



Report on an inspection visit
to court custody facilities in

Devon, Cornwall and Dorset

by HM Chief Inspector of Prisons

2–14 March 2026



Contents

Introduction.....	3
What needs to improve in Devon, Cornwall and Dorset court custody	4
Notable positive practice	6
About court custody in Devon, Cornwall and Dorset	7
Section 1 Leadership and multi-agency relationships.....	8
Section 2 Transfer to court custody	9
Section 3 In the custody suite: reception processes, individual needs and rights	10
Section 4 In the custody cell, safeguarding and health care	12
Section 5 Release and transfer from court custody	18
Section 6 Progress on recommendations from the last report.....	19
Appendix I About our inspections and reports	21
Appendix II Glossary	23

Introduction

This report presents findings from our recent inspection of court custody facilities in Devon, Cornwall and Dorset. Overall, the inspection was reasonably positive and almost two-thirds of previous recommendations were fully or partially achieved.

The main agencies involved in court custody operations continued to work well together, with a clear focus on the treatment of detainees and the conditions in which they were held. Custody staff worked hard to care for and meet detainees' needs, although some told us they were tired and demoralised by long working hours and frequent late finishes.

The geography of this region continued to hinder effective delivery and was further complicated by issues Serco faced in recruiting and retaining staff. Some outlying custody facilities were rarely used, which seemed a further inefficiency to already stretched staffing resources.

Of most concern was the persistent late arrival of detainees to court, which was now worse than at the last inspection. This adversely impacted the scheduling of court business, which often led to poor outcomes for detainees, particularly those remanded or sentenced to prison who frequently spent far longer in custody than they needed to. Due to lack of spaces in reception prisons, detainees were also often redirected to out-of-area jails or required to locate to police cells overnight, which was far from ideal and very costly.

There were, however, many positive aspects to the inspection. The custody estate was generally clean and well maintained, and the range and provision of food had improved. Health provision had also improved. We were pleased that children were rarely held in court custody and force was used rarely.

We hope this report will help the responsible agencies to build on their successes and improve yet further the service they provide.

Charlie Taylor

HM Chief Inspector of Prisons

March 2026

What needs to improve in Devon, Cornwall and Dorset court custody

We last inspected court custody in Devon, Cornwall and Dorset in 2019 and made 22 recommendations overall, two of which were about areas of key concern (see Section 6 for a full list).

At this inspection we found that there had been reasonably good progress and nine of the 22 recommendations had been achieved. Five recommendations were partially achieved, including both of the recommendations about key areas of concern. Eight recommendations had not been achieved.

During this inspection we identified areas of concern to be addressed by HM Courts and Tribunals Service (HMCTS), the prisoner escort and custody service (PECS) and the escort provider. All concerns identified here should be addressed and progress tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

During this inspection we identified two priority concerns. Priority concerns are those that are most important to improving outcomes for detainees. They require immediate attention by leaders and managers.

1. **The lack of staff and sufficient suitable vehicles made it extremely challenging to move detainees to court and onward to prison in a timely way.**
2. **The main agencies responsible for court custody did not do enough to address the reasons why some detainees were held in custody for longer than necessary.**

Key concerns

We identified a further seven key concerns.

3. **Staff did not do enough to shield detainees from public view when they alighted from vehicles in insecure areas, which compromised their privacy and dignity.**
4. **Not enough was done to meet the individual needs of some detainees.** Facilities to support detainees with disabilities were limited, interpreting services were not always used and female detainees were not always supervised by female staff.
5. **Scrutiny of the use of force was not sufficiently robust and failed to identify important learning to improve staff practice.** Body-worn video cameras were underused, limiting leaders' ability to make sure all force was justified.

