Investigation into the circumstances surrounding the death of a man in September 2010, shortly after his release from HMP Norwich

Report by the Prisons and Probation Ombudsman for England and Wales

December 2011

This is the report of the investigation into the death of a man, who apparently took his own life by jumping in front of a moving train in September 2010. He was 29 years old when he died. He had spent the previous weekend at HMP Norwich and had been released on conditional bail from a local magistrates' court the day before. My office investigates deaths of those in court custody and in prison. He had recently been released from both institutions and so I decided to use my discretionary powers to investigate his death. I offer my sincere condolences to his family and friends and all those touched by his death.

The investigation was carried out on my behalf by a senior investigator. A number of different organisations and individuals were involved in this investigation, some of whom fall within the remit of my investigations, and some who took part voluntarily. I am very grateful to the G4S regional manager responsible for Norfolk, and G4S staff based at the magistrates' court. I would also like to thank the Governor of Norwich and his staff for participating in the investigation. Finally, I am very grateful to HM Court Services staff at the magistrates' court, the National Offender Management Service Prisoner Escort and Custody Services regional manager and the man's criminal defence solicitor for their contributions. This report will be shared with all of the agencies who participated.

The man was arrested six days before his death and charged with a domestic violence offence. He had never been in custody before and found the experience very stressful. He was also anxious about his relationship with his family, his job and being in debt. He had attempted suicide some weeks before his arrest and harmed himself again while in the police cells. His behaviour and demeanour at court worried G4S staff and they began formal suicide monitoring procedures. Having been remanded into custody, the monitoring continued throughout his short stay in prison. However, on his second court appearance, he was released on conditional bail. Sadly, he died the following day.

This investigation highlights the difficult balance between offering support to someone who is not under formal supervision by any criminal justice agency and accepting that an individual is free to make decisions about their life, no matter how tragic the outcome. However, the investigation has highlighted gaps in the processes for sharing risk related information between the different agencies at court and for passing on information about potential breaches of bail. I make three recommendations to the National Offender Management Service (NOMS) as a result. The response to the recommendations is noted in the Recommendations section of the report. Notwithstanding those recommendations, I believe that G4S and prison staff treated the man with genuine compassion and sensitivity while he was in their care.

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 and prisoners involved in my investigation.

Thea Walton
Acting Deputy Ombudsman **December 2011**

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SUMMARY

1. On 26 August 2010, the man was arrested by the police on suspicion of assaulting his wife. He was denied bail and was held in police custody overnight. He had never been held in a cell before and found the experience very stressful. He tied items of clothing around his neck and banged his head against the cell wall. This information was properly recorded by the police and therefore escort staff who collected him and took him to court the following morning were aware of his vulnerability.

2. At court on 27 August, G4S staff (explained in paragraph 24) began formal suicide and self harm monitoring. Due to their concerns about the risk the man posed to himself, they decided that he should be monitored at all times. He told staff that he was very anxious about his court hearing and his future.

3. Before appearing in court, the man met his defence solicitor. The solicitor had no idea that police and G4S staff had concerns about his client, although he did know that he had attempted suicide a few weeks earlier.

4. The man pleaded guilty to the offence. Sentencing was deferred until a pre-sentence report was completed by probation staff. However, because he could not provide a suitable address to live at in the meantime (outside of the county where his wife lived), he was remanded into the custody of HMP Norwich until 31 August. Court staff were not aware that he had harmed himself in police custody or that he was being monitored under formal suicide prevention measures.

5. When the man arrived at the prison later that day, staff knew that he was vulnerable and began the suicide and self harm prevention procedures. He told staff that he had attempted suicide previously, suffered with depression and had been misusing steroids. Staff remained very concerned about the risk he posed to himself throughout the Bank Holiday weekend he spent at the prison. He spent much of his time talking to another prisoner trained to offer confidential support. At his request, staff removed sharp items from his cell so that he could not use them to hurt himself. He told staff that if he received a prison sentence at his next court appearance, it would be a "death sentence". He remained very anxious about his relationship with his wife and family, his job and his future.

6. The suicide and self harm monitoring procedures were still in place when the man arrived at court on 31 August. Having identified a suitable address to live at, the court decided that he could be released on conditional bail. Again, court staff and his defence solicitor were not aware of the risk he posed to himself.

