FINAL REPORT

ARTICLE TWO COMPLIANT INVESTIGATION

IN THE CASE OF 'DM'

September 2019

The young man at the heart of this report was found in the custody suite at Southampton Magistrates' Court in a state of collapse through self-strangulation. He suffered life-changing injury through hypoxia, which is lack of oxygen to the brain. After some four years in a nursing home and several periods in hospital, sadly, the young man died on 11 May 2019. I offer my condolences to his family for the heartache they have suffered.

To protect the privacy of the young man and his relatives, he is known in this report by the pseudonym 'DM'.

Barbara Stow
Lead investigator

COMMISSION AND TERMS OF REFERENCE

I am commissioned by the Secretary of State for Justice to conduct an investigation with the following terms of reference:

- to examine the management of DM by GEOAmey (the private contractor that provides escort services for Southampton Magistrates' Court) from being received into their custody until his life-threatening self-harm on 16 March 2015, and in light of the policies and procedures applicable to GEOAmey at the relevant time;

- to examine relevant health issues during the period spent in the custody of GEOAmey on 16 March 2015, including mental health assessments;

- to consider, within the operational context of HM Prison and Probation Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- to provide a draft and final report of my findings including the relevant supporting documents as annexes;

- to provide my views, as part of the draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State will take my views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

The Interested Parties to the investigation are:

DM, through his mother and Litigation Friend, represented by Ms Rika McMonnies, Peter Clarke, Solicitors, Southampton

The Ministry of Justice, through Mr Christopher Barnett-Page, Head of Safer Custody, Her Majesty's Prison and Probation Service (HMPPS)

GEOAmey, who are the contractors commissioned to provide the escort and custody service for the Southampton Magistrates' Court.

The investigators are:

Barbara Stow, Lead Investigator

Will Thurbin, Assistant Investigator

The clinical reviewer is Dr Jackie Craissati, Consultant Clinical and Forensic Psychologist.

I now present my report.

Barbara Stow
BA (Hons), MSt (Cantab) Applied Criminology and Management

September 2019

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THE STRUCTURE OF THE REPORT

Part One of the report contains:

- The reason for the investigation
- A note on the internal investigation by GEOAmey
- A note on a sufficient element of public scrutiny
- An executive summary of the investigation findings
- Conclusions and recommendations.

Part Two of the report contains a detailed account of the evidence we have considered and which is the basis for our conclusions and recommendations.

Annex

- A note of the procedure that the investigation has followed.

PART ONE:

THE REASON FOR THE INVESTIGATION

DM was arrested in a supermarket on the evening of Saturday 14 March 2015 and taken to Southampton Central police station. He was charged with theft of items to the value of £224 and common assault of two security officers who apprehended him. He was held in police custody over the weekend.

In the morning of Monday 16 March 2015, DM was collected by the escort and custody service for transport to the Magistrates' Court. He was visibly upset. He told a custody officer he was to lose his son and he wanted to kill himself that day. At the court, the officer completed a suicide and self-harm warning form. No special measures were identified on the form to keep DM safe.

DM was held in the custody suite until his case was heard at 10.00. At times he banged his head on the cell wall. He had a meeting with his solicitor, and custody officers spent time in his cell talking with him. In court, DM was sentenced to 12 weeks in prison. He was escorted back to the custody suite at 10.30 to wait for transport to Winchester prison. He asked to use the toilet. The cells officer escorted him there and stood at a discreet distance to wait for him to finish and to escort him to a cell.

While DM was in the toilet he had a brief shouted conversation with his solicitor, who was outside the cells area gate. The cells officer left his position, first to speak to the solicitor then to open the gate to admit an escort and another prisoner who also asked to use the toilet. The cells officer called to DM to ask if he had finished. There was no reply.

The other escort locked the new prisoner into his cell, then he and the cells officer went to the toilet area. They found that DM had made a ligature from a shoe lace and was hanging from a grille gate adjacent to the toilets. Escort officers called for help, removed the ligature, checked DM's condition, moved him from the corridor to the nearest cell, and placed him in the recovery position. An ambulance was called. Paramedics arrived and DM was taken to hospital, where his condition was critical and he was placed in intensive care. DM suffered severe life-changing injuries to his physical and mental condition as a result of hypoxia. He required 24-hour care in a nursing home.

In May 2019 DM died in hospital. An inquest has been opened which will investigate the circumstances of his death.

The present investigation was commissioned in 2017 as a result of the State's responsibilities under Article Two of the European Convention on Human Rights when someone suffers life-threatening or life-changing injuries while in the care or custody of the State.

The purpose of an investigation of this kind is to ensure as far as possible:

- that the full facts are brought to light
- that any culpable and discreditable conduct is brought to light
- that suspicion of deliberate wrongdoing (if unjustified) is allayed
- that dangerous practices and procedures are rectified
- and that those whose relative has been harmed may at least have the satisfaction that lessons learned may save others.

This report examines the circumstances in which DM's act of self-harm occurred and, importantly, what can be learned to prevent something similar happening in future. The report outlines:

- DM's history
- the events
- how the staff responded to the emergency
- the environment of the custody suite at Southampton Magistrates' Court
- a clinical review by a forensic psychologist
- the policies and procedures in place for escort and custody staff to identify and safeguard prisoners who are at risk of self-harm, and whether these were followed in DM's case
- evidence about the operation of the custody suite
- the wider context: whether what happened to DM is indicative of a wider problem, whether existing arrangements are adequate, and whether there are other practical measures which would reduce the risk of harm in court custody suites.

We make 15 recommendations.

THE INVESTIGATION BY GEOAMEY

GEOAmey, who are contracted by HMPPS to provide the escort and custody service at Southampton Magistrates' Court, conducted an investigation in the days after the event. We call this the internal investigation.

The internal investigation was led by GEOAmey's National Security and Investigations Manager. The evidence considered was attached to the investigation report, which was submitted to HMPPS on 15 April 2015. The investigation identified apparent breaches of company procedures, and some disciplinary enquiries followed. We are grateful to GEOAmey for providing access to documents from both the internal investigation and the disciplinary enquiries.

The internal investigation had the benefit of evidence provided by staff shortly after the event, when memories were still fresh. We have therefore attached importance to material compiled by the internal investigation in piecing together the sequence of events. But we have also sought some additional evidence from the staff present on the day, and third parties, explored some issues that we considered were not fully covered in the internal investigation, and we have focussed in particular on identifying underlying factors that may have contributed to what happened, and lessons that can be learned for future practice.

We are grateful to all the witnesses, many of whom no longer work in custody services, who agreed to attend for interview and to bring back to mind events from some three years before, which they had clearly found distressing.

NOTE ON A SUFFICIENT ELEMENT OF PUBLIC SCRUTINY

I am asked to provide my views as to what I consider to be an appropriate element of public scrutiny in all the circumstances of the case.

My objectives for the investigation have been:

- to bring to light, as far as is possible, the full facts that are relevant to the case;
- to find answers to the questions posed by DM's family;;
- to discover any shortcomings in systems, or in the conduct of individuals, that adversely affected DM's care
- to draw from what happened any lessons that may help to save other prisoners in future from suicide or catastrophic self-harm.

In conducting the investigation, I received full and prompt cooperation from all the Interested Parties. The majority of the custody staff who were working at the court on the day of DM's self-harm no longer work for GEOAmey. One former member of staff, who was centrally involved as the cells officer on the day, did not respond to my request to interview him, but his role was already well-documented and I do not think that the investigation has suffered in consequence. Where there are questions that I have been unable to answer, I believe that they have occurred because of the passage of time since the events and not through any wilful obstruction.

The report makes recommendations for changes that I hope will improve the care of people held in court custody. These recommendations will be considered by the Ministry of Justice and GEOAmey and their response will be published alongside this report.

There may be broader lesson to be drawn, too, from what we have learned of DM's history, of mental ill-health and substance abuse and their interaction with the criminal justice system.

It is for others to judge how far I have succeeded in meeting my objectives but, in my view, attention to the recommendations, and the publication of the report without delay once the inquest is concluded, will best serve to meet the proper requirement for public scrutiny by enabling those who have an interest in the care of people in custody, and a capacity to affect what happens there, to learn from what happened to DM.

EXECUTIVE SUMMARY

The events

1. DM had a history of substance abuse and self-harm. He was at times referred for mental health assessment but was not considered to have any enduring mental health condition. He hanged himself by a shoe lace from a grille gate in the custody suite at Southampton Magistrates' Court on 16 March 2015 when he was briefly left unsupervised during a toilet visit. He suffered substantial physical and mental impairment and required 24-hour care in a nursing home. Sadly, DM died on 11 May 2019. The Coroner is enquiring into the circumstances of DM's death and an inquest has been opened.

2. Before he was taken to the court, DM had spent two nights in police custody. He was taken to A and E by the police because of a suspected overdose of prescription drugs. This was not recorded in the Person Escort Record (PER) handed over by the police. The PER completed by the police recorded a risk of self-harm in general terms but gave no details of any events or assessments during the immediate period in police custody.

3. The escort service found DM visibly distressed. He told an escort officer that his son was to be taken away and he intended to commit suicide that day. At the custody suite the escort officer opened a suicide/self-harm warning form. There were no entries in the form about how DM was to be supported.

4. DM had a legal visit, then he was in a cell for about half an hour before going to court. Members of the custody staff spent time talking with him but there are no written records of this. At times DM banged his head on the cell wall. Some staff dismissed this as attention-seeking behaviour.

5. DM spoke of his distress about his son to his mother, to whom he spoke on the phone from the police station, and to his solicitor. Neither anticipated that he intended to take his life that day.

6. When he returned from court, DM was escorted to the toilet, from where he had a shouted conversation with his solicitor, who was outside the cells area gate. The cells officer was the only officer to carry a key to the cells area. After the solicitor left, the cells officer admitted another escort and prisoner into the cells area. The cells officer called to DM but he did not reply. He and his colleague

locked the other prisoner in a cell then hurried to the toilet. They found that DM had left the cubicle and attached a ligature to an adjacent gate.

7. Custody officers detached the ligature, checked and monitored DM's condition, and moved him into a cell. The officers say that DM continued to breathe, though in gasps. An ambulance was called, and attended within minutes, but some time could have been saved if the security gate to the courts complex had been told an ambulance was coming. The ambulance crew found DM in cardiac arrest. They used CPR, a defibrillator and oxygen. DM was taken to hospital in handcuffs. He suffered further cardiac arrest on the way.

