

**Investigation into the circumstances surrounding the
death of a man at the Crown Court
in December 2006**

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

October 2007

This is a report into the circumstances surrounding the death of a man in a Crown Court in December 2006. He had just been sentenced and therefore came within my terms of reference for investigation. The man was 43 years old when he apparently took his own life. I offer my sincere condolences to members of his family and all those touched by his passing.

The man had previously been convicted of the downloading of indecent images of children and was returning to the Crown Court for sentencing. Having been on bail, he was not known to any of the court staff.

Nor had he told his wife of the charge he had faced or his appearances in court. He had driven himself to court on the morning of his trial, and clearly did not expect a custodial sentence. In the event, he was sentenced to 18 months imprisonment and taken down to the cells at about 11.15am.

I have found no evidence that, in the two hours or so following his sentence, the man displayed any behaviour or gave any indication that he was at risk of suicide. He was checked regularly by staff and appeared 'OK'. However, at about 1.45pm he was found slumped behind the cell door with a ligature around his neck. Despite prolonged resuscitation efforts, staff and paramedics were unable to save him.

This investigation has been undertaken by my deputy ombudsman. I would like to thank the GSL Regional Manager for Court Services, the staff at the Crown Court and the Contract Manager (NOMS), for their co-operation and active participation in the investigation.

The circumstances of the man's death were sad and very unusual. However, I do not believe staff could have reasonably predicted his actions. On discovering the deceased, they acted quickly and appropriately.

I make no recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

October 2007

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SUMMARY

The man had been convicted of downloading indecent photographs of children and bailed to re-appear at the Crown Court for sentencing in December 2006. He drove himself to court that morning and parked his car in a nearby car park. He was not known to the court staff, and no information had been received to indicate he was at risk from suicide or self-harm.

Having been sentenced to 18 months imprisonment, the man arrived in the court cells at about 11.15am. He was seen by the custody officers and his solicitors before being located in cell 4. He was checked regularly over the next two hours.

At about 1.20pm, the man refused the offer of lunch. Twenty-five minutes later, he was checked again and found with a ligature around his neck attached to the door frame. Staff immediately entered the cell, removed the ligature and started to try and resuscitate him. An ambulance was called. Paramedics and staff continued with their resuscitation attempts until 2.25pm when he was pronounced dead.

Information received after his death strongly suggests that the man was not expecting to receive a custodial sentence. He had not told his wife of his conviction or his court appearance.

I make no recommendations following this investigation. Although the circumstances are sad and unusual, I judge that court staff acted promptly, professionally and appropriately at all times.

THE CROWN COURT

1. The Crown Court complex is owned and maintained by Her Majesty's Court Services. GSL Escort Services provide contract staff to deal with persons either brought from prison, responding to bail at court, or committed to custody from court.
2. The fabric of the court cells is the responsibility of the Crown Court. The mechanical locking systems are the responsibility of the local prison. The staff in the cell area are managed by GSL under a Service Level Agreement with HM Prison Service.
3. There are a total of eight cells in the Crown Court, six male and two female. They are all built for one person, but on occasions it is necessary for detained persons to share the accommodation. I understand this is kept to a minimum and risk assessed when necessary.
4. Information for detained persons is displayed in various languages and provides information about legal needs, visits, lay observers, medical matters and how to complain. GSL has also provided a leaflet called *What happens next?*
5. GSL escort staff receive an initial five week Home Office approved training course, followed by a minimum of a two week mentoring period.