7. The man returned to the court cells to collect his belongings. Staff thought he was very pleased to have been granted bail and no longer had any particular concerns about him. He was given a travel warrant to cover his train fare to Cambridge and left the court. Very sadly, the following morning, he apparently took his own life when he jumped in front of a moving train.

8. This investigation has highlighted gaps in the systems for passing information between the various criminal justice agencies involved in the court process. It

has also identified uncertainty amongst G4S staff about what to do if they suspect someone is going to breach the conditions of their bail. I make three recommendations to NOMS as a result of the investigation.

THE INVESTIGATION PROCESS

9. The police informed HMP Norwich of the man's death in September 2010 (over two weeks after his death). The prison contacted my office the same day and the investigation was allocated to a senior investigator. She visited HMP Norwich on 1 October when she met the Acting Deputy Governor, the Suicide Prevention Co-ordinator and staff who had contact with the man.

10. The investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. There was no response to the notices.

11. The prison provided her with copies of the relevant documentation, including that covering the man's time in the care of G4S, his prison record, the Assessment, Care in Custody and Teamwork (ACCT) document (explained in paragraph 22) and his medical record. G4S provided copies of staff incident statements made following his death.

12. The investigator carried out interviews with the G4S staff who had contact with the man while he was at court and the regional manager. She also spoke to HM Court Services (HMCS) staff at the magistrates' court. She visited HMP Norwich again and spoke informally to staff working in reception. She also talked to the man's criminal defence solicitor by telephone. Specialist advice was sought from staff at HM Inspectorate of Court Administration (HMICA) and I am very grateful for their assistance. Following the interviews, written feedback was provided to the Governor of Norwich, the G4S regional manager, the National Offender Management Service (NOMS) area contract manager (explained in paragraph 24) and the court manager.

13. HM Coroner was contacted and informed of the nature and scope of the investigation. Upon completion, a copy of this report will be sent to the Coroner to assist with his enquiries.

14. One of my family liaison officers contacted the man's wife to explain the purpose of my investigation and invite her to raise any concerns to be considered. She had no specific questions but I hope that this report will provide further details about the days leading up to her husband's death.

HMP NORWICH

15. HMP Norwich is a local prison accepting prisoners from courts in Norfolk and Suffolk. It holds up to 767 adult or young adult men either convicted or on remand.

16. NOMS publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. Norwich's performance has been deemed "good" (the second highest rating) for the past four published quarters.

HM Chief Inspector of Prisons (HMCIP)

17. HMCIP last inspected Norwich in February 2010. The inspection report identified "an understandable and appropriate" focus on safer custody and suicide prevention, following a number of self inflicted deaths. Suicide prevention measures were generally found to be "sound and supportive". However, first night and induction procedures were "unsatisfactory".

18. Relationships between G4S escort staff (explained in paragraph 24) and prison reception staff were "good". The reception area was "clean but not welcoming" (and is currently undergoing extensive refurbishment as a result). However, prisoners said that they felt well treated by staff on their arrival.

Independent Monitoring Board (IMB)

19. Every prison in England and Wales is monitored by an independent board of volunteers drawn from the local community, known as the Independent Monitoring Board (IMB). Members of the IMB have access to every part of the prison and all prisoners held there. Part of their function is to ensure the humane and just treatment of prisoners. The Board must report annually to the Secretary of State for Justice. The most recent annual report available for Norwich covers the period March 2009 to February 2010.

20. The IMB reported positively on the work of the safer custody team. However, they remained concerned that prison staff had not received sufficient training to identify prisoners with mental health problems and make suitable referrals to the mental health team.

21. The Board noted that reception staff were "dedicated and experienced" and dealt with arriving prisoners, particularly those who had never been in prison before, with compassion.

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT is the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they are concerned that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to determine the level of risk, the steps that might be taken to reduce it

and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night. As part of the process a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk is also included in review meetings.

Listeners

23. Listeners are prisoners who are trained and supported by the Samaritans to provide emotional support to other prisoners. The service is confidential, meaning that Listeners can only pass information to staff (or indeed Ombudsman's investigators) in certain limited and very specific situations. Listeners are bound by the confidentiality agreement even after the death of a prisoner they have supported.

