 if their cases were not listed until the afternoon. This was the case for four detainees at Harrow Crown Court who were transferred from HMP Wormwood Scrubs, all arriving before 9.10am, despite their cases being scheduled for 2pm. Records that we reviewed confirmed that this happened frequently at the crown courts. It was also common for detainees who had been bailed or acquitted, but previously remanded in custody, to wait for long periods before the

prison where they were originally held authorised their release. We saw one detainee at Harrow Crown Court who was released by the court, but was returned to an interview room, while it took a further two hours and 32 minutes before securing the prison's authority to release him. Elsewhere, we saw detainees in this position being returned to their cells to await confirmation of their release, which was inappropriate (see main recommendation 2.45).

4.6 During the inspection, we found some significant delays – up to four hours at some courts – before detainees were transported to prison following their court appearance. Records we reviewed showed regular delays of between four and five hours at most of the courts. The longest delay was just over nine hours at Barkingside Magistrates' Court, which on that occasion resulted in the detainee being held overnight at a local police station rather than being transferred to prison. We found women also experienced significant delays of between four hours and six hours 20 minutes, which meant they were not transported to prison until after 5pm. We found little evidence of transport being available to return detainees to prison at lunchtime. The delays were excessive and meant detainees remained in court custody cells for longer than necessary (see main recommendation 2.45).

4.7 We also found that a number of detainees who were scheduled to appear at Uxbridge Magistrates' Court were held at police custody suites for longer than necessary because not enough court cells were available. Several cells were out of use because of outstanding defects and cleaning issues (see also section on physical conditions). These detainees' transfers to court were deferred for several hours to allow cell space to be freed up, which was unsatisfactory (see main recommendation 2.45).

4.8 Detainees in police custody should have been able to appear before a magistrates' court if the court was sitting and it had enough capacity to hear the cases. Custody staff said they routinely accepted detainees throughout the day up to 3pm, provided cell space was available. At the discretion of the judiciary, detainees could be received after this time. Records reviewed showed that detainees were being admitted throughout the day at most courts and as late as 2.57pm, which was positive and prevented detainees from having to spend an additional night in police custody.

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

4.10 Printed information outlining detainees' rights and the complaints procedure were not always in cells before a detainee arrived, but if they were, custody staff did not always point them out, explain the information or check detainees could read and understand it. The information was readily available in several languages, but staff did not always provide detainees with versions in other languages even when detainees said they needed an interpreter.

4.11 Custody staff at all the courts asked detainees when they arrived who their legal representative was. There were insufficient legal rooms in a number of the courts, which led to lengthy queues on occasion. We saw legal representatives being allowed to speak to their clients at cell doors, which was not appropriate. Most of the interview rooms were small, cramped and often inadequately soundproofed. At Ealing, Uxbridge and Willesden magistrates' courts, interview rooms were in secure cell corridors, which put legal representatives at risk, as detainees could move freely along them if they needed to use the toilets. Detainees at all courts could keep legal documents with them.

4.12 Custody staff in all courts knew how to use the telephone interpreting service and loudspeaker handsets were available. However, a number of staff told us they were reluctant to use the service because they thought it was time-consuming and unnecessary, insisting they would use court-appointed interpreters instead to check how detainees were feeling.

We did not see this taking place, but we saw several foreign national detainees in court custody who would have benefited from the interpreting service to ensure they understood reception, risk management and release processes. For example, we saw a Lithuanian detainee being released on bail who appeared not to have understood where he was or how he would travel onwards from the court on release. Data supplied by Serco showed that the service was underused – only 16 calls in total from three of the courts we inspected had been logged in the year from 1 April 2016 to 31 March 2017. (See also paragraph 5.10.) Staff would also have been able to better assess and meet individual needs if they had used telephone interpretation services when they were required.

4.13 Data provided by Serco showed that only six complaints across all court custody suites in the area had been received during the year from 1 April 2016. Two of them were still under investigation, but the remaining four had been investigated appropriately by a senior member of Serco management. Detainees were not routinely told on arrival that there was a complaints procedure, but details were contained in the rights and complaints documentation (see paragraph 4.10). Notices detailing the complaints procedure and right to appeal to an independent body were displayed in all the custody suites, mostly in main reception areas where detainees did not have time to read them.

