

**Investigation into the death of a man
at a Magistrates Court in February 2008**

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

August 2009

This is the report of an investigation into the circumstances surrounding the death of a man in February 2008 in a holding cell at a Magistrates Court. The man had attended a hearing for non-payment of a fine that morning and was sentenced to seven days in custody. A few hours later he was found collapsed and not breathing. The final post mortem report was produced in December 2008. The man is thought to have died as a result of the combined effects of alcohol and cocaine. He was only 24 years old.

I would like to offer my sincere condolences to the man's family and to others who have been affected by his death. I apologise for the delay in issuing my report and for the additional distress this may have caused.

The investigation was initially led by one of my investigators. It was taken over by one of my Assistant Ombudsmen in September 2008 when my investigator left my office. We would like to thank the representative of the Prisoner Escort and Custody Services (PECS), for providing information and arranging interviews to assist the investigation. I am also grateful to the Detective Sergeant of Cambridgeshire Constabulary for sight of the witness statements taken as part of the police investigation.

This report tells a sad story of unusual circumstances. The man was in custody for just around two and a half hours before he collapsed and subsequently died. My investigation has concentrated on the few hours leading up to his death, and the response from court staff when he was discovered on the floor of his cell. It is clear that the man's death was sudden and could not have been foreseen by those responsible for his care. Having said that, my investigation has found that the prescribed level of checks was not carried out by staff and that, in particular, the last recorded check of the man at 1.30pm may not have taken place.

This is the fourth death I have investigated in a court setting since taking over all such investigations in 2004. I make three recommendations, all of which were accepted by G4S at draft consultation stage.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

August 2009

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SUMMARY

The man appeared at a Magistrates Court in February 2008 to answer for the non-payment of a fine. He was sentenced to seven days in custody. Little was known about him when Global Solutions Limited (GSL) staff collected him from the court witness box. The man was asked a number of routine questions as part of the 'booking in' process. He told one of the Prisoner Custody Officers (PCOs) that he had been in prison once before about six years earlier. According to the PCOs who first took him upstairs to the custody area just after 11.00am, the man seemed shocked to be in handcuffs but had accepted his short sentence.

In interview, the first PCO said that when the man was given a routine rub down search he could smell alcohol or something sweet on his breath. He did not think that the man seemed to be under the influence of alcohol and he was not slurring his speech or unsteady on his feet. No visible signs of injury were evident during this booking in process. At 11.14am, the man was placed in a cell on his own and was given a drink. It was very quiet that day and only two other prisoners were being held in other cells in the custody area. The man was not checked twice per hour as laid down in GSL instructions, and was next seen at 12.23pm as part of the 'lunch run'. The man declined the meal pack, but did take a glass of water and cup of tea. Some of the PCOs giving out the lunch packs subsequently recalled that the man appeared to lose his balance, spilling some of his tea, before regaining his composure. However, they were not concerned about him, and just thought that he had 'tripped over his feet'.

The court staff then had their lunch and no checks were made on the prisoners during the lunch period. I have made a recommendation about ensuring the minimum prescribed checks of two per hour are always carried out.

A second PCO said that he checked the man at 1.30pm, spoke to him, and that he was okay. Shortly afterwards, around 1.36pm, another prisoner was unlocked so he could use the toilet. When he was being locked back into his cell a few minutes later, the second PCO checked on the man. He found the man collapsed face down on the floor. The cell was opened quickly and staff saw blood coming from his nose and mouth, and that the man was not breathing. The custody staff tried to resuscitate the man whilst awaiting the arrival of an ambulance.

Rapid response paramedics arrived at 1.47pm, followed by another team of paramedics a few minutes later. Despite further attempts to resuscitate the man, a paramedic pronounced him dead at 2.07pm. The police doctor subsequently confirmed the man's death at 4.19pm. The paramedic report form indicated medical staff thought that, as some signs of rigor mortis were already present, the man had been dead for longer than the timing of the last check by the second PCO indicated.

The post mortem was completed in December 2008. The pathologist concludes that, on the balance of probability, the man died of the combined effects of cocaine and alcohol intoxication, most likely through the development of a cardiac dysrhythmia (when the heart beats either very fast or very slow, or irregularly). He considers that another explanation could be a fatal seizure associated with alcohol withdrawal (if the man had a chronic alcohol problem) exacerbated by cocaine. It is

probable that the man had drunk some alcohol before attending his court hearing, but that the cocaine was taken after he was in the custody of court staff. At draft consultation stage the man's family asked for clarification as to whether any plastic bag or wrapping (that might have contained the cocaine) was taken from the cell after his death. My investigator contacted Cambridgeshire Constabulary. The police said,

“We did not during the course of our investigation find / recover any type of wrap or wrapping. When, how and what type of cocaine the man took we do not know, the toxicology report suggests the cocaine was taken whilst at court, this is our best evidence, but beyond that we do not know.”

The pathologist reports that the man had several marks of injury on his body, to his face, back, knees and elbows. None of the custody staff noticed any bruises or cuts to the man's face during their interactions with him that morning. I do not think it likely that custody staff inflicted these injuries either deliberately or whilst carrying out unrecorded restraint procedures. My only explanation is that the man received the injuries during his collapse onto the hard cell floor.

During interviews with my investigators, the second PCO maintained that he carried out the check of the man at 1.30pm. A third PCO recorded that check. After reviewing all of the evidence available to me, I was not persuaded that the second PCO did in fact carry out that check. During the advance disclosure arrangements that the Ombudsman has in place¹, G4S (the new name for the company that incorporates GSL) looked again at the evidence surrounding this last check and concluded that there was no disciplinary case to answer by any of the staff on duty that day.

In total, I make three recommendations.

¹ Advance disclosure of the draft report takes place where individual staff are named and directly criticised in the PPO report. The service in remit is given the opportunity to respond to the criticisms before the report is sent out on general consultation.

THE INVESTIGATION PROCESS

1. I was notified of the man's death in February 2008 and, after some consideration of the circumstances, I decided that the case did fall within my remit to investigate. I appointed one of my investigators. An incident report, custody documents, and police statements from staff and prisoners, were made available to my investigator. Further information, including a copy of an internal investigation carried out by Global Solutions Limited (GSL), was also made available by the Eastern Area PECS contract manager.
2. During the course of the investigation, my investigator spoke at regular intervals with the Detective Sergeant (DS) and his investigation team at Cambridgeshire Constabulary. The DS agreed that my investigator could begin the investigation after initial police enquiries were complete, and offered to share information from his investigation. The DS forwarded a copy of all police statements to my office via Cambridgeshire Constabulary Headquarters. I am very grateful to the DS for sight of the documentation.
3. My investigator left my office in September 2008 and the case was taken over by one of my Assistant Ombudsmen. After reviewing all of the evidence, my Assistant Ombudsman decided to carry out some interviews herself. With the aid of another of my Assistant Ombudsmen, she interviewed five members of GSL staff at the end of October, toured the court cells area at Peterborough, and spoke with the PECS contract manager and the Regional Manager for G4S (the new name for GSL). The Regional Manager for G4S subsequently arranged for sections of the company's Operating Manual to be sent to my Assistant Ombudsman.
4. HM Coroner was informed of the Ombudsman's investigation. A preliminary post mortem report found no evidence of natural disease or traumatic cause of death. The final pathology and toxicology reports were completed in December 2008. They are discussed in detail in a later section of my report but the cause of death was given as "Combined effects of cocaine and alcohol intoxication".
5. One of my Family Liaison Officers (FLO) contacted the man's next of kin shortly after the investigation was opened. The FLO explained her role and that of my office and provided information about the investigation process. The man's family will receive a copy of my report.

