Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Ruddick, a prisoner at North Tyneside Magistrates' Court, on 12 December 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Steven Ruddick died in hospital of the effects of cocaine on 12 December 2022. He was 38 years old. I offer my condolences to his family and friends.

Mr Ruddick had attended court that day and had been remanded into custody at HMP Durham. However, he never made it to Durham because on his way there, he was taken to hospital to treat a suspected broken heel. Mr Ruddick unexpectedly took cocaine while at hospital and subsequently died.

GEOAmey escort staff provided good and effective care and did their best to meet his needs and manage his risk appropriately during the escort process.

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

Adrian Usher
Prisons and Probation Ombudsman **March 2024**

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Summary

Events

1. Mr Steven Ruddick was arrested on 11 December 2022 for the assault of a police officer and possession of an offensive weapon.

2. In police custody, Mr Ruddick told the custody nurse and separately, two mental health nurses that he wanted to kill himself.

3. While in police custody, Mr Ruddick was searched and nothing untoward found.

4. On the morning of 12 December, GEOAmey escort officers took Mr Ruddick to court for his hearing. The digital person escort record (DPER) that travelled with him to court did not record his suicidal intent.

5. Mr Ruddick was subject to further searches by GEOAmey staff, who found nothing of concern.

6. At court, Mr Ruddick was remanded to HMP Durham. Rather than take him directly to prison, three GEOAmey officers took him to hospital following advice from a healthcare practitioner at court that he had incurred a foot injury when he was arrested that needed hospital attention.

7. Mr Ruddick waited for assessment with the GeoAmey officers in a designated custody suite at the hospital. Mr Ruddick was handcuffed with an escort chain to one of the officers. He asked to use the toilet, and this was facilitated. The escort chain remained in place, while the toilet door was partially closed. Afterwards, they returned to the custody suite.

8. Soon afterwards and without warning, Mr Ruddick took what looked like a white substance wrapped in clear cellophane from somewhere on his person and placed it in his mouth. GEOAmey officers tried unsuccessfully to remove it from Mr Ruddick's mouth. They called hospital staff for medical assistance. In the meantime, Mr Ruddick had a seizure. Hospital staff took him into a resuscitation room, where they undertook cardiopulmonary resuscitation (CPR). However, Mr Ruddick died.

9. The post-mortem report noted that Mr Ruddick died from the effects of cocaine having swallowed a substantial amount which was rapidly absorbed.

Findings

Good practice: Management of Mr Ruddick's risk

10. The Liaison and Diversion Team and GEOAmey staff appropriately assessed Mr Ruddick's risk of self-harm during his short time in their care.

11. GEOAmey demonstrated good practice in ensuring Mr Ruddick's foot injury was medically assessed at court.

Learning outside our remit

12. Although Mr Ruddick had said in police custody that he wanted to take his life, the DPER completed by police and passed to GEOAmey did not adequately reflect this risk factor.

13. Although the nurse from the Liaison and Diversion Team had told the GEOAmey court custody manager of Mr Ruddick's suicidal intent, HM Courts & Tribunals Service (HMCTS) should have shared his risk information with the court (and other judicial services) in a timely manner.

14. Mr Ruddick's time in police custody is subject to investigation by other organisations.

The Investigation Process

15. The PPO was notified of Mr Ruddick's death on 13 December 2022. The investigator issued notices to staff at North Shields Magistrates Court and GEOAmey Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Ruddick's custody record. GEOAmey and HMCTS shared with us their respective investigation reports into the events of 12 December. He met the Northumbria Police Professional Standards and the Independent Office for Police Conduct (IOPC), who shared relevant information about their investigations.

17. NHS England commissioned a clinical reviewer to review Mr Ruddick's contact with the mental health team at North Shields Magistrates Court.

18. The investigator and clinical reviewer interviewed four members of staff at GEOAmey Durham in February 2023 and three mental health nurses from Cumbria, Northumberland, Tyne and Wear NHS Trust.

19. We informed HM Senior Coroner for County Durham and Darlington of the investigation. He provided us with Mr Ruddick's cause of death. We have sent him a copy of this report.