Recommendations

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

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

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

4.17 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 detainees arrived at court from local police custody suites and prisons and did not experience unnecessarily long journeys. Cellular vehicles, in which they travelled, were adequately equipped and contained drinking water, first aid kits, sanitary products and accessible anti-ligature knives. However, many of the personal cubicles inside the vans were badly marked with graffiti and not all the vehicles were clean and tidy. It was evident from discussions with escort staff and from our own observations that women, children and adult men regularly shared transport. Although partitions were available in some vehicles, they were not always used. Mixing vulnerable groups of detainees in such close proximity could have created additional anxieties and was not acceptable.

5.2 On arrival at court, most detainees were disembarked promptly from vehicles, but on occasion we saw detainees left unattended while still on board. Although we did not observe frequent long waits to disembark detainees, we did see some notable exceptions. During a busy period at Uxbridge Magistrates' Court, two detainees were held in vehicles outside the custody suite during hot weather for a prolonged period, until cell space became available. One detainee waited for over 20 minutes and the other for well over an hour; in the latter case the detainee was not given anything to drink during his journey or while he waited to disembark, even though the temperature inside the van was extremely high. Most vehicle docks were secure and protected detainees from media or public attention. Where there was no secure vehicle dock, staff made sure the detainees' privacy was maintained.

5.3 Court custody staff were generally professional and friendly when dealing with detainees. On a number of occasions, we observed staff reassuring or caring for detainees who were in distress or displaying difficult behaviour. For example, at Romford Magistrates' Court, each member of the staff team conducted themselves in a calm, professional manner when dealing with a detainee whose behaviour was very erratic and provocative over a prolonged period. However, despite these positive observations, we noted that this approach was not consistent. Too many of the staff we observed were somewhat distant towards detainees. They appeared reluctant to take the initiative and they often waited to be approached by detainees before they would interact with them.

5.4 Staff received some diversity input as part of their initial induction training, but there was little follow up or specialist training subsequently. This meant most staff relied mainly on their knowledge and experience when dealing with detainees from minority backgrounds. Although most staff attempted to deal with detainees fairly and considerately, they tended to treat detainees in the same way without always paying sufficient attention to meeting the distinctive needs of detainees from minority groups.

5.5 The court's facilities for detainees with a disability were poor and none of the custody suites inspected were suitably equipped or adequately adapted to meet their needs in full. Nevertheless, detainees with a variety of disabilities or mobility issues were still brought to

these courts. Staff did their best to cope with detainees with mobility problems, for example, removing their handcuffs and allowing them to hold on to staff members so they could negotiate stairs slowly. There was no information in Braille or in an easy-read format, but hearing loops were available at some sites, although not all staff knew how to use them.

5.6 All courts had designated areas for holding children, but apart from the separate cell location, there was little specific provision for children and they were treated in the same way as adults. Staff did not think that dealing with any welfare issues relating to children was part of their role and referred these matters to youth offending service (YOS) workers (see also paragraph 3.14). Activity boxes had been introduced into the suites, containing items such as puzzles and stress balls, which were intended to help children pass the time, but we saw little use being made of them. Although not offered routinely, sanitary products were readily available in women's toilets in all courts.

5.7 The SOP concerning transgender detainees had been revised and was much clearer. However, few staff we spoke to had had any experience of dealing with transgender detainees and there appeared to be a lack of up-to-date knowledge about how to look after this group of detainees.

5.8 Serco guidance on safeguarding vulnerable adults and children was in place and we were informed that specific awareness training continued to be rolled out. However, staff we spoke with were not always aware of their responsibilities and did not always know how to report a safeguarding concern if one arose (see paragraph 3.14).

5.9 A suitable range of religious material, covering all the main faiths, was available at all suites and there were notices on display explaining that detainees could worship in private. In most cases, however, religious artefacts were not stored respectfully. Some staff were sensitive to the needs of detainees during Ramadan, which took place during the inspection, and we observed detainees being asked when they were admitted if they were fasting; however, this level of awareness was not evident at all sites.

