Report on an inspection visit to court custody facilities in

Norfolk, Suffolk & Essex

by HM Chief Inspector of Prisons

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Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Minimising and managing physical restraint
A behaviour management and restraint system, aiming to provide secure estate staff with the ability to recognise young people's behaviour, use de-escalation and diversion strategies and apply behaviour management techniques to minimise the use of restraint. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/456672/minimising-managing-physical-restraint.pdf.

National Referral Mechanism
The National Referral Mechanism was put in place in the UK in April 2009 to identify, protect and support victims of trafficking.

Off-bail
A person is received 'off-bail' into court custody directly from the courtroom when they are on bail for offences and have not been detained in custody but are subsequently remanded into custody or given a custodial sentence.

Social/physical distancing
The practice of staying two metres apart from other individuals, recommended by Public Health England as a measure to reduce the transmission of COVID-19.

Introduction

HM Inspectorate of Prisons' inspections of court custody facilities 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 five areas:

- leadership and multi-agency relationships
- transfer to court custody
- in the custody suite reception processes: individual needs and legal rights
- in the custody cell: safeguarding and health care
- release and transfer from court custody.

This inspection covered the court cluster in Norfolk, Suffolk and Essex, and included 12 courts with custody facilities, comprising four Crown courts, six magistrates' courts and two combined courts. The prisoner escort and custody services (PECS) arm of HM Prison and Probation Service (HMPPS) contracted Serco on behalf of HM Courts & Tribunals Service (HMCTS) to provide court custody and escort facilities in the region. Although this was the first inspection of this cluster, it was our second time visiting these custody facilities, which had been reconfigured since 2014. Of the combined 80 recommendations made in the last inspections of Norfolk and Suffolk, and Cambridgeshire and Essex, respectively, 27 had been fully achieved, with partial achievement in 38, both of which reflected reasonable progress overall.

The throughput at court custody across England and Wales had declined substantially since April 2020, following the outbreak of the COVID-19 pandemic. Video facilities in police stations had instead been used to deal with detainees' first hearings in magistrates' courts, and, where necessary, similar technology was used to deal with those in prisons. The system had started to recover by the time we inspected the custody facilities in Norfolk, Suffolk and Essex courts, with the reintroduction of trials across the cluster and the resumption of normal business in custody facilities within magistrates' courts in Essex.

HMCTS, PECS and Serco had worked together to risk assess the reintroduction of in-person hearings to make court custody safe for detainees and the staff who worked there. Most of the measures introduced to manage and mitigate the daily risk of COVID-19 transmission were well embedded, but others, such as effective social distancing (see Glossary of terms) and delivering effective cleaning regimes, were inconsistent.

The areas that caused most concern centred around leadership and multi-agency arrangements. Formal structures and meetings between the three main agencies often lacked an appropriate focus on improving the detainee experience of custody, and data on key areas affecting detainees were either not collated or not used effectively to identify and drive forward necessary improvements. The conditions that detainees experienced were often inadequate. Training for custody staff was not sufficiently embedded in some areas, such as safeguarding, and equality and diversity. Despite this, however, the quality of staff was a strength and we found an appropriate culture, where detainees were consistently treated with humanity and respect. Release arrangements were also very good.

The recently retendered escorting and court custody provision contract introduced in August 2020 had the scope to deliver changes in the way that detainees were treated. Some welcome improvements had been introduced, such as the more proportionate approach to handcuffing, the fleet of new and safer vehicles and the more individualised approach to the care of children. The more focused attention to the health needs of detainees was being broadly realised but the full scope of the contract as intended was not yet being delivered.

We have made 22 recommendations that we hope will help HMCTS, and the key agencies they work with to deliver court custody, to make the necessary improvements.

Charlie Taylor
HM Chief Inspector of Prisons
December 2020

Fact page

Data supplied by HMCTS Norfolk, Suffolk and Essex Cluster, PECS and Serco (custody and escort provider)

HMCTS cluster	Norfolk, Suffolk & Essex
Cluster manager	Rachel Goodall
Geographical area	Norfolk, Suffolk & Essex
Court custody suites and cell capacity	
Great Yarmouth Magistrates' Court	10 cells
King's Lynn Crown Court & Magistrates' Court	5 cells
Norwich Crown Court	8 cells
Norwich Magistrates' Court	13 cells
Ipswich Crown Court	10 cells
Ipswich Magistrates' Court	8 cells
Basildon Combined Court	9 cells
Basildon Magistrates' Court	7 cells
Chelmsford Crown Court	11 cells
Chelmsford Magistrates' Court	20 cells
Colchester Magistrates' Court	17 cells
Southend Crown Court & Magistrates' Court but visited to conduct checks of the environment)	15 cells (closed at the time of the inspection
Annual custody throughput (1 October 2019 to 30 September 2020)	5,998 detainees
Custody and escort provider	Serco
Custody staffing	12 court custody managers 12 deputy court custody managers 72 prisoner custody officers

Background and key findings

S1 Key concerns and recommendations identify the issues of most importance to improving outcomes for detainees and are designed to help custodial institutions prioritise and address the most significant weaknesses in the treatment and conditions of detainees.

S2 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.

S3 The inspections of court custody look at leadership and multi-agency relationships; transfer to court custody; reception processes, individual needs and legal rights; safeguarding and health care; and release and transfer from court custody. They are informed by a set of *Expectations for Court Custody,* available at http://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/court-custody-expectations, about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.

S4 HM Inspectorate of Prisons last inspected court custody suites in Norfolk and Suffolk in 2013, and in Cambridgeshire and Essex in 2014. Since then, there has been reasonable progress and 65 of the combined 80 recommendations have been achieved or partially achieved.

Leadership and multi-agency relationships

S5 The working environment in courts and court custody had changed substantially since the introduction of measures to mitigate the transmission of COVID-19. In the early stages of the outbreak, fewer detainees experienced court custody, but trials had now resumed and during the inspection the operation of in-person custody cases in magistrates' courts were returning to near normal in Essex.

S6 COVID-19 risk assessments were comprehensive and most measures to reduce the transmission of the virus, such as the use of hand sanitiser and face masks, were reasonably well established. Others, such as 'touchpoint' cleaning and attention to social distancing, were inconsistent. Detainees were rarely briefed about the impact of COVID-19 during their time in court custody.

S7 The strategic managers across the three key agencies described a commitment to treating detainees with respect, which was broadly achieved. Despite this, the wider multi-agency relationships that are essential to delivering good outcomes for those detained in court custody needed improvement. A range of multi-agency meetings, where outcomes for detainees were discussed, often lacked appropriate focus or had lapsed during the pandemic. While most operational relationships were described as positive, it was evident that staff across the key agencies did not necessarily understand or appreciate the responsibilities and challenges faced by their counterparts. This led to frustrations, particularly among those who worked in custody, where a commitment to more effective communication was required.

S8 The greatest strength identified at this inspection was the custody staffing group and the appropriate culture they engendered. There were sufficient court custody staff, who had been properly vetted and received adequate training. However, understanding and embedding of learning in some key areas, such as safeguarding, equality and diversity, and mental health, were sometimes weak.

S9 We experienced serious issues with receiving timely and accurate information from the three agencies. The collation and analysis of data were not robust and data was not used well to drive or support the required improvements for detainees.

S10 We acknowledged the recently implemented retendered contract for the provision of escorting and court custody arrangements, and had seen some welcome improvements for detainees, but at the time of the inspection not all anticipated enhancements were being achieved. We were, however, hopeful that, in time, further improvements concerning the treatment and conditions for those held in court custody would be realised.

Transfer to court custody

S11 Person escort records (PERs) were made up of a handwritten record of events in the PER booklet and printed material identifying relevant risks and needs, reflecting the gradual digitalisation of the system. Most contained adequate information.

S12 Many escort vehicles were new, and those we saw were clean and well equipped. Detainees welcomed the added safety features, such as seatbelts, but some complained that the heating system was ineffective. A range of vehicles was available, to deal with diverse needs. Generally, women, children and men were transported in separate vehicles. Most journey times were reasonable and we did not see frequent long waits to disembark.

In the custody suite: reception process, individual needs and legal rights

S13 The majority of custody staff had several years' experience, and this showed in the calm and confident manner in which they behaved towards detainees. Officers articulated well how their job was to care for detainees and their safety, and they reassured detainees and defused tensions calmly.