20. The PPO's family liaison officer contacted Mr Ruddick's wife to explain the investigation and to ask if she had any matters that she wanted us to consider. Mr Ruddick's wife asked about the circumstances that led to Mr Ruddick's death, including where he obtained drugs. While we do not know where Mr Ruddick obtained cocaine, we have addressed her concerns in this report.

21. Mr Ruddick's wife received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy, and this report has been amended accordingly.

Background Information

North Tyneside Magistrates Court

23. North Tyneside Magistrates Court is a magistrate's court in North Shields. The court is run by Her Majesty's Courts and Tribunal Services (HMCTS). The Prisoner Escort and Custody Services (PECS) arm of HMPPS contract GEOAmey to provide court custody and escort services.

24. GEOAmey provide secure transportation between police custody, courts and prisons for prisoners in custody across the UK on behalf of the Ministry of Justice.

Cumbria, Northumberland, Tyne and Wear NHS Trust

25. Cumbria, Northumberland, Tyne and Wear NHS Trust works from more than 70 sites and runs a number of regional and national specialist services, including supporting people in their own homes and in hospitals. Their service includes Liaison and Diversion Teams which identify people in the criminal justice system (such as in police stations or courts) with mental health, learning difficulties, substance misuse or other vulnerabilities. They refer them for appropriate health or social care or divert away from the criminal justice system into a more appropriate setting, if required.

26. Mitie Healthcare provides primary healthcare for all patients in police custody in Northumbria.

Key Events

Police custody from 11-12 December 2022

27. At around 3.00am on 11 December, Mr Steven Ruddick was arrested and taken into police custody for criminal damage, affray, threatening a person with a bladed/pointed instrument and assaulting a police constable. At the time of his arrest, it was thought that Mr Ruddick was intoxicated, under the influence of an illicit substance or was having a mental health crisis. He had jumped out of a second floor window of a flat and had threatened the police with a machete before they tasered him.

28. An entry in his police electronic custody record (ECR) noted that Mr Ruddick was lucid at times and there was doubt about whether he was genuinely intoxicated. He was searched numerous times in police custody, including a strip search (where the individual removes their clothes and is normally required to squat to check for any items concealed in the anus), and nothing was found. Mr Ruddick told police he had not taken any drugs and had no thoughts of suicide or self-harm. They noted his history of attempted suicide and self-harm by jumping out of a window to escape arrest.

29. At 4.56am, Mr Ruddick's wife contacted the police station. She reported that he had been in a 'drug-induced psychosis' for the last seven months.

30. For most of the morning, Mr Ruddick's mood fluctuated. Staff saw him crying incoherently at times and he was still considered under the "influence of intoxicants". He said he had a broken foot and needed help but refused to answer questions.

31. At 12.30pm, a nurse assessed Mr Ruddick. Staff had escorted him by wheelchair to the medical room because he complained that he had a sore right foot. The nurse did not note that Mr Ruddick had a foot injury but noted that he was fit to be interviewed and advised that he should go to hospital if he was released from custody. He was prescribed paracetamol to relieve the pain. It was noted that Mr Ruddick would be referred to the mental health team because he had said that he wanted to kill himself. The police custody sergeant referred Mr Ruddick for an assessment by the nurse from the Liaison and Diversion Team. The nurse's contact with Mr Ruddick was noted in the ECR.

32. A mental health nurse from the Liaison and Diversion Team told us that she spoke to the police custody sergeant at 4.09pm, after which she and another nurse, also from the Liaison and Diversion Team, assessed Mr Ruddick in his cell. It was noted that Mr Ruddick had no formal mental health diagnosis and had a history of self-harm and drug use (crack cocaine). Mr Ruddick denied any recent drug use and said he had last harmed himself ten weeks earlier. While he engaged during the assessment and displayed no psychotic symptoms, Mr Ruddick sobbed and kept saying sorry. He also said he did not "want to be here anymore", although he did not disclose any plan or intent to kill himself. He said he needed help but gave no further details.

