

**Investigation into the circumstances surrounding the  
death of a man at Derbyshire Royal Infirmary following an  
appearance at Derby Crown Court  
in August 2008**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**April 2009**

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff involved in my investigation.

This is the report of an investigation into the death of a man who died on 7 August 2008 after ingesting strychnine (rat poison) in his cell at Derby Crown Court. He took the poison less than an hour after receiving a two year prison sentence. After resuscitation efforts, he was taken from the court to a local hospital where he was pronounced dead an hour later. The man was 48 years old. It would have been his first time in prison.

I would like to express my sincere condolences to the man's family and friends who keenly feel his loss. I must also thank the family for agreeing to meet with my investigator and for sharing their concerns. Their input was of great value to the investigation and I hope I have addressed all the matters they raised.

I should also thank the Prisoner Escort and Custody Services (PECS) lead for the Eastern Region, for the excellent support he gave the investigation. I am also grateful to the Senior Investigations Officer for G4S (then Global Solutions Limited), who shared his investigation report into the man's death. I am indebted too to the Detective Sergeant and Detective Constable from the local constabulary for sharing with my investigator the witness statements and other evidence gathered as part of the police's own investigation.

This is the fourth death in court that I have investigated since 2004. There are similarities between all of the deaths, although much of what happened to the man was unique to his situation.

Before his court appearance, the man had repeatedly told family and friends that he did not think he could cope with a prison sentence. However, his family, probation officer, and solicitor did not think that he was serious about any thoughts of attempting suicide. I conclude that staff at the court had no reason to suppose that the man was at risk of harming himself.

My report examines the search procedures that enabled the man to take a banned substance into a court cell, and the family liaison arrangements following a death of a prisoner at court. I make one local recommendation about suicide and self harm procedures. I also make three national recommendations about family liaison, search procedures, and prisoner support following a death in court custody. Even though there are so few deaths in court custody, I hope that lessons can be learned across HM Courts Service.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**April 2009**

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## **SUMMARY**

The man was convicted of firearms offences at Derby Crown Court on 7 August 2008. Before his court appearance he had been told that he could receive a custodial sentence, although his solicitor and probation officer were hopeful of a community punishment due to his previous good character.

Upon conviction, the man was taken into the anteroom behind the dock and broke down in tears. After the escorting custody officer had calmed him down, he was taken to the court cell area. Once there, a senior custody officer, accompanied by a custody officer, carried out a search and interviewed the man about how he felt about going to prison. (The man was fully clothed throughout the search. Strip searching is only used if there are grounds for suspecting the prisoner has something concealed about his person.)

After the initial interview and search, the man met his solicitor. Although the man was upset about receiving a prison sentence, his solicitor thought that he had reassured him that he was unlikely to spend more than a year in custody and was likely to go to an open prison. After the legal visit, the man was taken to his cell.

At around 4.10pm, strange sounds were heard from the man's cell. It was clear to officers that the man was in pain so they called the senior custody officer for assistance. The senior custody officer asked the man what he had done. He replied that he had taken strychnine that he had hidden in his sock. Staff moved the man to the floor to prevent him further injuring himself. Officers stayed with the man, while the senior custody officer asked for an ambulance to be called and spoke to the emergency services on the telephone. Paramedics arrived within 10 to 15 minutes. The man was taken to the local hospital where he was pronounced dead at 5.15pm.

My report examines national search procedures, the support offered to prisoners, and family liaison following a death in court custody. I make one local recommendation concerning suicide prevention measures. I have also made three national recommendations, which I hope can be shared across HM Courts Service.

## THE INVESTIGATION PROCESS

1. I was notified of the man's death on the evening of 7 August 2008. As the man was in custody at the time that he died, his death fell within my terms of reference.
2. I appointed a colleague to lead the investigation on my behalf. My investigator contacted the Deputy Head of the Prisoner Escort and Custody Services (PECS). He briefed my investigator on the circumstances and identified the PECS regional lead for the East Midland area as her point of liaison for the investigation.
3. In accordance with their policy, G4S (the company that provides escort and custody staff at court) completed an internal review in the days following the man's death. I am grateful to G4S for sharing a copy of this review with my investigator (it can be found at the first annex to this report). I am also grateful to the local constabulary for allowing my investigator access to the witness statements they took from court staff the day after the man died.
4. After reviewing the available paperwork, my investigator went to Derby Crown Court on Thursday 4 September. My investigator met the Court Manager, to explain the investigation process. She was then shown the court that the man had appeared in and the route he took to the cells following sentence. During the course of three interviews with staff, my investigator was told about searching procedures, the assessment of risk, and staff recollection of the events of 7 August. She met two officers from G4S, along with the PECS lead, and fed back her preliminary findings.
5. One of my family liaison officers contacted the man's wife and arranged a visit with my investigator. The man's son, parents and brother-in-law were also present at the visit, which took place at the end of September. The family expressed their concern about the searching procedures at court, the assessment of the man's risk of harming himself, and processes to check prisoners' wellbeing in the court cell. I trust that I have addressed these matters in sufficient detail later in this report.
6. The Coroner's officer subsequently provided my investigator with the man's court documents that were passed to the Coroner after his death. These included his pre-sentence report and warrant.
7. My investigator contacted the police to establish the size of the plastic bag the man used to store the poison with which he killed himself. The police file had already been passed to the Coroner's officer, to whom my investigator was referred. Unfortunately, no record was taken of the size of the plastic bag.
8. Following her visit, my investigator contacted the Head of Safety and Security in HM Courts Service, to discuss expectations relating to family liaison following a death at court and searching requirements. The Head of Safety and Security explained her remit extended to the court building and referred my investigator to PECS to discuss the matter further. She duly contacted PECS to discuss their views on searching procedures and family liaison.