5.10 The *What happens next* leaflet was accessible in a wide range of foreign languages and hard copies were available for non-English speaking detainees. Staff seemed confident about using the telephone interpretation service but told us they did not need to use it very often (see paragraph 4.12). Information leaflets on reception procedures at local prisons were also available, but only in English.

5.11 Detainees at Harrow Crown Court and Willesden Magistrates' Court received copies of free daily newspapers as they entered their cell, but elsewhere detainees had to ask for something to read. The range of reading material stored at most suites was narrow and consisted mainly of detective novels and old magazines. Very little suitable material was available for children or non-English speakers.

5.12 Arrangements for storing detainees' property safely were appropriate at most custody suites. The lockable cupboards at Harrow Crown Court were not in the main custody area, which made it difficult for court staff to supervise them. At Barkingside Magistrates' Court the property cupboard was left unlocked for a period.

5.13 The food offered to detainees at court consisted of microwave meals of low nutritional value. Despite the poor quality of the food, many of the detainees we saw were content to eat them, sometimes asking for and being provided with double portions. Food was regularly served at lunchtime and staff frequently also offered detainees something to eat outside this period, usually when they arrived. At some sites, for example, Harrow Crown Court, the kitchen facilities were grubby and the equipment was in poor condition and badly needed upgrading.

5.14 Staff ensured detainees had reasonable access to drinks. Tea and coffee were offered regularly and apart from at Willesden Magistrates' Court, where there was a small water dispenser in line with public health guidelines, we were not confident that water was always drawn from a suitable source. At Uxbridge Magistrates' Court, we saw a plastic bottle filled with tap water being used to distribute water to detainees. We were informed they did this regularly, but as the bottle was not sterilised between uses, there were associated health risks.

Recommendations

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

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

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

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

Safety

5.20 There was no formal risk assessment process for detainees when they first arrived. Instead staff carried out a dynamic assessment of detainees. This included assessing their demeanour and body language and asking them about their well-being. This approach was unsystematic, as detainees were not always questioned and staff did not ask the same questions or monitor behaviour consistently across the suites. Court custody managers mostly included a review of the person escort record (PER) in their identification of risk markers (indicators showing that a person has previously had a problem or posed a risk) and the information was usually shared during daily morning briefings involving most staff (see paragraph 5.21). PERs we inspected were not completed sufficiently well and too often no detailed risk information had been provided. Some warning markers were identified, but the dates of specific incidents were not included (see paragraph 5.40).

5.21 Staff briefings were not delivered consistently across the suites. We observed some that were thorough, included an appropriate focus on risks and detainee vulnerabilities and involved all staff on duty, who had to sign a written briefing sheet once it was finished. In other courts staff were not always briefed at the beginning of a shift or might not receive any briefing at all, which meant risk information and detainee vulnerabilities were not shared sufficiently well, which was unacceptable (see paragraph 2.46).

5.22 During busy periods in some suites, detainees had to share cells. Cell-sharing risk assessment paperwork was not always completed prior to detainees being co-located. We saw examples and records in which detainees' risks were not identified or considered robustly enough prior to them sharing a cell. This significantly increased risks when detainees were placed in cells together (see paragraph 2.46).

5.23 Most checks that staff carried out to ensure the welfare of detainees were appropriately set at intervals of 30 minutes. Despite the SOP being clear about what was required, practices

varied across suites, which led to inconsistencies. We saw observations that were not carried out on time and in some suites the observation times recorded by staff on the Serco electronic recording system (SERS) did not accurately reflect when the observations had been carried out, which was unacceptable. Some custody officers on cell visits interacted well with detainees when carrying out their observations, opening cell doors to talk to them and check on their well-being. In other suites, we saw staff looking through the cell door observation panel and recording only basic information about the detainee, rather than opening the cell door to talk to them, which would have enabled them to assess their well-being more accurately and ensure they were safe (see main recommendations 2.44 and 2.46).

5.24 Not all staff allocated custody duties routinely carried anti-ligature knives. We saw instances where none of the custody officers on cell visits carried them. In one suite only one member of staff carried one; we observed them leaving their custody duties to attend to other tasks without handing over the knife to the other custody officer on duty. These failings compromised safety and increased the risk of harm to detainees.