G4S - GLOBAL SOLUTIONS LIMITED

6. G4S, formerly Global Solutions Limited, is a company is involved in many business areas, one of which is to undertake prisoner movements into court custody and the inter-prison transfer of prisoners. GSL took over responsibility for prisoner transport from the police and Prison Service in 1993. Currently, G4S is contracted by the National Offender Management Service to operate two of the four contract areas in England and Wales. G4S employs and trains Prisoner Custody Officers (PCOs) to collect prisoners from police and prison custody and deliver them to Magistrates, Crown and County Courts. PCOs then have a duty to receive, process and hold prisoners at courts until hearings are complete.
7. The company also provides court custody areas with additional staff, responsible for keeping an electronic log of staff and prisoner actions whilst prisoners are in G4S's care. Since being awarded new prisoner movement contracts in 2004, G4S has operated a computer system called the Prisoner at Court System (PACS). It is standard practice for one member of staff to be delegated as the recorder, with responsibility for inputting data on the computer records, while other staff members carry out the necessary prisoner contact duties. The recorder enters the actions that another person has carried out, and at what time. The PACS system automatically records the time that the data is entered. The system is password operated and it is usual for other members of staff also to have password access to the system.
8. All G4S staff are trained in first aid to a certificate level. It is standard procedure to refresh staff training when certificates are close to or have expired.

PETERBOROUGH MAGISTRATES COURT

9. Peterborough Magistrates Court was purpose built in the 1970s to hear civil, adult criminal, youth, and family proceedings. There are two interview rooms and the custody area has the capacity to hold male and female prisoners separately. G4S operates the custody services within the court.
10. The last inspection report of the Cambridgeshire Magistrates Courts Committee (which has since been abolished and its functions assumed by Her Majesty's Courts Service (HMCS)) was published in July 2002. In the report, Her Majesty's Chief Inspector of the Magistrates Courts Service said that Peterborough's courthouse facilities provided reasonable levels of comfort for users and that the custody area was, in general, adequate for its purpose. With regard to the facilities to conduct court business with the appropriate level of privacy, HM Chief Inspector was more critical, and commented that Peterborough's interview facilities were unsatisfactory and lacking in appropriate seclusion.
11. There is a CCTV system at the court which provides coverage of the communal corridors and external entrances. HMCS does not routinely provide CCTV cameras in custody areas, although there is a greater likelihood of coverage in newly built courthouses and where courts have undergone major refurbishment. There are no CCTV cameras in the custody suite at Peterborough Magistrates Court. This has meant that the timings of staff checks on the man could not be verified.

KEY FINDINGS

The morning of 20 February 2008

12. The man travelled from Wisbech to Peterborough by bus for his court appearance. His father told the police that he telephoned his family at around 9.30am to say he had arrived. It is not known what the man did next. At some point that morning, either whilst en route to Peterborough or soon after arriving, he drank some alcohol. Cambridgeshire Constabulary reviewed CCTV footage of the courthouse entrance and this captured the man going into the building at around 9.58am. He was called into courtroom 1 for his hearing and was dealt with at 10.58am. As noted, the man was sentenced to seven days imprisonment.
13. Two Prison Custody Officers were then called to courtroom 1 to receive the man off bail and into custody. The 4th PCO attached himself to the man using restraints in line with standard procedures. According to the 4th PCO's statement to the police (and confirmed during interview with my office), the man seemed at first to be surprised to be restrained, but was compliant and chatty.
14. Both PCOs escorted the man from the witness box (unusually, the man was in the witness box, not the dock), out into the corridor and up the flight of stairs to the custody area. In her statement to the police, the 5th PCO said that she spoke with the man and "he seemed fine". During my investigator's interview, the 5th PCO said that, as she walked up the stairs with the man, she asked him if he had been in prison before and that he had replied, "Yes, a long time ago." She said that he had no problems walking up the stairs and that his speech was normal.
15. At 11.02am, the man was taken into interview room 2, and, in line with normal procedure, was given a 'Level A' search by the 1st PCO, the officer in charge of the custody area that day. (Several staff were on a training course, including the senior officer who is normally in charge.) The other staff in the room were the 2nd PCO and the 4th PCO. (A 'Level A' search is a detailed rub down search of a person. The person being searched is asked to remove their shoes for examination, but is not required to undress. The search includes a 'wand' passed over the body to check for any metal items such as needles, foil or blades.)
16. The man was asked if he had anything in his pockets before being asked to empty the contents onto the table. The 1st PCO recalled in his police statement that, because the man's hair was short, he could see there was nothing concealed. During interview with my investigators, the 1st PCO said, "I always do wand first in case of needles, razor blades and that. So I wanded him, had a chat with him at the same time because I'm checking to see if there's anything in his mouth, so I'm getting him to speak to me". (The wand would first have been checked to ensure that it was working by passing it over the PCO's keys.) The wand would have been passed over the man in a sweeping motion, starting at the collar.

17. The man was then given a 'pat down' search. The 1st PCO said that, because the man was wearing an olive green hoody, he first checked the hood to ensure there was nothing concealed within it. He then checked the man's shoulder, moving his thumb into the armpit and then passing his hands down his arm, using a downward motion to ensure that anything hidden would move downwards. Next, the 1st PCO moved his hands down the sides and front of the man's body. As the 1st PCO went to run his thumbs around the waistband of what the man was wearing, he realised that he was wearing a pair of shorts underneath the jeans he had on. After checking the waistband and legs of the jeans, the 1st PCO asked the man to undo his jeans to just above his knees so that he could check the pair of shorts. Once done, the man was asked to pull his jeans back up and then to sit down.
18. The 1st PCO described the man as "very, very chilled ... he was quite happy". During their conversation, the man had said that he had been inside before when he was a youngster. He said he wanted a cigarette and was disappointed to learn that the court was a non-smoking building. The 1st PCO thought that the search would have taken three or four minutes. He recalled that the man's breath smelled sweet, as though he had had a drink of alcohol or chewed "pear drop" type sweets. He said that the man did not appear to be drunk as he did not slur his words and was steady on his feet. The 1st PCO did not notice any injuries on the man at the time of carrying out the search.
19. Although no clothing was removed, any injuries that the man had to his face and head area would have been clearly visible at this time. The 1st PCO told the police in a follow up statement on 29 February 2008 that he could not specifically remember asking the man to remove his trainers in order to search the tongue, insoles and the man's feet (the socks are not removed). However, he said he must have done so because he always did this as part of the search process. Nothing was found during the search.
20. At the same time, the 5th PCO collected the hard copy Prisoner Escort Record (PER) from the 3rd PCO who was on reception desk duty that day. The 5th PCO took the PER into the interview room. The 4th PCO completed the initial pages of the 2050 record (the record that accompanies a person into prison). He recorded details such as the man's full name, home address, date of birth, description, and next of kin information.
21. This was also the time when the 4th PCO assessed the man generally. In interview, he said that the man appeared to understand the process, was able to give all of the relevant information, and did not appear to be under the influence of drugs or alcohol. The 4th PCO said he observed the man's general mannerisms, looked at his arms for signs of any previous self harm, and asked whether he had any worries.
22. The man told the 4th PCO that he had done a sentence in a young offender's institution (his family say this was in Norwich), and that he was fine about going to prison and not bothered about it. The PCO said that they chatted