9. My investigator requested an expert medical opinion from Offender Health on the response to the man's collapse in the court cell. Unfortunately, at the time of issuing this draft, Offender Health has not responded to the request.

## **DERBY CROWN COURT**

10. Derby Crown Court is located in the centre of the city. It is in a combined courthouse where both Magistrates and the Crown Court sit. Her Majesty's Inspectorate of Court Administration carried out a review of the Courts Service in Derbyshire in July 2006. The report found that the facilities at Derby Combined Court were good, and that defendants were treated with "courtesy and respect".
11. HM Courts Service runs the courtroom and public facilities, including the search procedures for entering the courthouse. The Prison Service has contracted the management of the court custody area, where the man was found, to a private security company, G4S.
12. The court custody area is secure from the rest of the courthouse. It can be accessed by authorised staff who escort prisoners through three locked gates behind the dock or through a discrete security entrance in the main forecourt. There are staff offices and then, through a further gate, a corridor of cells where prisoners are held awaiting transfer to prison.

### **G4S (formerly known as Global Solutions Limited)**

13. G4S is an international private security company that is contracted by the Prison Service to run escort and court services in the Eastern region of England. The Prison Service manage the contract with G4S through their Prisoner Escort Contract Services (PECS) department which is run regionally. At the time of the man's custody, G4S was known as Global Solutions Limited (or GSL).
14. The death of the man was the second death in court custody in the Eastern region in 2008. Although circumstances were different, the other death raises similar questions about the search procedure which I examine in greater detail later in this report.

## KEY EVENTS

### Court Appearance

15. The man arrived at Derby Crown Court with his family at 10.30am on the morning of Thursday 7 August 2008. The man's solicitor explained before his court appearance that the offence carried a maximum sentence of five years. The man's solicitor wrote to my investigator during the course of the investigation. He said he remembered explaining to the man that it was possible he would get a community order if the judge was lenient, but that he should expect a custodial sentence. The man's solicitor spoke with the man as soon as he arrived at court. The man's wife said that he seemed reassured by the discussion with his solicitor. His family waited with him for the court appearance.
16. The judge needed to see photographs of the firearms that the man was alleged to have in his possession before he could proceed with hearing the case. The hearing was adjourned until after lunch, to resume in court 3 at about 2.00pm. The man, his wife, children, parents and friends went into the town for lunch and returned to the court in good time for his appearance.
17. The dock officer for court 3 that afternoon had responsibility to check the defendant's identity and direct him into the dock. The dock officer is also expected to carry out a pat down search on defendants before they go into the dock. (A pat down search is carried out over clothing and is intended to find large objects such as weapons.) The dock officer said that he was sitting in the corner of the dock when the man approached. He opened the gate for him, checked his identity and directed him to stand in front of the seat so that the court clerk could formally identify him. The dock officer said that he did not carry out the required pat down search because it is not accepted practice at the court. He said that he has been working at Derby Crown Court for two years and had never seen a dock officer carry out a pat down search before the defendant went into the dock. He thought that this was because it would mean taking the defendant into the anteroom behind the dock to protect their dignity, and this would slow down court proceedings and was therefore impractical. (The anteroom is a small holding room behind the court that has benches around the walls. It is not visible from the courtroom.)
18. At 3.22pm, the man was sentenced to two years in prison. According to the man's solicitor, he did not visibly react to the sentencing. However, the dock officer recalled that the man slumped in his chair and looked dejected. As soon as the sentence was delivered, the man's son passed out in the public gallery. The dock officer took the man into the anteroom. The dock officer said that the man would not have seen his son collapse because no time elapsed between sentencing and his being escorted from the dock.
19. The man asked if he could see his family before he was taken to prison. The dock officer told him that he could not see his family at court, but that they could visit him in prison. (The dock officer subsequently explained to my investigator there are no circumstances in which a prisoner can see their family at the court. I am surprised that this is never allowed, but understand the practical difficulties of

enabling families to see prisoners at court after sentencing.) Upon learning that he could not see his family immediately, the man fell into the corner of the room and started sobbing. The dock officer said that it was not unusual for someone to react so emotionally to being sentenced.