33. After this assessment, both nurses discussed Mr Ruddick with the custody sergeant and documented their assessment and outcome within Mr Ruddick's mental health records and the ECR. The mental health nurse noted that until a police decision was made about Mr Ruddick, she would not be able to create a plan for him. She noted that he would not be diverted away from criminal proceedings due to the serious nature of the allegations against him. She noted that if the police released him outside of the Liaison and Diversion Team's working hours, he should be referred to the crisis team for an assessment. She noted that if he was still in police custody the following morning, the Liaison and Diversion Team would review him, and if he was charged, a report would be submitted to the court.

34. The referral to the Liaison and Diversion Team and the reason for it was documented on the ECR.

35. At 9.44pm, Mr Ruddick was charged with the offences that he was arrested for and remanded in police custody to appear in court the following day.

12 December 2022

36. A nurse from the Liaison and Diversion Team told us that at around 7.30am, she assessed Mr Ruddick's needs in his police cell in readiness for his court appearance. She noted that if Mr Ruddick was released from custody, he would be referred to the crisis team and if he was remanded into custody, collateral information about his threats to end his life would be passed to HMP Durham.

37. The nurse tried to talk to Mr Ruddick, who was calm but refused to engage in conversation. Instead, he said that regardless of the outcome of his court hearing, he intended to end his life. Mr Ruddick repeatedly said that there was no point in her talking to him "as he would be dead anyway". She told us that she tried several times to talk to Mr Ruddick, but he kept repeating his intention to take his life.

38. The nurse updated the police custody sergeant about her contact with Mr Ruddick and that he had stated that he wanted to end his life. She noted in the mental health records and updated the ECR. She drafted a report for the court which she emailed to HMCTS at 8.35am, in preparation for Mr Ruddick's hearing. She noted that Mr Ruddick had refused to engage and while he said that he had no thoughts of self-harm, he had repeated his intention to kill himself regardless of the outcome of his court case. She noted that the Liaison and Diversion Team would liaise with the relevant services once the outcome of the court case was known. The information was also passed to the mental health team at HMP Durham.

39. At 7.45am, GEOAmey's Prison Custody Officer (PCO) A and PCO B arrived at the police station to collect prisoners, including Mr Ruddick, who were attending court. They received Mr Ruddick's Digital Person Escort Record (DPER). It noted his risk of self-harm, violence, health issues and a history of concealing illicit items (cigarettes and a lighter) in police custody. It noted that the mental health team had seen Mr Ruddick in police custody. In the physical and mental health needs section of the DPER, it was recorded that Mr Ruddick had abrasions on his face which he had incurred during his arrest, he had mental health needs and his wife had reported that he had been in a "drug-induced psychosis" for the last seven months.

40. When both PCOs arrived at Mr Ruddick's police cell to collect him, he was sitting on a bench and could not stand up. Mr Ruddick said he had a foot injury and was in pain. The PCOs talked to the GEOAmey duty manager by phone and the police detention officer about whether Mr Ruddick was fit to travel. The police detention officer told them that Mr Ruddick had been assessed by a nurse and was deemed fit to attend court and therefore, GEOAmey should accept him. The DPER noted that Mr Ruddick had used a wheelchair while in police custody. The DPER did not, however, refer to any new risks for Mr Ruddick and did not note that he had said that he would kill himself.

41. Before he was escorted from his police cell to the GEOAmey vehicle, Mr Ruddick was allowed to wear his own jogging trousers and top over his police issue clothing (grey jogging trousers and grey top). His own clothing had been stored in a locker outside his police cell. GEOAmey searched his clothing but found nothing.

42. The police raised no concerns about Mr Ruddick when he was handed over to GEOAmey's care. PCO B conducted a level A search, which included using a wand (which identifies the presence of metal). (There are two levels of rub-down search – level A and level B. Level A are more thorough searches which include extra checks such as removing shoes, checking hair and inside ears, nose and mouth.)

43. Mr Ruddick struggled to walk as he was escorted on to the GEOAmey vehicle.

North Tyneside Magistrates Court

44. The GEOAmey vehicle arrived at North Tyneside Magistrates Court at around 9.33am. It was parked closer to the court entrance because of Mr Ruddick's poor mobility.

45. A Custody Court Manager (CCM) booked Mr Ruddick into court and completed a reception interview. As part of this, she reviewed his DPER and saw that he had a previous history of self-harm. When she asked Mr Ruddick about this, he said he was okay and was more concerned about the pain in his foot. He said that he was not given any medical attention in police custody.