8. There are some inconsistencies in the evidence. A member of the ambulance crew has been critical of the care provided by the custody staff and their attitude to DM. These inconsistencies are discussed.

Family liaison, hospital visits and use of restraints

9. In the absence of authority from a manager, escort officers at the hospital felt obliged to refuse to let DM's mother visit him in the Intensive Treatment Unit. The manager they consulted initially refused consent, but a clinician insisted, and a more senior manager later agreed that DM could receive one visitor at a time.

10. The investigation considers policies on the use of restraints, visits and family liaison. We recommend that a procedure should be in place to ensure that a senior manager takes charge of a serious incident and that PECS and the escort and custody contractors have in place a policy for family liaison, with a senior member of staff as family liaison lead. (PECS is responsible for commissioning and monitoring the escort and custody contracts.)

11. We note that family or friends may have information that will help to alert staff to a risk of self-harm. Official agencies need to ensure that adherence to data protection obligations to protect the privacy of prisoners does not prevent staff from being receptive to information that may be critical to prisoners' safety.

The clinical review

12. Records suggest that DM suffered from persistent and pervasive psychological difficulties, particularly in terms of his ability to manage stress. Medical records suggest a lack of curiosity on the part of services in seeking possible ways to support DM in achieving stability in his life.

13. The communication of risk by the police seems to have been limited.

14. DM appeared to have had a form of seizure on the escort van. The staff attended to him but their assumption that the seizure was fake was overly confident.

15. Some of the custody staff at the court did not appear to take the risk of self-harm seriously, on the basis that DM was familiar to many of them, and he had previously threatened to harm himself and had not done so, except to bang his head. There appeared to be no effort made to enquire further. Some staff assumed that DM was '*attention seeking'* and that therefore there was no risk of serious harm to self.

16. The Suicide and Self-harm warning form did not show any robust consideration of the options available to manage the risk. Some staff spent time talking with DM, but this was on an informal basis, not as part of a clear action plan. The review sets out the actions which would have been good practice.

17. The review comments that it would be helpful for there to be a Samaritans phone available in court cells for those in distress. Basic reading materials, such as magazines, may assist with distracting the prisoner in the short term.

18. Once DM was discovered, the staff appear to have acted promptly and appropriately, checking his airway was clear, that he was breathing and that there was a pulse. If any of the three elements are compromised, then CPR should be commenced. In DM's case, the staff assessed all three elements as present, and they placed him in the recovery position.

19. DM was moved into a nearby cell. It is not possible to determine, from the interview evidence, whether any problems occurred as he was moved that may have subsequently compromised his airway, breathing or circulation. When the ambulance staff arrived, DM was assessed as requiring CPR.

20. There was no portable telephone handset available in the custody area allowing the staff member on the phone to convey direct observations of DM to the emergency services operator. We understand that portable phones are now available.

21. The aftercare for staff was limited and variable. There should be guidelines for aftercare of staff involved in serious incidents immediately after the event, and at regular and fairly frequent intervals in response to individual need.

22. The Hampshire Liaison and Diversion Service now provides advice and support from a mental health practitioner in police stations and at court. This was not in operation at the time of DM's self-harm.

23. A new national Person Escort Record (PER) is currently being piloted which, provides more detailed guidance for staff, and highlights health and social care needs and risk of self-harm.

24. Court custody staff deal with large numbers of individual prisoners passing through for short periods of time. Many prisoners present with a range of behavioural problems or experience mental health difficulties. Identifying and assessing the risk of self-harm in such an environment is dependent upon a ***culture of curiosity and concern*** being promoted among custody staff. This requires leadership and training. A culture of curiosity and concern needs to be combined with the provision of simple procedures for ensuring that staff are supported to make simple enquiries, communicate concerns, and to keep basic records. Such procedures and routines help to counteract the risk of inadequate scrutiny or inaccurate assumptions being made by hard worked staff in a difficult environment.

25. We question whether sufficient attention is paid in the training of custody staff to developing skills in listening, exploring and responding to behaviours linked to instability of mental health, substance misuse, poor emotional self-control, threats to self and others, aggression, and poor cooperation.

26. The escort contractor's training module on mental health awareness appears to be unnecessarily focused on diagnoses and their indicators, rather than on responding to shared characteristics and the communication of distress. Closer working with local liaison and diversion teams may offer potential for increased skills development, and supervision and mentoring opportunities.

27. Traditional modes of training delivery could be supplemented by more creative learning opportunities including modelling behaviours, opportunities for reflective practice, learning lessons bulletins, and input from the local liaison and diversion teams.

The custody suite

28. The configuration of the custody suite is described. The grille gate to which DM attached a ligature was not locked at the time. This was a breach of the standard operating procedure on Pre-Custody Checks. Staff gave different explanations for the purpose of the gate and were uncertain whether it ought to have been locked. If the gate had been locked it would have been more difficult for DM to tie a ligature to it unobserved.

Non-compliance with policies and procedures

29. The escort officers who collected DM from the police station acted appropriately in accordance with standard operating procedures but there were substantial breaches of standard operating procedures once DM arrived at the court custody suite.

30. Entries in the escort records at court are sketchy, with no reference to the several visits that custody staff say they made to DM before he went to court, or that he was heard by several officers to be banging his head in the cell.

31. There are inconsistencies between the risks recorded on the PER and EPER (the handwritten and electronic person escort records).

32. An escort officer correctly recorded her concerns on the PER, and on a suicide and self-harm warning form, but no measures were recorded to keep DM safe, there were no records of observations, the form was not noted in the daily Occurrence book, and there is no evidence of a systematic briefing of staff.

33. There was no proper consideration of whether DM should share a cell.

34. There is no evidence that any consideration was given to removing DM's shoe laces or other items of clothing. We cannot be certain that proper consideration would have meant that the laces were removed or that, if they were, DM would not have devised another means of self-harm.

35. Contrary to the standard operating procedure, there is no evidence that the officer in charge informed the court of the suicide and self-harm warning form.

36. The standard operating procedure requires the opening of a warning form to be discussed with the prisoner. There is no evidence that this was done.

37. Procedures require that if a prisoner has mental health issues an assessment is made to determine whether they should be checked a minimum of six times an hour. DM was recorded as having a mental health risk. There is no evidence of any such assessment.

38. Procedures require that a prisoner for whom there is a suicide and self-harm warning form must be checked at irregular intervals a minimum of six times an hour, with a note of the interaction entered in the PER. DM was both the subject of a warning form and was reported to have mental health issues. In the half hour that DM was in a cell before he went to court, officers were with him for much of the time but none of the officers recorded this and there is no evidence that consideration was given to whether to seek medical advice when DM was banging his head.

39. In March 2015, there was no requirement for the cells officer to be equipped with a ligature knife. The knife had to be obtained from the office outside the cells area, and not all the staff on duty knew where to find it. By the time it was produced at the scene, an officer had managed to untie the ligature. As a result of DM's self-harm, the procedure was changed in April 2015 to require the cells officer to carry a ligature knife on their person. The procedure was changed again in June 2018 so that all officers now carry personally issued knives.

40. There was no explicit instruction until October 2015 that a prisoner outside their cell must be supervised by an officer in the immediate vicinity, who is in a communicable distance at all times and who must not be distracted.

41. The configuration of the cell block is challenging. Had the cells officer not left his post observing DM, all movements in and out of the cell block would have been stopped for the duration of DM's toilet visit. We recommend that PECS and GEOAmey review the number of custody officers required in the custody suite and how they are deployed.

Operations in the custody suite

42. We were told by witnesses that the custody suite was often short-staffed, that on occasion they would locate women prisoners in Cells 1 to 6 of the men's area, and sometimes they had to delay escorts to court. The local staff were supplemented by staff from the escort vans.

43. Health and safety reports repeatedly identified hazards in the cells and emphasised the safeguard provided by frequent irregular checks on prisoners identified as at risk of self-harm. Person Escort Records that we examined showed little evidence that such checks were made.

44. A report by the PECS Contract Delivery Manager in January 2015 is highly critical of the operations of the custody suite at that time, following the dismissal of a senior custody officer. The description of a lack of systems, oversight, and leadership corresponds with - and may explain - deficiencies that the investigation has identified in the operation of the custody suite on the day of DM's self-harm. The PECS report dates from January 2015, which suggests that these deficits were endemic at this time.

Keeping prisoners safe in custody suites

45. Across the whole population of prisoners in custody suites, the incidence of self-harm is low, but the consequences, as in this case, can be grave. Identifying those most at risk is challenging, and staff may become complacent. That is why it is necessary to have systems embedded in the management of the custody suite operations that are followed as a matter of routine.

46. The investigation examined the escort records for other prisoners in the custody suite on the same day as DM. These records indicate wholesale breaches of the requirements stipulated in the standard operating procedures for risk assessment, information sharing and safe custody.

47. The PERs we examined illustrate defects in the information in PERs received by the custody suite. They also show the prevalence of complex vulnerabilities in the population that passes through the custody service's care. We recognise that the custody team's task is challenging, but in the case of DM and the other prisoners in the custody suite whose escort records we examined, there was no indication of any risk assessment at all by the custody staff, and widespread non-compliance with the requirement for prisoners to be frequently checked.

48. Her Majesty's Inspectorate of Prisons (HMIP) has published Thematic Reviews on the Use of the Person Escort Record with Detainees at Risk of Self-harm (October 2012) and on Court Custody Suites (October 2015). The report on the PER found that it was often not used efficiently, and recommended multi-agency cooperation to improve the use of the PER. The Hampshire Constabulary says that in 2016 new policies, procedures and training achieved a significant

improvement in the quality of PERs completed by their police force. On a national basis, a multi-agency project is working on improvement to the PER. The investigation was invited to comment on a redesigned form that is currently being piloted.

49. HMIP's review of court custody suites was based on inspections of 97 courthouses. It did not include the Southampton Magistrates' Court. The review makes trenchant criticisms of the care and conditions in which persons in custody at court are often held. In particular, HMIP deplores a lack of effective risk assessment and calls court custody '*an accident waiting to happen*'. Many of the characteristics identified by HMIP correspond with those we have found in this investigation.