6. **There were too few custody and escort staff trained in the supervision of children.** Most court custody suites also lacked suitable facilities for children or appropriate distraction materials to occupy them.
7. **Custody staff did not receive training in resuscitation skills often enough to maintain their competence.**
8. **Digital person escort records (dPERs) did not always accurately identify a detainee's health risk.**
9. **Specialist mental health liaison and diversion support was not readily accessible for detainees in all court locations.**

Notable positive practice

We define notable positive practice as:

Evidence of our expectations being met to deliver particularly good outcomes for detainees, and/or particularly original or creative approaches to problem solving.

Inspectors found three examples of notable positive practice during this inspection, which other places may be able to learn from or replicate. Unless otherwise specified, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other locations. They show some of the ways our expectations might be met, but are by no means the only way.

Examples of notable positive practice

a)	A selection of reading glasses with varying strengths were available for detainees to borrow.	See paragraph 3.7
b)	The range of distraction materials at Exeter Law Courts was very good and much better than we see elsewhere.	See paragraph 4.13
c)	CASS+ (Community Advice & Support Service) provided free, confidential and practical help and emotional support for people going through court in Devon and Cornwall. This included advocating and working with individuals to engage with services and follow up support.	See paragraphs 4.26 and 5.2

About court custody in Devon, Cornwall and Dorset

Data supplied by HMCTS and the custody escort provider.

HMCTS cluster

Devon, Cornwall and Dorset

Deputy Head of Operations for Crime

Jessica Miller

Geographical area

Southwest England

Court custody suites and cell capacity

Barnstaple Law Courts	6 cells
Bodmin Law Courts	4 cells
Bournemouth Combined Court	9 cells
Exeter Law Courts	11 cells
Newton Abbot Magistrates' Court	2 cells
Plymouth Combined Court	8 cells
Plymouth Magistrates' Court	9 cells
Poole Magistrates' Court	10 cells
Truro Crown Court	8 cells
Truro Magistrates' Court	5 cells
Weymouth Magistrates' Court	6 cells

Annual custody throughput

1 January to 31 December 2025 8,737 detainees

Custody and escort provider

Serco

Custody staffing

2 area operations managers
10 court custody managers
3 deputy court custody managers
52 prisoner custody officers

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 Overall, this was a reasonably positive inspection with almost two-thirds of previous concerns (14 of 22 concerns) fully or partially achieved.
- 1.2 Agencies involved in delivering court custody in Devon, Cornwall and Dorset engaged constructively and cooperatively. Multi-agency arrangements worked well and continued to appropriately focus on detainee treatment and conditions.
- 1.3 However, the geographical area remained demanding. This, along with shortages of both staff and vehicles of a suitable size, exacerbated the challenges of moving detainees to and from court in a timely way. Due to lack of spaces, detainees remanded or sentenced to prison were frequently redirected to out-of-area establishments. More detainees than we usually see were located to police cells overnight, at great expense. Some of these issues from the last inspection had not only persisted but had got worse.
- 1.4 Serco worked hard to recruit and retain custody staff but often faced vetting delays and suffered from attrition. Vehicle escort staff frequently boosted custody staffing but their attendance was often delayed, unreliable or inconsistent. Some outlying custody facilities were staffed but used very infrequently which appeared an inefficient use of already stretched resources.
- 1.5 Well-trained custody staff were an asset and provided compassionate care. However, many were fatigued and frustrated by long hours and frequent unscheduled late finishes caused by late arrivals, extended court sittings and delays relocating remanded or sentenced detainees, particularly when local prisons were full.
- 1.6 HMCTS maintained good oversight of custody facilities, most of which were in a reasonable condition. Although some facilities showed their age, recent investment in some locations had improved the decorative state.
- 1.7 A range of data was collated but this was not always used well enough to improve outcomes for detainees. For example, issues found at the last inspection such as delays in detainees arriving at and leaving court, the unnecessary time some spent in court custody and an underuse of interpreting services persisted and had not been adequately addressed.

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 There were too few staff and vehicles of sufficient size and this, along with collections from multiple locations, caused many detainees to arrive late from police custody. It also meant detainees from prisons frequently arrived late.
- 2.2 Vehicles were generally clean and well equipped, but staff did not always use the built-in steps when helping detainees alight and male officers sometimes escorted female detainees.
- 2.3 Detainees mostly alighted vehicles quickly but some sites lacked secure parking, which exposed detainees to public view. When this happened, escort staff did not adequately protect detainees' dignity or privacy.