S14 Custody staff in several suites wore clear name badges, as well as having their identification cards visible, and in some cases they addressed detainees by their first name. They often took time to talk to detainees individually once they were in the cells, although there was generally little opportunity for detainees to have a private conversation with a staff member when they arrived. In general, private information about detainees was not displayed in public view.

S15 Most staff said that they had done some training in equality and diversity, usually online or in their initial training, but many were not able to recount what they had learned from the training, and for many it was not recent. Nevertheless, they showed a sound approach to dealing with the diverse needs of those in their care.

S16 Sufficient female staff were mostly available to provide appropriate care for detained women. Women were held in a separate section of the custody suite, and menstrual care products were freely available, although the range was often limited. Staff were aware of the policy in relation to transgender people, but a few were not confident about the right approaches in

practice. Good facilities for telephone interpreting were available but almost no staff had used them, often relying on court-appointed interpreters, which often led to unnecessary delays in meaningful communication. Essential documents were printed and provided in different languages when needed. Three courts were identified to deal with detainees with mobility difficulties, and we found no unmet need. Religious items were stocked and carefully stored in all suites, but were not routinely offered.

S17 There was a reasonably good overall approach to the identification and management of risk. There was good handover of risk information from escorting to custody staff concerning detainees in their care. Although there continued to be no formal, consistent assessment of risk, PERs and warning markers were primarily used to inform set levels of observations. Comprehensive briefings did not always take place.

S18 Staff could explain the signs of vulnerability, instability or low mood they looked for in detainees, and described how they would probe sensitively to identify and mitigate any further presenting risks. Checks were generally conducted at the required frequency, although some were cursory and involved little direct engagement with detainees. The hand-held devices which allowed the recording of observations in real-time were a welcome innovation and operated at most courts, but were often liable to issues with connectivity. Cell call bells were generally answered promptly and all staff now carried anti-ligature knives.

S19 Printed copies of detainees' rights were placed in each cell before a detainee's arrival but staff did not always check if detainees were able to read or understand the documentation. Enough interview rooms were available to facilitate legal consultations, either in person or on the telephone. Once requested by the court, detainees were produced without delay.

S20 There was a strategic commitment to prioritising custody cases and to ensuring that detainees spent the minimum possible time in custody. However, the considerations for HMCTS when listing cases were complex, and for a variety of reasons this commitment was not always achieved. It was often unclear why custody cases, particularly those involving women, children and vulnerable detainees, were not always prioritised. There was also a number of other reasons why cases were not heard promptly, including courts not starting on time, waits for relevant paperwork, and defence solicitors dealing with their non-custody clients first. A range of other factors further contributed to detainees remaining in court custody for unnecessarily long periods, including some extensive waits for transportation to an onward custodial institution. While the key agencies were aware of some of these issues, not enough was being done fully to understand or address the reasons for the delays or unnecessarily extended periods in custody.

S21 Notices detailing the complaints process were placed in each cell, but were not always explained to detainees. Staff had a reasonable awareness of the complaints procedure. Few complaints were received, and they were mostly responded to appropriately.

In the custody cell, safeguarding and health care

S22 Communal areas were well presented, but none of the custody facilities had any natural light and we were aware that most facilities had experienced issues with both heating and cooling systems. The condition of cells varied greatly. While some were very clean, others were grubby or had extensive graffiti, some of which was offensive. We found some potential ligature points, which staff were not aware of. We provided a separate report illustrating these findings.

S23 Minor repairs generally took place quickly, but deep cleaning, painting and expensive repairs were more difficult to arrange. Staff were familiar with emergency evacuation plans, but did not practise them regularly enough with detainees.

S24 Force was used infrequently against detainees. Staff used force only as a last resort, and described going to great lengths to avoid using it where possible. Overall, force used by staff on detainees appeared to be mostly necessary and proportionate in the circumstances described in the incident reports we reviewed. We found a much improved and proportionate approach to handcuffing and searching.

S25 Many detainees spoke highly of the standard of care they had received from staff. However, while we found that detainees were generally treated well, more could have been done to improve their experience of custody. Food preparation areas were kept very clean. Drinks were generally offered frequently. Only microwaveable ambient ready-meals were available, with a range to suit most diets, and meals were generally only served at set times, 11.30am being the earliest even when detainees indicated that they were hungry. Appropriate toilet and handwashing facilities were available, and generally afforded sufficient privacy, but soap, paper towels and toilet paper were not always stored hygienically. In each suite, there were a few paperback novels in English only, and recent newspapers were sometimes brought in by staff, but these and distraction packs were not always provided routinely.

S26 The concept of safeguarding was still not sufficiently well understood by most staff, who described it in terms of promoting welfare, rather than protecting from harm.

S27 The provision of specially trained escort custody officers to look after children was welcome, but had only just begun and some implementation issues were still being resolved. We met a child who told us that this support, including the provided distraction activities, had been helpful. While most courts had identified a holding room (rather than a cell) where children could be held, this was not the case everywhere, partly because of COVID-19 restrictions.

S28 The liaison and diversion (L&D) service and custody health provision were commissioned on the basis of a recent health needs assessment. A new health care contract had started in August for the custody suites; while the direction of travel was good, it was still too early to tell if the service had improved. Governance arrangements for the L&D service were good. The highly experienced L&D teams were effective and well integrated, and submitted court reports promptly.

S29 New custody staff received first-aid training, but ongoing refreshers were carried out only every three years, which was not sufficient to maintain a level of confidence or competence. Custody staff responded appropriately to health emergencies. Few told us that they had received mental health training, but there were trained mental health first-aiders across all sites. Custody staff generally knew where the defibrillators were held, but almost none of these were suitably equipped for optimum use.

S30 Medicines management was variable and complex. Access for those coming from prison was mostly well managed, but those coming from police custody or arriving with unlabelled or complex medicines could miss doses. Nicotine replacement therapy products were not available.

Release and transfer from court custody

S31 Pre-release risk assessments were properly focused and carried out thoroughly. Face coverings were offered to all those leaving the custody suites, and staff were quick to offer travel warrants, bus fares or, if necessary, a taxi.

S32 For each of the three counties, there were separate sheets giving contact details for relevant services in the community, for men, for women and for children. These were very useful but in English only, and in most sites there was very little other information in the form of leaflets about key services or the prisons to which detainees were commonly taken from these courts.

S33 When a detainee had come from prison and been released by the court, release was commonly delayed by unexplained waits for a governor's authorisation to release. In a period of 10 weeks before the inspection, in 64% of the 53 relevant cases there had been a delay of over an hour, and not enough was done to escalate, understand or address these delays.

Key concerns and recommendations

S34 Key concern: The range of multi-agency meetings was not always properly focused on delivering positive outcomes for detainees. There was a lack of understanding of the responsibilities, pressures and challenges faced by each of the key agencies and how they needed to better coordinate. Communication between relevant staff was not always sufficiently effective.

Key recommendation: Relationships and communication between the three key agencies responsible for custody should be improved and prioritise the delivery of good outcomes for those detained.

S35 Key concern: Serco had a comprehensive range of policies and procedures, but many custody staff told us that they were not aware of these, or were unable to describe adequately what was required of them in a number of important areas. This was particularly acute in equality and diversity, safeguarding and mental health awareness, and had been an observation at our last inspection. We were not convinced that detainees would always be treated in keeping with policy requirements, or that concerns would be identified consistently and appropriate referrals made if required.

Key recommendation: The approach to delivering training and development to custody staff should be improved, to ensure that they understand what is required of them and can implement what they have learned, particularly in equality and diversity, safeguarding and mental health awareness.

S36 Key concern: We experienced serious issues in receiving data requested in advance of the inspection. Not all data were provided in a timely way, there were gaps and some data were inaccurate. The routine data that were collated and analysed were too limited and did not cover a sufficient range of issues that directly affected detainees. There was no action to identify and address shortfalls in concerns identified such as delays in obtaining authority to release from prison or the use of telephone interpreting.

Key recommendation: Comprehensive data covering activity affecting detainees in court custody should be collated and analysed, so that action can be identified and taken to address any shortfalls.

S37 Key concern: The conditions across the court custody estate varied greatly and some were inadequate. All custody suites lacked natural light. We found potential ligature points across the estate, particularly around door frames, in ventilation grilles and where sealant had failed, about which staff were unaware. Some cells contained extensive, and sometimes offensive, graffiti. We were also aware of ongoing issues with heating and cooling systems in most custody environments. Cleaning and maintenance were not always carried out well enough to ensure that conditions were appropriate for detainees.