50. We make 15 recommendations.

CONCLUSIONS AND RECOMMENDATIONS

General observations

1. Safe and humane care for prisoners held in the courts requires effective relationships, between staff and prisoners, between colleagues, and between the agencies the custody suite serves. Above all it requires capable leadership.

2. Custody officers have serious responsibilities and a challenging task. They deserve leadership that is confident, competent and open-minded, with a knowledge and understanding of the purpose of procedures, and expectations that their team will comply. The senior custody officer role is crucial and, in turn, requires the active support, interest and engagement of his or her managers.

3. We recommend that the complement of staff required in the custody suite at Southampton Magistrates' Court, the way they are deployed and their access to technology (or manual record-keeping) should be reviewed, to ensure that it matches the requirements, including capacity for staff to engage appropriately and sufficiently with prisoners considered to be at risk, and to record the result. There is nothing more demoralising than being required - in theory - to comply with admirable procedures but not having the time or the tools to do so. On the other hand, it is not clear that, at least in 2015, staff were always deployed in the most efficient way.

4. The failure, according to the records, to provide appropriate risk assessment for any of the prisoners in the custody suite that day, is shocking. It is likely that insufficient numbers of staff played a part, or that staff were not deployed effectively.

5. In her clinical review, Dr Craissati speaks of the need for custody staff to have a culture of curiosity and concern in their interaction with the prisoners in their care. That requires effective leadership, and staff who feel valued, and are confident in their roles.

6. After DM's self-harm, his mother experienced the custody service as obstructive, defensive and aloof. That was not the intention of GEOAmey or the Prisoner Escort and Custody Service but there was no scheme in place for compassionate liaison with families.

7. The Thematic Report on court custody by the Inspectorate of Prisons describes the different priorities of the custody service and HM Courts and Tribunals Service, neither of which seemed to include the quality of care provided to prisoners. They also suggest that those who work in the courts often know little of what goes on in the cells. There are instances in this report that illustrate that separation: the apparent reluctance to work with the HMCTS health and safety officer; the failure to alert the HMCTS security gate to the incoming ambulance; the failure (contrary to the operating procedure) to pass on information about prisoners' vulnerability.

8. The Chair of the Bench said she regretted the demise of the Court Users' Group and that newly appointed magistrates were no longer required to visit the cells. We found some indications of co-operation: the court delivery manager now speaks with the senior custody officer each day; at a national level, the multi-agency work on the Person Escort Record is welcome. Custody staff have a responsibility for security. That should not be confused with a defensive mentality of secrecy. It is in the interests of court personnel, the custody staff and the care of prisoners that the courts and the custody staff should have an understanding of each other's work and the challenges they face.

9. Some of these matters are outside the scope of this investigation. Others require cultural change that we can only encourage. Within our remit we make 15 practical recommendations.

RECOMMENDATIONS

STAFFING AND ACCESS FOR RECORD-KEEPING

10. There need to be sufficient numbers of staff available in the custody suite to enable compliance with the requirements in standard operating procedures, including those for risk assessments for vulnerability and cell-sharing, engaging with prisoners at risk and making a note of those interactions, and supervising prisoners outside their cells.

11. Procedures and routines, with timely completion of basic records, help to counteract the risk of inadequate scrutiny or inaccurate assumptions being made by hard worked staff in a difficult environment. The staff need to be deployed efficiently and to have sufficient access to IT or manual record-keeping tools to meet the requirements in standard operating procedures.

Recommendation 1

We recommend that PECS and GEOAmey review the number of custody officers required in the Southampton Magistrates' Court custody suite and how they are deployed.

Recommendation 2

We recommend that PECS and GEOAmey review the access for staff in the custody suite at Southampton Magistrates' Court to update computerised or manual records to ensure it is sufficient to enable compliance with requirements.

FACILITIES IN THE CUSTODY SUITE

12. It is to the credit of the custody staff that at their own initiative some would bring magazines or newspapers to offer to prisoners for distraction while they wait in the cells. This should not be left to chance.

Recommendation 3

We recommend that there should be a requirement in place that some means of distraction should always be offered to prisoners in court custody suites.

Recommendation 4

We recommend that GEOAmey investigates the practicality of providing telephone access to the Samaritans for prisoners in the custody suite at Southampton Magistrates' Court.

FIRST RESPONSE IN AN EMERGENCY

Recommendation 5

13. We recommend that GEOAmey reviews the advice and training to staff to ensure that it is clear that a prisoner who is ill is not left unattended.

Recommendation 6

14. We recommend that consideration should be given to locating defibrillators accessible to court custody staff and ensuring that all staff are competent to recognise the circumstances when they should be used and to use them. (It may be practicable to provide defibrillators in conjunction with the courts – see Recommendation 15 below).

Recommendation 7

15. We recommend that a local contingency plan is put in place for the steps to be taken in the event of an emergency. This should include notification of court security staff when an ambulance has been called and that a member of staff able to report changes in the patient's condition and to act on advice needs to stay on the telephone to the emergency services.

LEADERSHIP IN SERIOUS INCIDENTS

Recommendation 8

We recommend that in conjunction with PECS, GEOAmey puts in place a procedure for a senior manager to be notified whenever a serious incident of illness or other harm occurs.

The designated senior manager should take immediate responsibility for

- ensuring that families are notified at the earliest opportunity,
- facilitating access for family members, and
- anticipating the need for decisions about restraints,

with due regard to access for medical procedures, the paramount requirement to preserve life, and an appropriate balance, based on risk assessment, between the claims of compassion and security.

FAMILY LIAISON

Recommendation 9

16. We recommend that in conjunction with PECS, GEOAmey develops a policy for family liaison, with a senior member of staff designated as family liaison lead and with training for that role.

Recommendation 10

17. We recommend that GEOAmey and HMPPS consider how friends and families of prisoners at risk can be encouraged and enabled to pass on any concerns about risk of self-harm. Protocols may be required as to how to reconcile requirements of privacy and requirements of safe custody that may be in conflict.

AFTERCARE FOR STAFF

18. When custody officers experience traumatic incidents, that should be acknowledged by managers. Staff should be offered appropriate support immediately and over an extended period, both for their welfare and to reduce the risk that their ability to work effectively will be impaired.

Recommendation 11

19. We recommend that GEOAmey puts in place express policy for aftercare for staff involved in a serious incident through immediate informal support from managers, and further recognition over a longer period, as well as access to independent counselling for staff who wish to use it.

MENTAL HEALTH AWARENESS AND SUPPORT

Recommendation 12

20. We recommend that GEOAmey review the staff training modules on mental health awareness and interpersonal skills in the light of Dr Craissati's advice in paragraphs 5.42 to 5.46, noting in particular her focus on behaviours likely to be encountered in a prisoner population, and in developing skills in listening, exploring, and responding to, complex issues and the communication of distress, in a busy and fast-moving environment.

Recommendation 13

21. We recommend that the managers responsible for the Southampton court custody suite work with the Hampshire Liaison and Diversion Service to ensure that the service is well understood by custody staff and used effectively.

THE PERSON ESCORT RECORD

Recommendation 14

22. We are aware that the project to improve the effectiveness of the Person Escort Record is a work in progress and that our observations may have been overtaken as the new form is piloted and developed. However, we invite the Project Group on the Person Escort Record to consider the defects in the use of the PER that we found in this investigation; to consider our comments on the pilot form, and in particular:

- the importance of entries about suicide or self-harm on the risk indicator page stating the nature and date of incidents giving rise to concern, and the source of the information considered to indicate a risk; and

- ensuring that there is clear guidance to staff about when an entry for suicide and self-harm on the risk indicator page should prompt completion of a warning form and/or the Red Flag page.

LIAISON WITH THE COURTS

Recommendation 15

23. We recommend that HMPPS and HMCTS review and report on their progress in implementing the recommendations on Court Custody made by the Inspectorate in 2015. We recommend specifically that:

- Automated external defibrillators should be provided in all courthouses, accessible to the custody and court staff, who should be instructed in their location and use (see also recommendation 6 above).

- HMCTS local managers should have access and a responsibility to visit court custody suites regularly to monitor conditions and resolve problems.

- HMPPS ensures that performance requirements for contractors, and contract monitoring, include measures focusing on treatment and conditions for those in custody, a requirement for regular liaison with HMCTS staff, and an understanding that HMCTS have a responsibility to monitor standards.

- that where magistrates wish to visit custody suites to see the conditions in which people appearing before the courts are held, HMCTS, HMPPS and the contractors facilitate this.

PART TWO: THE EVIDENCE CONSIDERED BY THE INVESTIGATION

CHAPTER ONE:

DM AND HIS HISTORY OF SELF-HARM

Who is DM?

1.1 DM was aged 34 in March 2015. As a boy, he attended a community school for children with special educational needs. DM's mother, Mrs M, told us that he had been involved in substance misuse since he was 16.

1.2 By 2015, DM had 30 convictions dating back to 1997. He spent several short spells in prison. Mrs M told us his offending was mainly acquisitive crime to feed his addictions. He smoked heroin and crack cocaine but never injected. He stopped using drugs while in prison but started drinking when he came out. In the community and in prison, at times he received drug treatment medication, for reduction or maintenance.

1.3 A pre-sentence report prepared in May 2012 said DM reported that he was expelled from mainstream school for fighting when he was 13. He had begun using cannabis at the age of 12, his drug use escalated, and he became addicted to crack cocaine. He reported that he was offered heroin whilst in prison and became addicted to poly-drug use, using heroin and crack cocaine daily. In 2012 he was experiencing a period of sobriety, accepted responsibility for his offending, regretted his actions and showed some victim empathy and remorse. A drug treatment centre confirmed that DM had provided negative drug screens for 18 months and was taking prescribed Suboxone, but they were not aware of his alcohol issues. According to the pre-sentence report, DM said he had started to consume alcohol heavily some 18 months previously when he stopped using Class A drugs, but he wanted to address his alcohol misuse. He was said to present as mentally unwell and with inadequate social/interpersonal skills, impulsive behaviour, inappropriate problem-solving strategies and difficulty understanding other people's point of view. Because of his poor mental health, it was thought he would have particular difficulty coping in custody.