20. As a security measure, dock officers must handcuff prisoners to escort them between the anteroom and the court cells. The officer said that he was not prepared to handcuff someone who was so upset, so he talked to the man for a couple of minutes to try to calm him down. Eventually, the man was handcuffed and escorted down a staircase through three locked gates to the court cells.
21. According to the dock officer, the man was anxious but calmer during the two minute walk. He said that he reassured the man that he would see his solicitor who would explain what the sentence meant, and how long he was likely to spend in prison. Throughout their conversation, the man did not mention any thoughts of suicide or self harm. The dock officer said that the man presented with no more risk than usual for someone who had just received a prison sentence.
22. When they arrived at the court cells, a Senior Custody Officer (SCO) and a Prisoner Custody Officer (PCO) were in the central area in front of the staff office. They took over the custody of the man to conduct the initial interviews and to search him. The dock officer told my investigator that he explained to the officers that the man was not happy with his sentence and that he had been sobbing.
23. The dock officer was in a hurry to return to the dock for the next defendant. He said that he did not consider the man a suicide risk. If he had, he would have told the SCO and the PCO in their handover. As a dock officer, he said that it was not his responsibility to raise a suicide and self harm warning form, but that he would expect the SCO and the PCO to make that judgement. (This form should be completed when any member of staff is concerned that a prisoner is at risk of harming himself or attempting suicide and accompanies the prisoner as he is transferred to prison.) After leaving the man with the SCO and the PCO, the dock officer did not see him again.

### **Initial Interview**

24. An initial interview is carried out with every prisoner who has been taken into custody from bail. It is intended to assess a prisoner's risk to himself and others and establish if he has any immediate needs. The SCO happened to be standing in the area in front of the main office, next to the searching and interview room, when the dock officer brought the man down to the court cells from the dock. The PCO was also near the interview room. In interview, the SCO remembered that the dock officer introduced the man, explained that he had been sentenced for two years, and warned the officers that he had been "a bit moody or mardy". The SCO's initial impression was that the man was annoyed. Neither the SCO nor the PCO recalled the dock officer mentioning that the man had been sobbing and the SCO did not remember any signs that he had been crying.
25. The man was shown into the interview room by the SCO. Usually only one officer will conduct a search and the initial interview. On this occasion, the PCO carried

out the search while the SCO conducted the interview. Due to the small size of the room, the interview and the search were conducted at the same time. In interview, the SCO said he thought that the man seemed shocked and then, after a couple of minutes, angry because he could not believe that he had received a prison sentence. It was the SCO's impression that the man was not expecting a sentence of imprisonment. The SCO estimated that, in his experience, around 75 per cent of prisoners off bail are annoyed to be given a prison sentence, so this was not unusual. He said that the man was not aggressive towards staff and was not violent. By his smart appearance and the manner in which he carried himself, the SCO judged the man to be "a family man" and described him as appearing "decent and respectable".

26. During the initial interview, the SCO asks prisoners if they have been in prison before. If, like the man, the prisoner has no previous custodial experience, the SCO then explains what to expect and hands out a booklet entitled *What happens next?* When the SCO asked the man if he understood what had happened in court, he responded, "I think so, yes." The SCO explained his sentence and that it was unlikely he would spend two years in prison. He told the man that most prisoners only serve half their sentence and are released if they have behaved well. The officer said that it was for the prison to decide whether the man would be eligible. (I do not criticise the SCO, but his advice to the man was not entirely accurate.) He also told the man that his solicitor would advise him about appeal procedures, but that, if he did appeal, the judge could increase the sentence so it was a risk. (This was not correct either.) The SCO said that it was likely the man would spend most of his sentence in an open prison. (An open prison accommodates lower risk prisoners and has a regime designed to enable prisoners to reintegrate into the community and prepare for release.) He explained that the man would have an opportunity to speak to his solicitor who would be able to advise him more fully. He went on to ask how the man felt, particularly about going to prison. The man said that he had no particular feelings about going to prison, but that he should not be going there.
27. The SCO has completed G4S courses in suicide prevention measures and mental health awareness. Taking into account the man's demeanour, the SCO thought that he was more annoyed than at risk of attempting suicide or harming himself.

### **Level A Search**

28. While the interview was taking place, the officers were carrying out the search on the man. The SCO asked the man to turn out the contents of his pockets onto the interview table, and to take off his jacket, tie and belt. The tie and belt were put in the man's property to be transferred to the prison, and the jacket was returned after the search was finished. After the man had removed these items, the SCO explained the search procedure. The PCO took over the main Level A search.
29. The PCO explained to my investigator that a Level A search is used on all prisoners who arrive from bail into the court cell area. First, the prisoner is asked to empty their pockets of any possessions and take off their belt, tie and jacket.