G4S

24. G4S is a private company which holds the contract for escorting detained persons from police custody to court and on to prison in the Norfolk area. The company is also responsible for staffing the cell areas of all of the courts in the county. The G4S regional manager is responsible for managing the day to day operations in the area. In addition, the contract is overseen by a regional NOMS manager from the Prisoner Escort and Custody Services (PECS) department.

KEY EVENTS

25. The man was originally from Poland but had been living with his wife and young child in Suffolk. He apparently spoke good English and told prison staff that he had two jobs because he also had to support family in Poland. On 26 August 2010, he was arrested and charged with assaulting his wife and was held in police custody overnight as a result.

26. While he was in police custody, staff completed the Person Escort Record (PER). The PER is designed to highlight the risks the escorted prisoner may pose to themselves and to others. The risks include physical and mental health, use of violence, substance use and suicide or self harm. The initial page of the PER (Part A) is completed by the police or the prison, depending on where the prisoner originates. The PER Part B serves as an ongoing record of the prisoner’s time whilst being escorted and should be updated by escort staff during the day. The PER recorded that, when refused police bail, he had tied his sweatshirt around his neck and had headbutted the cell wall in attempts to harm himself. He said that he did so because he felt frustrated.

27. At 8.18am the following day, he was collected from the police station by G4S escort staff and taken to the magistrates’ court.

28. Once at court, G4S staff completed a Suicide/Self Harm Warning Form, which serves to further highlight the individual’s vulnerability to the receiving prison. The form was completed by Prisoner Custody Officer (PCO) A. The PCO recorded that the man had made “statements of intent to self harm/commit suicide” and had tried to harm himself since his arrest. He directed that staff check him five times per hour and noted that his shoes had been removed from the cell (in case he tried to use the laces to harm himself).

29. PCO B was working at the court that day. She was interviewed by the investigator and said that the man used his cell bell frequently. (Each cell is fitted with an emergency bell which the detained person can use if they need staff attention.) She described him as increasingly stressed. He told staff that it was the first time he had ever been “locked up” and that he could not cope.

30. At 9.50am, the man rang his cell bell and threatened to headbutt the wall again. As a result, staff decided that he should be constantly monitored (when a member of staff remains at the cell door at all times). Because of the cell lay out, they decided to move him to a holding room closer to the staff office which was more appropriate for constant monitoring. The PCO said that he seemed happier in this room. PCO C spoke to him and he told her that he “was not a criminal”. She reassured him that staff were there to help and support him.

31. At about 11.00am, the man met his criminal defence solicitor. The investigator spoke to the solicitor by telephone during the investigation. He explained that he was the duty solicitor that day and met the man for the first time in the court cells. (Under the duty solicitor scheme any detained person can receive free legal advice if they do not already have an appointed solicitor. In each region, a number of firms of solicitors take it in turns to attend police stations and courts

when asked to.) He said that he was not told that there were any concerns about the man's demeanour in police custody or at the courts, or that a Suicide/Self Harm Warning Form had been opened. However, he had been given some information from the Crown Prosecution Service (CPS) which noted that he had attempted suicide in July 2010. During their meeting, he had no concerns about him.

32. The man then returned to the holding room. PCO C, who was interviewed as part of this investigation, said that he seemed in higher spirits, talking and laughing with them. However, he was still worried about the possible outcome of his court hearing and was anxious that he might lose his job. Staff continued to constantly monitor him.

33. At 12.04pm, the man appeared in court and pleaded guilty to common assault. He was escorted by a Senior Custody Officer (SCO). Although both the CPS and the solicitor had historic information that he posed a risk to himself, this was not mentioned to the magistrates or the legal adviser. (Magistrates – who are not legally qualified - must sit with a legal adviser, normally a qualified solicitor or barrister, who advises them on matters of law.) No mention was made of the open Suicide/Self Harm Warning Form or that his behaviour at both the police station and in the court cells had caused concern.