5.25 The cell call bell system was not always explained to detainees when they were placed in their cell. We saw some detainees who had not had the system explained to them banging on their cell doors rather than using the cell bell to attract staff's attention. Most cell call bells received a prompt response.

5.26 Searches of detainees varied across the suites. In some, we observed all detainees being searched whether they arrived from police custody or from a prison; searching those arriving from a prison without good reason was in breach of the Serco court custody searching protocol. Although staff carried out most searches respectfully they lacked consistency. Some searches were carried out at the booking-in desk, while others took place outside cells and were not always conducted in sufficient privacy. Some, but not all detainees were asked to remove their shoes and others were searched after seeing their legal representatives, which was unnecessary.

5.27 Detainees were generally taken to the court dock promptly. In some courts, there were either not enough affray alarms or they were broken and where this was the case staff supervising court docks were issued with mobile alarms. However, we noticed some staff did not carry a mobile alarm when they needed to.

5.28 Release arrangements for detainees were inadequate. Most staff were not properly focused on securing a safe release for detainees, including the most vulnerable. A new pre-release risk assessment had been introduced, but staff were unclear if they were meant to be using it at the time of the inspection. We saw extremely limited use of the new assessment tool and so its effectiveness could not be assessed. The existing pre-release form did not focus sufficiently on detainee welfare and was not always completed before a detainee was released. Detainees being released were not routinely asked if they required any assistance with their travel arrangements once they had left the custody suite. Although travel warrants were available in most suites, the system was no longer suitable because they could not be used on buses or swapped for a ticket at an unstaffed underground station with an automated entry system. Detainees were provided with petty cash but not consistently and in some suites insufficient funds were available. In one court the funds could not be located. Leaflets outlining sources of support were not routinely handed out to detainees on release. (See main recommendation 2.47.)

Recommendations

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

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

Use of force

5.31 Use of force was reasonably low. Across the eight courts we inspected, there had been 26 incidents involving force between 1 April 2016 and the end of March 2017. From the sample of incident reports we examined, in most cases the use of force appeared to be reasonable and proportionate. Supporting paperwork generally reflected the justification for its use, control and restraint techniques were explained and attempts to de-escalate the incident prior to force being used were documented. Despite this, an incident we witnessed in which force was used was not reported until we raised the matter, undermining our confidence in the rigour of internal reporting procedures. During the inspection, we observed staff using effective de-escalation techniques when faced with challenging situations.

5.32 Handcuffs were routinely applied on detainees, including on children, even in secure court custody areas. Although we saw some cases in which children and detainees with mental health issues were not handcuffed, it was not a routine consideration for all vulnerable detainees. Individual risk assessments were not carried out to justify the use of handcuffs, which was often disproportionate. (See main recommendation 2.48.)

Physical conditions

5.33 The physical conditions in most court custody suites were poor. We carried out a random sample of cell checks in each of the suites and found potential ligature points in all but one of the cells. Too many were in an unacceptable condition – cell benches had dirt ingrained on them and there were stains on cell walls and significant amounts of graffiti on cell doors, floors and walls, some of which was offensive (see Appendix II). Many cells were either poorly ventilated or had no ventilation at all and none had any natural light. We observed cells in some suites where the ventilation was so poor on hot days that the cell door observation hatches were left open, presenting a potential ligature risk. In some cells the width of the bench was too narrow to sit on.

5.34 The toilets in communal areas were often dirty and too many had no toilet seats. Some toilets in the main corridors were inadequately screened. Although toilets in most suites had soap dispensers, hand towels and toilet rolls were not consistently available.

5.35 The cleaning and maintenance of the suites, including cells, were inadequate. Cleaners visited most suites every day, but the cleaning regime was not effective. A deep cleaning programme was required to remove ingrained dirt and stains. During the inspection, the court custody suite at Uxbridge Magistrates' Court had not been cleaned for over a week, which was unacceptable.