The PCO said that if the officer had received information that the prisoner was at risk of suicide or self harm, the prisoner would also be asked to remove their shoelaces, which are kept with the tie and belt, because of the potential for them to be used as a ligature. However, the man did not mention any thoughts of suicide or self harm and the PCO had not been warned that he might be at risk. The man told the PCO that he was alright, just shocked to be going to prison. In interview, the PCO remembered the man saying that he was lucky not to have received a five year sentence, which was the maximum sentence for his offence. He said that the judge was lenient to have given him just two years.

30. Once the man had removed his jacket, tie and belt, and the belongings from his pockets, the PCO started the Level A search. To conduct a Level A search, an officer must wear plastic gloves. No clothing is removed apart from the prisoner's shoes. The aim of the search is to find contraband (any item that cannot legally be brought into custody, for example tobacco, mobile telephones, needles, blades or drugs). The search starts at the top of the head with the prisoner facing the officer. Using his hands, the officer rubs down the body, checking the ears and around the collar. Each arm is searched followed by the prisoner's torso, outside of the clothing. Once the officer reaches the waistband, they ask the prisoner to run two fingers around the waist band in front of the officer. The officer then runs his own two fingers around the waistband. This is to prevent a prisoner from concealing sharp objects or weapons around the waist and to prevent injury. Each leg is then searched outside of the trouser leg. The prisoner is asked to remove their shoes, and the officer taps each shoe on the floor. If there is an insole, the officer will remove the insole and tap each shoe on the floor again. The officer feels down the front of the foot over the sock. The PCO told my investigator that at that stage he takes the extra precaution of feeling between each toe through the sock. (The sock is not removed as part of a Level A search.) After the prisoner has been searched facing the officer, the prisoner is asked to turn around to face away from the officer, still with their shoes off. The officer will then start the search again from the top of the head. He searches the prisoner in much the same way as before. When he reaches the sock the officer feels the underside of the foot.
31. The PCO specifically remembered the man's search. He said that he did not find any contraband during the search. He recalled searching the man's foot area and said that there were no bulges or rustling as he did so. He said that he was surprised to learn later that the man had apparently hidden a packet of strychnine in his socks because he had searched the foot area. The PCO said that he would have brought the SCO's attention to anything that he had found. He said that in the event he had found something or had reasonable grounds to believe that the man was concealing something, he would ask the senior custody officer to seek authorisation for a strip search. The SCO would then have to contact the regional manager for authority to strip search the prisoner. The PCO said that there were no such grounds for concern and he did not ask the SCO to ask permission for a strip search.
32. The SCO told my investigator that he remembered the PCO asking the man to remove his shoes and feeling over his socks. The SCO did not recall any bulges or rustling when the PCO was patting down the sock area. The SCO said that

there were no grounds for suspicion. He said that if he, or any officer, had received information that a prisoner was hiding contraband, he would contact a senior manager for authorisation to strip search the prisoner. There were no grounds to suspect that the man was hiding contraband and no such authorisation was sought. The man's socks were not removed at any time during the search.

### **Legal interview**

33. Once the interview and the search were completed, the PCO escorted the man to the interview room to meet his solicitor. In his statement to police, the man's solicitor remembered that the man "did not seem overly upset, his face was expressionless". He said he explained to the man that it was unlikely that he would serve the full two years and he would probably be sent to an open prison. The man responded, by saying, "I can't do two years." The solicitor understood this to mean that the man was disappointed with his sentence. He did not think that it was a serious statement of intention to cause himself harm. In his statement, the man's solicitor said that, if he had been concerned about the man's state of mind, he would have alerted court staff. The man's solicitor reiterated to the man that he would not spend two years in prison and raised the possibility of appealing against his sentence. He said that the man was listening but was "not displaying any emotion" throughout their exchange. At the end of the interview, the man gave his solicitor his wallet, car keys and mobile phone, which the solicitor has since returned to his family. The man's solicitor said that he would confirm their meeting in writing. The interview took about 20 minutes. A second PCO escorted the man to cell one, where he had to wait for the escort services to collect him and take him to prison.

### **Events in cell 1**

34. Checks on prisoners who have not been assessed as a risk of suicide or self harm are carried out irregularly at least once an hour. Unfortunately, there is no record of the time that the man was located in cell 1. The manual record of legal visits shows that the man saw his solicitor, but there is nothing to say when the visit started or ended. The first PCO wrote in his police statement that "about an hour" elapsed between the end of the legal visit and him hearing the man in distress. In his statement, he said that he carried out a number of cell checks during this hour, "including about three on [the man]".