34. The investigator spoke to one of the court legal advisers and the court manager as part of the investigation. Both said that information relating to a defendant's vulnerability is usually passed to the court through the CPS, the defence solicitor or G4S. The legal adviser explained that the magistrates can decide to remand someone into custody if they consider that this is the safest option. She said that, on that basis, it is important that they are given full information about the risks defendants pose to themselves and to others. They told the investigator that communication between the different agencies and individuals in the local area was generally good. They agreed that the nature of the court meant that they often dealt with the same prosecutors, solicitors and probation staff and got to know them quite well.

35. The SCO was also interviewed as part of the investigation. He explained that there is currently no formal system for G4S staff to pass information relating to a detained person's risk to themselves or others to other relevant agencies. The investigator also interviewed the G4S regional manager. She explained that, although G4S staff accompany the defendant in court, they play no role during the hearing. She said that G4S staff would not be responsible for informing the court of any concerns, but that these should be raised by the defence solicitor. She said that the defence solicitor should be aware of any Suicide/Self Harm Warning Forms or open ACCT documents.

36. The court legal adviser explained that the legal adviser in court that day recorded that the magistrates had considered releasing the man on conditional bail. However, they wanted him to live at an address outside Suffolk and away from his wife. He could not provide such an address on 27 August and so he was remanded into custody, to appear again on 31 August. The court asked that a pre-sentence report be prepared by the local probation trust by 20 September.

(The pre-sentence report provides the court with more detailed information about the offender and the circumstances of the offence and can help to decide the appropriate sentence.)

37. PCO B told the investigator that, when the man returned to the court cells to await his transfer to prison, he was very stressed. She said that staff had spent time talking to him and trying to reassure him.

38. The man arrived at Norwich at 2.15pm. Reception staff were made aware of the Suicide/Self Harm Warning Form and at 3.00pm opened an ACCT plan for him. An officer completed the Concern and Keep Safe form, the first stage of the ACCT process. Officer A recorded that, in addition to harming himself in police custody, he had also cut his wrists and taken an overdose two weeks before. (It seems that he gave differing information about the exact timing of his previous acts of self harm.) The officer noted that he was in a very low mood.

39. Before the next stage of the ACCT support process took place, the man was assessed by a nurse, who conducted the First Reception Healthscreen. (The purpose of the healthscreen is to identify any immediate physical or mental health concerns requiring referral to the doctor or other specialist service.) She recorded that he was “pleasant” and spoke very good English. He told her that he had tried to overdose on painkillers, sleeping tablets and alcohol seven weeks previously, because of problems in his marriage. Following that attempt, he had been assessed by a doctor. However, he explained that his marital problems continued and he had tried to strangle himself while he was in police custody. He said that he had two children but “feels at this time they would be better off without him”. He told the nurse that he wanted to die. He admitted to using steroids, smoking cannabis and occasionally drinking alcohol. She referred him to the substance misuse doctor.

40. At 3.40pm, a Senior Officer (SO) completed the Immediate Action Plan, the second stage of the ACCT process. The SO wrote that the man should move to A wing (the induction wing), pending the ACCT assessment interview. Staff were directed to check him twice an hour and he was offered the opportunity to telephone the Samaritans or talk to a Listener. The SO noted that the man had said he would kill himself because of his worries about being in prison and his domestic situation.

41. Shortly afterwards, at 4.15pm, the man moved to A wing and underwent part of the induction. Officer A completed the First Night Interview, which gathers brief details about the prisoner including areas of vulnerability or concern. He told the officer that he had not expected to be remanded into custody and was “fearful for his safety”. He told the officer about his recent acts of self harm and said that he had suffered with depression in the past. The officer asked if he had any immediate concerns (for example, letting his family know he was in prison) and he said he did, although the exact nature of his concerns is not recorded.

42. During the evening, staff made entries in the ACCT plan On-going Record (where they detail their observations of and conversations with the prisoner). They noted

that he had been issued with an international telephone card and had managed to speak to his family. He was locked in his single cell at 8.00pm.

43. At 8.45pm, he pressed his emergency cell bell (as at court, each prison cell is fitted with an emergency call bell, which prisoners can use if they need to talk to staff) and told Officer B that he "could not cope". The officer wrote that they talked for 45 minutes. He said that he was distraught at being separated from his family and found it hard to understand why the court had remanded him into custody. At his request, the officer removed the razor, knife and spoon from the cell, so that he could not use them to hurt himself. The officer arranged for him to talk to a Listener, which he did until 11.15pm. On returning to his cell, he told staff that he was okay.