5.36 The system in place for reporting defects was inefficient. Staff used an email reporting system, which was not responsive enough and many reported defects remained unresolved for long periods. At Barkingside Magistrates' Court, two legal rooms had been out of use for over 12 months because the intercom system was broken. At Willesden Magistrates' Court one cell was out of use because graffiti had not been removed. At Harrow Crown Court

there were 11 outstanding defect reports dating back to 22 February 2017. At Isleworth Crown Court two cells that had been damaged by detainees had been out of use for six months. Numerous cells across the suites were out of use because they had a range of defects, including broken lighting and faulty cell call bells. The delay in resolving these problems was causing frustration among staff and, in some cases, affecting the safety of the custody environment. Reduced cell capacity delayed the transfer of some detainees from police custody suites and meant more detainees shared cells, potentially increasing risks (see paragraphs 4.7 and 5.22).

5.37 Most staff were aware of fire evacuation procedures and court custody managers we spoke with knew how to evacuate detainees in an emergency. Evacuation instructions were displayed in all suites, but some were out of date. Practice fire drills and exercises on what to do in the event of a fire had been carried out in all suites in the previous 12 months.

Health

5.38 The medical services provider United Safe Care offered prompt telephone advice from a doctor who would dispatch a health professional to attend the courts within two hours if required. Data provided by Serco indicated that the health provider had been called 158 times between April 2016 and March 2017, which is higher than usual. There had been no calls from Willesden or Romford magistrates' courts, but Barkingside Magistrates' Court had been responsible for 98 (62%) of all calls, of which 64 had required visits to the custody suite. Custody staff we spoke to were aware of the service and those who had used it were positive about the arrangements in place. Details of how to contact the medical services provider were clearly displayed in each suite, but in some cases they were out of date. We saw United Safe Care staff attend two of the court custody suites to treat detainees and their response times were appropriate.

5.39 Custody staff had generally completed a first aid at work qualification and received updates every three years, which was not enough to maintain an adequate level of skills (see paragraph 3.8). Many staff had not used or practised these skills and no resuscitation equipment, suction, oxygen or automated external defibrillators (AEDs) were on site. First aid boxes were fit for use and contained sufficient stocks but were not always routinely checked.

5.40 Custody officers relied on the PER and detainees for information, but health issues were not always identified on the PER. A man arrived from prison and had no information recorded on his PER indicating that he had previously suffered a stroke or outlining when he should take the medication that accompanied him. The information only came to light after he became unwell. A paramedic from United Safe Care attended the suite and appropriately accessed a 'medical in confidence' envelope, which should only be opened by a healthcare professional, containing the detainees' medical history. We saw loose sheets containing confidential medical and risk assessment information attached to PERs completed by the police, instead of being recorded on the PER, creating the risk that vital information could be misplaced or confidential information shared inappropriately.

5.41 Some detainees arrived from police custody or prison with their prescribed medication and instructions, which staff handed to detainees so they could administer the medicine themselves; staff recorded administration times on the PER. Medications were stored securely, but staff told us they were sometimes kept unsecured with the PERs in the custody suite offices, which meant they could have been mislaid. Staff were aware of safe drug administration requirements, including supervision.

5.42 We were told that detainees could keep their asthma inhalers with them in their cells, but we did not see this happening. In some cases, we were told that detainees could also keep their angina sprays (to relieve heart pain or tightness), but that insulin pens or blood sugar testing equipment would be stored in custody offices so they were secure but available, if required.

5.43 Full mental health liaison and diversion services were available at six of the custody suites – they were not available at Willesden or Romford magistrates' courts. We were advised that the Hendon Magistrates' Court mental health liaison and diversion provision was to be transferred to Willesden Magistrates' Court later in 2017. The service assessed all adult detainees who had an identified vulnerability, including mental health, substance misuse or housing problems; however, those with mental health needs were prioritised. Anyone could refer a detainee to the service, including probation or court custody staff, magistrates or solicitors. Most were referred because they had mental health problems and drug and alcohol issues. Liaison and diversion practitioners checked PERs and spoke to custody staff to identify detainees' vulnerabilities.

5.44 Detainees at Hendon Magistrates' Court had access to a specialist intellectual disability practitioner. The service was also available in Uxbridge Magistrates' Court from 1 June 2017.

5.45 A mental health charity provided practitioners in each of the six courts and worked in partnership with a number of NHS mental health trusts across the different sites. Overall detainees in these courts had good access to skilled mental health professionals, including forensic consultant psychiatric input.