Plymouth Magistrates' Court Entrance

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 treated detainees with respect. They interacted patiently and politely, and showed kindness and compassion, taking time to reassure detainees who were anxious, worried or frustrated.
- 3.2 Staff carried out routine reception interviews which were generally thorough. However, some lacked privacy, which discouraged detainees from sharing personal information.

Meeting individual and diverse needs

- 3.3 Custody staff generally understood detainees' individual needs and provided appropriate support for older, transgender and neurodivergent detainees. On arrival, staff usually asked about religious needs and met such needs well.
- 3.4 Facilities for detainees with disabilities or impaired mobility remained inadequate; only one custody suite in the region was suitable, which displaced some detainees significantly farther from home.
- 3.5 Data showed low use of telephone interpreting services. Although we observed good practice in some facilities, staff did not always use interpreting services when needed. Key documents were available in multiple languages, including braille.
- 3.6 Staff broadly met women's needs, but female detainees were not always supervised by female officers.
- 3.7 Some custody facilities provided new reading glasses in various strengths for detainees to borrow. This was a positive initiative which we have not seen elsewhere.

Risk assessments

- 3.8 Staff identified and managed risk reasonably well. Escort staff shared relevant risk information, but digital person escort records (dPERs, see Glossary) were often incomplete and lacked detail, including health information (see paragraph 4.23).

- 3.9 Staff spoke to detainees on arrival, but initial engagement was sometimes brief and lacked privacy. Staff were more considered with arrivals off-bail (see Glossary).
- 3.10 Staff briefings were generally thorough. Risk profile charts were completed consistently and staff conducted checks at the required frequency. Staff remained alert to vulnerabilities and mood changes, and we observed good interactions with vulnerable detainees.
- 3.11 When cell sharing was required, staff assessed associated risks appropriately. Staff responded promptly to cell call bells. Routes to court remained safe with sufficient working affray alarms.

Individual legal rights

- 3.12 Staff now focused well on prioritising vulnerable detainees for court. However, several factors still led to detainees spending longer in custody than necessary, including late arrivals at court, delayed court start times, delays in legal consultations, limited cell capacity, morning arrivals for afternoon listings and long waits for transfers to prison after hearings. These persistent issues remained unaddressed by leaders since our last inspection.
- 3.13 Courts accepted additional detainees from the police later in the day, which reduced overall custody time.
- 3.14 Rights information was available in all cells but was rarely explained to detainees.
- 3.15 Custody suites generally had enough interview rooms for legal consultations. Although some rooms were not soundproofed, staff supervised them discreetly. Staff moved detainees to court promptly when requested.

Complaints

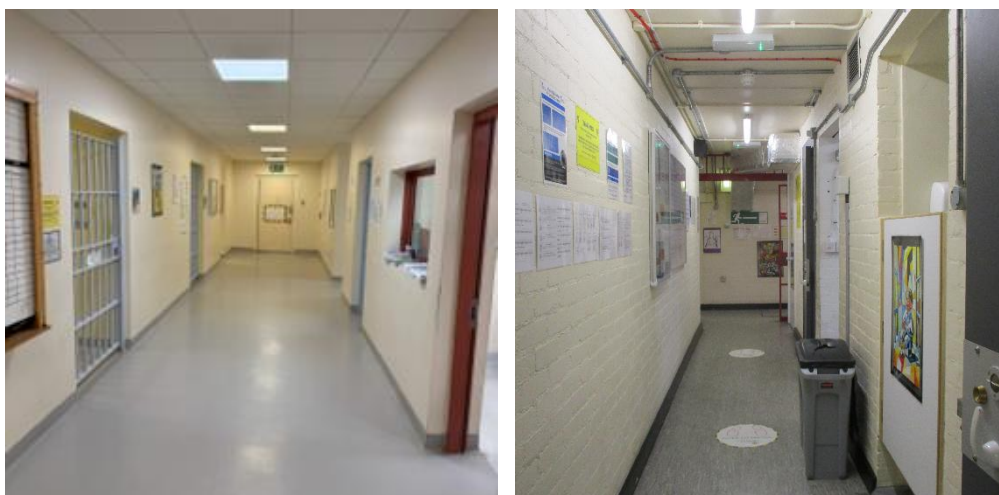
- 3.16 Custody staff did not always explain the complaints procedure clearly. Complaints were rare. However, responses often lacked information about the appeals process.