23. In his interview, the 2nd PCO described the man as a “cheeky chappie” and said he had no concerns about him at all. He did not appear to be worried or concerned about being in custody. The 2nd PCO told my investigators that he did not recall smelling any alcohol on the man’s breath, and that he did not remember seeing any injuries or bruising on his face.
24. When interviewed by the police, the 3rd PCO said that all the information she had about the man was then recorded on the electronic version of the PER. She booked the man into custody by telephone (under Operation Safeguard) with the Operational Control Centre at Wakefield. The control centre arranged for the man to be transferred to the custody of a local police station, Bridge Street Police Station. The 3rd PCO recalled that the man did not ask where he was going next. This was “a little unusual”.
25. Around 11.10am, the man was taken to the male side of the custody area by the 4th PCO and allocated cell 4. The remaining paperwork was completed and his transport to the police station was arranged. The 5th PCO told the police that it was the policy to locate prisoners in single cells when possible. There were only three prisoners in the custody area that day and so they were accommodated separately.

The afternoon of 20 February

26. The 5th PCO went into the ‘crew room’, which is a communal staff area next to interview room 1 around lunchtime. She saw the 3rd PCO who told her that, apart from the man and the two occupants of cells 6 and 7, there were no other prisoners due in that day. When interviewed by the police, the 5th PCO described the day as quiet. On the day that my Assistant Ombudsmen visited, there were 12 people in custody and they were told that this is a more typical number.
27. According to the electronic PER, the man was next seen as part of the lunch rounds at 12.23pm by the 1st, 2nd and 4th PCOs. The man was offered a packed lunch and a drink. He declined the food but did accept a cup of tea and water. The 4th PCO told the police and GSL’s internal investigator, who is a Custody Team Leader, that the man appeared to ‘rock’ on his feet. He said that this reminded him of how someone under the influence of alcohol would move in an attempt to steady themselves. The 4th PCO went on to say that the man only did this once, and that he could not say he had been drinking as there was no alcohol smell on his breath, nor was his speech slurred.

28. During interview with my investigators, the 4th PCO clarified that it was as the man came to the cell door and took his cup of tea that he rocked back, as though he had lost his balance. He recalled asking the man if he was alright and that he had replied, "Yes." The 4th PCO said it is not unusual for prisoners to decline the lunch (a packed lunch of sandwiches, crisps and a chocolate bar) and that this is simply relayed to the person entering the information onto PACS so the food refusal is recorded. In this instance, the entry was made as "Food and drink given", so the food refusal was not recorded. The 1st PCO brought a cup of water and told the investigators that the man had a big grin on his face as he gave it to him. He thought that it was when the man had his cup of tea in one hand and went to get the cup of water with his other that he became unsteady on his feet for a second. The 1st PCO said it might have been that he "tripped over himself". All three PCOs then left the cell and the 2nd PCO closed the door behind him.
29. Around 12.30pm, the 5th PCO left the courthouse with the 3rd PCO to buy some food. Both told the police that they bought their lunch at 12.45pm and returned to the custody area at the court around five or ten minutes later. The 4th PCO told my investigators that he sat in the crew room with the 1st and 2nd PCOs eating their meals. The 5th and 3rd PCOs arrived back at the crew room around 12.55pm. None of the staff said that they recalled hearing any cell bells during the lunch period, and they were confident they would have heard the audible buzzer had one gone off. No routine checks were carried out by staff during the lunch period. Around 1.15pm, the 1st PCO was called over to Peterborough Crown Court to deliver some vegetarian sandwiches to one of the prisoners being detained there.
30. The 4th PCO went downstairs with the 1st PCO at about 1.20pm in order to unlock the doors. (No member of staff is permitted to leave the court with their keys for security reasons.) He remained outside for a short while in the fresh air, returning between 1.30pm and 1.35pm just as "the buzzer went off" for a prisoner who wanted to use the toilet. The 5th PCO stayed in the crew room on her own while her colleagues went back to the custody and cell areas. She thought that the 2nd and 4th PCOs had gone to interview room 1 (next to the male cells area). In fact, only the 2nd PCO was there as the 4th PCO had gone downstairs to let the 1st PCO out to go to the Crown Court. The 3rd PCO had gone to the PACS terminal at the front desk.
31. According to the electronic PER, the 2nd PCO checked the man's cell at 1.30pm and spoke with him. (The electronic PER for one of the other prisoners in cell male 7 also recorded a cell check time of 1.30pm.) The 4th PCO was downstairs at 1.30pm. The 1st PCO was at the Crown Court. The 5th PCO was in the crew room. Only the 2nd and 3rd PCOs were in the custody area.
32. According to the electronic PER, another prisoner in cell 6, was "spoken to" by the 2nd PCO at 1.30pm. In his police statement, the prisoner thought that he was in cell 6 and that this cell was immediately next to the man's cell. The prisoner was unsure of the exact time, but thought he was taken into court at about 11.00am. (The PER states he was taken to court room 1 at 11.41am.)

33. When my investigators spoke with the 2nd PCO, he said that he did carry out the cell checks at 1.30pm. He could not recall why he had decided to do a check at that time, just that he had. G4S indicated that it is standard practice for an officer to undertake cell checks because they are due or for the reception officer to remind officers cell checks are required. The 2nd PCO said he opened the hatch, asked the man if he was okay, and that he had said "Yes." My investigator asked the 2nd PCO why, as the last person to see the man alive at 1.30pm, he had not mentioned this in his statement to the police. The 2nd PCO replied, "I only answered the questions that the police officer asked me." My investigator asked the 2nd PCO to try to recall exactly what the man had been doing when he made the check at 1.30pm – for example, if he was standing up, sitting down, or lying on the bench. She also asked if the man was chatty, whether he smiled, and how he looked. The 2nd PCO said he could not remember. He said that he presumed there were other PCOs about. In fact, there were no other staff in the cells area.
34. The 4th PCO said that, when he came back upstairs and in through the main door, he thought the 3rd PCO was at the desk (where the PACS terminal is) and the 2nd PCO was sitting in interview room 1 (immediately adjacent to the male cell area). A buzzer went off and 2nd and 4th PCOs responded.
35. Another prisoner, (cell 7), had pressed his buzzer because he needed to use the toilet. In his police statement, the 2nd prisoner said this was at about 1.30pm, or shortly afterwards. The toilet is in the entrance to the cell area. It is customary for two officers to unlock the prisoner and then wait just outside the cell area (with the door closed to ensure privacy) whilst the prisoner uses the toilet. Both PCOs stood just outside the cells area for two or three minutes. At interview with my investigator, the 4th PCO said he did not remember hearing any unusual noises or banging during these minutes and no one else pressed their buzzer. The 2nd prisoner did not hear anything either (the toilet area is immediately adjacent to the man's cell). The other prisoner was asleep in his cell and did not hear any noises. The 2nd PCO said during interview that he thought he "heard a bang" but he could not say where it had come from. When asked to clarify, the 2nd PCO replied, "I think I did but I can't say I'm 100 per cent sure on that." The 2nd prisoner was then locked back in his cell and the 2nd PCO commenced a visual check of the other cells.
36. The 2nd PCO said that when he reached the man's cell he looked through the observation panel and saw him lying face down. The 2nd PCO shouted to the 4th PCO "In here now," then unlocked the door and both PCOs entered the cell. The 4th PCO saw the man lying face down, with his head towards the