1.4 DM's mother told us that, in 2014, DM spent a period as an in-patient in a psychiatric hospital but there was no continuity of care when he was discharged. In prison DM was at times referred for mental health assessment but was not considered to have any enduring mental health condition. His distress was

attributed to his substance misuse, and practical problems in his life. His mother said DM had a tendency to bang his head on the wall when he was not coping well with being in custody. On one occasion she had visited him in a police cell and found him banging his head.

1.5 In March 2015, DM was living mainly with his mother. She told us DM had a turbulent relationship with his girlfriend, and Social Services did not want him to stay with her. DM had been seeing a social worker on a regular basis. He had a son, who has now been adopted, and his girlfriend had a child from a previous relationship.

1.6 As a result of hypoxia (lack of oxygen to the brain) DM's physical functioning and capacity to communicate were severely limited and he had no independent mobility. His mother told the investigation he was highly susceptible to infection and that his condition was likely to be life-curtailing. He spent several spells in hospital and otherwise received 24-hour care in a nursing home until his death in May 2019.

DM's physical health

2011

1.7 At HMP Bullingdon prison in 2011, DM asked to wear his own clothes as he said he was allowed to at Winchester because of an allergy. The prison doctor recorded a diagnosis of *prurigo nodularis*, a skin condition that causes intense itching.

2012

1.8 In July 2012 at Winchester prison, a nurse attended when DM reported feeling dizzy and cold with uncontrollable shivering. DM stated he had experienced similar episodes previously which were going to be investigated before he came into custody. An ambulance was called, the episode lasted about 10 minutes but was then spontaneously resolved.

1.9 In August 2012 DM reported that he had woken up shaking all over and unable to communicate. He told a nurse he had suffered a head injury in April but had run away from the hospital when he was supposed to have a CT scan.

1.10 In October 2012 a nurse was called to the wing as DM was shaking and twitching. This continued for several minutes then DM said he felt fine. He said similar episodes happened about once a month, sometimes continuing for several hours.

1.11 There was a further episode of shaking and twitching on 10 November. DM was advised to have a CT scan after he was released on 21 November.

2013

1.12 When DM was admitted to Winchester prison in November 2013 it was noted that he was under the care of a GP and a community drug team. He was taking sodium valproate for epilepsy, and methadone, and mirtazapine. DM said he had a long-term skin condition and could usually only wear his own clothes.

DM'S history of self-harm

1.13 DM spent several periods in prison on remand or serving short sentences. Police and prison records show periods when he was identified as at risk of self-harm. Some of these records refer to instances witnessed by staff; others to what DM told them about what he had done in the past or how he felt at the time.

2009

1.14 DM was in Winchester prison for two months in 2009. A care plan drawn up by a drug treatment worker says DM spoke of past incidents of smashing his head on the wall and an overdose requiring a brief intervention.

2011

1.15 DM was admitted to Winchester prison in March 2011. He presented as very distressed and wanting to kill himself. A mental health nurse opened an ACCT plan. DM said he had tried to jump off a bridge two weeks previously and the police had brought his mother to come and talk to him.

1.16 When he was transferred to HMP Bullingdon prison in April 2011, DM told staff he had tried to kill himself by cutting in Portland YOI in 1998.

2012

1.17 In April 2012, DM cut his forearm with a razor blade. His girlfriend called the police, who took him to hospital. At the hospital, DM allegedly spat at a police officer and was arrested, but he absconded, then handed himself into the police and was remanded to Winchester prison.

1.18 On admission to prison, DM told prison staff he had made cuts to his wrist with a razor, requiring 14 sutures, and that he had smashed his head on the side of a police van as he '*wanted to be dead*'. He said he felt very low and had possible intentions of suicide that night or in the near future. An ACCT plan was opened, then closed on 11 May after three weeks, when detox medication was said to be working and DM feeling better physically.

1.19 The pre-sentence report prepared later in May 2012 (see paragraph 1.3 above) said DM was taking antidepressants and said he had attempted suicide by cutting his wrists and drinking a bottle of morphine when he ran away from hospital. He also said he had tried to hang himself in prison two days previously as he '*has had enough of life'*. The report highlighted a risk of suicide.

1.20 Shortly after the ACCT plan was closed, DM admitted breaking the spyglass in his cell. In a statement, he said he had asked to see the Senior Officer, as he had been advised, because he was depressed and feeling like cutting himself again, after being confined to his cell for three days, missing some meals and suffering from back pain. He said that if he had not broken the spyglass, he would have harmed himself instead.

1.21 On 1 June 2012, DM was transferred from Winchester to Guys Marsh prison, then on 26 June back to Winchester. An ACCT plan was opened again on 28 June. DM was said to have made a small cut to his arm after an argument with staff and throwing his meal down the landing. He said he used self-harm as a release, that he had once tried to hang himself in a Care and Separation Unit (prison segregation unit) and that he had cut his wrists numerous times. He said he had not had any help in the past and used drugs to control his distress. He was waiting to see the mental health team. Immediate concerns he reported were not being able to speak to his family having not been given his PIN credit to use the telephone, and problems with medication, especially antidepressants. The ACCT plan was closed on 15 July when DM no longer had thoughts of self-harm, was no longer on Basic regime (without privileges), and was to share a cell with a friend.

1.22 In July 2012, DM told a prison GP that several months before, he had attempted suicide by overdosing on morphine.

2013

1.23 DM was in Winchester prison for four weeks in December 2013. An OASys assessment says DM:

'informs me he tried to end his life last year by cutting his wrists and the previous OASys of 28 February 2013 states he has self-harmed in the past by banging his head against a wall when withdrawing from heroin.'

He was said to have disclosed no current thoughts of self-harm.

2014

1.24 DM's mother told us that in February 2014 DM was taken from police custody to a mental health centre as he was suicidal. She said he stayed there for some weeks but did not received good continuity of care afterwards.

1.25 On 17 April 2014, DM was taken from Lyndhurst police station to Southampton Magistrates' Court. The police recorded no special risks on the PER. Custody officers recorded that in the court custody suite DM banged his head on the cell door and cut himself. Custody officers cleaned the cut and maintained a constant watch. DM received a 20-week sentence suspended for 12 months and a 12-month curfew.

1.26 On 5 November 2014, DM's girlfriend called the police because he was climbing out of a window and threatening suicide. When a police officer attended to restrain him, DM was said to have assaulted the officer and was charged with that offence and taken into custody. He pleaded guilty and was ordered to pay £25 compensation. DM's solicitor says the court recognised the highly charged emotional circumstances of the situation; and that until then DM had been observing the terms of the suspended sentence, but from this point his mental health began to deteriorate and he started offending again.

2015

January 2015

1.27 On 7 January 2015, DM was taken from Southampton police station to Southampton Magistrates' Court charged with a public order offence. Risks recorded in the Person Escort Record of 7 January refer to warning signals from the Police National Computer and include:

'Suicide/self-harm cuts wrists/jumps off buildings/overdoses
Violence – on arrest in 2002
Concealed items – heroin and a lighter in 2011'
Alcohol and drug user suffers from fits.'

1.28 At the Magistrates' Court, DM was interviewed in the custody suite by the senior custody officer and a suicide and self-harm warning form was opened. He was remanded on charges of failing to answer bail, threatening behaviour and breach of a community order and was admitted to HMP Bullingdon.

1.29 At HMP Bullingdon, on 13 January, a drug and alcohol practitioner at HMP Bullingdon recorded:

'[DM] informed me he attempted suicide a 'couple of months' ago in the community and was under a mental health team … prior to coming in to custody due to making several attempts on his life. He showed me fresh scars on his wrists. Said he did not feel suicidal at present and that when he is feeling low he calls for a listener. I felt no need for ACCT currently. Am referring to [Mental Health In-reach Team].'

1.30 On 20 January DM was sentenced to four weeks in prison for the public order offence, and the suspended sentence was activated in part. The PER states that he was on an open ACCT. Because of time served on remand he was automatically released on 28 January.

<u>Summary and observations</u>

1.31 DM's offending history was associated with his substance misuse, which he said he used to control his distress. He served several terms in prison either on remand or for short sentences and said he was introduced to heroin in prison. In 2012/13 he engaged successfully with a drug treatment centre in the

community. With the aid of medication, he remained drug free for up to 18 months and for part of that time free of alcohol. He is said to have been an in-patient in a psychiatric hospital for some weeks in early 2014.

1.32 In 2011 a prison doctor noted that DM apparently suffered from a skin allergy. In 2012 there are reported brief unexplained episodes of uncontrollable shaking and twitching observed by prison healthcare staff. In 2015 he was taking prescribed medication to control epilepsy.

1.33 DM resorted to self-harm both in the community and in prison. There was considerable information in both prison and police records about episodes of self-harm. On two recorded occasions he was sentenced for offences against police officers who had been called to assist because he was engaged in, or threatening, self-harm. In April 2014, he was observed to have banged his head against the walls of a cell in the custody suite at Southampton Magistrates' Court sufficiently to draw blood, and he spoke at times of having banged his head in cells or police vans on other occasions. Police were called in November 2014 when DM apparently threatened to jump from a window. In January 2015, he was said to have fresh scars from cuts to his wrists. At Southampton Magistrates' Court a senior custody officer interviewed DM and opened a suicide and self-harm warning form.

CHAPTER TWO:

WHAT HAPPENED BEFORE DM WENT TO COURT

ARREST AND POLICE CUSTODY - SATURDAY 14 TO MONDAY 16 MARCH 2015

Saturday 14 March

2.1 DM was arrested in the evening of Saturday 14 March 2015 and taken to Southampton Central police station. On arrival, he was reported in the custody record to have a bump on his forehead from hitting his head on the side of the police van.

2.2 The police and prosecution papers say that when DM was arrested he was carrying a bottle, apparently of methadone prescribed in his own name. At the police station, DM claimed to have taken a large number of pills and at 20:53 he was taken to Southampton General Hospital. Before they arrived at the hospital, officers became suspicious that DM was swallowing unknown pills. A single pill was seized from him. At 21:30 an officer reported that DM threatened to take more pills that he had secreted internally.

2.3 DM remained at the hospital overnight. It is not clear from the medical records whether it was confirmed that he had taken pills.