46. At 10.08am, the CCM contacted GEOAmey's medical advisory service and asked for Mr Ruddick's foot to be assessed as he was struggling to walk. The DPER was updated with this information.

47. At approximately 10.54am, the GEOAmey paramedic examined Mr Ruddick. In his report, the paramedic noted that Mr Ruddick had heel pain and found it hard to walk. Mr Ruddick said he had jumped from a two-storey building and landed on his feet two days earlier. The paramedic prescribed Mr Ruddick pain relief (codeine and paracetamol). He advised that Mr Ruddick should go to hospital after the court hearing. The CCM said that the paramedic had told her that Mr Ruddick's heel may be broken.

48. At around 12.20pm, Mr Ruddick was given a level B rub-down search before he was escorted into the court dock for his hearing. The court remanded him into custody at HMP Durham and instructed him to return to court on 4 January 2023. He was returned to the court holding cell.

49. After the court hearing, the CCM contacted a PCO who was acting as the Controller at GEOAmey base. She told him that the paramedic had advised that Mr Ruddick should be taken to hospital to have his heel X-rayed. He told her that he would provide a three-person vehicle crew to escort Mr Ruddick to hospital as soon as possible. None were available at that time.

50. The first available escort crew arrived at the court at around 1.15pm. PCO C contacted the CCM and told her that he had assigned PCO D as the third officer for the escort crew and she would attend as soon as possible. He explained that no male officers were available. The CCM advised that this should not be a problem as Mr Ruddick had not been a problem while in custody at court and had been of good character. It was agreed that as University Hospital Durham was two minutes away from HMP Durham, they would take Mr Ruddick there.

51. At 1.26pm, GEOAmey staff completed a welfare check on Mr Ruddick. They did not note any concerns and he was told that he would be transported to hospital to have his foot assessed.

52. At 1.39pm, GEOAmey staff escorted Mr Ruddick to the toilet. Mr Ruddick said he was keen to go to hospital as his heel was causing him a significant amount of discomfort.

53. No concerns were raised during welfare checks on Mr Ruddick that afternoon.

54. At 2.32pm, GEOAmey staff again escorted Mr Ruddick to the toilet and raised no concerns.

55. At 2.35pm, PCO D arrived at court.

56. At 2.36pm, Mr Ruddick was handed over to two PCOs.

57. At 2.47pm and just before Mr Ruddick was put in the escort vehicle, the CCM received a telephone call from a nurse from the Liaison and Diversion Team at the police station. She had called to asked about the outcome of Mr Ruddick's court hearing. When told that Mr Ruddick had been remanded to prison custody, she said that he was at risk of self-harm having said in police custody that he intended to kill himself. She appeared surprised that this information had not been passed to GEOAmey sooner.

58. The CCM immediately opened a suicide and self-harm warning document to monitor Mr Ruddick. He was placed under six observations an hour. The escort staff taking him to hospital were told about this. The CCM had seen Mr Ruddick during the day at court and he had interacted well with staff.

59. The GEOAmey staff helped Mr Ruddick into the escort vehicle. He continued to struggle to walk and appeared in visible pain. When asked how he was feeling, Mr Ruddick said he was okay. He was not very talkative, and his mood appeared low. The escort vehicle left the court at around 3.00pm. On his way to hospital, staff raised no concerns about Mr Ruddick.

University Hospital Durham

60. At 3.43pm, Mr Ruddick arrived at hospital, and PCO E booked him in. PCO D and PCO F remained with Mr Ruddick in the vehicle. Mr Ruddick told PCO D that he had mental health problems but was not getting any help. He talked about the events that had led to his foot injury.

61. At 3.59pm, the GEOAmey staff escorted Mr Ruddick by wheelchair from the vehicle into a side room, known as the custody suite, in the accident and emergency department. An escort chain (a long chain that is attached by a handcuff on either end to an escorting officer and the prisoner) was used. While they waited, PCO D told us that Mr Ruddick's mood fluctuated. While he was more talkative, he was also upset at times. He said that he did not "want to be here anymore". She spoke to him about his family and tried to lift his mood.