Key recommendation: Cells should be safe, clean and in a good state of repair.

Section 1. Leadership and multi-agency relationships

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

1.1 HM Courts & Tribunal Service (HMCTS) in Norfolk, Suffolk and Essex operated as a single cluster. Three key agencies delivered court custody services across the cluster: HMCTS, which had overall responsibility; prisoner escort and custody services (PECS), part of HM Prison and Probation Service, which commissioned and managed the contract provision; and Serco, the contracted service provider. Serco had retained responsibility for the new contract, awarded in August 2020. HMCTS had reconfigured their regions since our last inspections of Norfolk and Suffolk (N&S), and Cambridgeshire and Essex (C&E) in 2013 and 2014, respectively, which meant that this was our first inspection of this cluster but our second visit to the custody facilities within the newly aligned region. There had been a reasonably good commitment to implementing recommendations made at the last inspections, and 65 out of 80 had been achieved or partially achieved, although more work was needed to drive further necessary improvements.

1.2 Courts had stopped operating for a time at the beginning of the COVID-19 pandemic, and the requirement for court custody stopped almost entirely in April and May 2020. Hearings for those remanded in custody by the police were generally conducted via video technology in police stations, and Crown court trials had been substantially curtailed. At the time of the inspection, there remained in place arrangements for dealing with cases remotely, where possible, but trials had resumed and magistrates' courts had returned to business as usual. In Essex, this meant that detainees were now delivered to court custody, rather than having their cases dealt with remotely while they remained in police custody. The reintroduction of in-person hearings had been challenging, but there had been a proactive multidisciplinary response to deal with this. Virtual hearings had been commonplace in Norfolk and Suffolk before the pandemic, and were mostly continuing that way.

1.3 The three agencies had successfully risk assessed and implemented measures to make court custody safe for detainees and staff during the COVID-19 pandemic. Many of the amended working practices were well embedded. Staff and most detainees wore face masks and sanitised their hands regularly. However, other measures, such as 'touchpoint' cleaning and attention to social distancing, were not delivered consistently. In addition, we rarely saw detainees being briefed or provided with information about how their experience of court custody would be affected in light of the COVID-19 measures.

1.4 HMCTS had a clear line-management structure for the cluster, in which six magistrates' courts, four Crown courts and two combined facilities operated. HMCTS managers or their delegated representatives had regular contact with Serco staff, but some in-person contact was not as frequent as it had been pre-COVID-19. Required audits were not completed consistently and were not always focused on the delivery of positive outcomes for detainees. Other than issues concerning the estate, there was limited action to identify and address other important shortfalls that affected detainees.

1.5 HMCTS was responsible for the upkeep of court buildings, including custody facilities. It contracted a private provider to undertake the cleaning and maintenance in 11 custody suites, while a separate contractor was responsible for the private finance initiative facility at Ipswich Crown Court. HMCTS was the conduit between custody staff, and cleaning and

maintenance contractors. Oversight of the cleaning and maintenance arrangements was reasonably good and issues were escalated where necessary. However, contractual complexities and budgetary constraints made some maintenance work difficult to progress, particularly costly work (see paragraph 4.5).

1.6 Strategic managers from each of the key agencies shared an aim to ensure that detainees were held in good conditions and were treated well. During separate interviews, they all maintained that inter-agency relationships to achieve this were good and that communication was effective. However, some formal multi-agency meetings and face-to-face interactions had lapsed or stopped since the start of the pandemic, and the focus on detainee care and welfare was not evident from the meeting minutes we were shown.

1.7 The listing of court cases was a judicial responsibility and process, but an HMCTS listings protocol allowed for custody cases to be prioritised. There was a broad strategic commitment to do this. While the majority of routine contact between operational staff was broadly described as positive, some custody staff did not feel that relationships were as effective as they should have been, particularly in relation to dealing with custody cases promptly and as a priority, and shared their frustrations throughout the inspection. There was, however, a lack of understanding by custody staff about the requirements for ensuring that a detainee was ready for their court appearance. Mutual awareness of the responsibilities, pressures and challenges faced by each agency was sometimes lacking, and communication between relevant HMCTS personnel and Serco staff was not always as effective as it needed to be. More needed to be done to improve the appreciation of the roles of key HMCTS staff and custody staff, and to enhance communication between the respective agencies (see key concern and recommendation S34).

1.8 Serco staffing levels in court custody were sufficient and officers were properly vetted. Initial training for custody staff was generally adequate. Serco had a comprehensive range of policies and procedures that staff could refer to, but many custody staff told us that they were not aware of these, or were unable to articulate adequately what was required of them in a number of important areas. This was particularly acute in equality and diversity, safeguarding and mental health awareness, and had been a concern during our last inspection (see key concern and recommendation S35). There was, however, an appropriate culture among the custody staffing group, which was a real strength and mitigated some of the other shortfalls.

1.9 At the time of the inspection, there had been no external scrutiny of court custody since the beginning of the COVID-19 crisis. Before that, independent lay observers had visited court custody suites regularly to observe the conditions in which detainees were held, and their treatment.

1.10 We experienced serious issues with receiving data requested in advance of the inspection. Data received were not consolidated by the three agencies, were not always received in a timely way, had gaps and were not always accurate. Different agencies were responsible for different aspects of the work, and no single organisation collated or analysed the whole range of data, to inform action to address any shortfalls affecting detainees. Serco was primarily focused on providing data to affirm contract compliance, and generally collected no other data routinely. There was little demographic breakdown or analysis of data concerning detainees. We received several varying figures for the throughput of detainees, and much of the data we requested were not readily accessible. Data concerning the delays experienced by some detainees released from court custody when they had formerly been located in a prison (see paragraph 5.3 and recommendation 5.5) and the lower than expected use of telephone interpreting (see paragraph 3.8 and recommendation 3.12) were also not routinely collated or analysed (see key concern and recommendation S36).

1.11 We acknowledged the recent implementation of the retendered contract for escorting and custody services, and were aware of plans to develop and improve the provision further. There had been some improvements already, including a new fleet of vehicles (see also paragraph 2.3). However, a number of contractual requirements were yet to be realised or fully embedded, including moving detainees quickly to prison once their hearings were concluded. We were hopeful that, once fully implemented, the contract had the capacity to deliver better outcomes for detainees in some important areas.

Section 2. Transfer to court custody

Expected outcomes:
Escort staff are aware of detainees' individual needs, and these needs are met during escort.

2.1 Person escort records (PERs) were made up of a handwritten record of events in the PER booklet and printed material identifying relevant risks and needs, reflecting the gradual digitalisation of the system. The printed material was stapled to the front of the PER, often in such a way that it was difficult to read the reverse of each page. In a few cases, the printed material was extensive and repetitive, so it was difficult for staff to identify quickly the information they needed. Some police officers had chosen to append loose-leaf police documentation relating to charges instead of recording pertinent details in the PER. These pages were at risk of being lost, and further compromised the effectiveness of the PER as an effective briefing and risk assessment tool.

2.2 Nevertheless, when read carefully, most PERs contained enough information to enable escorting staff to meet detainee needs. Court custody staff routinely examined the PER before detainees entered the suite, and used the information it contained to inform their risk assessment (see paragraph 3.14).

2.3 Many escort vehicles were new, and those we saw were clean and well equipped. The new fleet included a range of vehicles to meet a variety of needs. Detainees welcomed the added safety and comfort features, including seatbelts and soft seats. Cells on the vehicles could be observed by escorting staff on closed-circuit television, and in most cases observations were regularly recorded. Each cell also had a small interactive screen, designed to provide information to detainees, but these were not yet operational. Some detainees and staff complained that the heating system on the vans was not good enough to heat both detainee and staff areas simultaneously. Most escort staff routinely wiped down the cells on vehicles after each use, but we saw some exceptions to this.

2.4 Women, children and men were generally transported in separate vehicles. However, at Chelmsford Magistrates' Court we saw two vehicles holding women and men without the partition being used. In one case, a woman was held in the front cell but the men disembarked first, which created unnecessary risks. Vehicles transporting women had at least one female escorting officer.