Sunday 15 March

2.4 Back at the police station, on Sunday morning, DM asked for his girlfriend to be informed of his arrest. A risk assessment was completed, recording that DM said he suffered from epilepsy, had a cut to his head, his methadone was due and he was taking mirtazapine (an anti-depressant). The custody record says he was asked about self-harm and said he had harmed himself in the past but had no current thoughts of suicide. It was noted that DM was a methadone user so there were possible issues of withdrawal.

2.5 At 12:30 DM saw a nurse who told him that he could not be given methadone from the bottle he had been carrying as it was not sealed. He was offered 'Dfs' (dihydrocodeine) but declined. It was noted that he took medication for epilepsy but had not had a fit for a couple of years. The medical advice was for 30-minute checks and to encourage food and drink.

2.6 At 17:46 a healthcare professional was called to check DM for drugs withdrawal. At 18:46 DM buzzed the intercom and said he had hurt his head. There was blood on his head and in the cell. At 19:15 another healthcare review was requested as DM had again hit his head on the wall causing bleeding. He was said to be distressed at confinement. Self-harm risk was said to be '*medium*'.

2.7 DM was charged at 20:04. He was said to have been charged in a police cell due to his agitated behaviour in custody to that point.

2.8 At 21:35 a doctor gave DM methadone. Self-harm risk was then said to be '*low*'. The police arranged with DM's girlfriend for his clothes to be brought to the police station during the night.

Monday 16 March

2.9 According to a review dated 17 June 2015 by the Professional Standards Department of Hampshire Police, at 05:28 on Monday morning the custody sergeant requested a medical review as DM had head-butted the wall again. He was said to be very distressed. He said he had been off alcohol for five weeks with no support and had personal problems. Self-harm risk at this point was said to be '*high*'.

2.10 The investigation's copy of the custody record does not record this request for a medical review but says, without further detail, that at 05:10 DM was awake in his cell being seen by a nurse. The custody record entry for 06:22 notes DM's cut to his head and that he is a methadone user. It says risk to health and well-being is *'low'* and no risk of self-harm identified. A note says '*as he is being remanded*' DM cannot be referred to MENDOS, which was a mental health diversion and support service.[1]

2.11 DM spoke on the telephone with his mother, Mrs M, from 06:58, then with his girlfriend from 07:35 before being transferred to the custody of GEOAmey, the escort and custody service. (The investigation attempted to contact DM's

[1] MENDOS was the service offered by Southern Health NHS Trust and Southampton City Council, providing assessment and advice for those with mental health problems. MENDOS operated with two practitioners visiting police custody and the Southampton courts, from Monday to Friday working hours only. MENDOS staff were not available in the court on the Monday 16th during the morning hours that DM was detained there. (See also paragraph 5.16 of this report.)

girlfriend. We do not know whether she received our communications but we have not heard from her.)

2.12 Mrs M says she contacted the police sometime during the weekend to see if DM was in custody, but they would not confirm it. When DM telephoned her on Monday morning, he was upset at the thought of losing his son. He said he was going to hang himself and that he could not take any more. He asked her to look after his son. His mother tried to reassure him. She did not think DM would harm himself.

2.13 DM was also upset as he thought there would be no one at court to support him. His mother did get to the court but he had already gone up. She said his stepfather and his girlfriend were at the court during the hearing.

2.14 Mrs M said she did not contact the police station to tell them what DM had said to her as they were always unwilling to talk to her about DM because he was an adult.

MONDAY 16 MARCH 2015 - TRANSFER TO THE PRISONER ESCORT AND CUSTODY SERVICE

The Person Escort Record (PER) completed by the police

2.15 The Person Escort Record is a form in which the authorities who have custody of a detained person record information about the prisoner, risks to be taken into account, changes of circumstances and significant events. There is a paper form which is held and updated by the staff having custody. It is generally called the PER. A parallel electronic record (the EPER) is also maintained.

2.16 The front cover of the PER has a box in which the police are asked to indicate whether a care plan is enclosed. There is no entry on the front cover of DM's PER to indicate presence of a care plan. The risk indicator page completed by the police says that DM was charged with non-domestic burglary and common assault and that he had a previous custodial history with the police and in prison.

2.17 In the section of the risk indicator page for details of current and relevant risk there are entries for:

- Suicide/self-harm – DM was said to have banged his head on a van door in 2015 (it is not stated whether this was on a previous occasion or at the time of his current arrest)

- Concealing weapons or other items – DM was said to have concealed heroin and a lighter internally in 2009.

There is no evaluation of the level of risk of self-harm, which had apparently been recorded at a medical review in police custody 05:28 as high, then recorded in the police custody record at 06:22 as being low.

2.18 There were no identified risks for escape, violence or any other risk to other people.

2.19 Health risks identified were:

- Medical - drug addict
- Mental - panic attacks

2.20 There is no reference in the Person Escort Record to DM having been taken to hospital while he was in police custody that weekend. There are no recorded events while DM was detained at the police station. (The Hampshire Constabulary have commented on a draft of this report – see paragraphs 9.38 and 9.39.)

2.21 The EPER does not exactly correspond with the PER. It indicates risk types drugs, escape, medical, suicide, violence, and weapons.

What happened when the escorting staff collected DM from the police station?

2.22 Escorting staff working out of the Eastleigh vehicle base collected prisoners from Southampton police station for the magistrates' and crown courts. The escorts that morning were not regularly based in the southern area. Prison Custody Officers J and K and a third officer were usually based in GEOAmey's Manchester area. They were assigned a six-person vehicle. Officer J was the driver. Officer A and Officer B were usually based at GEOAmey's vehicle base in Nottinghamshire. They used a two-person vehicle, with Officer B driving.

2.23 At 08:01 DM was signed into the custody of the escort service. The 'receiving officer' was Prison Custody Officer B.

2.24 The escort handover page of the PER form indicates that DM did not have any prescribed medication but the box to indicate that prescribed medication is held by the escort has been initialled, seemingly by the police 'dispatching officer'. A medical assessment/care plan, the charge sheet and a property card are said to be enclosed. There are references for three sealed items of property or cash. No enclosures were included with the copy of the PER supplied to us by GEOAmey. We were told that the escort and custody service would not retain these but they would have been passed on to HMP Winchester, which became responsible for DM after he was sentenced. They were not among the documents held in Winchester's records for DM and we note that the reference to a care plan is not consistent with the front cover of the PER which did not indicate a care plan (see paragraph 2.16 above).

2.25 Custody officers K and B found DM tearful and upset when they collected him from his cell.

Prison Custody Officer K

2.26 In an interview on 23 March 2015 for GEOAmey's internal investigation, Officer K said he went to DM's cell, where he seemed to be having a telephone conversation through the intercom system. DM came out of his cell, upset and crying. Officer K asked him if he was OK. He replied he was *'sorry'* and '*It's not your fault*.' Officer K searched him and Officer B escorted him to the vehicle.

Prison Custody Officer B

2.27 Officer B was not interviewed for the internal investigation nor asked to make a written report. However, she gave the current investigation a written report she had prepared shortly after the incident in case it was required.

2.28 In this report, Officer B said that when she and her colleague were given their assignment at the vehicle base she was aware that one of the prisoners they were to collect, whom she now knew to be DM, had a suicide marker against his name. Officer B explained to the investigation that the Blackberry (hand-held computer) carried by the escorting officers contained summary information for the prisoners they were to carry.

2.29 When she collected the Person Escort Record from the Custody Desk Officer at the police station, Officer B turned the first page to locate any risk markers. On

the suicide line it said, '*banged head on van door 2015*'. She asked the police desk officer about this as they were already aware of a suicide marker. The police officer replied that DM had got upset when he was given a police blanket and had an allergic reaction, but when they gave him his own blanket he calmed down, he was now OK and had no suicide or self-harm thoughts. Officer B said she continued to fill in the PER form and signed for DM's property. When checking the property, she noticed it included a blanket.

2.30 Officer K offered to search DM for the two female officers. The cell door was opened, and it appeared DM was finishing a phone call. Officer B heard him say he was sorry. He ended the call and stepped out of the cell. He appeared very upset and was *'crying his eyes out'*. He was escorted to Cell 1 in the vehicle, which was directly behind the driver. Officer B and Officer K went to collect the other prisoner for the two-cell vehicle and meanwhile her colleague, Officer A, talked to DM.

2.31 Interviewed for the current investigation in December 2017, Officer B could not recall any medical assessment or care plan accompanying the PER and she did not know what the entry for this on the front sheet referred to. She recalled that there was always a doctor present when they called at Southampton police station in the mornings. She was confident that nothing travelled with DM except the PER and his bagged property. She did not recall anything having been said about DM having been in hospital while he was in police custody.

Prison Custody Officer A

2.32 In her written report prepared on 16 March 2015, Officer A says that on the police handover she and her colleague were told that DM banged his head on the van door because he was allergic to police blankets, but that he was now OK as he had his own. In her interview for the current investigation in December 2017, Officer A said they were told that when he was arrested DM wanted to bring his own blanket and the police wouldn't let him, but he was now OK as, the police said, '*his Mum's brought it in*'. She had noticed there was a blanket in his property bag so that seemed to confirm what the police had said.

2.33 Officer A's report says that DM came out of his cell crying and she asked him if he was OK. He replied that he was just upset and it was not her fault. While they waited for the second person for the vehicle, Officer A talked with DM. He asked for a cigarette. Officer A said she didn't smoke. DM told her his son had been taken from him. He spoke of the situation with his partner and told Officer

A he was going to kill himself. They discussed this. Officer A said *'that's not the answer'* and '*he'll be no help to his son if he's not here'*. They were talking calmly to each other.

2.34 Officer A was not interviewed for the internal investigation. In her interview for the current investigation, Officer A said the police in Hampshire would generally let the escorts see the medical sheets, but she did not recall anything about DM having been to hospital. The PER indicated that there was an accompanying medical assessment or care plan. Officer A said this might be an A4 sheet printed off a computer which might, for example, say whether he had received medication, but she could not say from memory whether she saw an attached sheet and, if there was an attachment, she would have expected the front sheet specifically to indicate this, not just for '*Yes'* to be circled against the line for Medical Assessment/Care Plan. The front sheet said '*No*' against prescribed medication.

2.35 Officer A told us that when they opened the cell door DM was talking to someone on the intercom and crying and sobbing. She said that the police in Southampton could enable prisoners to speak on the telephone from their cells through an intercom system.

