

**Investigation into the death of a man in hospital
following an appearance at Crown Court
in June 2007**

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

February 2008

This is the report of an investigation into the circumstances surrounding the death of a man who died in hospital after taking an overdose of anti-histamine tablets in the dock at a Crown Court. He was 40 years old and had been on bail. He was attending a re-trial on 28 June 2007 on charges of cruelty and grievous bodily harm committed in 2002.

The investigation was led by one of my investigators. My senior family liaison officer contacted the man's cousin and she and my investigator visited her. I offer her, and all those affected by his death, my sincere condolences.

The circumstances of this case are highly unusual, and may indeed be unique. I have only investigated one previous death at a Crown Court, and I believe that the manner in which the man took his own life may be without precedent among deaths in custody in the UK. These highly unusual circumstances mean that my investigation has a necessarily narrow focus. He was in the custody of the court escort services for less than two hours between being found guilty and being pronounced dead.

I am grateful to the Senior Investigations Officer for SERCO Home Affairs for sight of his report into the man's death. I am also grateful to the Metropolitan Police for sight of the witness statements gathered as part of the police investigation.

This is a very sad story. I conclude that the man's death could not reasonably have been foreseen by the court escort and custody services. I make two formal recommendations designed to improve guidance to staff. I have also suggested that there might be benefits if the lessons from this report were to be shared more widely amongst court administrators.

Stephen Shaw CBE
Prisons and Probation Ombudsman

February 2008

CONTENTS

Summary

The investigation process

The events leading up to the man's death

Issues considered during the investigation

Conclusion and Recommendations

SUMMARY

The man suffered from epilepsy and autistic spectrum disorder. In 2004, he was found guilty of cruelty and grievous bodily harm to his three month old daughter and sentenced to five years in prison. He was released on appeal in December 2006 pending a re-trial. During his time in prison he said that he was badly bullied and told his family on numerous occasions that he would rather die than return to jail.

The man's re-trial began on 5 June 2007. The Tamil interpreter employed by the court to translate for him during his trial, said that part way through the proceedings the man had told him that he had 200 tablets which he intended to take if he were found guilty. The interpreter said he did not believe that the man meant what he said.

Immediately after the jury returned a verdict of guilty at about 4.30pm on 28 June 2007, the interpreter said he saw the man add a powdered substance to a bottle of clear liquid which he had with him in the dock. He then drank some of the liquid before the dock officer removed the bottle from him.

Counsel for the defence told the judge that the man appeared to have drunk something that he should not have and the judge directed that a doctor should be called immediately. He was taken to the custody area and an ambulance was called at 4.40pm. He refused to say what substance he had taken and said that he wanted to die.

Paramedics arrived at 4.50pm. The man was handcuffed, escorted to the ambulance and taken to the local hospital. At the hospital he had a number of fits and went into cardiac arrest. He was pronounced dead at 6.14pm. A post mortem and toxicology report showed he had died from an overdose of anti-histamine.

I conclude that the manner of the man's death could not have been reasonably foreseen by any of the employees of the court escort and custody service. I also conclude that the circumstances are extremely unlikely to occur again. I make a local recommendation to amend Director's Rule 15.5 to give advice to staff at the Crown Court about what prisoners off bail should be allowed to take into the dock. I make a national recommendation that guidance is issued to all court escort staff on their responsibilities to prisoners who refuse emergency medical treatment.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 29 June 2007. After some discussion it was decided that the case was within my remit to investigate and I appointed one of my investigators. She obtained further information from the court escort services contract manager for the Crown Court.
2. My investigator also contacted the senior investigations officer for SERCO (the company who provide escort services at the Crown Court), and obtained a copy of his report into the man's death. She spoke to the deputy court manager at the Crown Court to explain that an investigation would be taking place. My investigator spoke at length with a Detective Inspector from the police and he agreed to provide her with copies of the witness statements taken during the police investigation. She spoke to the contract compliance manager for the Crown Court and obtained a copy of the Director's Rules for prisoners appearing off bail (the rules by which court escort staff operate). My investigator remained in regular contact with the Coroner's Officer throughout the investigation.
3. My senior family liaison officer wrote to the family offering them the opportunity to be involved in my investigation. The man's cousin contacted my senior family liaison officer to say that she would like to be involved in our investigation. My senior family liaison officer and investigator visited her to explain the nature and purpose of the investigation and to hear her particular concerns.