37. The 2nd PCO knelt down beside the man and noticed that he had blood around his nose. The 4th PCO said they began to roll the man onto his side into the recovery position. Both PCOs said the man's body did not feel rigid as they did this. The 4th PCO said the man had some blood on his face.
38. According to the PER, the ambulance was called at 1.39pm by the 3rd PCO. She shouted to the 5th PCO in the crew room for help. As the 5th PCO entered the man's cell, the 2nd PCO asked her to fetch some wipes. After the 2nd PCO used the wipes, the 4th PCO said he could see that the man's lips were blue. The man was then put onto his back and the 2nd PCO began chest compressions whilst the 4th and 5th PCOs went to get a resusci-aid (a device to protect someone giving mouth-to-mouth). The resusci-aid is kept in the first aid box in the manager's office (a few metres from the entrance to the cells area). The 4th PCO told my investigators that he initially struggled to get the plastic seal off the box, but then got it open and the 5th PCO took the mouthpiece out.
39. During interview with my investigator, the 5th PCO said, "What I remember about the first time I saw the man ... were his hands, his hands were clenched... both his hands." She estimated that they took less than a minute to collect the medical equipment.
40. When the 5th PCO returned to the man's cell, she began to administer two breaths to every set of chest compressions the 2nd PCO carried out. Both PCOs said they heard a gurgling sound coming from the man and tilted him onto his side. As they did, a small amount of fluid drained from his mouth. The staff then rolled him onto his back and administered another set of chest compressions and breaths. The 5th PCO said she could not see the man's chest rising as she gave him the breaths. The 5th PCO thought they had rolled the man onto his side three times.
41. Meanwhile, the 4th PCO had asked the 3rd PCO to ask the 1st PCO to return to the Magistrates Court. The 4th PCO said he would go downstairs to the van area and open the doors, ready for the ambulance staff. It took the 1st PCO approximately two minutes to get back and he saw the 4th PCO on the way in through the vehicle area. The 1st PCO entered the custody suite, took some gloves out of the drawer, and went into the man's cell. He took it in turns to administer chest compressions with the 2nd PCO whilst the 5th PCO was doing mouth to mouth. He tried to rouse the man by shouting his name and rubbing his arms and hands. The 1st PCO told my investigators that he was not able to open up the man's hands. He said two of his fingers had come up and he could not get them down and they appeared to be "locked". In his police statement he said the man's "fingers on both hands were scrunched up, finger tips coming towards the palm of his hand and his fingers looked blue." The 1st PCO patted the man on the back to try to remove any obstructions from his airway and rubbed his arms in order to try and rouse him.

42. The first paramedic arrived in the downstairs van area at 1.45pm and got to the cell two minutes later at 1.47pm. He told the 2nd and 5th PCOs to continue CPR while he got his equipment in place. The paramedic also asked the 1st PCO to cut the man's clothes from his torso and then took over CPR from the officers. The ambulance team arrived at 1.50pm. The 4th PCO said that another ambulance team also arrived in the downstairs van area. The ambulance crews took over efforts to resuscitate the man.
43. The Patient Report Form completed by the East of England Ambulance Service records that they were called by 999 at 1.41pm and arrived at 1.45pm. They noted that the staff said they last checked the man at 1.30pm and found him in cardiac arrest at 1.38pm. The form indicates that the paramedics found that the man had no pulse, his skin was cyanosed and cold, and that his pupils were unreactive and dilated. There was a small amount of blood coming from his nose. They tried unsuccessfully to gain access to a vein so that drugs could be administered. The man remained in asystole (when there is no cardiac electrical activity) throughout their efforts, and was recognised as dead at 2.07pm. The form records that one of the man's shoes was off when the paramedics arrived and that they removed the other shoe and his clothing during their efforts to resuscitate him. The paramedic completing the form wrote, "All ambulance staff agreed patient appeared to have been in cardiac arrest longer than told given his colour, marks to knees and rigidity of arms and legs."
44. During interview, the 5th PCO said that she recalled the paramedics removing a shoe from the man and "doing something to his toes". The 5th PCO said she had felt confident about using resuscitation techniques.
45. The 5th PCO asked the paramedics if she could go back into the cell where the man lay after he had died. One of the paramedics accompanied her. She wanted to say a prayer for the man. Her reason for wanting to do this was because she did not want his mother to feel that he was all alone and that nobody had cared. She said a prayer over the man and then left the cell.

Events following the man's death

46. The 3rd PCO first telephoned GSL's contract manager to notify him of the man's death. As the contract manager was in a meeting, the 3rd PCO spoke to a person at GSL's vehicle base to ask for assistance. The person made her way to Peterborough Magistrates Court and helped The 3rd PCO deal with telephone calls and the necessary paperwork following a death in custody.
47. The police arrived at approximately 2.30pm and began to take statements from the staff on duty and the prisoners in the other cells. The police doctor arrived in the custody area at 3.50pm and pronounced the man dead at 4.19pm. The man's family were told of his death by a police family liaison officer.

48. The following week, a debrief session was held for staff who had been on duty. The 1st PCO said that he had found this session very good. He also said that he felt very supported by management, and that he had been rung at home and offered support. The 4th PCO said that on the following Monday he spoke with some counsellors. He said that he felt GSL were there if needed, but he did not know what else they could do.
49. On 29 February, both the 1st and 2nd PCOs gave further statements to the police. In his follow up statement, the 2nd PCO confirmed that, when he entered the man's cell, he noticed that one of his white training shoes had either been taken off or had come off, but that the man was wearing his other shoe. The 2nd PCO explained that he did not know why the man was only wearing one shoe, and confirmed that he had not removed his other shoe during the course of administering CPR. In the 1st PCO's follow up statement, he gave a full description of what constituted a Level A search.
50. Shortly after the man's death, GSL's contract manager carried out an internal investigation on behalf of GSL. GSL's contract manager spoke to all the staff on duty on 20 February and formed a picture of what happened to the man in the few hours he was in the care and custody of staff. GSL's contract manager concluded that the man should have been checked more often than he was. He made a recommendation reminding staff of the Standard Operating Procedure that requires staff to carry out and record a minimum of two checks per hour on all prisoners in court custody cells.