2.36 While they waited for the second prisoner or their vehicle, Officer A talked to DM and asked him why he was so upset. He said his son had been taken away from him and was in the care of his girlfriend. He had been barred from seeing them both and just wanted to kill himself. He was expecting to go to prison for three months. Officer A had talked with him about thinking of the future and he calmed down, but he kept asking for a cigarette.

The journey to the court

Entries in the Person Escort Record (PER) and Electronic Person Escort Record (EPER)

2.37 The PER and EPER require staff to complete a running record of events during the period in custody. Vehicle officers' record departures and arrivals on a Blackberry and these entries are automatically transferred to the EPER. Other events are entered manually. All the entries on the PER are handwritten.

2.38 The electronic PER records that the escort vehicle left the police station at 08.40 and arrived at the court house at 08.49.

Prison Custody Officer A

2.39 In her report for the internal investigation, Officer A says that, as her colleague, Officer B, started the engine, they heard banging from Cell 1. The vehicle was stopped and both officers went into the back to speak to DM. They found him upright in his chair, asking the officers '*What's up?*' They told him to stop banging his head. He said he was just tapping his toe. He appeared fine, talking normally, looking through the glass at the officers, then talking to them for most of the way to court.

2.40 When they arrived at the court a six-cell vehicle was being unloaded so they had to wait. DM was talking to the officers, asking for a cigarette and wanting the other vehicle to hurry up, saying if he didn't get off the vehicle soon, he would fit. About 60 seconds later DM was slumped in his chair and his leg and arm were tapping. PCO A rang the court to inform them of their situation. After about 40 seconds DM sat upright in his chair and was talking about his medication. He showed no sign of discomfort and did not mention a fit. They were then able to go into the court cells and DM went straight on a legal visit. Officer A says she opened a suicide and self-harm warning form at the court as she could not find any forms on the vehicle.

Prison Custody Officer B

2.41 In her report, Officer B says that when they went to DM to ask him to stop banging his head, he insisted he was just putting his feet on the cell wall to tie his shoe laces. He demonstrated what he meant and Officer B was satisfied that could have been the noise. Also, she had noticed that, when they collected DM from the police station, he had a small scab on his forehead and the scab was still dry. They then drove to the court, which took about five minutes, and most of the way DM was talking to them.

2.42 At the court, Officer B explained to DM they would have to wait a few minutes for the other vehicle to unload. He said he needed to get off as he needed a cigarette. He then said he felt he was going to have a fit.

Prison Custody Officer K

2.43 In his interview on 25 March 2017, Officer K said that, as the prisoners in his vehicle were being admitted to the custody suite, he heard the buzzer for the vehicle dock and a conversation about a prisoner on the other vehicle having a

fit. He said he knew it was the two-cell vehicle that had followed them and he felt frustrated as he wanted to move his vehicle to allow the two-cell in but there seemed to be no urgency.

2.44 After a couple of minutes, he moved his vehicle to allow the two-cell vehicle in. He and Officer J were initially meant to be assisting at the Crown Court so he parked the vehicle and went to the Crown Court. However, they were then called to assist at the magistrates' court and he and Officer J went there, leaving their colleague at the Crown Court.

Suicide and self-harm warning records

2.45 Prison Custody Officer A wrote on the PER Record of Events that DM was

'*telling me he is going to kill himself today. Very distressed as his son's been taken away from him. Suicide/self-harm form commenced*.'

No time is stated for this entry but it appears before the entry recording arrival at the court. The PER says the escorts handed DM over to the custody suite at 08:50

2.46 An entry in the EPER timed at 08:45 says:

'[Self harm] Form opened due to concerns on the van delivering custody to court/custody started banging his head on cell wall/DP calms down after talking with staff/placed on intermittent watch.'

I do not know when this entry was made or the basis for the statement about intermittent watch, which is not recorded anywhere else.

Suicide and self-harm warning form

Prison Custody Officer A

2.47 In her written statements, Officer A says she was unable to complete a warning form before arriving at the court, as there were no forms on the van. In her home area forms were kept in a folder on the custody vans. At the court, she asked the custody officer working the computer for a form. Other custody officers asked why she wanted one and said that DM was a regular and '*does that all the time'.* Officer A signed the warning form at 09.10.

2.48 There is a series of check boxes on the form. Under nature of concern Officer A ticked

- statements of intent,
- seems very depressed and
- an act of self-harm since his arrest in that he had been banging his head on a door.

She did not tick the boxes for bizarre behaviour or other signs of mental disorder, signs of withdrawal from drugs/alcohol or reaction related to offence or the court proceedings.

2.49 She indicated history of self-harm between one and five years ago and wrote on the form that DM

'banged head on door on collection from the police station. He told me that he is going to kill himself today. Very distressed as he has had his son taken off him.'

2.50 Section 5 of the form is to record actions undertaken to ensure the prisoner's safety while in custody. There are check boxes for sharing a cell, frequency of observations, and other support such as a telephone call to family or the Samaritans, referral to a medical practitioner. There are no entries in this section of the form.

2.51 On the basis of practice in her home area, Ms A told us she would have expected that the warning form would have led to 10-minute checks and a cell-sharing risk assessment. She said she would have expected the court custody staff to complete the section about actions to ensure the prisoner's safety.

Prison Custody Officer B

2.52 Officer B told the current investigation that when they explained to the court staff that DM had said he wanted to commit suicide they said, '*We know him, he's always like that.'* They suggested it wasn't necessary for the escorts to open a warning form and that they would do it, but Officer A insisted, as DM had spoken to her about his intention. Officer A and Officer B asked for a form and the Acting Senior Custody Officer went to the filing cabinet but asked Officer A many times which the correct form was. It was as if the staff did not know what they were looking for.

2.53 From her experience, Officer B said she would have expected the Senior Custody Officer to have talked to DM, to put somebody else in with him, and to have a constant watch, to prevent him harming himself:

'What they should have done is they could have put an Officer on a Constant Watch with him, which would mean an Officer going in, sitting with him, talking to him, calming him down, preventing him from banging his head, or they could have put him in with another prisoner to … because then you can identify if he's gonna harm himself a lot quicker. And … to be honest, in my opinion they didn't know what to do with him.'

The Acting Senior Custody Officer (ASCO)

2.54 The Acting Senior Custody Officer did not make an individual written report on the day of DM's self-harm, but he prepared an overall 'incident report' for GEOAmey based on his own evidence and the reports by other staff.

2.55 In the incident report, ASCO states that: the suicide and self-harm warning form was opened because of risk markers for suicide and because Officer A was concerned about DM as he had been hitting his head on the cell wall while in transit; and that, as acting senior custody officer, he made sure all staff were made aware that DM was on a warning form.

2.56 In his interview for the internal investigation, ASCO said he remembered DM arriving and that they opened a warning form as they placed him in the cell because he was banging his head on the vehicle cell and also the wall of cell 12, to the effect that it left blood on the cell wall. The warning form was not noted on the white board where prisoners were listed along with any risk codes but ASCO said everyone was briefed and all the staff were aware of the warning form.

2.57 For the current investigation, we asked ASCO who should have completed Section 5 of the warning form. He thought this depended on the circumstances and that many different people could have filled it in. He said he had not considered it feasible for DM to share a cell as the person he had asked to go in with was a juvenile, and in any event other risk markers on the PER suggested he was not suitable to share. ASCO said he had not met DM before, and, as he had come straight from the police station not from prison, they were reliant on the limited information provided by the police.

2.58 We asked ASCO what precautions staff were expected to take if a prisoner was at risk of self-harm. ASCO said that most of the people coming from the police station had some sort of markers, for drugs, violence or suicide. If you had the staff, they should be watched every 10 minutes, if not more, and, if you had the staff, you could put an officer in with them on a rota. To decide what safeguards were needed you would look to see how long it was since the issues that were the basis of the risk. If it was based on something that happened 10 years ago you wouldn't sit in the cell with them all day when there could be someone in the next cell who'd come from the police station for the first time and might be vulnerable to self-harm.

BEFORE DM WENT TO COURT

2.59 The PER and EPER record that, at 08:52, on arrival at the custody suite, DM was given a drink, his property was received, he was searched, informed of his rights and placed in Cell 12; that he had a legal visit from 09:00 to 09:30; that he was searched at the end of the visit; and that he was taken to court at 10:05. Neither the PER nor the EPER record any other interactions with staff or any consideration of risk of self-harm or cell-sharing.

Acting Senior Custody Officer (ASCO)

2.60 In his interview for the internal investigation, ASCO said DM continued to bang his head and ASCO went to the cell to ask him what the matter was. DM replied, '*You don't understand*' and '*I am going to lose everything*'. He asked if he could have a cigarette and ASCO told him he could not smoke in the custody suite. He asked if he could share a cell, but this was not allowed *'because it was felt that there was no one else in the Custody Suite that was compatible with DM'*.

2.61 It is not clear from the interview or from the incident report at what point these conversations took place but on balance this seems to have been after the legal visit. ASCO says that after he spoke with DM, Prison Custody Officer C went into the cell and talked with DM and he seemed to calm down. ASCO says he went back to the cell and told DM he would get him up to court as quickly as he could.

2.62 ASCO was asked whether he considered putting DM on constant watch. ASCO said '*No*', because he had a legal visit at 09:00, he was in his cell to speak to him, and Officer C went to sit with DM until five minutes before he went to court.

Removing DM's shoe laces had not been considered because Officer C was sitting in the cell with him.

2.63 ASCO told the current investigation they had opened a form on DM because he was banging his head on the van. DM then started banging his head in the cell and there was a bit of blood. ASCO sat with him and DM explained he was not going to be able to see his kids. DM was crying, but they got him calmed down and got him a coffee. ASCO said he thought he had stayed in the cell with DM for about 10 minutes. He stopped banging his head, and ASCO told Officer F, who was the cells officer, to keep an eye on him.

2.64 ASCO said he told DM he could not share with another prisoner because he was off bail, and the Standard Operating Procedures (SOPs) say you can't put an unconvicted person in with a convicted person; and because of his risk markers; and because there was nobody in the cell block suitable for him to share with. He said DM asked to share with the person in a particular cell but that person was a juvenile out of prison and you can't put an adult in with a juvenile.