Section 4 In the custody cell, safeguarding and health care

Expected outcomes: Detainees are held in a safe and clean environment in which their safety is protected at all points during custody.

Physical environment

- 4.1 The condition of the custody estate varied, with some old and worn facilities. Communal areas and cells were, however, generally well maintained and in reasonable condition. The maintenance contractors acted promptly to address reported defects.



Communal areas at Exeter Law Courts (left) and Newton Abbott Magistrates' Court

- 4.2 Cleaning was mostly good. However, cells in a small number of facilities were not adequately cleaned between each use. Graffiti and ligature risks were less common than we usually see and, when these were identified, staff removed cells from use. Most facilities lacked natural light but were enhanced by colourful artwork. Benches remained hard and uncomfortable and were unsuitable, especially for the many detainees experiencing long stays. We provided leaders with a comprehensive report detailing our findings, which was responded to constructively.



Cell with natural light at Weymouth Magistrates' Court (top), graffiti at Truro Crown Court (bottom left) and bench at Weymouth Magistrates' Court

- 4.3 Most toilets and hand-washing facilities were clean. They were stocked with soap, toilet paper and paper towels, though these were not always stored hygienically and most toilets lacked seats. Where privacy was limited, for example due to low doors, staff supervised toilets discreetly.



Poole Magistrates' Court men's toilet

- 4.4 We provided leaders with an illustrative report of the issues and defects found across the estate which they responded to promptly and proactively.
- 4.5 Staff understood emergency evacuation procedures and practised them regularly.

Use of force

- 4.6 Staff used force infrequently. The footage and documentation we reviewed showed a strong focus on de-escalation.
- 4.7 However, from cases we reviewed, when force was used to prevent self-harm we were not assured it was always used as a last resort and sometimes resulted in prolonged and disproportionate use of handcuffs.
- 4.8 Body-worn video cameras were now available, but their use was not yet well enough embedded. We received footage for only 18% of incidents involving force in the previous 12 months, which limited review and oversight. Staff said they hesitated to activate cameras because they feared the footage would be used for discipline rather than learning purposes.

- 4.9 The statements we reviewed were of good quality and justified each use of force. However, internal scrutiny was inconsistent and rarely included reviews of camera footage. Some cases we reviewed showed learning that had not been identified, including poor techniques.
- 4.10 Searching and handcuffing were now more proportionate than at the last inspection. We saw no routine searching but, at a small number of courts, staff still routinely handcuffed detainees without a dynamic risk assessment.

Detainee care

- 4.11 Detainees told us custody staff looked after them well and we observed kind and supportive interactions.
- 4.12 Staff provided drinks and food promptly on arrival and at regular intervals. Provision had improved and this now met most dietary needs. The new menu included instant noodles, fruit pots, crisps and biscuits alongside existing microwaveable meals.
- 4.13 Most courts provided distraction materials but availability varied, promotion was often weak and options for non-English speakers were limited. Exeter Law Courts had notably better provision, mostly supplied by the staff team, offering reading materials, soft footballs, playing cards, colouring books, fidget toys and stress balls. There were also chalkboards in cells.