ISSUES

The post mortem and toxicology reports

51. A doctor carried out the toxicology tests on the man's blood and urine. The levels of ethanol in the blood and urine were 102mg/100ml and 165mg/100ml respectively. The level of cocaine in the man's blood was 217µg/l and in his stomach, 12.4mg/l. The level of benzoylecgonine in his blood was 487µg/l. Some cocaine metabolites were also present in the man's urine (including cocaethylene). No other drugs were detected. The toxicologist commented that, "These results suggest likely social level use of alcohol and use of cocaine in the hours prior to death."
52. The post mortem was carried out by a Consultant Forensic Pathologist. The man's heart, lungs, liver, kidney and brain showed no signs of underlying disease, and the pathologist concluded that there was no evidence of natural disease that caused or contributed to his death.
53. The pathologist noted several marks of recent injury on the man's body. He recorded swelling of the left scalp, some bruising above the left eyebrow, bruising and an abrasion above the right eyebrow, bruising down the bridge of the nose, bruising and small abrasions around the mouth and lips, and bruising and an abrasion on the chin. The man also had bruising around his elbows, forearms, the front of his knees and on the front of his shins. His back also had some bruises. The pathologist's conclusion was,

"There are signs of trauma with evidence of multiple impacts to the head / facial area including the nose. I cannot exclude the possibility that some of these may represent marks of assault. However, given the amount of bruising around the elbows and knees, it may well be the case that these are due to repeated falls. Bruising identified over the back may well also be due to a fall or falls. However, on the basis of anatomical findings alone, I cannot exclude the possibility that they occurred as a result of restraint at some stage."

The pathologist noted the findings of a neuropathologist, who "described features suggestive of mild to moderate non-fatal head injury".

54. Continuing his conclusions, the pathologist wrote:

"In my opinion there is no evidence of any direct traumatic cause of death ... there is evidence of mild alcohol intoxication and recent use of illicit cocaine whilst alcohol intoxicated ... on the face of it they suggest that there has been use of cocaine whilst at Court. In relation to alcohol there is likely to have been a greater degree of intoxication prior to attending Court with the final level detected at the time of death reflecting a falling blood level ..."

(This is supported by the higher urine alcohol level versus the blood alcohol level.)

55. The pathologist suggested that the toxicological findings about alcohol and cocaine use needed to be reconciled and that further information should be sought in relation to the likely timing of the man's facial and other injuries. He said that they may relate to an earlier period of substantial alcohol intoxication many hours before death.
56. In the concluding paragraph of his report the pathologist stated, "In my opinion, it is likely at least on the balance of probability that the deceased died of combined effects of cocaine and alcohol intoxication most likely through the development of a cardiac dysrhythmia [when the heart beats either very fast or very slow, or irregularly]. If the deceased was known to have chronic alcohol abuse problems then a fatal seizure associated with alcohol withdrawal and exacerbated by cocaine would be another possible mode of death." At draft consultation stage the man's sister said that he did not have alcohol abuse problems and that he would not be suffering from alcohol withdrawal.
57. Blood alcohol concentration (BAC) is the concentration of alcohol in a person's blood. The number of drinks consumed is a poor measure of BAC, largely because of variations in weight, sex and body fat. However, it is generally accepted that the consumption from sober of one standard drink of alcohol (that is 14 grams / 17.74ml ethanol content) will increase the average person's BAC roughly 0.02% to 0.05% and would return to 0% about one and a half to three hours later.² The United Kingdom legal limit for drivers is 80mg of alcohol per 100ml of blood (0.08% expressed as BAC) or 107mg alcohol per 100ml urine.
58. The man's blood alcohol level at the time of his death was 102mg/100ml and his urine level 165mg/100ml. He was therefore over the legal driving limit for alcohol. An average person with a BAC of 0.102% would be more extrovert and uninhibited in their behaviour. They would have impaired reflexes, reasoning, depth perception and distance acuity, but the average person would not be slurring their speech, staggering or having emotional swings of behaviour.³ The 1st PCO said that he smelled something 'sweet' on the man's breath when he was speaking to him in the interview room shortly after 11.00am. He said, however, that the man did not appear to be drunk as he was not slurring his words and was steady on his feet.
59. A pre-sentence report was written in October 2002 after the man had been convicted of actual bodily harm. That offence had occurred as the man left a public house after consuming about seven or eight pints of strong lager during the course of the afternoon and evening. The man recognised that alcohol was a contributory factor in the offence he committed, but said he was not alcohol dependent. This information is clearly several years old and my investigator does not know the extent to which the man's drinking behaviour may have changed subsequently. However, it is not suggested that the man

² Taken from Wikipedia.com

³ Taken from Wikipedia.com

had drunk more than a moderate amount of alcohol before arriving at court on the morning of his death.

60. The man took cocaine at some point during his time in court. My investigator looked into how a person can collapse from the use of social levels of alcohol and cocaine. Clinical data indicates that the concurrent use of alcohol and cocaine is associated with increased risk of death from cardiovascular complications, hepatotoxicity (chemical driven liver damage), and behaviour leading to personal injury. The increased risk from the combined use of alcohol and cocaine is enhanced by the formulation of a third compound, ethylbenzoylecgonine (also known as cocaethylene). The toxicity of this compound is greater than cocaine and its effects last longer on the body.⁴ Cocaethylene was identified as being present at the post mortem for the man. Because the man did not die from personal injury or hepatotoxicity, the pathologist concludes that the man is likely to have died from cardiac dysrhythmia.
61. There is nothing to indicate that the man intentionally took his own life or that he was even aware of the increased risk he was putting himself under by taking cocaine when he was already under the influence of alcohol. The man had no history of self harm or suicide attempts, and had appeared at ease with coming into custody that day.

Bruising and injuries noted at post mortem

62. The post mortem report indicates that the man had bruising around his head and facial area, back, elbows and knees. The pathologist indicated that they may have been due to a fall or repeated falls, but he was unable to exclude the possibility that they occurred as a result of restraint at some stage.
63. The police specifically asked the 1st and 4th PCOs, who were in the interview room at the time that the man was searched, whether they remembered seeing any marks or bruising. None of the PCOs my investigators spoke with recalled any injuries visible on the man. The 1st PCO would have been best placed to give an accurate account of any injuries to the man's face and head area as he was the officer carrying out the Level A rub down search. There is no indication that the man had any injuries on his face at 11.00am, when this search was carried out. The rub down search is a search with all clothes on and so staff would not have been aware of whether the man had injuries to his back, elbows or knees, but there was nothing in his demeanour to indicate that he did.
64. The 1st, 2nd and 4th PCOs saw the man again at around 12.20pm, when they were giving out the lunch packs. They did not report seeing any injuries to the man's head or face at this time.
65. There was no indication during my investigators' interviews with the members of court staff on duty that day that the man may have been involved in some

⁴ Taken from Emedicine.com

sort of unrecorded restraint procedure. The man, by all accounts, was easy going and compliant with staff; a “model prisoner”. There does not appear to have been any reason why any member of staff would have needed to physically restrain the man, much less to have done so and then decided not to record it via the appropriate mechanisms. When PCOs enter the cells area they normally do so with another officer. There is usually a third PCO at the desk immediately outside the cells area making entries in the PACS system. I find it hard to believe that all these staff would have colluded to ‘cover up’ a restraint or assault. The only time that this area was not staffed during 20 February was over the lunchtime period between 12.20pm and 1.30pm.