2.5 Women and children had the longest journeys, with some women spending four hours a day on vehicles for trials lasting many weeks. Most journey times were reasonable, however, given the location of the local prisons, and we did not see long waits to disembark, except at the weekend, at Chelmsford Magistrates' Court. Few courts had any clothing to give to detainees. One woman who arrived at Chelmsford Magistrates' Court from Southend Police Station appeared in court in her pyjamas, dressing gown and slippers, which was inappropriate.

2.6 The vehicle bays at Basildon and Great Yarmouth Magistrates' Courts and King's Lynn Combined Court were too small for the larger vehicles, so detainees sometimes had to disembark outside of the vehicle bay, potentially in public view. We were satisfied that this was managed as well as possible to protect detainees' privacy and dignity. At Basildon Magistrates' Court, detainees were sometimes transferred from the adjacent police station in handcuffs across an area in public view, but this was rare.

Recommendation

2.7 Women and children should be transported separately from men.

Section 3. In the custody suite: reception processes, individual needs and rights

Expected outcomes:
Detainees receive respectful treatment in the custody suite and their individual needs are met. Detainees are held in court custody for no longer than necessary, are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Respect

3.1 Custody staff presented a professional approach and appearance across the whole area. Most staff in the suites had served in this role for several years, and this depth of experience showed in the calm and confident manner in which they interacted with detainees. Officers could describe well how their job was to care for detainees and their safety, and they did this with humanity. They demonstrated an ability to reassure and inform those in their care and to defuse tensions by carrying themselves in an understated manner, having a good-humoured approach and controlling their responses to aggression or frustration.

3.2 Many detainees told us that they had very much appreciated the caring and helpful approach of all the staff in the custody suites, and their willingness to spend time talking to them.

3.3 In many suites, the custody officers wore clear name badges, as well as having their identification cards visible, which helped to build trust. They addressed detainees properly and respectfully, and fairly often by their first name.

3.4 Staff often took time to talk to detainees individually once they were in the cells, especially those who were not familiar with court processes or the experience of detention. When detainees first arrived, staff were informal and friendly in going through the preliminaries. However, in some suites they were less than thorough in explaining key points or discovering the individual's specific needs at this stage. There was generally little opportunity for detainees to have a private conversation with a staff member when they arrived (see also paragraph 3.14). The names of those being detained were potentially visible to anyone walking through a circulation area in a few courts but, otherwise, private information about detainees was not displayed in public view.

Meeting individual and diverse needs

3.5 Most staff said that they had received some training in equality and diversity. For newer staff, this had been during their initial training, while for others it was mainly through online training materials. Several said that they had just been asked to read the published policies. Many were not able to describe what they had learned from the training, and for many it was not recent (see key concern and recommendation S35). Nevertheless, in all our observations in the suites, the staff showed a generally sound approach to dealing with the diverse needs of those in their care.

3.6 Women were held in a separate section of the custody suite – and in a separate corridor, where this was possible. In all suites, menstrual care products were freely available in the toilet areas, although the range was often too limited and they were sometimes inappropriately stored on the floor (see Appendix II). Sufficient female staff were available to

provide appropriate care for detained women; in all but one of the courts, this was through a balanced gender mix of custody staff, and reserve staff were readily available in the remaining court. In most cases, a 'females in custody' information sheet was put in the cells occupied by women.

3.7 There was a comprehensive policy concerning the treatment of detainees who identified as transgender. While some staff described well how they had supported transgender detainees, not all staff were fully conversant with the policy and we were not assured that transgender detainees would consistently be treated in line with the policy.

3.8 Cordless telephone handsets with amplification were available for use in all courts, to access interpreting services, and details of these services were displayed in all custody suites, but hardly any staff could recall having used them. At one court, they had been used for a detainee being released. When a detainee who did not speak good English arrived, staff generally waited until a court-appointed interpreter could come to the cells before interacting with them in a language they could understand. This meant that meaningful communication was often not possible until well after their arrival, and that a prompt assessment of risk and welfare needs was not undertaken. A range of documents could be printed out quickly in all common languages.

3.9 At three courts, there were some physical adaptations to enable detainees with mobility difficulties to move between the cells and the courtrooms. Although none was fully compliant with requirements under the Equality Act for reasonable adjustments in this respect, for example there were no adapted cells with lowered cell call bells. However, we found no unmet need. Managers at the other sites were assertive in ensuring that any potential detainees with such difficulties were not brought to their cells. Walking aids were routinely removed from detainees when located in cells, without an individual risk assessment. For example, at one court a detainee who used a crutch was not allowed to have it in their cell, despite being well known to staff and having been on trial for two months with no issues.

3.10 No information was available in Braille, and few staff were aware of any assistive listening systems, although some said that they would borrow one from the court if necessary.

3.11 Religious items were stocked, and were stored carefully and respectfully in all courts. In some suites, those arriving were briefly asked if they had any religious requirements, but in several this did not happen.

Recommendations

3.12 Telephone interpreting should be used when a detainee is received who does not speak good English, unless an interpreter is available promptly.

3.13 All courts should have hearing loops and Braille versions of key information for detainees. (Repeated recommendation N&S 5.22, C&E 5.26)

Risk assessments

3.14 There continued to be no formal, consistent or recorded risk assessment of detainees on arrival at the court custody suites. Despite this, the overall identification and management of risk was reasonably good. Escorting staff shared relevant risk information with court custody staff about the detainees they transported to court. Staff checked the information provided by the police and prison staff, recorded in the detainee's PER, so they were aware of their

potential risks before the individuals were located in cells (see paragraph 2.2). On entry to the suites, custody staff communicated with detainees respectfully. However, although interactions were generally positive, they were often too brief and were not conducted in private, with the potential to inhibit the disclosure of any information relating to risk and vulnerabilities (see also paragraph 3.4). Some staff used a basic checklist as a guide for new receptions but this was not used consistently, and the information obtained from detainees was not always recorded. The process for detainees received directly from courts (off-bail; see Glossary of terms) was more thorough, as custody staff often had little or no information provided to them beforehand and needed to undertake more comprehensive assessments of risk.

3.15 Once detainees were located in their cell, staff were alert to the need to ask more probing questions sensitively if they had concerns. Staff explained to us how they did this, identifying any signs of vulnerability, instability or low mood, in order to manage individual risks. If a detainee was identified as being at a risk of self-harm, they would be subject to an enhanced level of checks or placed on a constant watch if considered necessary. Staff understood the different frequency of checks that were available to them to check on the safety and welfare of detainees. The checks we observed were generally carried out at the required frequency, although they were often cursory, with limited engagement with detainees, which was a missed opportunity for staff to monitor for any changes in mood or behaviour (see paragraph 3.4). Once completed, checks were recorded at the cell door by officers using a hand-held device, which was a welcome innovation. However, there were some connectivity issues at a few courts. In these cases, checks were clearly communicated to the staff member responsible for recording this information on the electronic custody recording system.

3.16 All custody staff should receive a comprehensive briefing to inform them of the risks relating to the detainees in their care. However, briefings did not always take place, or were carried out before detainees arrived, when these details were not available. The quality of briefings varied and they did not always impart relevant information concerning the risks posed by or to detainees.

3.17 During the inspection, there was no need for detainees to share cells. Cell call bells were tested every morning and were generally clearly audible (see paragraph 4.2). Detainees who were new to court custody were told how to use the bells when they were located in cells. When activated, the bells were answered promptly. Routes to court were safe, with adequate affray alarms available to staff, and they did not pass through any public areas.

3.18 All court custody and escort staff now carried personal-issue anti-ligature knives.

Recommendations

3.19 The assessment of each detainee's risks on arrival should be carried out consistently.

3.20 All staff should receive a thorough briefing, covering the current risks presented by detainees while held in court custody.

Individual legal rights

3.21 Printed copies of detainees' rights were placed in cells as part of the opening checks for each custody suite. However, on arrival at court, very few detainees were asked if they could read or understand the document. Staff told us that if a detainee intimated that they could not

read, they would read the rights document to them, but we saw a number of cases when this did not happen.

3.22 When detainees arrived at a court, custody staff asked them for the name of their legal representative, and there were processes to advise them that their clients were in custody. The number of available consultation rooms in the custody suites, to allow legal visits to take place either socially distanced or via telephone, had reduced but there were enough to meet current demand. Telephone handsets, which only accepted incoming calls, were available in all suites to facilitate consultations when legal representatives chose not to attend in person. However, these did not always function effectively because of poor signal strength, which caused frustration for all parties involved.