44. It appears that the man slept well during the night. At 7.00am on 28 August, he rang his cell bell again and asked for a pen. He told Officer B that he was "ok" but the officer noted that he seemed "low". Later that morning he talked to the Listener again and also attended the Roman Catholic service.

45. At 10.25am, Office C, an ACCT assessor and the man met for the ACCT assessment interview. She recorded details of their meeting in the ACCT plan, noting that he had never been in prison before and "can't cope". He told her that he was "devastated" that he was having problems with his wife "as he loves her so much". He said that his life had "hit rock bottom" because he thought he was going to lose his job and he had debts. He was upset at the thought of not seeing his young son.

46. The officer asked him about his earlier attempts to harm himself. He told her that he and his wife had argued three weeks earlier and he had cut his arm as a result. He had passed out at the sight of his blood and then took 90 tablets before telephoning his wife to tell her what he had done. He said that he had been taken to hospital and "was really upset that he was still alive".

47. He told the officer that for the previous eight months he had two jobs and that this had "destroyed his marriage". She wrote that he was now "emotionally exhausted" and realised that he was suffering with depression. He said that he could not cope with being in prison and that "being dead would be less painful than losing everything in his life".

48. The officer asked him how he felt over the previous few days. He said that he had felt "really bad" the previous day and had "terrible thoughts of killing himself". She noted that he had "done the right thing" and alerted night staff. He said that his thoughts were "all over the place".

49. When asked about people or aspects of his life that might help him to cope, he said that he wanted his wife to forgive him so that they could save their marriage. He also said that he wanted to keep his job so that he could "honour his responsibilities as a father" and visit his family (including another child) in Poland more often.

50. The officer noted that he did not have very much money left with which to make telephone calls, but needed to contact a friend in Cambridge to arrange a bail address. (Newly arrived prisoners are given a small amount of credit to enable them to make telephone calls in their first days in prison. Eventually, they are expected to use their own money.) She also wrote that he needed to be able to talk to a Listener "whenever possible" as he was very vulnerable.

51. The investigator spoke informally to the officer. The officer said that she spent a lot of time talking to the man because she was based on his wing over the weekend. She described him as being like "her shadow" when the prisoners were allowed out of their cells. She said that he had seemed "obsessed" with his wife and child. He told her that he had no life without them and that "if he could not have them, no one could". During their conversations, he said that he "admired" a murderer and understood why he had acted as he had. (In July 2010, the murderer shot dead his ex-partner's new boyfriend, and shot and wounded his ex-partner and a police officer. After several days on the run and a standoff with the police, he apparently killed himself. The events received extensive media coverage.)

52. The substance misuse doctor assessed the man at 11.40am. The doctor recorded details of the appointment in the clinical record. He noted that the man suffered with depression as a result of marital and financial problems. He prescribed zopiclone (a sleeping tablet) and citalopram (an antidepressant). The medications were to be given to him every day. The doctor arranged for him to be assessed by a doctor again on 1 September.

53. The man collected his lunch but, at 12.15pm, rang his cell bell and told Officer C that he had been sick. She told him that this might be because he felt emotional.

54. An entry by the officer at 1.45pm noted that the man was standing in front of the sink in his cell, holding a plastic knife to his neck. She wrote that he was in "floods of tears" and that the Listener was with him again.

55. At 2.50pm, a Developing Prison Service Manager (DPSM), the wing manager, Officer C and the man met for the first ACCT case review. During the review, he explained that he was returning to court on 31 August and hoped to be given bail. He thought he had arranged a suitable bail address which helped him to feel more positive. He said that he had been prescribed sleeping tablets and antidepressant medication. The DPSM recorded that the man had talked to a Listener and promised "not to do anything silly" before his court hearing. They agreed that the ACCT should remain open until 31 August, when, if he returned to Norwich, it would be reviewed. The DPSM changed the level of observations to once an hour, day and night.

56. During the afternoon, the man spent time talking to the Listener, another Polish prisoner, and Officer C. She noted that he had been crying again because he could not accept the situation he found himself in. However, later that afternoon, he spoke to his brother by telephone which seemed to make him feel better.