66. During this time the actions of individual staff have been described in their statements – two had gone to buy their lunch from a local store, and the others sat eating their lunch in the crew room before being joined by the other two members of the team. There is no indication that anyone left for any period of time and there were no unusual noises or buzzer presses from the cells area. There is nothing in the police statements given by the other two prisoners in the custody suite to suggest that the man was assaulted during this lunchtime period. I therefore conclude that the man did not receive the bruising to his body or facial area as a result of staff assault or restraint once he was in the custody of the court.
67. I therefore have to speculate as to how the man may have come about his body and facial injuries. Perhaps he fell to the ground very heavily as he collapsed, landing face down with his knees, elbows and face taking the brunt of the impact onto the cell floor. Perhaps he was able to get up but then collapsed for a second time. (The timing of the man’s collapse is something that I will discuss later in this report. Suffice to record here that such a fall(s) would have made a certain amount of noise.)

Searching the man in interview room 2

68. The 1st PCO searched the man using routine Level A search techniques. This is in accordance with Standard Operating Procedures for searching prisoners in court custody. In his statements to the police, the 1st PCO detailed the extent of his search and confirmed that, although he did not remember specifically checking the man’s footwear, he would have done this as a matter of course. Because one of the man’s trainers was off when the PCOs attended his cell, it is possible that the cocaine that the man took at some point had been hidden in his trainer or sock (although no wrapping or container was found by the police). The paramedics recorded that they removed the other trainer during their efforts to resuscitate the man.
69. I judge that the rub down search described by the 1st PCO followed the guidelines given by GSL for carrying out this type of search. Whilst my investigators were visiting Peterborough Magistrates Court they spoke with the PECS contract manager and the Regional Manager for GSL. Both said that it was rare to carry out a full search (that is, removing a person’s clothing). According to the Operating Manual, a full search is only carried out “in exceptional circumstances”. The Manual indicates that, when a full search

70. The Prison Service routinely carry out full searches of all adult men before they leave prison to go to court. Those coming from home, off bail and into court custody, receive a rub down search by court custody staff. Whilst there is no guarantee that someone who is full searched has no hidden items, it is plainly easier to conceal things about your person when your clothing and underwear are not removed during searching. In a recent report into the death of a man in another court, I asked G4S to consider whether to adopt new procedures for those people who come off bail into custody. I asked them to consider whether a full search would be appropriate in these situations or whether an 'enhanced' rub down could be adopted, whereby the person was asked to remove their shoes and socks for checking.
71. G4S responded to the recommendation in that report by saying that they did not think a Level A (rub down) search could be extended in the way the report suggested. Legal advice is that the removal of socks as part of a Level A rub down search would constitute a more intrusive search than the standard procedure. For this reason prisoners should not be asked to remove their socks routinely but rather where there is intelligence or reasonable suspicion that an item of contraband has been concealed and where it is considered to be necessary and proportionate response. It would be difficult to justify the routine removal of items of clothing as part of a rub down search as it would begin to blur, unacceptably, the distinction between rub down search and a full search. Finally it would be very difficult to sustain different definitions of a rub down search at different places in the custodial system. A Level A search is designed to be conducted in the same manner whether it is conducted by prison staff in a prison or PCOs at court. Consistency is important in this context, a different standard of rub down search would be practically and legally difficult to justify.
72. I do not therefore repeat that recommendation here. The man did not display behaviour during his booking in procedures that should have triggered the threshold for a full search.

Single cell occupancy

73. The 5th PCO confirmed that it was GSL operating policy to locate prisoners in single cells when possible. The exception is if the custody area is busy when, through lack of space, prisoners are 'doubled up' (have to share a cell). Little was known about the man when he was taken off bail and into the custody of GSL staff. He was, therefore, not considered to be a risk to himself or others. On the morning that the man was taken to cell 4, there were only two other prisoners in the custody area and the 5th PCO told police that staff were

Regular checking of cells

74. During interview with my investigators, the 5th PCO explained that it is normally herself or the 3rd PCO who works the PACS computer system. The system allows the operator to record information against individual prisoners and groups of prisoners. For example, the operator could record “prisoner seen and spoken to” as a group instruction against every prisoner, rather than having to make several individual entries. The 5th PCO said that, when the officer comes out of the cells area and tells her about a check or toilet visit, she records the officer’s name next to the entry about that prisoner.

75. In her statement to the police, the 3rd PCO gave a full explanation of the PACS system, and her role as recorder. When asked by my investigators how many checks on each prisoner was routinely required each hour she replied, “it’s two or three times an hour”. She went on to explain that when a PCO goes into the cell area to answer a buzzer, they generally check all the other prisoners at the same time. The 3rd PCO added:

“If we haven’t had need to go in there for 15, 20 minutes, the desk officer will usually say, ‘Oh I’ll need some cell checks,’ and then somebody will go in and do them.”

The 3rd PCO told my investigators that she would only record a cell check when someone told her that they had done one.

76. The 1st PCO told my investigators that after doing a check on prisoners you go to the PACS person and shout out, “Cell check, such and such person, sitting, standing, reading, appears to be asleep (as appropriate).”

77. The GSL Standard Operating Procedures (Edition 1, August 2004) sets out the minimum requirements for carrying out cell checks. Paragraph 4.1.11 says the following:

“Staff are responsible for the continuing care of all prisoners and will check all prisoners in their custody, both during escort and at court, to ensure that their general welfare and well-being is being maintained. Prisoners not subject to any special arrangements or risks will be checked at irregular intervals with a minimum of two checks per hour ...”