3.23 Detainees at all courts could keep legal documents pertaining to their case, and pencils and paper were available if they wished to prepare notes.

3.24 Court custody staff told us that if a detainee wanted to tell a friend or family member where they were, they would refer this request to the detainee's legal representative or they might make the call on behalf of the detainee, depending on the circumstances involved. They were aware that foreign national detainees had the right to contact their relevant consulate, embassy or high commission if they wished, but none had experienced such a request.

3.25 There was a strategic commitment to prioritising custody cases through the listings protocol (see paragraph 1.7) and to ensuring that detainees spent the minimum possible time in custody. However, the considerations for HMCTS when listing cases were complex, and for a variety of reasons this commitment was not always achieved. It was often unclear why custody cases were not always prioritised, and, while there were sometimes good reasons that were in the best interests of the detainee, this did not always appear to be the case. There were also a number of other reasons why cases were not heard promptly, which are explained below.

3.26 Through our observations and analysis of data between 19 October and 14 November 2020, we encountered a range of factors that contributed to detainees potentially spending longer in custody than strictly necessary. Courts did not always start promptly in the morning. In the data we reviewed, at least 19% of detainees appearing at the magistrates' courts and 15% of those appearing at the Crown courts did not appear in court until after 2pm, even though the majority had arrived much earlier. Despite the new contract commitment to transporting detainees to court in a timely way, those appearing in Crown courts were generally still routinely delivered to court early in the morning, even when their cases were listed in the afternoon.

3.27 Once hearings were completed, the new contract expected women and children to be moved to their onward custodial institution within two hours, and men within three hours. The differences were mainly to account for the generally longer journeys experienced by women and children. Despite this, some detainees experienced much longer waits before they were eventually moved. The longest wait we came across was almost six and a half hours for a man. We were told that the delays were generally due to the lack of availability of vehicles. The impact of these waits was of particular concern for women, and during the inspection one woman who had been on trial for a long time was enduring two-hour journeys each way, and on one occasion did not return to prison until 9pm, which made for a very long day. The restricted opening hours of reception at HMP Chelmsford, particularly over lunchtime and on Saturday mornings, continued to delay the transportation of detainees to prison.

3.28 Delays with hearings were often attributed to the police experiencing difficulties in transferring case files to the court and Crown Prosecution Service (CPS). We were also told that the CPS had implemented a change to the way that defence solicitors requested case

papers, and a system malfunction was preventing the transfer of the documents. These technical issues were preventing cases from progressing and were delaying detainees from having legal consultations with their counsel. During our sites visits, the key agencies were having regular strategic meetings in an attempt to rectify these issues. However, further delays were often experienced when solicitors represented multiple clients, including detainees, and we were told that they often chose to deal with their off-bail clients first, rather than those in custody, who should have been prioritised.

3.29 Some detainees experienced other delays that resulted in them being held for longer than necessary in court custody. Non-English-speaking detainees were sometimes affected by the late or non-attendance of court-appointed interpreters to assist with their cases. For detainees released from court who had previously been located in a prison, there were some excessive waits for formal authorisation of their release (see paragraph 5.3 and recommendation 5.5). In addition, some children could experience long delays in waiting for a placement order which dictated their onward destination (see paragraph 4.26).

3.30 Some detainees appeared to spend unnecessarily long periods in custody because of a combination of the factors explained above. While the key agencies were aware of some of these issues, not enough was being done fully to understand or address the reasons for the lack of proactive prioritisation, the delays and the unnecessarily extended periods in custody.

3.31 Once requested by the court, detainees were produced without delay.

Recommendations

3.32 Detainees should spend the minimum possible time in court custody; they should have their cases prioritised and heard promptly, and the reasons for delays should be explored and addressed.

3.33 HMCTS and PECS should liaise with HMP Chelmsford regarding their hours of operation for receiving prisoners, to reduce delays in transferring remanded or sentenced detainees. (Repeated recommendation C&E 4.17)

Complaints

3.34 Notices about the complaints procedure were placed in each cell before a detainee's arrival but were available only in English. They were pointed out to some detainees, but were not routinely explained. Posters containing details of detainees' rights, including the complaints procedure, were displayed in the custody suites but the information in these varied from that placed in the cells. In neither case was it made it clear that detainees had the right to appeal to an independent body if not satisfied with the outcome of their complaint. Court custody staff had a reasonable awareness of the complaints procedure, but they were less clear on the handling of confidential complaints.

3.35 Few complaints were received. Data supplied by Serco showed that only seven complaints had been received from 1 November 2019 to 30 October 2020. When complaints related to matters outside Serco's control, there was poor sharing of information with other relevant key agencies, and responses did not address the issues raised. Otherwise, complaints were responded to appropriately.

Recommendation

3.36 All detainees should be given comprehensive and accurate information about the complaints process.

Section 4. In the custody cell, safeguarding and health care

Expected outcomes:
Detainees receive respectful treatment in the custody suite and their individual needs are met. Detainees are held in court custody for no longer than necessary, are informed of their legal rights and can freely exercise these rights while in custody. All risks are identified at the earliest opportunity.

Physical environment

4.1 Communal areas were generally well presented, but none of the custody facilities had any natural light, which meant that they were oppressive. The condition of cells varied greatly and some were inadequate. While some were very clean and had little or no graffiti, others were grubby and had run marks from spilt liquids on the walls, or extensive graffiti, some of which was offensive. Although staff told us that cells were cleaned daily, the extent of this cleaning was not always sufficient, particularly at the Essex Crown courts (see key concern and recommendation S37).

4.2 We found some potential ligature points across the estate, many of them around door frames, in ventilation grilles or where sealant around benches had failed. We provided a separate report illustrating these findings. Staff were unaware of many of these risks before we pointed them out. Although staff signed for daily cell checks, these tended to focus on the presence of litter and the functionality of the cell call bell, rather than the physical fabric of the cell.

4.3 At Ipswich Magistrates' Court, the cell call bell system did not produce an audible alert and was therefore not fit for purpose, and at Basildon Crown Court, staff had to leave the cells area to cancel calls. However, we did not find detainees waiting too long to speak to an officer.

4.4 Staff in most courts reported difficulties with temperature control – too cold in winter and too hot in summer. We met detainees who wore coats in their cells, and saw the portable air conditioning units which were used in hot weather. Staff could describe the protocols for monitoring temperatures and for closing suites if temperatures became unacceptable.

4.5 Staff at Colchester Magistrates' Court lacked confidence in the affray alarm system, which malfunctioned regularly, despite some attention from the maintenance team. Minor repairs generally took place quickly, but deep cleaning, painting and expensive repairs were more difficult to arrange (see paragraph 1.5). Staff were familiar with emergency evacuation plans, but did not practise them regularly enough with detainees.

Recommendation

4.6 Emergency evacuations should be practised at least annually in all custody suites and should involve detainees.

Use of force

4.7 Almost half of custody staff were out of date with their control and restraint training. However, a grace period of six months had been granted by PECS because of COVID-19, and there was a comprehensive training plan to ensure that this would be rectified at the earliest opportunity. At the time of the inspection, no custody staff were trained in minimising and managing physical restraint (MMPR; see Glossary of terms), which was designed for use with children, but this was mitigated slightly now by the fact that children were generally in the care of specialist staff who were trained in these techniques (see paragraph 4.24).

4.8 Force was used infrequently against detainees, with 14 uses in the year to the end of September 2020, of which two involved children. From conversations with custody staff, we were confident that great efforts would be taken to de-escalate potentially volatile situations before resorting to the use of force, and that it was generally used only as a last resort.

4.9 We reviewed paperwork submitted by custody staff concerning 18 incidents involving the use of force against detainees. Although a few individual statements lacked detail, the quality of the paperwork was adequate overall, and we were able to build a picture of what had led to the incident, and what action had been taken by staff. When used, force was often at a low level – for example, to guide detainees to cells, to remove reluctant detainees from the dock on conclusion of their hearings or to prevent them from harming themselves. Protracted or sustained force was used rarely and there was good attention to de-escalating situations quickly. We were satisfied that, when used, force was generally necessary and proportionate to the risks posed.

4.10 There was no clear approach to the quality assurance of use of force documentation, and this was of particular note when children were involved. We had some concerns about a low-level incident involving a child that had not been thoroughly reviewed to ensure that the force used had been necessary or to identify any learning points (see paragraph 4.23).