57. That evening, he spent more time with the Listener, before being locked in his cell at 9.15pm. Again he seemed to sleep well during the night. At 7.15am on 29 August he asked to speak to a Listener again and staff arranged for him to speak to him once more.

58. He went to the Roman Catholic service again that morning. Officer C noted that he seemed upset when he returned to the wing later. He told the officer that if he was returned to custody after his court hearing the following Tuesday it would be a “death sentence”. He remained upset during the afternoon, and spent time with the Listener. He asked to speak to him again in the evening and did so until 10.50pm.

59. At 1.15pm on Monday 30 August (a Bank Holiday), the man was upset and asked to speak to the Listener again. The two men spent a couple of hours talking and then he mixed with others on his landing. He spoke to the Listener again for an hour that evening before being locked in his cell at 8.00pm.

60. The following day, 31 August, the man was due to appear in court. Reception staff completed the PER, recording that he was on an open ACCT plan. Healthcare staff in reception gave him his daily doses of medication before he left so that, if he was released from court, he could take them as scheduled that evening. He was passed to G4S staff at 7.45am, who continued to make entries in the ACCT On-going Record.

61. According to the PER form, the man arrived at the magistrates’ court at 9.20am. The SCO and PCOs A and B were all working at the court again that day. The SCO told the investigator that, on his arrival at the court, he said that his four days in prison had been “the worst of his life”. Again, staff checked him regularly because he was on an open ACCT plan. However, they agreed that he was in much better spirits because he was sure he would be released on bail.

62. At 12.35pm, he appeared in court again. The court legal adviser interviewed by the investigator was the legal adviser on that occasion. She said that she was not aware that he was on an open ACCT plan and no mention was made of his behaviour.

63. The man had arranged to live with a work colleague in Cambridge and so the court agreed to release him on conditional bail. He was told that he was not allowed to contact his wife, except through his solicitor to arrange contact with his child. He was due to appear in court again on 20 September.

64. The man’s solicitor told the investigator that he was not aware of the open ACCT plan either. He said that he should have been made aware of this because, if necessary, he can arrange for relevant agencies, such as mental health workers, involved in the bail process. He also agreed that it was very important for the magistrates and legal adviser to have the full information when making any decisions about bail.

65. Before leaving the court building, the man returned to the cells to collect his property. The G4S staff told the investigator that he was in high spirits. He was

given a rail warrant to cover his journey to Cambridge. PCO A said that he told them that he intended to contact his wife (thus breaking the conditions of his bail). PCO B also thought that he planned to visit his wife. They did not pass this information on to anyone, telling the investigator that it was difficult to know what to do in such a situation. He had not yet broken his bail conditions, and in fact, might not do so. On that basis, they felt uncomfortable about informing the police. The SCO thought that, although he had not heard him talk of visiting his wife, G4S staff should probably tell the court if they had information that a defendant planned to break the conditions of his bail. The legal adviser confirmed that the court should be made aware of such a situation.

66. At 10.00am on 1 September, the man jumped from a railway bridge in Cambridge and was hit and killed by a train.

67. Officer C was not at work on 31 August, but on her return to the prison on 1 September she outlined her concerns about the man's state of mind in an email to managers. The email was forwarded to the police, but, sadly, was not received until after his death.

Support for staff and prisoners

68. G4S staff interviewed as part of this investigation said that they had been very shocked to learn of the man's death. They all agreed that they had been offered sufficient support from their managers. The G4S regional manager explained that they had been reminded of the dedicated employee support telephone helpline.

69. Officer C said that, having learnt of the man's death, she was well supported by the prison and, as a member of the staff Care Team was aware of the support mechanisms in place. She also told the investigator that she had offered support to the Listener.

ISSUES

Responding to the man's risk to himself

70. After his arrest on 26 August for assaulting his wife, the man was held in police custody. He quickly showed signs of vulnerability, tying clothing around his neck and headbutting the cell wall. Information about his risk to himself was recorded on the PER. When he arrived at the magistrates' court the following day, G4S staff immediately opened a Suicide/Self Harm Warning Form. His demeanour continued to be a cause for concern and staff decided to constantly monitor him. Having been remanded into custody, staff at Norwich quickly began ACCT procedures, which remained in place until he was released on bail on 31 August.