2.65 ASCO said he had not come across DM before. He commented that the police had not done a self-harm form. If ASCO had thought they needed medical advice about DM banging his head they could have got the number for a medical helpline from the Vehicle Base.

2.66 ASCO did not know whether DM knew that the staff had opened a warning form, or whether anyone had told his solicitor.

Prison Custody Office E

2.67 Officer E's written statement, prepared for the internal investigation on the day of DM's self-harm, describes what happened only from 10:45. In his interview for the internal investigation on 23 March 2015 Officer E says he came on duty at about 08:00 and was designated court/legal visits officer. He initially assisted the rest of the staff with opening and closing checks. He says that the staff who brought DM in said he had been banging his head on cell walls at the police station. Officer E says DM was well known to the custody staff and this was normal behaviour for him. He also used to say he was going to have an epileptic fit and needed to speak to someone, though Officer E could never recall him having a fit.

2.68 Officer E says DM was placed in a cell before the legal visit. He says he went to talk to him for five or ten minutes to calm him down. Officer E was uncertain when that was but believed it was before the legal visit. He recalled that DM was talking about losing visiting rights to his son and that he was not allowed to see him for about three years. Officer E then handcuffed DM and took him to his legal visit. He could not recall taking him back to his cell.

2.69 Officer E's interview for the internal investigation makes no reference to knowledge of a suicide and self-harm warning form. Officer E told the current investigation he could not remember whether he knew about the warning form but that made no difference to what he was doing in the cell as they knew it was a normal thing. He was aware DM was banging his head. But he also knew he was crying because he thought he might lose access to his son. Officer E said they got hold of DM's solicitor to come down quickly so they could get him into court early. We asked Officer E whether the custody team would have told the court about DM's mental state. Officer E said they would not tell the court anything like that – *'It's a bit too personal, as such. We would just say: 'We've got a problem prisoner. We would like to get him up.''*

2.70 We asked Officer E why both he and Officer C had escorted DM to court. Officer E said it was because he knew DM and, unfortunately, the same thing happened every time with DM: '*he wants to speak to someone, says he is going to have an epileptic fit and bangs his head on the wall.'* So Officer E would normally go in and try to talk him down and arrange to get him into court quickly.

Prison Custody Officer C

2.71 In her written report, Officer C said that when DM came back from his legal visit he began banging his head on the cell wall. The Acting Senior Custody Officer, and Officer F, the officer based in the cells area, spoke to him to try to calm him down. They then closed the cell door. DM continued to bang his head, so Officer C asked to be let into the cell to talk to him. They spoke for about 20 minutes, during which DM told Officer C there was a social services meeting arranged for 15:00 that day which he was upset about. Officer C's report does not mention the suicide and self-harm warning form.

2.72 In her interview for the internal investigation Officer C was asked whether staff were briefed about the warning form. She said that everyone knew about it so they must have been. She recalled that Officer F, who was the cells officer, and

Officer E, had both been to the cell to talk to DM. At first it seemed to work but then he started to bang his head again.

2.73 Officer C said that any time DM came into the custody suite she would make an effort to talk to him. He was known to bang his head on previous occasions. If anyone was upset, she would always go in and sit and talk to them. She had not found DM different that day from any other day. He had things on his mind about his children.

2.74 Shortly after 10:00 Officer C escorted DM to court with Officer E. On the way to court he had spoken about a social services meeting to take place that afternoon.

2.75 Officer C had no recollection of being told that DM had been taken to A and E by the police as he claimed to have taken an overdose. She said that if people have tried to take their own life, they would aim to monitor them more closely.

Prison Custody Officer F – the cells officer

2.76 Officer F was designated cells officer. He was based in the secure cells area, for which he carried keys. In a written statement required by GEOAmey he said the cells officer's duties were to ensure prisoners' safety and security, dispense drinks and food, and arrange legal visits, court visits and toilet breaks. Officer F said he would unlock the gate between the cell complex and reception and another officer would accompany the prisoner to the interview room or the court.

2.77 In his report for the internal investigation on 16 March 2015, Officer F says that he took over responsibility as cells officer at 09:20 and was informed by both Officer C and Officer A that DM had been banging his head against the walls of the police station cell, resulting in a bloody graze on his forehead. Officer F says he knew DM from previous dealings and that banging his head was '*a normal practice to gain attention*'. He said he was shown a copy of the '2052' opened by Officer A and then entered the cell block and spoke to DM. ('2052' is the reference number of a suicide and self-harm prevention document formerly in use in the prison service.)

2.78 In his interview for the internal investigation Officer F says that he signed for the cell keys and went into the cell area. He had already been briefed that DM was banging his head and he went to speak to him. He asked DM if he was OK. DM

said he could not go to prison and was worried about his son. At the time, Officer F thought DM meant his son had died, but a colleague told him that the issue was that he was to be denied access. Officer F spoke to Officer A and Officer C about raising a warning form and Officer A showed him the PER and the form already raised. DM then buzzed his cell bell, and Officer F went back to the cell.

2.79 DM asked to share a cell and have a cigarette. At this point the Acting Senior Officer came into the cell and explained that neither could be permitted but he would try to get him into court as soon as possible. ASCO went back to the office. Officer F remained in the cell area and let Officer C into the cell to talk to DM.

2.80 Officer F says Officer C then took DM for a legal visit. This seems unlikely from the sequence of events related by the PER and others. Since DM was on a legal visit until 09:30, it seems likely that Officer F's conversations with DM before he went to court all took place after 09.30. This is confirmed by a statement made later by Officer F. In this, he says that Officer C still had the keys when DM came back from his legal visit. Officer C let DM in, then Officer F took over the keys. He heard DM shouting for someone to come and see him. Officer F went into his cell. DM said he could not go to prison and was going to smash his head on the wall if he had to go to prison. He asked for a cigarette and to share a cell. He said he had lost his son. At the time, Officer F thought he meant his son had died but he learned later it was a custody issue.

2.81 After talking to DM, Officer F went to the window of the custody suite office. He did not know if DM was on a self-harm warning form. One of the escorts said she had opened it. Officer F asked if anyone thought of putting DM on constant watch. Every time he opened the door then closed it, DM would start banging his head against the wall. He had done this before at the magistrates' court.

Prison Custody Officer A

2.82 Officer A was asked to write a report on the day of DM's self-harm but she was not interviewed for the internal investigation. Speaking to her manager a few days after the event she remembered additional information and wrote a further report which she provided to the current investigation and referred to during her interview.

2.83 In this report, Officer A recalled that before leaving the court she stayed for a cup of tea. DM returned from his legal visit and was put in a cell. After a few minutes, he began banging. The cells officer went to speak to him and while the officer was in the cell DM stopped banging. The cells officer then came to the office and told the ASCO DM was banging his head because he wanted a cigarette and to be put in with someone else. During this time, he began banging again. The cells officer went back to speak to DM again.

2.84 Officer A and her colleague, Officer B, with whom she was seconded from the East Midlands, mentioned to the ASCO that he could justify putting DM in with someone else as he was on a suicide/self-harm form. That was when the phone call came through for them to go elsewhere. They said to the ASCO that if he couldn't release them he could let the Base know and they would stay, but he said another crew was on its way and told them to do as they were told and to leave.

2.85 Officer A told the current investigation that they heard DM banging his head in the cell because he wanted a cigarette and he wanted someone to talk to. She and Officer B asked if he could be put in with someone else but was told '*we don't do that here'* and nothing more was said. Because they were '*foreigners*' they didn't like to interfere. An officer did go in and talk to him but it didn't calm him down. Officer A was not sure when they left the court but thought it would be between 09:30 and 09:40.

Prison Custody Officer B

2.86 In the written report that Officer B gave to the current investigation (see paragraph 2.27 above), she said that she and her colleague asked the Acting Senior Custody Officer for keys and were told to get a cup of tea first. She and Officer A were in the office and could hear a banging sound from DM's cell. She remembered seeing the cells officer standing with the cell door open some of the time but not all the time and the Acting SCO there some of the time but not all the time. The cells officer said DM wanted to go in with someone else and both Officer B and Officer A said it would be a good idea and justifiable because of the warning form. The phone rang and they were told to pull out.

2.87 Officer B told the current investigation that while the Acting Senior Custody Officer was looking for a warning form in the filing cabinet, they could hear DM banging in his cell. The ASCO said DM wanted to go in with someone else. Officer B and Officer A told him he could justify this because of the warning

form. They were then told there was a phone call and they had to go to Portsmouth and another crew would be coming. Officer B said that in her home area a senior custody officer would not let them leave in a situation like that until another crew arrived. Officer B said that when they left, *'It didn't feel like the staff were looking after him right but felt as if they didn't want them there interfering. The ASCO was quite abrupt and told us to get on our wa*y.'

Prison Custody Officer J

2.88 Officer J was one of the officers seconded from Manchester who collected prisoners from the police station in the six-cell vehicle. Officer J's written report on 16 March 2015 described events only after 10:35. It makes no reference to knowledge of a suicide/self-harm warning form. In a later statement and interviews, Officer J said she was allocated to assist in taking people up to court so was not involved in cell allocation. At about 09:45 she heard a banging noise and asked the staff about it. She was told it was a prisoner in Cell 12 banging his head but did not know at the time it was DM. Officers went to speak to him and Officer C sat in the cell with him. Officer J said she knew that the escorting staff had opened a warning form for DM because '*he had told his Mum that morning he would do something*'. (Officer J would have learned only later at the hospital what DM had said to his mother in the telephone call he made from the police cell.)

Prison Custody Officer K

2.89 Officer K's written report on 16 March 2015 described events only after 10:40. It makes no reference to a self-harm warning form. In his interview for the internal investigation, Officer K said that the three officers from Manchester were initially meant to be assisting at the Crown Court so, after delivering their prisoners, he took the vehicle to the Crown Court. They were then called to go back and assist at the magistrates' court so he and Officer J returned there sometime before 09:30. He was asked to do visits duties and took a prisoner to a legal visit.

2.90 At some point in the morning Officer K heard banging from the cells but did not know it was DM. At another time he walked past DM's cell and saw the cell door was open, there was blood on the walls, a graze on DM's head and Officer C was with him. Replying to a question, Officer K said he knew that DM was on a suicide and self-harm warning form and that the escorting officers, Officer A and Officer B, had opened it due to him banging his head.