62. At 4.16pm, Mr Ruddick asked to use the toilet for a poo. At 4.25pm, staff identified the toilet that displayed the least risk for Mr Ruddick to use. PCO E searched the toilet area, before Mr Ruddick used the toilet under the supervision of the GEOAmey staff. The escort chain remained in place, although he was out of sight as the toilet door was partially closed. While using the toilet, Mr Ruddick complained about privacy issues and being handcuffed. As soon as staff were confident that Mr Ruddick had finished using the toilet, they went in and saw that Mr Ruddick was washing his hands. When he finished, PCO D completed a pat-down search on Mr Ruddick. She told us that her main concern was that Mr Ruddick had had suicidal thoughts so her pat-down search may not have been as thorough as it should have been. Nonetheless, she found nothing.

63. At 4.30pm, the GEOAmey staff returned with Mr Ruddick to the designated custody suite. PCO E got Mr Ruddick a cup of coffee from the vending machine in the corridor. PCO D told us that a couple of minutes later, she saw Mr Ruddick use his left hand to put something quickly into his mouth. It appeared to be a white powder wrapped in what looked like cling film. He then tried to take a sip of his coffee, but this was knocked out of his hand by one of the PCOs. PCOs D and E tried to retrieve the package by squeezing Mr Ruddick's mouth. However, Mr Ruddick refused to listen to the staff's instructions to spit it out. He chewed on the white powder while laughing.

64. PCO E left the room to call for help and returned with a hospital nurse. In her police statement, the hospital nurse noted that Mr Ruddick had swallowed a package and refused to spit it out. The nurse said that Mr Ruddick stated that he had swallowed cocaine and that it was enough to kill him. He said he felt suicidal and that was why he had taken it. The nurse left the room to get medical assistance.

65. As the nurse left, PCO F heard Mr Ruddick say something like, "This is good stuff - the heart attack is coming". Mr Ruddick then appeared to have a seizure and started to slide off his chair. PCO F and PCO D placed Mr Ruddick on the floor while trying to protect him from hurting his head. Hospital staff arrived with emergency equipment and took over Mr Ruddick's care. The cuffs were removed, and he was taken into the emergency resuscitation room.

66. Despite the hospital medical team administering emergency care, their resuscitation attempts were unsuccessful, and they declared that Mr Ruddick had died at 5.18pm.

Contact with Mr Ruddick's family

67. After the hospital had confirmed Mr Ruddick's' death, GEOAmey appointed a family liaison officer (FLO). The FLO tried to visit Mr Ruddick's wife but found that the home was derelict. A neighbour confirmed that Mr Ruddick's wife no longer lived there. The address details had been obtained from his custody record and confirmed by the police. The FLO therefore phoned Mr Ruddick's wife instead.

68. The FLO broke the news of Mr Ruddick's death to his wife and offered support and her condolences. In line with Prison Service instructions, Prisoner Escort and Custody Services contributed towards the costs of Mr Ruddick's funeral.

Support for GEOAmey staff

69. After Mr Ruddick's death, the GEOAmey Vehicle Base Manager and the GEOAmey Regional Manager debriefed the escort staff to ensure they had the opportunity to discuss any issues arising, and to offer support. All staff were offered follow-up support.

Post-mortem report

70. The post-mortem toxicology report noted that Mr Ruddick died from the effects of cocaine, having swallowed a high concentration of it.

Inquest

71. The Coroner's inquest held on 13 November 2025 determined the medical cause of death to be the effects of cocaine.

72. The jury returned a narrative conclusion, stating that Mr Ruddick died by suicide. However, they also concluded that the failure of GEOAmey staff to conduct a full level B search, including trouser pockets and any other part of his trousers, more than minimally contributed to his death.

Findings

Identification and assessment of Mr Ruddick's risk

73. Mr Ruddick had a number of risk factors for suicide and self-harm. The day that he was arrested, he was violent, had jumped out of a second floor window and appeared to be either under the influence of a substance or to be having a mental health crisis. He had a history of self-harm and in police custody, he stated repeatedly that he intended to take his life.