71. I am very pleased to find that both G4S and prison staff responded appropriately to the risks the man clearly posed to himself. Both acted in line with Prison Service Order 2700, Suicide prevention and self harm management.

72. The ACCT entries indicate that he received extensive support, particularly from Officer C and the Listener, while he was in prison. The interviews with G4S staff also reveal the extent of the support offered to him while in the court cells. I think that all the staff did everything that they could to support him while he was in their care and I commend them for that.

Sharing information about the man's risk to himself and to others

73. On both occasions that the man appeared in court, the formal suicide and self harm monitoring procedures were in place.

74. The man's criminal defence solicitor knew that his client had harmed himself some weeks before his court hearing. However, he told the investigator that he did not know that his behaviour in both the police and court cells had been a cause for concern. He did not think that the CPS was aware either (although no one from the CPS was interviewed during this investigation). He said that he did not know that he was on an open ACCT plan on 31 August.

75. The legal adviser in court on 31 August said that it is important that the court is provided with information about risk to self and others when making decisions about bail. She did not know that the man was on an open ACCT plan when he appeared in court. Although the legal adviser in court on 27 August was not interviewed, his colleague explained that no mention of the man's vulnerability had been recorded in the notes. On that basis, she thought it highly unlikely that the court had been made aware of the concerns.

76. Interviews with G4S and court staff and the solicitor highlight the good working relationships between the different agencies at the magistrates' court. Much was made of the fact that the cells are generally staffed by the same individuals and that the same solicitors, prosecutors and probation staff appear on a regular basis. Although all interviewees agreed that information was generally shared between the different organisations, none could identify a formal and robust

system for doing so. In this case, it seems that important information was not effectively communicated to those who needed it.

77. In 2005, HMICA and HMCIP published a joint thematic review of prisoner escort and court custody. The review highlighted that “[r]elevant information about the risks prisoners may constitute to themselves or others is not always shared effectively between agencies”. This finding led to a recommendation that

> “HMCS, NOMS, PECS and the contractors review arrangements at both strategic and operational levels for identifying, sharing and eliminating risks associated with escort and court custody and ensure communication of risk is effective and timely.”

78. In my view, this investigation reveals continuing problems in this area and further work is needed. I make the following recommendation:

NOMS should ensure that all PECS contract holders establish formal systems for sharing information about open Suicide/Self Harm Warning Forms or ACCT plans with all relevant parties.

79. While he was in prison, the man said that he “admired” a notorious offender who had recently been in the news. Given that he was in prison because of a domestic violence offence, this could have indicated that his family were at risk of further harm. On her return to work on 1 September, Officer C outlined her concerns regarding him in an email to her managers. Sadly, by this time, he had already died. However, he had been released from court the previous day and his comments about the murderer had not been made known to the court. It is possible that the magistrates might have reached a very different decision about whether or not to grant bail, or the conditions to impose, had they known.

80. On 1 September, Officer C said that she would complete a Security Information Report (SIR, which highlights any information relating to the safety of prisoners, members of the public or the security of the prison). Ideally, an SIR should have been completed immediately the man made the comments. Of course, it is impossible to know what action security staff might have taken had they received the information earlier. The investigator has not been given any information to suggest that he committed any further acts of violence against his wife and family after he was released on bail.

The man’s release on conditional bail

81. On 31 August, the man was released from court on conditional bail. As a condition of his bail, he had arranged to live with a work colleague pending further court appearances. He was not under the supervision of the local probation trust or other criminal justice agency. Because he apparently killed himself so soon after leaving prison and being granted bail, this investigation has considered whether anything was done, or should have been done, to offer ongoing support.

82. Given that there were significant concerns about his vulnerability, G4S staff were asked whether they would routinely inform any other agencies if they were worried about someone being released from court. The regional manager explained that currently it seems that no one has responsibility for someone once they have been released, even if they are still on bail. She said that G4S had discussed the issue internally but had not identified a solution.

83. A member of reception staff at Norwich told the investigator that if a prisoner is released from prison having reached the end of their sentence on an open ACCT plan, staff complete a discharge interview. Part of that interview includes asking if there is anyone the individual would like to be contacted. He also explained that the names of any prisoners released on an open ACCT plan (including the man) are faxed to the police on a weekly basis.