5.46 Partnership working between the liaison and diversion practitioners and custody staff was not always effective. We were told and observed that custody staff did not always cooperate with or support practitioners. At one court, we saw practitioners speaking to detainees through cell hatches where they were expected to divulge personal and sensitive information in a less than confidential environment, which was unacceptable. Data from NHS England indicated that in the 12 months to March 2017, 1645 detainees were referred to the service and 1337 received a face-to-face assessment. Sixty-two of them were referred for an assessment under the Mental Health Act 1984, of whom 26 were detained in hospital. Mental health and custody staff said detainees sometimes experienced delays in being transferred to a mental health hospital because of external factors, such as the lack of available staff to complete assessments and bed availability. We were told that this had on occasion resulted in someone being remanded in prison overnight and we saw one detainee remanded overnight and two detainees remanded over a weekend because no practitioners were available in the court on a bank holiday or Saturday. Very few custody staff had received mental health awareness training.

5.47 Detainees with substance misuse problems had usually been seen in police custody or at the transferring prison. Custody staff demonstrated a reasonable understanding of drug 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

5.48 Custody staff should receive annual first aid refresher training to maintain their skills. They should have access to regularly checked equipment, including an AED.

5.49 PERs should identify detainees' health risks, while maintaining appropriate confidentiality. All inadequately completed PERs should be completed in full and captured on the incident reporting system. The information should be formally escalated to the sending prison or police force.

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

5.51 Custody staff should have regular mental health and substance misuse awareness training.

Section 6. Summary of recommendations and good practice

Main recommendations

6.1 Adequate staff should always be deployed in court custody to ensure that all necessary duties can be undertaken and that detainees are looked after and kept safe at all times. (2.44)

6.2 HMCTS, PECS and the escort and custody contractor should investigate the reasons for prolonged periods that detainees, including children, spend in court custody cells. Measures should be put in place to ensure detainees have their cases prioritised where possible and are transferred and released without delay. (2.45)

6.3 Measures to identify and manage detainees' risks should be applied consistently. Staff should complete a standard risk assessment for each detainee. Cell-sharing risk assessments should be completed for all detainees before they share a cell. Set levels of observation should be adhered to. (2.46)

6.4 Release planning and arrangements should be improved to ensure all detainees, particularly the most vulnerable, are able to get home safely. (2.47)

6.5 Handcuffs should only be used if justified and proportionate. (2.48)

6.6 The court custody environment should be improved. Outstanding repairs across the court custody suites should be completed as a matter of urgency. All offensive graffiti should be removed immediately. The current cleaning regime should be significantly improved to ensure that all cells, toilets and communal areas are cleaned every day to an acceptable standard. (2.49)

Recommendations

Leadership, strategy and planning

6.7 There should be an HMCTS safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and adults at risk. (3.16)

6.8 Conditions, including the environment, provision of activities and support offered on release, should be improved for detainees held in the IACs. (3.17)

Individual rights

6.9 All detainees should be informed of their rights while in court custody in a language and format they understand. (4.14)

6.10 HMCTS should ensure all interview rooms are in an appropriate location and are soundproofed to ensure confidentiality. (4.15)

6.11 Telephone interpreting services should be used as necessary to check on the welfare of foreign national detainees and to ensure their risks are appropriately managed and they understand what is happening to them. (4.16)

6.12 All detainees should be informed of the complaints process. (4.17)

Treatment and conditions

6.13 Cellular vehicles should be free of graffiti and men, women and children should be transported in separate escort vehicles. (5.15)

6.14 Suitable arrangements should be in place at all court custody facilities to ensure that the needs of detainees with disabilities can be met. (5.16)

6.15 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)

6.16 Kitchen areas within court custody should all be clean and properly maintained. (5.18)

6.17 Disposable water bottles should not be reused to store or serve water. (5.19)

6.18 All custody staff should receive a comprehensive briefing at the start of duty focusing on risk management and the care of vulnerable detainees. (5.29)

6.19 Staff undertaking observations and cell visits should carry anti-ligature knives at all times. (5.30)

6.20 Custody staff should receive annual first aid refresher training to maintain their skills. They should have access to regularly checked equipment, including an AED. (5.48)