4.11 In response to a main recommendation at the previous inspection, there was now a much-improved picture concerning the handcuffing of detainees in court custody. Where the use of handcuffs had previously been routine for all detainees, they were now only used when supported by an individualised risk assessment, which reflected a far more proportionate approach. A similar perspective had been adopted towards searching. We saw little of either practice during the inspection, and when we did come across them there was generally a good rationale for their use.

Recommendation

4.12 Managers should scrutinise use of force documentation, to ensure that force is only used proportionately and as a last resort, and to identify areas for improvement.

Detainee care

4.13 Many detainees we spoke to were complimentary about the standard of care they had received from staff. They appreciated that staff were prepared to take time to talk to them and understand their concerns and needs. One described the staff as 'golden' and 'good people'.

4.14 Almost all courts had a separate kitchen for preparing food, and all the food preparation areas were cleaned often and kept in good condition. The only food available was a range of microwaveable ambient ready-meals, with no fresh food or snacks, which could have improved the otherwise limited offer. The range of ready-meals suited most diets but in the majority of courts there were none suitable, for example, for those with coeliac disease or requiring a kosher diet. However, staff would go out to buy other food when necessary.

4.15 The policy of the custody contractor was that food should only be served at set times, and not before 11.30am. Some detainees were hungry before this time – even those coming from prison, who might not have had any breakfast in the morning. In most courts, but not all, some staff showed sensible flexibility in providing food earlier when circumstances justified it and this approach should have been universal. Tea, coffee and water were the only drinks available, and in most courts these were offered with sufficient frequency.

4.16 Detainee toilets and handwashing facilities were available in all cell corridors. In the majority of custody suites, they were in good condition and afforded sufficient privacy. In many cases, soap, toilet paper and paper towels were lying loose on basins, toilets or even the floor, which was unhygienic (see Appendix II).

4.17 The provision of reading materials and distraction activities could have been more proactive and consistent. At each court, there was a small supply of novels, but in English only, with no provision for children or those speaking other languages. In some courts, staff brought in newspapers and magazines, and left them for detainees to read; these were occasionally offered, but usually issued only on request. Distraction packs and monthly packs of puzzles, quizzes, and so on, sourced from the Recoop charity, were available in most courts. In one suite, these were placed in each cell, but in general they were less commonly issued. Several courts had a box of games, some suitable for children, but there was little evidence of these being used.

Recommendations

4.18 Detainee toilets should have hygienically stored supplies of toilet paper, soap and paper towels (or an electric dryer) which are freely available.

4.19 Detainees should be offered, and provided with, appropriate reading materials and distraction activities routinely.

Safeguarding

4.20 Serco had now developed its own safeguarding policy, but the concept of safeguarding was still not sufficiently well understood by most staff, who generally described it in terms of promoting welfare, rather than protecting from harm (see key concern and recommendation S35). Even when staff could describe vulnerabilities which might cause them concern, they were vague about what action they should take. There was little awareness of modern slavery or the National Referral Mechanism (see Glossary of terms), neither of which were mentioned in the policy document. HMCTS still did not have a safeguarding policy.

4.21 In general, staff in Norfolk and Suffolk had a better awareness of safeguarding than those in Essex because they had received 'toolbox talks' on the subject, and a few had completed online training modules for both adult and child safeguarding.

4.22 Across all three counties, most staff knew the names of the safeguarding officers and where to find their contact details. Most courts held these details in a red 'safeguarding' folder,

which included the safeguarding policy, the 'toolbox talks' and various other policy documents, such as for religious worship and care of transgender detainees. We considered that this juxtaposition of safeguarding and welfare material had contributed to staff's lack of clarity about safeguarding.

4.23 During the inspection, we identified three potential safeguarding cases. One (identified at Norwich Magistrates' Court) had appropriately resulted in a referral but this had not been escalated to PECS, as we would have expected, to ensure that appropriate action would be taken (see paragraph 3.35). The other two cases were less likely to result in a formal referral, but required investigation, and we were not confident that the work done in relation to them had been sufficient. One of these had involved the low-level use of force against a child.

Children

4.24 Since mid-November, children in court custody had been cared for by teams of three, comprising escort custody officers (ECOs) and dual-badged officers (DBOs), all of whom were specifically trained to work with children and had received training in MMPR techniques (see paragraph 4.7). Some early implementation issues relating to the respective responsibilities of ECOs and court custody officers in the custody suite had emerged and were being resolved.

4.25 We met a team of three ECOs/DBOs, looking after a child who had travelled in a small non-cellular vehicle and been given various resources, including a tablet computer (for use in the vehicle) and distraction activities. The child told us that the support he had received had been helpful.

4.26 During September and October 2020, 19 children had been held in court custody on a total of 40 occasions. Placement orders were usually received within an hour of the case outcome. However, on three occasions children had waited longer than two and a half hours, which was excessive. In addition, on four occasions delays of over an hour had been compounded by waits for transport. We did not understand why a new placement order for children on trial had to be requested every day. This delayed departure, even if only by a short period, and therefore had a negative impact on outcomes for children (see recommendation 3.32).

4.27 Most courts had identified a holding room (rather than a cell) where children could be held, although this was not the case everywhere, and there was generally a small range of games or distraction activities available. In some courts, social distancing requirements meant that rooms which had previously been identified as suitable for holding children (often, legal consultation rooms) were not currently suitable. A child we met was held in a cell, but the door was kept open some of the time.

Health

4.28 There was a published national health needs assessment (HNA) in place which set out the needs of those detained within court custody. This HNA had informed both the new court custody health contract with IPRS Aeromed, which started in August 2020, and additional NHS England commissioning plans to increase the onsite health provision within courts with a high footfall. No onsite additional health provision had yet been commissioned within these areas. In addition, while the direction of travel was positive, it was too early to tell if the IPRS Aeromed contract had improved outcomes for detainees, as the court throughput had been

reduced by the COVID-19 pandemic. The IPRS Aeromed court custody health provision comprised a telephone helpline, with the option to attend if required.

4.29 The liaison and diversion (L&D) services in Norfolk and Suffolk were provided through a tripartite agreement with Norfolk and Suffolk Foundation Trust, and support services by Julian Support and Phoenix Futures. These contracts were amalgamated with the police physical health contract novated to the local authority. Essex L&D providers were Essex University Partnership Trust, with subcontracts for support services from Phoenix Futures and Open Road. All services had maintained a physical presence at court, with some adaptations to control the spread of infection and protect staff.

4.30 Services for both regions had an all-age, all-vulnerabilities model, which was provided by effective and highly experienced teams. These teams were well integrated into custody areas, court proceedings and community services, and were providing timely reports for court on those referred. Norfolk and Suffolk had one registered clinician covering all the courts from Monday to Friday, and in Essex there were more clinicians operating but they often also covered some courts remotely. At the sites with no onsite cover, not all staff knew how to contact the L&D teams directly and would request access via the court custody manager or HMCTS security staff. Some custody staff told us that they did not make L&D referrals if no one from the team was on site.

4.31 PERs were used to ensure that health-related issues were communicated between prisons, police custody and Serco. L&D staff were not present at all sites to review these documents, and were reliant on custody staff to relay any health and well-being concerns; this process was less consistent when custody staff knew that no L&D staff were on site.

4.32 New custody staff received first-aid training, but ongoing refresher training took place only every three years, which was not enough to maintain a level of confidence or competence. Custody staff responded appropriately to health emergencies. Few told us that they had received mental health training (see key concern and recommendation S35), but there were trained mental health first-aiders across all sites. Custody staff generally knew where the well-promoted defibrillators were held. However, almost none of these were suitably equipped for optimum use. Most had out-of-date, open or paediatric pads attached. Only two had a razor, to ensure that pads could be applied effectively, and none of the HMCTS security staff were able to produce a record of regular checks.

4.33 The L&D services demonstrated effective clinical governance structures. Quarterly oversight reports were produced that included performance data, incident monitoring and training records. Although the L&D teams had a separate complaints process, this was not made clear to detainees. Custody staff told us that health concerns would be raised on the Serco complaints form, sent out to the investigations team and then passed on to the relevant responsible authority. This did not enable a confidential process.