35. In his statement to police, the first PCO recalled sitting in the main office with the rest of the staff about half an hour after the man had been located in his cell. The first PCO heard what he described as a "yelping noise" from the cell area. The second PCO was the officer in charge of cells that day which meant that it was his responsibility to check on prisoners' wellbeing. The second PCO went to check where the sound was coming from. The first PCO and the second PCO walked past cell 1 at first, because they believed the sound to be coming from further away. However, they turned back on themselves and looked through the observation panel in the door of the man's cell. The first PCO described the man, "laid on his back on his bench with his arms across his chest. He looked in pain."

36. The first PCO opened the cell door. According to the officer's police statement, the man first said, "I've took some stuff, boss, I'm not going to custody, tell my wife I love her." The first PCO asked what the man had taken and he replied that it was strychnine. The officer remembered that the man was a pest controller and thought that strychnine was probably rat poison. The first PCO called for help from the SCO.
37. After the initial interview with the man, the SCO resumed his normal duties in the court cell area. At about 4.10pm, he was in the main office where he was contacting prisons to book in prisoners who had received custodial sentences. (He had booked the man into HMP Nottingham straight after their interview to secure his placement.) The main office is about ten metres away from cell 1 where the man was located. When he put the telephone down, he heard an officer shouting for him. As he was heading towards the cell, he saw an officer holding a plastic cup with blue plastic inside it. It was the cup from the man's cell, thought to be one that he used to dissolve the poison in a cup of tea. The SCO instructed that the cup be preserved in case it was needed as evidence.
38. When he got to the cell, the SCO could see that the man was in distress and asked him what he had done. The man told him that he had taken strychnine. The SCO asked where the man had concealed the strychnine and he responded that he had put it in his sock. The SCO remembered that he was shaking and thought that he was in danger of having a fit. With the assistance of other officers, he moved the man from the bench to the floor of the cell to prevent injury from a fall. He asked officers to contact the emergency services and inform the Operational Control Service (OCS). The electronic log shows that the ambulance was called at 4.10pm.
39. The man appeared to calm down after he was moved to the floor. The SCO was worried that he might be drifting into unconsciousness, so placed him in the recovery position. He found a faint pulse. The SCO asked officers to monitor the man while he spoke to the ambulance service. Whilst on the telephone, he explained the urgency of the situation. The SCO then requested that the vehicle lock be opened in preparation for the arrival of the ambulance to avoid any delay. (A vehicle lock is where all incoming vehicles are stopped and searched before entering the court buildings.)
40. According to the man's electronic PER, the paramedics arrived within 10 to 15 minutes. When the paramedics arrived, they felt for a pulse but could not find one. They used a heart monitor and found no output. They moved the man into position ready for cardio pulmonary resuscitation (CPR) and used an ambubag to administer oxygen. The SCO assisted with chest compressions. The paramedic advised the SCO that the police should be contacted. This was duly done by court staff.
41. The paramedics prepared for the man to be transferred to hospital. It is standard practice for officers to accompany prisoners in the ambulance with a hospital pack which contains security restraints, bed watch documentation, and contact numbers in the event of an emergency. (At no point were the restraints used on the man.) The SCO asked the two PCO's to accompany the man to the hospital.

The man was taken to the local hospital. Both the PCO's followed in their own car behind the ambulance because there was no room for them. The man was admitted to the hospital and taken to one of the resuscitation bays in the accident and emergency area.

42. Shortly after the man was transferred to the hospital, a Detective Inspector contacted the SCO. He advised that staff should be alert to symptoms of strychnine poisoning, for example stiffening of the face. If any such symptoms had presented, staff had to go to accident and emergency for urgent treatment. Fortunately, staff did not experience any such symptoms.
43. The man was in cardiac arrest at the time of his arrival at the hospital. He was injected with atropine which is commonly used to speed up the heart rate. According to the consultant who treated the man, the dose on this occasion was larger because it was being used to treat the symptoms of an agricultural poison. Despite continued efforts to resuscitate the man, the consultant pronounced the man dead at 5.11pm.

### **Prisoner support**

44. Custody officers spoke to the other prisoners in the court custody area to check on their wellbeing. No note was made in their records to indicate that they had witnessed a death while at court. Staff told my investigator that prisoners offered them support, for which they were grateful.