84. Identifying possible solutions in this complex area is not easy. The man was released on bail. He was not under the supervision of any criminal justice agency, other than the police who would only become involved if he broke the conditions of his bail (discussed further below).

85. Had he not recently been released from prison, his death would not even have been subject to an investigation such as this. On one level, one must accept that the choice to end his life was his to make. However, where risk is identified, it is important that the individual is offered all the support possible.

86. Again I do not think that that the entire responsibility rests with G4S staff (or their counterparts in other areas of the country). However they may be the last to see someone as they leave court. On that basis, I wonder if there are small changes that could be made to the process, which would meet the needs of those being released and ensure that staff are not left feeling that more could have been done.

87. The discharge interview system in place at Norwich, outlined in paragraph 74, might offer a solution. I do not think it would be onerous for G4S staff, or the staff of other PECS contract holders, to ask an individual who is being released from the cells area (and who is on an open ACCT plan or Suicide/Self Harm Warning Form) whether there is anyone they would like to be contacted. Of course, the individual may well refuse (I do not think that more can be done in that case) and there is no guarantee that contacting someone on their behalf will prevent them from harming themselves. However, in my view, it is worth consideration.

NOMS should require all PECS contract holders to introduce a discharge interview when someone on an open ACCT or Suicide/Self Harm Warning Form is released from court cells.

The man's intention to break the conditions of his bail

88. Having been granted conditional bail, the man returned to the court cells to collect his belongings and get his travel warrant. While there, he told some of the G4S staff that he planned to contact his wife, which he was not allowed to do under the conditions of his bail.

89. In interviews with the investigator, staff said that they did not pass this information on because they were not sure that they should. At this point, the man had not yet breached his bail conditions, merely indicated that he intended to. However, in my view, their obligations are clear and such information must be passed immediately to the court and to the police, who can decide the appropriate action.

NOMS should remind all PECS contract holders of their staff's obligations to inform the relevant agencies if they believe an individual intends to break the conditions of their bail or commit an offence.

CONCLUSION

90. On 1 September 2010, the man apparently took his own life. He had been released from court on conditional bail the previous day, having been convicted of a domestic violence offence and spending four nights in prison. From his first hours in police custody until his appearance at court five days later, it was clear that he was vulnerable and was experiencing serious suicidal thoughts.

91. His vulnerability was promptly identified and he was properly monitored and supported while he was at court and in prison. However, this investigation has found that information about his risk to himself was not communicated to all those involved in making decisions about him.

92. This investigation has highlighted the delicate balance between offering support to someone and recognising that they are entitled to make decisions for themselves, no matter how tragic the outcome.

RECOMMENDATIONS

1. NOMS should ensure that all PECS contract holders establish formal systems for sharing information about open Suicide/Self Harm Warning Forms or ACCT plans with all relevant parties.

   NOMS has accepted this recommendation, noting that "there is provision within the PSI for sharing of information as proposed. PECS Contractors are required to comply with Prison Service procedures and policies in relation to care of prisoners including ACCT. This includes completion of applicable risk assessments, reporting and supervision forms, and attendance of local HMP Safer Custody meetings."

2. NOMS should requiring all PECS contract holders to introduce a discharge interview when someone on an open ACCT or Suicide/Self Harm Warning Form is released from court cells.

   NOMS has partially accepted this recommendation, noting that: "this is a recognised good practice but is not a contractual requirement as there is no defined outcome. It would be necessary for agencies to accept responsibility for receipt of such information. PECS will engage with contractors to formalise the interview process within their Standard Operating Procedures but neither PECS nor their agents have accountability for the prisoner once released from custody."

3. NOMS should remind all PECS contract holders of staff's obligations to inform the relevant agencies if they believe an individual intends to break the conditions of their bail or commit an offence.

   NOMS has partially accepted this recommendation, noting that: "this is a recognised good practice but is not a contractual requirement. It will be for the police to take responsibility for responding to such information – the prisoner's release cannot be delayed for example. PECS will engage with contractors to formalise the notification to the police within their Standard Operating Procedures."