4.34 Medicines arriving at court with detainees were not placed in secure drugs cabinets, but were locked in secure cupboards and safes. Medicines management was variable and complex. Access to medications for those coming from prison was mostly well managed because they were generally labelled appropriately, with a clear indication of the time they were to be administered. This was not always the case for those coming from police custody, who often arrived with their own unlabelled or complex medicines, and who could subsequently miss doses if their medication could not be verified or issued in the court custody setting. Custody staff did not always understand medical prescriptions and would have to spend time clarifying and authorising medicines with prison, police and IPRS Aeromed staff. There were no arrangements to provide simple remedies such as paracetamol or nicotine replacement therapy, and custody staff told us that those withdrawing from drugs and alcohol would be managed through the IPRS Aeromed health

advice telephone line or local accident and emergency department if there were delays in accessing treatment.

Recommendations

4.35 Liaison and diversion staff rotas and contact details should be published and accessible in court custody offices, to ensure equitable access across the courts.

4.36 All automated external defibrillators should be regularly checked and signed for, and this should be undertaken by staff who understand the minimum requirements for these checks.

4.37 Custody staff should have annual life support training.

4.38 Detainees should be able to access medicines at times to meet their needs.

Section 5. Release and transfer from court custody

Expected outcomes:
Detainees are released or transferred from court custody promptly and safely.

Release and transfer arrangements

5.1 For those being discharged from the custody suites, staff carried out a pre-release risk assessment, and a pre-release check list was also used. This process was carried out with exceptional thoroughness in all cases that we observed. Face coverings were offered to all those leaving the custody suites. In every case, officers checked how the person was going to get home. They provided travel warrants to all who needed them, and also provided bus fares to those living locally. They made allowance for the infrequency of bus services in some of their rural areas, and were ready to arrange taxis when this was the only practical way for the person to get home within a reasonable time. We found that they had shown considerable care for people with specific needs, such as a vulnerable older man who had been accompanied to the railway station by court staff, who had then liaised with station staff.

5.2 In each of the three counties, information sheets had been prepared, giving the names, addresses and contact numbers for relevant services in the local community. There were three different sheets for each county: for adults in general, for women and for children. These were very useful but they were not available in languages other than English. Apart from these sheets, in most courts there was very little other information in the form of leaflets about key services or the prisons to which detainees were commonly taken from these courts. A generic 'What happens next?' leaflet was available in the custody suites for those going to a prison but was rarely provided. Similarly, the leaflet concerning COVID-19 information for onward detention was not provided routinely.

5.3 Since targets had been introduced under the new contract, there had been a renewed emphasis on prompt release once a detainee's court hearing had been completed. However, when a detainee had come from prison and been released by the court, authorisation for release was required from a governor at the prison, in case other matters required continued incarceration. In these circumstances, which were common, release was often delayed by unexplained waits for receipt of the governor's authorisation. In the 10 weeks before the inspection, in 64% of the 53 relevant cases there had been a delay of over an hour, waits of over two hours were not uncommon and there had been several delays of over three hours. Sometimes there were legitimate reasons, such as waiting for the setting of licence conditions or clarification of immigration status, but in general the delays were excessive. In some cases, it was clear that the custody staff had kept in touch with the prison, to try to expedite the process, but often to no avail, and not enough was done to escalate these cases to PECS, or to understand or address these delays (see also paragraphs 1.10 and 3.29). There were also delays, often of over two hours, before a child could be taken to a custodial institution, which were due to the wait for a formal placement order (see paragraph 4.26).

Recommendations

5.4 Every court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages. (Repeated recommendation N&S 5.53, C&E 5.58)

5.5 HMCTS should work with PECS to ensure that the governor's authorisation to release is issued as promptly as possible to the custody staff.

Section 6. Summary of key concerns and recommendations

The following is a listing of repeated and new key concerns and recommendations included in this report.

Key concerns and key recommendations

6.1 Key concern (S34): The range of multi-agency meetings was not always properly focused on delivering positive outcomes for detainees. There was a lack of understanding of the responsibilities, pressures and challenges faced by each of the key agencies and how they needed to better coordinate. Communication between relevant staff was not always sufficiently effective.

Key recommendation: Relationships and communication between the three key agencies responsible for custody should be improved and prioritise the delivery of good outcomes for those detained. (Directed to: HMCTS, PECS and Serco)

6.2 Key concern (S35): Serco had a comprehensive range of policies and procedures, but many custody staff told us that they were not aware of these, or were unable to describe adequately what was required of them in a number of important areas. This was particularly acute in equality and diversity, safeguarding and mental health awareness, and had been an observation at our last inspection. We were not convinced that detainees would always be treated in keeping with policy requirements, or that concerns would be identified consistently and appropriate referrals made if required.

Key recommendation: The approach to delivering training and development to custody staff should be improved, to ensure that they understand what is required of them and can implement what they have learned, particularly in equality and diversity, safeguarding and mental health awareness. (Directed to: HMCTS, PECS and Serco)

6.3 Key concern (S36): We experienced serious issues in receiving data requested in advance of the inspection. Not all data were provided in a timely way, there were gaps and some data were inaccurate. The routine data that were collated and analysed were too limited and did not cover a sufficient range of issues that directly affected detainees. There was no action to identify and address shortfalls in concerns identified such as delays in obtaining authority to release from prison or the use of telephone interpreting.

Key recommendation: Comprehensive data covering activity affecting detainees in court custody should be collated and analysed, so that action can be identified and taken to address any shortfalls. (Directed to: HMCTS, PECS and Serco)

6.4 Key concern (S37): The conditions across the court custody estate varied greatly and some were inadequate. All custody suites lacked natural light. We found potential ligature points across the estate, particularly around door frames, in ventilation grilles and where sealant had failed, about which staff were unaware. Some cells contained extensive, and sometimes offensive, graffiti. We were also aware of ongoing issues with heating and cooling systems in most custody environments. Cleaning and maintenance were not always carried out well enough to ensure that conditions were appropriate for detainees.

Key recommendation: Cells should be safe, clean and in a good state of repair. (Directed to: HMCTS, PECS and Serco)

Recommendations

Transfer to court custody

6.5 Recommendation (2.7): Women and children should be transported separately from men. (Directed to: HMCTS, PECS and Serco)

In the custody suite: reception process, individual needs and legal rights

6.6 Recommendation (3.12): Telephone interpreting should be used when a detainee is received who does not speak good English, unless an interpreter is available promptly. (Directed to: HMCTS, PECS and Serco)

6.7 Recommendation (3.13): All courts should have hearing loops and Braille versions of key information for detainees. (Repeated recommendation C&E 5.26) (Directed to: HMCTS, PECS and Serco)

6.8 Recommendation (3.19): The assessment of each detainee's risks on arrival should be carried out consistently. (Directed to: HMCTS, PECS and Serco)

6.9 Recommendation (3.20): All staff should receive a thorough briefing, covering the current risks presented by detainees while held in court custody. (Directed to: HMCTS, PECS and Serco)

6.10 Recommendation (3.32): Detainees should spend the minimum possible time in court custody; they should have their cases prioritised and heard promptly, and the reasons for delays should be explored and addressed. (Directed to: HMCTS, PECS and Serco)

6.11 Recommendation (3.33): HMCTS and PECS should liaise with HMP Chelmsford regarding their hours of operation for receiving prisoners, to reduce delays in transferring remanded or sentenced detainees. (Repeated recommendation C&E 4.17) (Directed to: HMCTS and PECS)

6.12 Recommendation (3.36): All detainees should be given comprehensive and accurate information about the complaints process. (Directed to: HMCTS, PECS and Serco)

In the custody cell, safeguarding and health care

6.13 Recommendation (4.6): Emergency evacuations should be practised at least annually in all custody suites and should involve detainees. (Directed to: HMCTS, PECS and Serco)

6.14 Recommendation (4.12): Managers should scrutinise use of force documentation, to ensure that force is only used proportionately and as a last resort, and to identify areas for improvement. (Directed to: HMCTS, PECS and Serco)

6.15 Recommendation (4.18): Detainee toilets should have hygienically stored supplies of toilet paper, soap and paper towels (or an electric dryer) which are freely available. (Directed to: HMCTS, PECS and Serco)

6.16 Recommendation (4.19): Detainees should be offered, and provided with, appropriate reading materials and distraction activities routinely. (Directed to: HMCTS, PECS and Serco)