### **Contact with the family**

45. The man's family were leaving the court at the time that the man was taken to the hospital and they remember seeing an ambulance. At that point, they did not realise that it was carrying the man. The police broke the news of the man's death to them at their home later that evening.
46. When the man's family met my family liaison officer and my investigator, they said they had a number of concerns. (Unfortunately, many of these were outside of the remit of my investigation because they related to the circumstances surrounding the man's arrest and sentence). However, they also wanted to know whether there was any closed circuit television (CCTV) in the court custody area. (My investigator confirmed that there was no CCTV system in the court custody area.) They also wanted to know whose care the man was in while he was at court. (As I have explained above, HM Courts Service is responsible the public areas of the court, including the courtroom. G4S is responsible for the care of prisoners in the court custody area.)
47. The family were concerned too that the man was not watched and had been left alone in his cell. They also wanted to know whether prisoners were often located by themselves. (The man had not been assessed as at risk of harming himself, so – like all other prisoners – he was only subject to checks hourly. I will explore the assessment of the man's risk later in this report.)

## **Staff Support**

48. Staff were offered the opportunity take the following day off work. A trauma intervention counselling session was held the following Monday with six officers who were involved in the man's care. The counsellor took staff through what had happened on 7 August. The SCO told my investigator that he found the session helpful. Following the group session, everyone had an individual session with the counsellor. However, the first PCO said that he did not have an opportunity to speak to the counsellor alone and felt that he would have benefited from further support. My investigator fed that back to G4S staff at the time of her interview with the officer, and extra counselling was arranged for the PCO. All staff were given the telephone number for the Independent Counselling and Advisory Services Ltd (ICAS).
49. I am pleased with the level of support that staff received following the man's death.

## ISSUES

### **Were there any missed signs that the man intended to take his life?**

50. The man's probation officer said in his police statement that he was "having difficulties coping". However, the man assured his probation officer during the interview for his pre-sentence report that he had no thoughts of self harm. Following this meeting, the man's probation officer concluded that there was nothing that caused him "major concern". The probation officer said in his police statement that, had he been worried, he would have arranged for a psychiatric assessment.
51. The man told his friends and family repeatedly that he could not cope with a prison sentence which seemed an overwhelming contrast to his customary outdoor lifestyle. When one friend tried to make arrangements to meet the man after 7 August, he replied, "If I'm still here." They understood from that the man thought he might be in prison. None of his friends or family thought that the man seriously intended to end his life if he received a prison sentence. As a result, no one felt it necessary to alert court staff about the threats to harm himself.
52. There is a telephone intercom outside the court cells that the SCO told my investigator can be used to contact the court officers directly. When my investigator put this to the PECS lead, he said that the telephone is not for this purpose. Any such information would be passed on to court staff who would tell officers in the court custody area of the prison. If the telephone can in fact be used in the way described by the SCO, I suggest that the court manager and G4S work together to better promote the service. If it is not the case, G4S will wish to ensure that its staff are told.
53. The dock officer was the first person to speak to the man following his sentence. He recalled him slumping over, "dejected," when he heard that he was going to prison. When he was taken to the anteroom, the man asked if he could speak to his family and broke down when he was told he could not. The dock officer told my investigator that such a reaction was "not unique". Despite his obvious anxiety, the man did not speak of any thoughts of self harm or suicide and the officer was not concerned that he was at risk of harming himself. The dock officer said that it is not his responsibility to raise suicide and self harm warning forms. If he had considered the man at risk, he would have alerted the SCO and the first PCO and they would have raised the form upon further assessment. I am concerned that the dock officer did not know that he could raise a suicide and self harm warning form. I understand that the role of a dock officer is a pressured one, but the welfare of prisoners should always remain a major priority. In discussion with the PECS lead from PECS, it is clear that any officer can indeed raise such a form. I am satisfied that it would not have made any difference to the outcome in this case because the dock officer did not consider the man at risk of attempting suicide.

**G4S should remind all staff at Derby Crown Court that any member of staff may raise a suicide and self harm warning form.**

54. I understand that any concerns raised by the dock officer would have been explored further in the more in-depth interview with the SCO. One of the principal functions of that interview is the assessment of risk. I am satisfied that the man did not say anything during that meeting to alert staff to a risk of suicide. In his interview, the SCO explained that, when making this judgement, he takes into consideration whether the prisoner is upset or has been crying, whether they seem confused by the environment, and how they interact with officers. He also assesses their body language, and whether they establish good eye contact or are looking down or fiddling. The SCO has undertaken a G4S training course in suicide prevention measures and has also received mental health awareness training.
55. The SCO said that one of the things he looks for in his assessment of risk is whether a prisoner has been crying. Although the dock officer remembered telling the SCO that the man sobbed following his sentencing, the SCO did not remember being told. While the SCO listed a number of factors he took into consideration when assessing the man's level of risk, it is of obvious concern that the handover between the dock officer and the SCO was not as effective as it should have been.
56. During his interview for this investigation, the SCO told my investigator that he "glanced through" the man's court documents because he was handed them during the course of the initial interview. I am concerned at such a cursory approach to what could prove to be critical information. However, in this case, I do not think that any of the information contained in the man's pre-sentence report or the court warrant would have alerted staff to his level of risk. The man's family wrote to my investigator after the draft was issued for consultation. They were concerned that information about his anxiety and the stress of the criminal justice system included in the pre-sentence report did not indicate to court staff that the man was at high risk of self harm. As the probation officer told police that he did not think the man was at risk of suicide, I cannot agree with the man's family that it was possible for his report to have indicated a high risk of self harm to the SCO.
57. However, I am surprised that the initial interview was conducted at about the same time as the man was being searched. While it would have been much better to have completed the initial interview in a more private situation, I do not suggest that the SCO's judgement of the man's level of risk would have been any different.
58. I am satisfied that the man gave no indication of his intention to harm himself. I conclude, therefore, that court staff assessed the man's level of risk appropriately given the information that they had available to them at the time of assessment.
59. As it cannot be known if they had any effect on the man's actions, I make no formal recommendations in relation to the handover between the dock officer and the SCO, nor about the circumstances in which the initial interview was conducted, nor about the advice that the SCO offered to the man about the rules governing the time he would serve or the implications of an appeal against