KEY EVENTS

6. The man was born in 1963 and lived in the Bedford area.
7. The man had been convicted of downloading indecent photographs of children, and bailed to re-appear on 4 December 2006 at the Crown Court for sentencing. He travelled independently to court. He parked his car in a nearby car park before proceeding to the court. On arrival, like others answering bail, he would have presented himself to the court officers and waited in the public waiting area for his appearance.
8. At 10.45am, the man appeared before the judge in Court Room 3. He was sentenced to 18 months imprisonment and taken down to the cell area. On arrival in the court cells, the man was seen by the custody officers and basic information was obtained. He was also searched in accordance with agreed procedures. His mobile phone and car keys were removed from his possession and secured. (They would have gone with him when he transferred to prison later in the day.) After checking him in and completing the searching process, staff placed him in cell 4.
9. At 11.35am, his solicitor arrived for a legal visit. During their conversation, arrangements were made for the solicitor to take possession of the man's car keys and arrange for the car to be moved. It was also agreed that the man could have supervised access to his mobile phone to note down the numbers for taking into prison. On conclusion of his legal visit, the man returned to cell 4.
10. At 11.56am, the man was placed on the Operation Safeguard list, as all the prisons were full. At this stage it was not known where he would be taken. Normally he would have been allocated to the local prison but, due to overcrowding, prisoners have sometimes had to be located in police cells until prison places become available.
11. Over the next hour, the man was seen by the custody officers in his cell and noted to be 'OK'. At about 1.20pm, he was offered lunch but refused. At about 1.45pm, a Custody Officer attended a cell call bell in the cell area. One prisoner asked to use the toilet. Whilst Officer A waited for this prisoner to return to his cell, he decided to check on the others.
12. On checking cell 4, the Custody Officer could not initially see the man. As he looked closer, he saw him sitting with his back to the cell door with his legs stretched out in front of him. The officer banged on the cell door and called out the man's name, but got no response. He then raised the alarm and two Custody Officers, officers B and C ran to his assistance.
13. Officer B managed to push the door open and saw a ligature made from shoe laces which he immediately removed. Officer C and Officer B then began cardio pulmonary resuscitation (CPR). An ambulance was called and a paramedic arrived less than five minutes later. The paramedic took over the

resuscitation efforts assisted by by the two officers. Officer C was also in attendance, providing assistance as required.

14. An ambulance arrived at the cell area at approximately 1.55pm. The ambulance crew and paramedic continued to try to resuscitate the man for a further 30 minutes. The resuscitation was not successful and at 2.25pm the paramedic pronounced that the man had died. The doctor and Coroner were called, as were the police.
15. The police took control of the area and also arranged for their family liaison officer to break the news to the man's wife. At this point it emerged that the man's wife did not know that her husband had been convicted of any charge, much less that he was appearing in court for sentencing. I conclude that the man himself was not expecting to receive a custodial sentence.
16. Following the man's death, all relevant staff completed witness statements in accordance with GSL policy. A hot de-brief was held. Staff were also offered trauma counselling and support.

ISSUES

17. The man had arrived at court having been on bail. He was not known to any of the court staff, and no information had been received from any party to suggest that he was at risk of suicide or deliberate self-harm.
18. The Custody Officer that conducted the man's initial assessment gathered no information to suggest there were any risk factors.
19. If a Custody Officer is at all concerned about an individual's mental health or suicide risk, they remove any potential ligatures. This can be a fine balancing act between humanity, dignity and safety, and decisions can only be made using the available information at the time. The officer did not consider it necessary to remove the man's shoelaces. I consider this to have been an appropriate decision given the presenting circumstances at the time.
20. All the relevant staff have suicide and self-harm training and should be familiar with HM Prison Service processes and policy for suicide and self-harm. My deputy ombudsman was confident that, if there were obvious presenting risk factors, appropriate action would be taken to minimise risk and protect the detained person.
21. Apparently self-inflicted death in court cells is very rare. The death of this man was the first such death to be referred to my office since I became responsible for investigating the deaths of prisoners in April 2004. (There has been one subsequent death in court cells.)
22. It would appear that the man was not anticipating a custodial sentence for the offence of which he had previously been convicted. In retrospect, the nature of that conviction, and the prospect of a custodial penalty, might appear as risk factors. However, that is to use the benefit of hindsight. At the time, there was no reason for court staff to believe that the man was any more at risk than any other prisoner in their charge.
23. I judge that staff acted promptly, professionally and appropriately at all times.
24. The circumstances of the man's death are sad and unusual. However, I make no recommendations.