Distraction materials at Exeter Law Courts

Safeguarding

- 4.14 There had been no safeguarding referrals in the previous 12 months. Staff knew who to contact if they had concerns and demonstrated a good understanding of safeguarding procedures and available support.
- 4.15 The experienced safeguarding team was well known and contact details were clearly advertised. Each court held a comprehensive safeguarding file that staff referred to when supporting vulnerable adults.
- 4.16 Several meetings provided oversight of adult and child safeguarding referrals and wider safeguarding issues. These proactive forums aided the identification of emerging concerns before they became significant risks.

Children

- 4.17 Few children were held in court custody. Staff prioritised well those children that were held and generally dealt with them quickly. Youth offending teams supported children effectively and were available at all courts.
- 4.18 Very few custody staff were trained to supervise children. Courts relied on transport and specialist children and young people (CYP) teams from out of the area whose attendance was invariably delayed. As a result, children usually travelled with adults from police stations.
- 4.19 CYP teams generally only arrived later in the day to transfer children who were remanded or sentenced to custody, leaving untrained staff responsible for their care until then.
- 4.20 Most facilities lacked dedicated children's rooms. Children were generally placed in non-cellular rooms, or unlocked cells as a last resort, and were kept separate from adults. Most courts had limited distraction materials for children until CYP teams arrived.

Health

- 4.21 Detainees and custody officers accessed medical support through a telephone helpline provided by IPRS Aeromed, with paramedic attendance when required. Since the last inspection, staff had gained confidence in the service and valued the added support, including treatment for alcohol-withdrawal symptoms.
- 4.22 The service largely met detainees' needs but long journeys between sites caused extended response times at more isolated courts. Staff also did not use video consultations effectively to support triage.
- 4.23 Custody staff received resuscitation training only every three years, with no system to maintain confidence or competence. Staff also lacked the skills and basic equipment needed to monitor physical signs that would inform clinical risk assessment and guide decisions on

escalating paramedic call-outs, particularly in isolated sites. dPERs often failed to record key clinical risks and essential health information, such as medication timings.

- 4.24 Custody staff now had ready access to an automated external defibrillator and simple pain relief, and managers carried naloxone for opiate overdoses. However, there was no provision for detainees experiencing nicotine withdrawal.
- 4.25 Custody staff understood medicine-safety requirements. They stored and administered detainee medicines appropriately and allowed detainees to keep items such as asthma inhalers in their cells.
- 4.26 Detainees with drug and alcohol problems received no direct support unless subject to a court treatment order. However, the CASS+ (Community Advice & Support Service) team provided proactive practical and emotional support, including post-release signposting. Where CASS+ was not present, support time and recovery workers from liaison and diversion teams offered similar support.
- 4.27 Specialist mental health support was proportionate to need and excellent at busy sites such as Exeter. However, some courts were less well served. For example, during our inspection, we were unable to contact practitioners aligned to Plymouth courts.
- 4.28 Few mental health crises were reported in custody, but we identified some potentially acutely unwell detainees, particularly women, who had been remanded to prison. It was unclear what support they had received before or during custody.

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 Staff provided reasonable support to detainees before release. They completed risk assessments, identified support needs and had access to information about local and national support agencies.
- 5.2 Courts in Cornwall and parts of Devon benefited from the CASS+ service (see paragraph 4.26), which proactively signposted detainees to local support. Staff and detainees told us they valued the provision.
- 5.3 Detainees were usually given enough means by way of train tickets or bus fares to travel home, which was particularly important in rural areas. Taxis were used if necessary.
- 5.4 Staff released detainees with property in bags clearly marked as police or prison issue, which identified them publicly. Detainees were rarely allowed to change into their own clothes and were released in police or prison tracksuits and footwear, which was undignified.
- 5.5 Detainees who were remanded or sentenced often waited a long time for transfer to prison (see paragraph 1.5). As a result, they frequently arrived at prison late in the evening, reducing time for initial risk screening and increasing anxiety on their first night.
- 5.6 Waits to release detainees who originated from prison were mostly reasonable. However, there were some delays processing court outcomes and/or slow responses from prison leaders which sometimes extended detention. We observed one detainee wait nearly five hours, which was an excessive deprivation of liberty.