THE EVENTS LEADING UP TO THE MAN'S DEATH

4. On 29 April 2004, the man was convicted of cruelty and grievous bodily harm and sentenced to five years in prison. He lodged an appeal against his conviction and was released in December 2006 pending a re-trial. During his time in prison he regularly complained to his family that he was the victim of bullying. He expressed a desire to end his life on many occasions and said that he was only awaiting the outcome of his appeal before doing so.
5. A psychology report prepared for the Crown Prosecution Service in June 2006 as part of the appeal process said:

“Should [the man’s] [sic] appeal be rejected, consideration should be made regarding the appropriateness of his disposal to prison. In my view he is inappropriately placed in prison due to his psychological and practical needs relating to ASD. He will continue to remain extremely vulnerable to bullying and exploitation from others in prison and his risk of suicide is, and will continue to be, high.”
6. The man’s re-trial started on 5 June 2007. The court security officer who was responsible for searching people’s bags as they entered the court building said that he remembered the man asking him on 24 June whether he would be searched if he left the court building and came back in. The court security officer said he told him that he would be searched on each occasion that he entered the court building.
7. A Tamil interpreter employed by the court to translate for the man said that part of the way through his trial the man had told him that he had 200 tablets, which he intended to take if he was found guilty. He told the interpreter that, if the judge told him to go home to get his belongings to prepare for prison, he would take the tablets. The interpreter said that he thought that this statement was “part of his autism”.
8. The interpreter said that, on 28 June 2007, the jury retired to consider their verdict at about 1.20pm. He said he, the man and his solicitors waited in the court waiting room. At about 2.00pm, the man told him again that he would take the tablets if the verdict went against him. At about 4.20pm, they were called back into the court and the jury returned a verdict of guilty. The interpreter said that he was sitting on his right-hand side and noticed that he had a Coca-Cola bottle half filled with a clear liquid. The interpreter said this was not unusual as the man had brought one with him every day of the trial. He said he saw him produce a powdered substance from a bag and add it to the liquid in the bottle. He then began to shake the bottle. The interpreter said he presumed from what the man had said previously that the substance was tablets in a powdered form. He tried to pull his hand away to prevent him from adding more powder to the bottle and tried to get the attention of the dock officer using sign language. The interpreter said he did not get any response from the dock officer. He said the man then started drinking from the bottle. He tried to grab his right hand to stop him and screamed “Stop it.”

9. The interpreter said the dock officer then came over and between them they managed to remove the bottle from the man. The interpreter said he managed to convey to the defence team what had happened and they told the judge. The judge requested probation reports and advised the court officers that the man should be seen by a doctor.
10. The dock officer for the week commencing 25 June 2007 said that prisoners who appear in court off bail and their bags are searched before they enter the court. He said that, on 28 June 2007, he looked into the man's bag before he first entered the dock and saw papers, a photograph and a bottle containing clear liquid. The dock officer said he asked the interpreter to tell the man not to take the bottle out of the bag. He said the judge summed the case up and sent the jury out to consider their verdict. At about 4.25pm, he was told that the jury had returned. He returned to the court and again looked into the man's bag before he entered the dock. He said he saw the same contents in the bag as he had seen that morning.
11. The dock officer said that after the judge returned to the court, the junior defence barrister approached the dock and asked the man how long he had spent in prison. He said he appeared agitated and upset. After the verdict was given, the man slumped in his seat and looked depressed. The defence barrister began to tell the judge what the man's original sentence had been and at this point the dock officer heard the interpreter say, "You can't drink that!" The dock officer said he looked up and saw the man drinking as quickly as possible from his bottle. He said he "rushed" over and grabbed the bottle from him and put it on the floor near his seat. He heard the defence counsel tell the judge that the man appeared to have drunk something he should not have. The judge remanded him into custody pending reports, and asked the dock officer to make sure that he saw a doctor immediately. The dock officer took the man to the cells and an ambulance was called. He then returned to the court to retrieve the bottle. As he got back to the custody area the ambulance crew arrived.
12. The SERCO court manager said that he was in the custody area when the dock officer returned with the man from the court. He said the dock officer told him that the judge had said that the man should see a doctor because he might have swallowed something he should not have. The SERCO court manager said he asked for an ambulance to be called. The entry in the occurrence book showed that this was at 4.40pm. The SERCO court manager said that the man appeared steady on his feet and was able to walk. The SERCO court manager began making plans for a hospital bedwatch and contacted court security to warn them of the imminent arrival of an ambulance. He said the man appeared placid and calm. A barrister brought the bottle to the custody area and told the SERCO court manager that it was the one the man had drunk from. The SERCO court manager said that it was about a third full with a cloudy liquid. He said the man appeared slightly restless and he heard him say, "I want to die. I don't want to go to hospital. I want to kill myself."
13. The SERCO court manager said the ambulance arrived and the man's barrister tried to persuade him to go to hospital. He again heard him say, "I don't want to go to hospital. I want to die." The SERCO court manager said that his first