78. During interview with my investigators, the 2nd PCO said that he had read the Standard Operating Procedures when he first started working for the company, but that he was not very familiar with its contents. He did know of the requirement to carry out two checks per hour on those prisoners who are not deemed to need special monitoring. The instruction about cell checks is

79. According to the electronic PER on the PACS system, the man spent two hours and 23 minutes in cell 4 before he was found collapsed. He was initially located in the cell at 11.14am. He was seen again at 12.23pm when the lunch packs were being given out, one hour and nine minutes after being put into the cell. According to the electronic PER, the man was then seen twice in quick succession, once at 1.30pm, and again at 1.38pm. The latter check on the man was carried out when the 2nd PCO returned another prisoner to his own cell, having escorted him to the toilet. My investigator compared the man's irregular checking times with those of another prisoner located in cell 7, and found that the checking times, specifically over the lunchtime period, were the same for both men.
80. The 3rd PCO explained that when she went out to lunch with the 5th PCO, her colleagues (the 1st, 2nd and 4th PCOs) remained to carry out cell checks and ensure that the prisoners were given lunch. The 3rd PCO returned from her lunch at around 12.55pm. Her statement did not say when she resumed her duties at the reception desk, but it did confirm that, when checks are carried out, her colleagues inform her and she records the action and the name of the PCO. In recalling the man's cell checks, the 3rd PCO said, "All the updates I put on the man's log were completed within five minutes of me being told the update by the PCO, I do not believe there were any delays in why this information would not have been put on straightaway."
81. The man was a normal risk prisoner and should have been checked at least twice an hour, every hour. It is not clear why the man was not checked between 11.14am and 12.23pm, when two checks should have been made. No cell checks were made over the lunchtime period, between 12.23pm and 1.30pm. A further two checks should have been made during this period.
82. It was not clear during my investigators' interviews who was accountable for ensuring the minimum number of checks were carried out – the PACS recorder or PCOs covering the cells area. The former is best placed to know when the last check was made because the electronic record is directly in front of them. I accept the account from staff that Wednesday 20 February 2008 was an exceptionally quiet day, with only three prisoners in the custody area. This would inevitably mean that the number of visits to cells, for example to answer cell bells, unlock for using the toilet, asking for a drink, or solicitor meetings, would be reduced. If the routine checking of all the other prisoners is usually done at the same time as these activities then I can see why checks were missed on this day. However, I do not find this acceptable. Fewer prisoners in the cells meant that staff were less busy than usual, and so had less justification for overlooking the mandatory twice hourly checks. Staff spent too much time in the crew room over the lunch period, and no one

G4S managers should ensure that the minimum of two cell checks per hour are carried out by court custody staff in accordance with paragraph 4.1.11 of the Standard Operating Procedures.

G4S should revise the local instructions given to staff working within Peterborough Magistrates Court and replicate key requirements from the Standard Operating Procedures so as to make them more accessible and user friendly for staff.

The 1.30pm check

83. There are discrepancies between the statements that staff gave to the police and the GSL internal investigator. The discrepancies are centred on whether the man's cell was checked at 1.30pm. None of the PCOs on duty that day referred to the man's cell check at 1.30pm when they were interviewed by the police, just a few hours after his death. As I have mentioned, the PER stated that the 2nd PCO carried out a check at 1.30pm, but he failed to mention this check in his police statement. This check was recorded by the 3rd PCO.
84. During interview with my investigators, the 3rd PCO said that two PCOs normally go into the cell complex together in case a cell needs to be opened. She said, "You don't want to put yourself in a position where you're one on one with a prisoner". G4S responded that it was standard procedure for a single officer to perform cell checks which require the officer to open cell hatches and check individuals and that it is only when the cell door needs to be opened that two officers are required.
85. The 2nd PCO said that, when carrying out a cell observation he would open the hatch and say something like, "Are you alright?" If he got a response he would shut the hatch and walk on. If the person was lying on the bench and looked asleep, he normally opened the door and asked if the person was okay. The 2nd PCO said that he always obtained a response of some sort before moving on.
86. The PACS entry was made by the 3rd PCO at 1.30.39pm. During interview with my investigators, the 3rd PCO confirmed that the entry would only have been made in response to the 2nd PCO coming out of the cells area and telling her that he had seen and spoken with the man. When asked whether she could actually recall the 2nd PCO going into the cells area at that time she said, "No, I don't think I can. But he must have done because I put it on PACS. Its months ago." Regrettably, my interviews were not carried out until October 2008 and so it is understandable that some detailed recollection of the exact sequence of events had been forgotten. However, the 3rd PCO's police statement, made only a few hours after the man's death, did not mention the 1.30pm check. The 3rd PCO detailed only the time that the man was found collapsed by both the 2nd and 4th PCOs at 1.38pm.

87. The PACS system also recorded that a check was made on the 1st prisoner in cell 6 at 1.30pm, and indicated that the 2nd PCO saw and spoke with him. In his police statement, the 1st prisoner said that after his court appearance at 12.00pm he returned to the cells area, fell asleep, and heard nothing else until he was woken by staff to move to another cell. The PACS system recorded the time he was moved to the female side of the custody area as 2.12pm. This account casts doubt on the PACS entry that the 1st prisoner was “spoken to” by the 2nd PCO at 1.30pm. The 1st prisoner indicated in his police statement that he was asleep at this time. The 2nd PCO told my investigators that, in such situations, he normally opens the cell and gets a response from the prisoner who appears asleep. If this did happen, it would have meant the 2nd PCO opening a cell alone, as no other PCOs were in the custody area. If the cell had not been unlocked, the check should have indicated that the 1st prisoner “appeared asleep” on the PER record and not that he was “spoken to”. If the 1st prisoner had been awake at 1.30pm, he would most surely have heard the ensuing shouts and commotion after the man was found collapsed a few minutes later and his police statement would have reflected this.
88. During the course of GSL’s own internal investigation, GSL’s contract manager interviewed the same members of staff, including the 1st, 2nd and 4th PCOs. In the 2nd PCO’s statement, made eight days after the man died, he said, “... on the next cell check, I remember speaking to him, but can’t remember what was said at approximately 13.30hrs.”
89. The 2nd PCO also said in his statement to GSL that the man was of no concern to him at 1.30pm, and that his next contact was at around 1.36pm when the man was found on the floor. The 2nd PCO said, “... at approx [sic] 13.36hrs I carried out a cell check on the man by opening the hatch and saw him lying face down on the cell floor.”
90. His statement to the police suggested that the only check he made after the lunch run at 12.23pm was the one recorded at 1.38pm on the PER. His statement flows straight from the lunch run to the check when the man was found collapsed. I find it difficult to understand why a crucial check, just seven or eight minutes before a man was found collapsed and not breathing, was not mentioned to the police. If it was the case at 1.30pm that the man was fine and well, the 2nd PCO would surely have told police when recounting events just a few hours later. However, during interview with my investigators, the 2nd PCO said that he only answered the questions the police put to him directly. During advance disclosure, G4S said that the police drafted the staff statements and then asked the PCOs to check them. When the custody staff were checking the statements, “they did so checking for accuracy rather than omission”.
91. The 2nd PCO was asked by my investigators whether he could remember where the man was in the cell at the 1.30pm check or how he had appeared. The 2nd PCO said he could not remember any details, just that the man had said he was okay. During discussions later on, the 2nd PCO made reference to that fact that he had ‘re-lived’ the events of that day many times in his head. It does therefore surprise me that the 2nd PCO was unable to recall any details