Section 6 Progress on recommendations from the last report

The following is a list of all the recommendations made in the last report.

Main recommendations

Handcuffs should only be used on detainees if proportionate and justified by an individualised risk assessment.

Partially achieved

Court custody cells should be sufficiently warm and thoroughly cleaned daily, and potential ligature points should be identified and eliminated.

Partially achieved

Recommendations

Ongoing training and development for court custody staff, including court custody managers, should be improved, and include equality and diversity, mental health and safeguarding awareness.

Partially achieved

HMCTS should develop a safeguarding policy, and all staff should be made aware of safeguarding procedures and referral mechanisms for children and vulnerable adults at risk.

Achieved

The reasons for the prolonged periods that some detainees spend in court custody cells should be investigated and addressed.

Not achieved

Information concerning detainee rights while in court custody should be available in a range of formats.

Achieved

There should be sufficient interview rooms at each court, and these should be soundproofed to ensure confidentiality.

Achieved

Staff should use professional telephone interpreting services as necessary to check on the welfare, risk management and understanding of non-English-speaking detainees.

Partially achieved

Women and children should be transported separately from adult men.

Not achieved

The needs of detainees with disabilities should be better identified and consistently met.

Not achieved

Names and other personal data about detainees should not be displayed in areas where other detainees can view them.

Achieved

The individual needs of children transported to, and held in, court custody should be understood and consistently met.

Not achieved

Custody staff who deal with children should receive specific training, including the use of minimising and managing physical restraint (MMPR) techniques.

Not achieved

Every detainee in court custody should have a written assessment that gives clear summary information about their risks and needs.

Achieved

Person escort records should include detailed and specific information concerning risks posed by or to detainees, to ensure that they can be properly looked after in court custody.

Not achieved

All custody staff should receive a comprehensive briefing at the start of duty that is focused on risk management and the care of detainees, particularly the most vulnerable.

Achieved

Set levels of observations should always be carried out at the required frequency.

Achieved

Detainees should only be searched in secure areas on the basis of a robust and individual risk assessment.

Achieved

All custody staff should receive annual refresher training in basic life support skills.

Not achieved

All detainees should receive prescribed medications as required.

Achieved

Person escort records should identify the detainee's health risk while maintaining confidentiality.

Not achieved

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

Partially achieved

Appendix I About our inspections and reports

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.

The inspections of court custody look at leadership and multi-agency relationships; transfer to court custody; reception processes, individuals 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 [Expectations – HM Inspectorate of Prisons \(justiceinspectorates.gov.uk\)](https://www.justiceinspectorates.gov.uk), about the appropriate treatment of detainees and conditions of detention, which have been drawn up in consultation with stakeholders.

Four key sources of evidence are used by inspectors: observation; discussions with detainees; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for detainees. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which HMCTS, the prisoner escort and custody service (PECS) should attend to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for detainees; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Inspection team

This inspection was carried out by:

Kellie Reeve	Team leader
David Foot	Inspector
Natalie Heeks	Inspector
Fiona Shearlaw	Inspector
Steve Eley	Health Inspector

Appendix II Glossary

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.

Children and young people (CYP) team

Officers who only work with and escort children. They undertake specific training, including minimising and managing physical restraint, to provide an enhanced level of care and support. They are deployed from a central resource and remain with children throughout their stay in custody.

Digital Person escort record (dPER)

The dPER is the key electronic document for ensuring that information about the risk posed by detainees on external movement from prisons or transferred within the criminal justice system is always available to those responsible for their custody. It is a standard form agreed with and used by all agencies involved in the movement of detained people.

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.

Crown copyright 2026

This publication, excluding logos, is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: [Our reports – HM Inspectorate of Prisons \(justiceinspectrates.gov.uk\)](https://www.justiceinspectrates.gov.uk)

Printed and published by:
HM Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England

All images copyright of HM Inspectorate of Prisons unless otherwise stated.