6.17 Recommendation (4.35): Liaison and diversion staff rotas and contact details should be published and accessible in court custody offices, to ensure equitable access across the courts. (Directed to: HMCTS, PECS and Serco)

6.18 Recommendation (4.36): All automated external defibrillators should be regularly checked and signed for, and this should be undertaken by staff who understand the minimum requirements for these checks. (Directed to: HMCTS, PECS and Serco)

6.19 Recommendation (4.37): Custody staff should have annual life support training. (Directed to: HMCTS, PECS and Serco)

6.20 Recommendation (4.38): Detainees should be able to access medicines at times to meet their needs. (Directed to: HMCTS, PECS and Serco)

Release and transfer from court custody

6.21 Recommendation (5.4): Every court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages. (Repeated recommendation N&S 5.53, C&E 5.58) (Directed to: HMCTS, PECS and Serco)

6.22 Recommendation (5.5): HMCTS should work with PECS to ensure that the governor's authorisation to release is issued as promptly as possible to the custody staff. (Directed to: HMCTS and PECS)

Section 7. Progress on recommendations from the last report

This is the first HMI Prisons inspection of Norfolk, Suffolk and Essex court custody facilities following its restructure. HMI Prisons last inspected Cambridgeshire and Essex court custody facilities in 2014 and Norfolk and Suffolk court custody facilities in 2013. In this section, we have listed all the recommendations from the two reports.

Summary of recommendations from 2013 inspection of Norfolk and Suffolk court custody facilities

Main recommendation

There should be a programme of regular deep cleaning, graffiti should be removed and standards of daily cleaning should be improved. (2.29)
Not achieved

National issues

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

HMCTS should make more use of video link and `virtual court` facilities to reduce the need for detainees to be transported long distances to courts. (2.32)
No longer relevant

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

Recommendations

Background and key findings

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

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

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

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

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

Leadership, strategy and planning

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

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

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

Individual rights

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

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

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

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

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

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

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

Treatment and conditions

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

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

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

All staff should receive diversity training. (5.20)
Partially achieved

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

All courts should have hearing loops and Braille versions of key information for detainees. (5.22)
Not achieved (Recommendation repeated, 3.13)

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

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

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

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

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

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

Every court should have information leaflets about local support organisations and local custodial establishments, which should be available in a range of languages. (5.53)
Partially achieved (Recommendation repeated, 5.4)

The court custody estate should be checked daily for ligature points and any found immediately rectified. (5.64)
Not achieved

All staff should hold a current first aid qualification and receive annual updates to maintain an adequate skill level. (5.79)
Not achieved

First aid kits should contain sufficient in-date equipment to manage all predictable incidents, including an automated external defibrillator and equipment to maintain an airway, which staff are trained to use. (5.80)
Not achieved

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

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

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

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

Summary of recommendations from 2014 inspection of Cambridge and Essex court custody facilities

Main recommendations

There should be sufficient staff on duty to ensure the safety of detainees, staff and visitors at all times. (2.24)
Achieved

A standard risk assessment pro-forma should be completed for each detainee, and staff should be trained in completing it. (2.25)
Partially achieved

Court custody staff should be trained to identify and refer appropriately detainees about whom they have child protection or safeguarding concerns. (2.26)
Partially achieved

Handcuffs should only be used if necessary, justified and proportionate. (2.27)
Achieved

Interpreters should always be obtained when needed in court, and a professional telephone interpreting service should be available in each custody suite. (2.28)
Partially achieved

National issues

HMCTS and PECS should establish agreed standards in staff training, treatment and conditions, and detainees' rights during escort and in court custody. Standards should address detainee care and risk assessment, clarify the responsibilities of each organisation for resolving problems, and enable monitoring of complaints in court custody, and these should be included in the measurement of performance. (2.29)
Partially achieved

HMCTS should make more use of video link, 'virtual court' facilities and other provisions to reduce the need for detainees to be transported long distances to courts. (2.30)
No longer relevant

Recommendations

Leadership, strategy and planning

There should be regular inter-agency forums covering all courts in the cluster, and their remit should include improvements to the care of detainees during escort and in court custody. (3.11)
Partially achieved

The length of time that detainees, particularly young people and those who are vulnerable, spend waiting in court cells should be reduced. (3.12)
Partially achieved

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

Individual rights

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

Escort vehicles should be available to take detainees to custodial/secure establishments without delay following completion of their court case. (4.16)
Partially achieved

HMCTS should liaise with HMP Chelmsford regarding their hours of operation for receiving prisoners, to reduce delays in transferring remanded or sentenced detainees. (4.17)
Partially achieved (Recommendation repeated, 3.33)

HMCTS should liaise with the Youth Justice Board to reduce delays in transferring young people to more appropriate custodial facilities. (4.18)
Partially achieved

At every court, detainees should be told on their arrival about their rights, including the process for making a complaint, and staff should offer to read or explain them if necessary. (4.19)
Partially achieved

Detainees' notice of rights should be available in a range of languages. (4.20)
Achieved

Sufficient comfortable, private and soundproofed interview rooms should be made available at all courts for legal consultations. (4.21)
Achieved

Complaints should be logged and there should be a process for monitoring and analysing trends. (4.22)
Achieved

Treatment and conditions

Cellular vehicles should be clean inside and free of graffiti. (5.19)
Achieved

Adult men, women and young people should not be carried in the same escort vehicle. (5.20)
Partially achieved

Serco Wincanton should liaise with local prisons, Cambridgeshire Constabulary and Essex Police to discuss the transfer of information and completion of person escort records (PERs) for detainees. (5.21)
Partially achieved

Detainees should be transferred from cellular vehicles and neighbouring police stations to the court cells in privacy. (5.22)
Partially achieved

Detainees should not be left unaccompanied on cellular vehicles. (5.23)
Achieved

All staff should receive diversity and equality training that includes how to care for young people. (5.24)
Partially achieved

Young people in court should be supported by a named staff member who is appropriately trained. (5.25)
Achieved

All court cells should have hearing loops and Braille versions of key information for detainees. (5.26)
Not achieved (Recommendation repeated, 3.13)

All courts should have a copy of the holy books of the main religions, a suitable prayer mat, which is respectfully stored, and a reliable means of determining the direction of Mecca. (5.27)
Achieved

The PECS contractor should produce a policy setting out the correct approach to caring for transgender detainees and ensure that staff implement it. (5.28)
Partially achieved

All courts should have a stock of appropriate reading materials, including some suitable for young people and non-English speakers. (5.29)
Not achieved

Food offered to detainees should be of adequate quality and calorific content to sustain them for the duration of their stay, and food preparation areas and equipment should be kept clean. (5.30)
Achieved

Cell sharing risk assessments should be completed for all detainees subject to sharing, before this takes place. (5.54)
Achieved

The outcome of cell visits should be communicated to the prisoner custody officer updating the custody computer system, and records should reflect this. (5.55)
Achieved

When closed-circuit television is in use, it should be used in addition to, not as a substitute for, cell visits. (5.56)
No longer relevant

Anti-ligature knives should be carried at all times by staff undertaking observations and cell visits. (5.57)
Achieved

Each court should have information leaflets about local support organisations and local custodial establishments, and they should be available in a range of languages. (5.58)
Partially achieved (Recommendation repeated, 5.4)

A programme of regular deep cleaning should be put in place and graffiti should be removed. (5.66)
Not achieved

All staff should receive annual updates in first aid that is appropriate for the environment, to maintain an adequate skill level. (5.77)
Not achieved

First-aid kits should contain sufficient in-date equipment to manage all predictable incidents, including an automated external defibrillator and equipment to maintain an airway, which staff are trained to use. (5.78)
Not achieved

All detainees who require prescribed medications while in court custody should have access to them. (5.79)
Partially achieved

All detainees should have access to mental health support at all times that the courts are open. There should be clear process agreed with the courts and mental health trusts for the provision of Mental Health Act assessments. (5.80)
Achieved

Court custody staff should receive regular training to identify, support and appropriately refer detainees who may be experiencing mental health- or substance use-related problems. (5.81)
Partially achieved

Section 8. Appendices

Appendix I: Inspection team

Kellie Reeve	Team leader
Jeanette Hall	Inspector
Martin Kettle	Inspector
Fiona Shearlaw	Inspector
Tania Osborne	Health care Inspector

Appendix II: Photographs

Unhygienic storage of toilet paper and menstrual products at Colchester Magistrates' Court