74. The post-mortem report found that Mr Ruddick died from the effects of cocaine. From police evidence and this investigation, it appears that Mr Ruddick had concealed cocaine internally, most probably in his anus. The IOPC told the investigator that, after Mr Ruddick's death, they found two clear plastic bags in his pocket, with remnants of cocaine and faeces on them.

75. Mr Ruddick had a history of concealing items in police custody. As part of their investigation, the IOPC is reviewing the quality of the strip search to which Mr Ruddick was subjected, including the requirement for him to squat. We have not been able to establish exactly when Mr Ruddick hid the package. In the absence of evidence, we can only speculate that this was done at some point just before he was arrested. We know he was searched numerous times from the point of his arrest, in police custody, later at court and by GEOAmey at the hospital. However, nothing was found on any of these occasions. It seems most likely therefore that he retrieved the package while using the hospital toilet.

GEOAmey's contact with Mr Ruddick

76. Despite the inadequacy of the information GEOAmey received from the police, when the nurse from the Liaison and Diversion Team told GEOAmey staff at court that Mr Ruddick had made threats to take his life in police custody, they promptly started suicide and self-harm prevention procedures. He was to be monitored every ten minutes. In reality, he was monitored almost continuously because he was handcuffed to a GEOAmey officer. (Although he was out of sight while using the toilet, the same procedure would have been followed even if a male officer was present.) While the GEOAmey staff noticed that Mr Ruddick's mood fluctuated, he gave them no indication that he was at imminent risk of suicide.

77. Staff made every effort to prevent Mr Ruddick from swallowing the cocaine. GEOAmey staff and the Liaison and Diversion Team provided effective care and did their best to meet his needs during the very short time he spent in their care.

78. This was a very unusual situation for the GEOAmey staff involved. Mr Ruddick had been searched several times before his death, with nothing found. Even after they had been alerted to Mr Ruddick's risk of suicide, we do not think that GEOAmey staff could reasonably have predicted Mr Ruddick's actions.

HMCTS

79. Following Mr Ruddick's death, HMCTS reviewed their procedures about the sharing of risk information for those attending court. Firstly, it was found that the Liaison and Diversion Team's report should have been available to the court's legal adviser at the start of Mr Ruddick's court hearing. This did not happen. Secondly, the Liaison and Diversion Team's report (and other information about a prisoner's mental health) should also have been shared with the court and sent to Prisoner Escort and Custody Services (GEOAmey) and the prison within an hour of Mr Ruddick's court outcome. Again, this did not happen.

80. HMCTS are reviewing their processes for the sharing of mental health reports and risk information with PECS and other criminal justice partners.

Learning outside our remit: Police custody

81. Mr Ruddick's period in police custody is not within the remit of this investigation. We were, however, given access to his police ECR.

82. In police custody, it was noted that Mr Ruddick told the Liaison and Diversion Team that regardless of the outcome of his court hearing, he would kill himself. While the police knew about Mr Ruddick's suicidal thoughts, they did not update the DPER to reflect his level of risk. The nurse from the Liaison and Diversion Team told us that she also gave a verbal handover to the custody sergeant on duty about Mr Ruddick's suicidal intention. Despite this, the DPER was still not updated. The DPER document provided to the investigator shows that it had not been updated from 11.18pm on 11 December. The only reference to Mr Ruddick's history of attempted suicide and self-harm was that he had jumped out of a window.

83. We consider that the information passed from the police to GEOAmey escort staff on the DPER did not adequately reflect Mr Ruddick's risk. We will share our findings with the IOPC who are carrying out their own investigation. It is not possible to say, however, whether the correct sharing of this risk information with GEOAmey would have made any difference to the outcome for Mr Ruddick.

Good practice

84. Although GEOAmey had accepted the police's assessment of Mr Ruddick's foot injury in good faith, they were concerned enough when he arrived at court to ask their own medical practitioner to assess him. This was good practice. After Mr Ruddick's death, GEOAmey also reviewed this issue and suggested that more consideration should have been given to Mr Ruddick's mobility issues and he should have been given a walking aid. GEOAmey have highlighted that their staff will be given further advice about responding to the needs of prisoners with mobility concerns.

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