response was that the man was in custody and he had to go to hospital. He tried to confirm this with his supervisor but she was unsure of the exact position. He said the ambulance crew told him that they could not force the man to accept treatment. The SERCO court manager said that he impressed upon them that the man had to go to hospital and two prisoner custody officers guided him to the ambulance. He said he did not resist.

14. A prisoner custody officer said she was sitting at the desk in the custody area when the man was brought down from the court. She said she asked him what he had drunk and he said he would not tell her. She asked him to empty his pockets and noticed a plastic bag containing a blue box of 'Sleepeasy' tablets. She asked him if he had taken any of the tablets and he again replied that he would not tell her. The prison custody officer said she heard the man say, "I want to die." She said he seemed agitated and would not stand still. She said he refused medical assistance. She noticed his legs begin to give way and two officers supported him under the arms. He was then handcuffed to one of the officers and led into the ambulance.
15. A paramedic arrived at the court at 4.50pm. He said that he was met by a security guard who told him that the man had swallowed some liquid and showed him some milky fluid in a bottle. He said the man was alert and walking about the room. He said the man told him that he did not want any treatment. A man dressed in robes and a wig then said to the paramedic, "You've got to take him." The paramedic said he explained that he had no powers to force the man to receive treatment. He said a debate ensued and eventually the security guards handcuffed the man and took him to the ambulance.
16. The paramedic said that when he got into the ambulance the man vomited twice. His heart was found to be beating very fast and a priority call was put through to the hospital. The ambulance arrived at the local hospital at 5.11pm. They were met by a doctor and taken directly to the resuscitation room. By this time he was having seizures. He was pronounced dead at 6.14pm.
17. A post-mortem examination and toxicology report showed that the man had died as a result of consuming a fatal dose of anti-histamine.

ISSUES CONSIDERED

The man's risk

18. Ordinarily persons who have been remanded into custody are taken to the custody area of the court and pages one and two of form F2050F (Prison Service Record) are completed. At this point a Prisoner Escort Record (PER) is also completed. The prisoner is assessed and one of the questions addressed is whether they pose a risk of self-harm or suicide. In this case I would have expected the man to have been deemed a high risk of self-harm or suicide but the risk assessment process was overtaken by events. I do not consider that these events could have been foreseen by anyone other than the interpreter (who had been told by the man on more than one occasion, the most recent at 2.00pm that afternoon, that he had tablets and intended to take them if he were found guilty).
19. The interpreter had vital information that he shared with no one and about which he made his own judgement. He is not employed by the court escort and custody service and I am unable to make any recommendations in his regard. The court may wish to consider whether interpreters need further guidance on what to do when they receive such information from defendants.

Did the dock officer respond appropriately?