sentence. However, both HM Courts Service and G4S will wish to consider if there are training and other implications arising from these matters.

### **Were searching procedures appropriately conducted?**

60. The dock officer did not conduct the required pat down search when the man went into the dock. He told my investigator that it was not practical to carry out such a search at that time because it would involve taking the defendant into the anteroom which would slow down court proceedings. I understand the dock officer's point of view, but he is required to pat down the defendant going into the dock. A pat down search is a quick search for large equipment. Such a search is not designed to find small items, such as a bag of strychnine and therefore has no bearing in this case. However, I strongly suggest that G4S and PECS review the policy and practice in this area.

61. The first PCO explained the Level A search process to my investigator at length. It is designed to find small items as well as weapons. Footwear is removed for the Level A search. My investigator sought clarification about what the term 'footwear' referred to in this context and The PECS lead provided the following definition:

“Footwear refers to a shoe, slipper or trainer not a soft covering like a sock, stocking etc. However, as we discussed, should staff have any information or concerns raised by behaviour or 'lumps' then all foot coverings would be removed.”

62. The first PCO told my investigator that he searched the sock area, both with the man facing towards him and away from him. He felt the top and the underside of the foot and between the toes while the man was wearing the sock. The first PCO has been working at Derby Crown Court for two years. The SCO, his supervisor, told my investigator that the first PCO was a thorough officer and he had confidence in his searching technique. The SCO was present throughout the searching process. The SCO and the first PCO told my investigator that, despite searching the sock area in accordance with procedures, neither saw any sign of bulging or heard plastic rustling during the search. It seems unlikely that a thorough search would not have discovered a plastic bag in the sock (if that indeed was where the man hid it), although my investigator was assured that a full search was carried out. In their response to the draft report, the man's family have raised their concern that the initial interview and the search were carried out at the same time. They felt that this could have undermined the quality of the search process.

63. Despite contacting the police and the Coroner's office, my investigator could not establish the size of the plastic bag that contained the strychnine. When the man told the SCO that he had put it in his sock, he was already in considerable distress. There is no other evidence that this was in fact where the bag was placed. A Level A search does not search every possible hiding place on the body. A prisoner is not strip-searched until they reach prison unless there are substantial grounds to believe that they are concealing something. There were no such grounds to suspect the man and he was not strip-searched.

64. The PECS lead told my investigator that it is for reasons of decency that prisoners are not routinely strip-searched when entering the custody of the court. As is often the case in a custodial environment, a balance between security and decency must be struck. I am satisfied both that the policy strikes the right balance and that it was applied appropriately in the man's case.
65. The death of the man in a court cell was an unusual event but not a unique one. I believe, therefore, that security measures to protect staff and to protect prisoners should be tightened. The other death to which I have referred earlier in this report was similar insofar as that prisoner was also off bail and also brought an illegal substance into the court custody area in his sock. Assuming that the man did likewise (as he said), this means that two of the four deaths in court custody that I have investigated have involved a prisoner hiding a dangerous substance in his sock. With that in mind, I make the following recommendation:

**PECS and G4S should consider whether the Level A search could be extended to include the removal of all footwear including socks as a matter of routine.**

#### **Was the response to the man's collapse appropriate?**

66. I judge that the response to the man's collapse was both prompt and appropriate. It is unfortunate that I do not have the benefit of a clinical opinion to strengthen my findings, especially as this is the first case in five years of investigating deaths when a prisoner has taken strychnine. However, I understand that the strength of the poison is such that survival is rare even with immediate medical treatment. As soon as the man was found, he was moved to the floor and put in the recovery position. The emergency services were called and arrived speedily, and the man was taken to hospital. I believe there was little else that could have been done.