92. The 'check' at 1.30pm was of course recorded electronically, and the 3rd PCO said during interview that she would only have made that entry in response to being asked to do so by the 2nd PCO. But no other PCOs observed the checks, or were even present in the cells area. The other two prisoners do not mention being checked at 1.30pm in their statements to the police.
93. Rigor mortis⁵ is the stiffening of the body after death because of a loss of Adenosine Triphosphate (ATP) from the body's muscles. ATP is the substance that allows energy to flow to the muscles and help them work, and without this the muscles become stiff and inflexible. Rigor mortis begins throughout the body at the same time but the body's smaller muscles - such as those in the face, neck, arms and shoulders - are affected first. Rigor mortis normally appears within the body around two hours after death, with the facial and upper neck and shoulder muscles first to show its effects.
94. My investigator found other references to rigor mortis that indicated it can start as quickly as ten minutes after the person has died, but that one to two hours is more usual.
95. When the man was found collapsed and not breathing at 1.38pm, the 1st and 5th PCOs both described some degree of stiffness in the man's hands and fingers when they were attempting to resuscitate him. The 1st PCO described the man's hands as being "scrunched up" and "locked". The 5th PCO said his hands "were clenched". Although I am not medically qualified, I interpret these descriptions as indicating that rigor mortis had started to set in. This would lead to an estimate of the man's time of death as being at least before 1.30pm, and in all likelihood some considerable period beforehand.
96. The East of England Ambulance Service Patient Report Form was completed by a paramedic. It indicates that the paramedics were called at 1.41pm and arrived at 1.45pm. In the section of the form headed, "History / Mechanism of Injury", he has written, "Cardiac arrest. Last checked 1330. Found in cardiac arrest 1338. Patient had been found face down with blood from nose." The form goes on to show that the man was cold and cyanosed (a bluish colour of the skin due to insufficient oxygen in the blood) and that both his pupils were unreactive and dilated. The paramedic was unable to gain access to a vein in order to administer medication. In the comments section of the form, the paramedic wrote:
- "... ECG asystole [no electrical activity in the heart]. CPR continued ... patient in asystole throughout ... all ambulance staff agreed patient appeared to have been in cardiac arrest longer than told given his colour, marks to knees and rigidity of arms and legs."

⁵ Explore Forensics (UK) website

97. The report makes it clear that several medically trained professionals were all of the view that the man had been dead for longer than the court staff told them.
98. If the 1.30pm check was carried out by the 2nd PCO, then the man must have collapsed and stopped breathing at some point within the following eight minutes. A fall or falls heavy enough to cause considerable bruising to the face, elbows, knees and back must have made some noise on the hard cell floor, a noise that staff or prisoners just a few metres away would seem likely to have heard. There were only three prisoners in the cells area that day, one of whom was asleep, so there would have been only low levels of background noise. During interview with my investigators, the 2nd PCO thought he might have heard a “bang” whilst the 2nd prisoner was using the toilet, but the 4th PCO did not remember hearing anything. If this “bang” that the 2nd PCO might have heard was the man’s collapse, that would put the timing of the collapse between 1.36pm and 1.38pm. There would have been no time for rigor mortis to set in at all if this were the case. I am unconvinced that this was the sequence of events that afternoon.
99. During interview with my investigators, the 2nd PCO was asked several times whether he did carry out the 1.30pm check. Each time he replied that he did, but could not provide any detailed recollection.
100. During advance disclosure, G4S reviewed all of the evidence that my investigators had considered. I had made a recommendation that G4S carry out a disciplinary investigation into the circumstances surrounding the 1.30pm check. They responded by saying, “... The computerised custody records show the check was completed and data entered on the system. The 4th PCO has consistently confirmed the check was undertaken. The 3rd PCO has confirmed she would not have entered data on the PACS system to indicate a check had been undertaken if the 2nd PCO had not given her this information... It is likely that the 2nd PCO was coming back through the cell area door when he told the 3rd PCO that he had done the cell checks. The 3rd PCO simply cannot now recall”.
101. G4S did not accept that a disciplinary investigation into this matter was required. Primarily because of the evidence of the onset of rigor mortis, I remain of the view that, on the balance of probabilities, the 1.30pm check did not actually take place.

First Aid training

102. Paragraph 4.10.2 of the Operating Manual states that immediate first aid should be administered by staff who will be trained as certificated first aiders and who have their certification revised and training updated or refreshed on a three year cycle. The life support offered by the PCOs in response to the man’s collapse was commended by one of the paramedics. Administering life

103. From various statements made to the police and during interviews with my investigators, it was clear that not everything was at hand to respond immediately to the man's collapse. The 5th PCO had to leave the cell with the 4th PCO to obtain some items - a mouth piece, wipes and gloves. Staff could have been issued with little packs containing gloves, wipes and a resusci-aid. This could be attached to their belts and would ensure there was no delay, however short, in commencing resuscitation. I would therefore ask G4S to review the way that first aid equipment is stored at court and whether to issue small medi-packs to its staff.

G4S should review the storage of first aid equipment at courts and consider issuing small belt attached medi-packs to its staff.

Liaison with the man's family

104. The family was told of the man's death by the police. They were not offered assistance towards funeral expenses, nor the chance to visit the custody area in Peterborough Magistrates Court. They were not given details of a named contact for any questions they might have wanted to ask about the man's death. These are all issues that the Prison Service has developed detailed instructions and guidance about, transforming the way in which it liaises with bereaved relatives. They apply whenever a person dies in prison custody, whether by natural causes, accident or otherwise.
105. Even though deaths in court custody are rare, this being only the fourth such death I have investigated since April 2004, I judge that procedures should be put in place so that bereaved families are provided with appropriate information, assistance and support. In the previous death in court custody report that I referred to in paragraph 73, I asked PECS, who are responsible for custody suites, and HMCS, who are responsible for courts, to draw up an appropriate family liaison policy that reflects the good practice that the Prison Service has developed.
106. The response to that recommendation was accepted. The reply said, "Prisons have established procedures in line with PSO 2710 (Follow up to Death in Custody) and the mechanisms to support them, such as care teams. While it may not be possible to replicate these arrangements in the escort context, PECS will be seeking to develop a national family liaison policy to provide the necessary support. PECS intend to consider including this in the requirement when the contracts for the escort of prisoners and their management at court are re-tendered (in 2010)". I do not therefore repeat that recommendation here.

RECOMMENDATIONS

1. G4S managers should ensure that the minimum of two cell checks per hour are carried out by court custody staff in accordance with paragraph 4.1.11 of the Standard Operating Procedures.

G4S accepted this recommendation at draft consultation stage and said, "This is standard operating procedure as indicated in G4S Standard Operational Procedures Manual. G4S managers will monitor more closely in addition PEM will periodically test PERS to check compliance".

2. G4S should revise the local instructions given to staff working within Peterborough Magistrates Court and replicate key requirements from the Standard Operating Procedures so as to make them more accessible and user friendly for staff.

G4S accepted this recommendation at draft consultation stage and said, "Standard Operating Procedures (SOPs) are available to all G4S staff. G4S managers will raise with all staff the importance of adhering to SOP's and will be included in refresher training modules".

3. G4S should review the storage of first aid equipment at courts and consider issuing small belt attached medi-packs to its staff.

G4S accepted this recommendation at draft consultation stage and said, "G4S will review the current arrangements and consider issuing belt attached medi packs to its staff".