20. The dock officer said in his statement that, on the morning of 28 June, he warned the man not to take his bottle out of his bag after he had done so once. One of his duties as dock officer is to make sure that the person in the dock does not do anything untoward to himself or others. The man sat in the front row of seats in the dock next to a wall, with the interpreter on his other side. The dock officer was stationed in a row of seats behind him and to the side. It is clear that in a very short space of time, the man removed the bottle from his bag, put powder in it and began drinking from it. At the same time the dock officer was making a phone call to the SERCO court manager and there was a certain amount of activity in the room. I believe there was enough to distract the dock officer legitimately from his duty to observe the prisoner in the dock and make sure nothing untoward happened. It seems clear that as soon as the dock officer became aware that the man was drinking from his bottle he reacted quickly (and to greater effect than the interpreter, who was sitting next to him and watched him put the powder in the bottle).
21. I do not take issue with the dock officer decision to allow the man to take the bottle into the dock or with the search process. He had no reason to believe that the man presented a risk to himself and I do not believe it can have been reasonably foreseen that he would take an overdose while still in the dock.

The response of the court escort and custody service staff

22. Once it had been established that the man had consumed something he should not have done, the judge directed that a doctor should be called immediately. The SERCO court manager took the decision to call an ambulance because it would be quicker than calling a doctor. The paramedics were at the court within about 20 minutes of the man having drunk from the bottle and 10 minutes after being called. I consider that the court manager was absolutely right to call an ambulance and the response of the court escort and custody service staff was appropriate.

23. The circumstances of the man's death were extremely unusual, but the issue of a prisoner refusing medical treatment in an emergency is one that may arise again. In this case, I believe that the staff acted in his best interests and according to the duty of care they have towards those in their custody. Nevertheless, I believe they would benefit from clear guidance about their role and responsibilities in such situations because prompt treatment is crucial to preserving life in a medical emergency.

CONCLUSION AND RECOMMENDATIONS

24. The man's experience of prison seems to have left him with a dread of returning there and a determination not to do so at whatever cost. Although he appears to have formed a clear plan to take an overdose if found guilty, I do not believe his death could reasonably have been foreseen by any member of the court escort and custody service.
25. I believe the manner of the man's death – an overdose taken in the dock – may have been unique among deaths in custody in England and Wales and may never be repeated. Nevertheless I believe it would be sensible for guidance to be given to staff about what they can allow defendants off bail to take with them into the dock. The current Director's Rule (number 15.5) does not appear to cover this question. Given that water is available to defendants if they ask for it, it may be sensible to prevent them from taking unsealed bottles into the dock with them.

I recommend that the contract manager for the Crown Court amends Director's Rule 15.5 to include advice on what prisoners off bail may take with them into the dock. This should include a consideration of whether prisoners should be allowed to take only unsealed bottles into the dock.

This recommendation was accepted by the Prisoner Escort and Custody Services (PECS) at draft report stage. They said:

"It is considered that on this occasion that stopping the man taking a bottle of liquid into the dock may not have prevented him taking an overdose. PECS will issue a notice to all escort contractors that any liquid refreshment sealed or not will not be allowed in the possession of the prisoner. If liquid refreshment is required then this will be provided by the court."

26. I also believe it would be sensible for all court escort staff to have guidance on their responsibilities to prisoners who refuse emergency medical treatment.

I recommend that the Head of the Prisoner Escort and Custody Services (PECS) directs all his contract managers to inform the relevant contractors to issue guidance to staff on their responsibilities to prisoners who refuse emergency medical treatment.

This recommendation was partially accepted by PECS at draft stage. They said:

"Escort contractors will seek medical assistance in all cases where it is thought necessary or requested by a prisoner, including the calling of the emergency services. In this case the emergency services were called and the prisoner continued to refuse medical assistance and on this basis the paramedics were unable to try and treat him. However, the escort contractor was able to persuade the prisoner to eventually go to hospital. Further guidance is being sought from the Dept of Health to establish what else may be done under these circumstances."

27. The Head of the Prisoner Escort and Custody Services may also wish to consider if copies of this report should be sent to all senior court administrators. Given the highly unusual nature of the circumstances described in this report, I make no formal recommendation to this effect. Nevertheless, I think that there is some important learning that it would be beneficial to share.