#### **Prisoner support**

67. The SCO told my investigator he thought the other prisoners in the cells knew what was happening that day. When the man was discovered in cell 1, he asked officers to move the prisoner in the cell opposite to afford the man some privacy and to avoid distressing the prisoner. He remembered that the prisoners in the court cells themselves checked to see if staff were alright following the man's transfer to hospital.
68. Although none of the prisoners told staff that they were upset by what had happened, I am surprised that no record was made of the man's collapse on their records. The effect of witnessing or hearing a death can be distressing, particularly when people are themselves in the vulnerable position of being in custody. There is no requirement for such a record to be made in prisoners' files, so I do not criticise staff at Derby Crown Court. However, I make the following national recommendation:

**PECs should require custody officers to make a record of any death in custody on the Prisoner Escort Records of other prisoners in the custody area.**

### **Family support**

69. The man's son collapsed in the public gallery when his father received his custodial sentence. He recovered from his collapse and the family spoke briefly with the solicitor. The man's solicitor then went to speak to the man in the court cells. His family waited for the solicitor because they thought he would speak to them after his meeting with the man. However, the solicitor did not return to speak with the family. Due to the delay in leaving the court, the family saw the ambulance arrive at the court, but they did not realise that it was intended for the man. Police went to break the news of his death to the man's wife and children later that evening.
70. In the Prison Service, there is a family liaison policy specifically to guide staff on support for families following a death in prison custody. For example, the news should normally be broken by a representative of the establishment where the prisoner died, the family is invited to look around the prison, funeral expenses are offered, and there is a nominated point of contact to deal with any of the family's queries. There is no such policy for prisoners who are in the custody of the court. In fact, any contact with the deceased's family is made through local police.
71. I understand that there is currently no requirement for G4S to provide family liaison and I do not imply that they have failed to meet their obligations. However, the man's death is the third death in court custody in just over 12 months. While I hope that this frequency is a statistical 'blip' and that such deaths will remain very rare, I think that HM Courts Service should work with PECS to formalise family liaison arrangements following a death in court custody. Had the man died a matter of hours later in the custody of the prison, the man's family would have had better consideration. I make the following national recommendation:

**HM Courts Service and PECS should consider the development of a national family liaison policy.**

## RECOMMENDATIONS

I make one local recommendation and three national recommendations:

1. G4S should remind all staff at Derby Crown Court that any member of staff may raise a suicide and self harm warning form.

*PECS accepted this recommendation, with the following comments:*

*“Although he had no reason to open a suicide and self harm warning form for the man, the PCO dock office interviewed as part of the investigation was incorrect when he said it would not have been his responsibility to do so. All PCOs are able to do so and are advised as part of their training. PECS will issue a Notice to Contractors instructing them to remind their staff of this.”*

2. PECS and G4S should consider whether the Level A search could be extended to include the removal of all footwear including socks as a matter of routine.

*PECS did not accept this recommendation. They responded:*

*“This recommendation is problematic. I do not think a Level A (rub down) search can be extended in the way the report suggests. Legal advice is that the removal of socks as part of a Level A rub down search would constitute a more intrusive search than the standard procedure. For this reason, prisoners should not be asked to remove their socks routinely but rather where there is intelligence or reasonable suspicion that an item of contraband has been concealed and where it is considered to be necessary and proportionate response. It would be difficult to justify the routine removal of items of clothing as part of a rub down search because it would begin to blur, unacceptably, the distinction between rub down search and a strip search. Finally, it would be very difficult to sustain different definitions of a rub down search at different places in the custodial system. A Level A search is designed to be conducted in the same manner whether it is conducted by prison staff in a prison or PCOs at court. Consistency is important in this context, a different standard of rub down search would be practically and legally difficult to justify.”*

3. PECS should require custody officers to make a record of any death in custody on the Prisoner Escort Records of other prisoners in the custody area.

*PECS accepted this recommendation, undertaking to complete the following by April 1:*

*“Although none of the prisoners told staff that they had been upset by what had happened, witnessing or hearing of a death can of course be distressing. PECS will issue a Notice to Contractors instructing them to*

*record any significant event on the PERs of other prisoners in their custody.”*

4. HM Courts Service and PECS should consider the development of a national family liaison policy.

*On receipt of the draft report, HMCS and PECS discussed this recommendation and accepted it in principal.*

*The Chief Executive of HMCS, wrote:*

*“Prisons have established procedures in line with Prison Service Order 2710 (which concerns procedures to be undertaken following a death in custody) and the mechanisms to support them, such as care teams and chaplains. While it may not be possible for PECS to replicate these arrangements for court custody, PECS will consult colleagues in the Prison Service, the police and those in my organisation, with a view to establishing a national family liaison policy to provide the necessary support.”*

*PECS replied with the same answer, adding:*

*“PECS intend to consider including [a family liaison national policy] when the contracts for the escort of prisoners and their management at court are retendered.”*