6.21 PERs should identify detainees' health risks, while maintaining appropriate confidentiality. All inadequately completed PERs should be completed in full and captured on the incident reporting system. The information should be formally escalated to the sending prison or police force. (5.49)

6.22 Detainees should have prompt access to mental health services, including assessments and transfers to health facilities. (5.50)

6.23 Custody staff should have regular mental health and substance misuse awareness training. (5.51)

Section 7. Appendices

Appendix I: Inspection team

Kellie Reeve	Lead inspector
Fionnuala Gordon	Inspector
Ian MacFadyen	Inspector
Fiona Shearlaw	Inspector

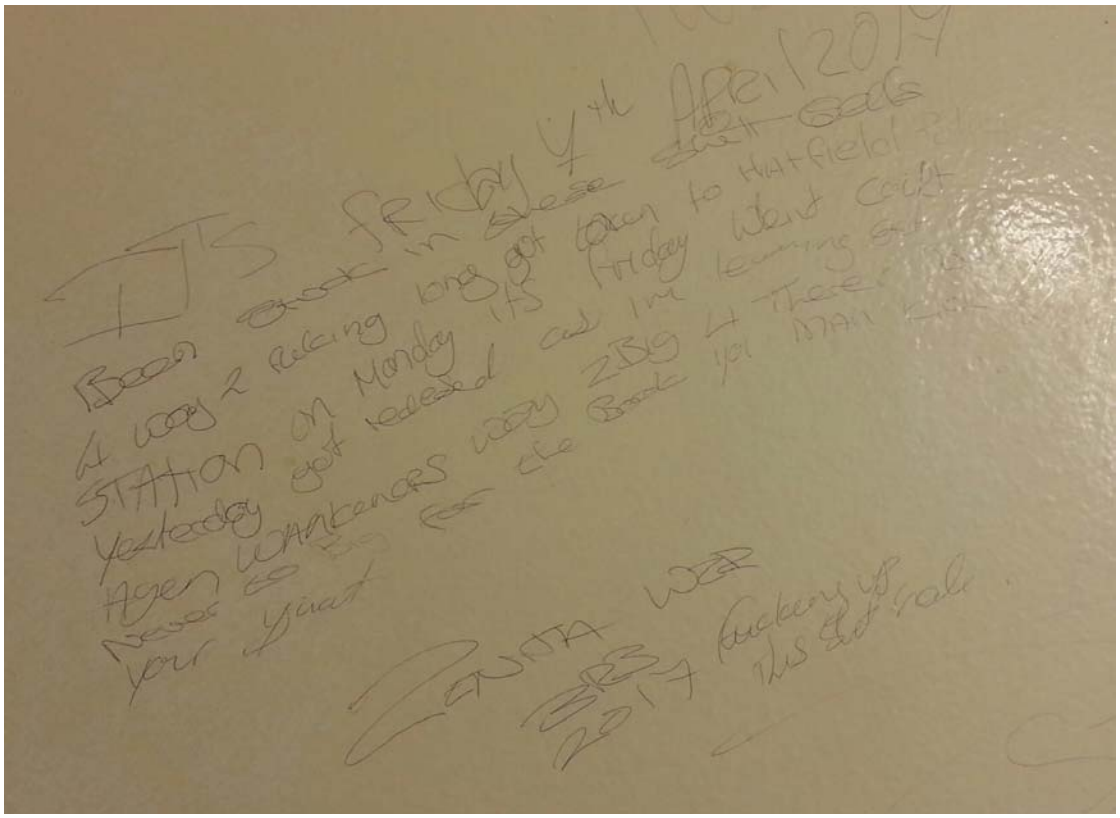
Appendix II: Photographs

Fresh graffiti on back of cell door at Hendon Magistrates' Court

Graffiti in cell at Uxbridge Magistrates' Court

Graffiti on bench top within a cell at Ealing Magistrates' Court

Graffiti in a cell at Uxbridge Magistrates' Court



Graffiti in a cell at Barkingside Magistrates' Court

Stains on a cell wall at Uxbridge Magistrates' Court