DM's solicitor

2.91 The legal visit recorded in the PER as being from approximately 09:00 to 09:30 was with DM's solicitor who had acted for him numerous times over several years.

2.92 In a statement dated 10 March 2016, the solicitor said DM had a history of mental health problems. He was well-known for self-harming and had threatened suicide on numerous occasions. The solicitor was notified DM would be in Court that morning as the police were not giving bail. When he saw DM in the custody suite he was threatening suicide. He was fed up with going in and out of prison and with his alcohol problem and said enough was enough. He was particularly upset about the prospect of a custodial sentence.

2.93 The solicitor recalled DM had a head wound where he had been banging his head. DM also dwelt on difficulties in his relationship and was placing too much emphasis on a social services meeting about custody of his son that was to take place the following day. DM was extremely anxious that if he was sentenced to custody he would miss the meeting and never see his son again. The solicitor tried to calm his fears, advising him this was unlikely and that he would probably be out of prison in six to eight weeks and be able to attend further meetings. DM seemed to calm down and accept the situation and by the time the solicitor went up to court DM appeared a little more quiescent. The solicitor said the detention officers had been pleased to see him that morning. He formed the impression they did not want DM to be there longer than necessary given his self-harming and the fact he was '*quite clearly, at that point, unbalanced.'* The solicitor believed they were fully aware of DM's propensity for self-harm and in the normal course of things DM was sometimes quite *'dramatic'* and expressive about how hopeless his life was and how he would harm himself.

2.94 The investigation understood that DM's solicitor had not brought any specific concerns about DM's state of mind to the attention of the custody officers and we asked him about this. The solicitor said that the prison staff knew DM well. He knew from the staff, when he first came down to the custody suite, that DM

'had made what were, in truth, the usual suicide comments … which I believe may have been mentioned to me by staff. Sadly, I saw nothing new to report that they could not already have known.' The solicitor said the detention staff were fully aware of DM's history and his state of mind at that time. DM was always very vocal and not less so that morning.

CHAPTER THREE:

AFTER DM CAME BACK FROM THE COURT UNTIL HE WAS TAKEN TO HOSPITAL

3.1 The PER and EPER record that at 10:32 DM returned to the custody suite having been sentenced to 12 weeks, that an ambulance was called at 10:50 and arrived at 11:00, that paramedics gave medical attention to DM in a cell and they left to take DM to hospital at 11:20.

WHEN DM RETURNED TO THE CUSTODY SUITE

Prison Custody Officer C

3.2 In her report, Officer C said that she and Officer E brought DM back to the cell block. He was asking how long he would have to serve in custody and Officer C told him six weeks. At this point DM asked to use the toilet, and Officer C left DM with the cells officer, Officer F, whilst she escorted another prisoner to court 3. That prisoner (Prisoner 6) was discharged by the court and she brought him back to the cell block to organise his property and release. The escort records for Prisoner 6 say that he was escorted to the court by Officers C and Officer K at 10:33, returned at 10:45, and was released at 10:47.

3.3 In her interview for the internal investigation, Officer C said DM did not seem overly upset about his sentence. He asked if he would be going to Winchester prison. Officer C said she didn't know, as it was often full. The cells officer said the toilet was free, and Officer C left to take the next prisoner to court.

Acting Senior Custody Officer (ASCO)

3.4 In his interview for the internal investigation, ASCO said that DM seemed quite calm when he came back from court. In contrast with the statements by other members of staff, ASCO said DM went into his cell for four or five minutes before being taken to the toilet by the cells officer. However, in his interview for the current investigation he corrected this and said that DM was taken directly to the toilet.

Prison Custody Officer E

3.5 In his interview for the internal investigation, Officer E said that on the way out of the court DM said something to his girlfriend. He could not recall what, but thought it was nothing negative. (The investigation tried to contact DM's girlfriend to invite her to contribute to the investigation but we do not know whether she received our communications and we have not heard from her.) On the way back to the custody suite DM was positive about having only six weeks' time to serve. He was then placed in his cell.

3.6 In an undated statement, Officer E said there were tears in the dock during the hearing, but this was not unusual behaviour for DM. He had a pleasant exchange with his girlfriend on the way out of court. There was nothing to concern the staff. He was smiling and happy.

3.7 In his interview for the current investigation, we asked Officer E whether it was in his mind that there were any special precautions to be taken as a safeguard for DM when he came back from court. Officer E replied,

'*Nothing more than DM would normally require, which was just calming him down and going in now and again to have a chat with him. With DM, the usual practice would be to get him to court as soon as possible then if he was to go to prison then to go and see him a couple of times and get him on the first bus to prison.'*

Officer E said that on this occasion when he came down from court DM was happy and positive. They spoke about his son and the fact he would have only six weeks in prison. He was definitely more upbeat than he had been before.

DM's solicitor

3.8 In a statement prepared on 10 March 2016, DM's solicitor said he went downstairs after the hearing as he knew DM had not wanted a custodial sentence. He was in a hurry because of commitments elsewhere that needed attention. He went down through the visiting cell block into the area adjacent to the office and was expecting to see DM in his cell. However, he was told DM was to be taken to the toilet. He called out to ask DM if he needed to see him and if he was all right. DM said he didn't need to see him and was fine. The solicitor apologised for having to leave, then left. He had not seen DM, but he had sounded OK, though he recognised that clearly proved not to be the case.

Prison Custody Officer F – the cells officer

3.9 In his written report for the internal investigation, Officer F says DM returned from court at about 10:30 and asked for a toilet visit, saying he was unwell and had already been to the toilet several times that morning. Officer F says he led DM to cell 1 then watched him go down the corridor (past Cells 1 to 6) to the toilets.

3.10 DM's solicitor came to the gate and asked if he could see DM. Officer F called down to DM to tell him his solicitor was here. DM said that he had diarrhoea and would be a while. Officer F relayed this to the solicitor and the solicitor and DM '*chatted for several minutes across the cell block, finally checking that DM was OK before leaving'*. Officer F said he walked back to Cell 1 to check that DM was indeed OK and had understood the solicitor's message, then walked back to the gate to the cells to let in Officer E with Prisoner 1.

3.11 In his interview for the internal investigation on 24 March 2015, Officer F was asked what provisions were put in place when DM returned from court. He said that they never got that far as he asked to go to the toilet straightaway and there was no time to judge his frame of mind. He seemed fine when his solicitor spoke to him.

3.12 Officer F said that he escorted DM to the left-hand toilet. He then went to the bottom of the corridor and stood by Cell 1 so he could observe DM. Some minutes later the solicitor came to the gate leading into the custody suite to see DM. Officer F informed Officer E, who was standing by the solicitor, that DM would be about 10 minutes as he was in the toilet. At this point, DM and the solicitor struck up a conversation which lasted only a couple of minutes. Officer E then escorted the solicitor back to the visits area.

Officer F said he walked back to Cell 1 and shouted to DM to see if he had understood what the solicitor had said. DM shouted that he had understood. Officer F said he *'could not see DM however I was satisfied that all was well as I could hear him talking to me.*'

3.13 Officer F then went back to the gate to admit Officer E and Prisoner 1. He watched Officer E put Prisoner 1 in his cell, but Prisoner 1 wanted to use the toilet. Officer E told him he would have to wait, as someone was already using

the toilet. They then put Prisoner 1 in his cell. This process would have taken no more than a couple of minutes.

3.14 At this point Officer E and Officer F went back to Cell 1 and Officer F called to DM but there was no response. They then went down the corridor, again calling to DM but getting no response. When they got to the toilet, they could see DM was not there and they saw him to the left, hanging from a grille gate. Officer E went to his left and Officer F to his right to support DM's weight. They called for assistance and Officers J and Officer K came to assist.

3.15 Officer F believed that DM must have come out of the toilet and tied the ligature between the times he spoke to him just after the solicitor had left and when they discovered him. He said there was probably a couple of minutes when he did not have sight of him.

3.16 Officer F was asked whether he could see DM from the bottom of the cell corridor by Cell 1. Officer F said he could not see him but knew he was OK because he was communicating with his solicitor.

3.17 Officer F was required by GEOAmey to make statements or to be interviewed on a number of occasions. At two disciplinary meetings in October 2015, but not in previous statements or interviews, Officer F is reported to have said that before going to the gate to let Officer E and Prisoner 1 into the cell area he went back to his position by Cell 1 and was able to see DM in the toilet cubicle.

3.18 In a further meeting on 6 November 2015, Officer F was challenged about his claim to have seen DM in the toilet after the solicitor left. Officer F said that it was a mistake and not a deliberate attempt to mislead. He said it was what he remembered at the time, but several months had passed since the events, he had been on sick leave for four months and had other personal problems. On 22 October he had relied on what he had said on 1 October.

3.19 In the meeting on 6 November 2015, Officer F is reported to have said that he stood by the gate while the solicitor spoke to DM to ensure that the solicitor could hear him. Officer F confirmed that DM replied to him immediately after the solicitor left and said that before going to let in Officer E and Prisoner 1 he looked to see that DM had not come out of the toilet. From outside Cell 1 you could see both toilet doors but not the grille gate.

3.20 After they had locked Prisoner 1 in his cell and walked down the corridor, Officer F and Officer E could see DM at the grille gate when they reached Cell 5, which was one cell before the last cell in the corridor.

Prison Custody Officer E

3.21 In his interview for the internal investigation, Officer E said he was aware that DM was talking to his solicitor while using the toilet. Officer E followed DM's solicitor around to the legal visits area, as he was going to bring another prisoner back from a legal visit. He said he did not know who let DM's solicitor out of the custody suite.

3.22 Officer E told the current investigation he stood beside DM's solicitor while he spoke to DM from outside the cell area gate, then escorted the solicitor to where he could buzz to be let out of the custody suite. Officer E said he did not hear DM speak again once he had left with the solicitor. There is a book in which visitors should sign in and out of the custody suite. This is in the lobby to the custody suite and is not supervised. Neither of DM's solicitor's visits that day were entered in the book so it is not possible to verify exactly when he arrived and left.

3.23 While Officer E was in the legal visits area, the buzzer went to indicate that another legal visit had finished so he went and handcuffed Prisoner 1 and took him back to the cell block where Officer F let them in. Prisoner 1 asked to go to the toilet. Officer E asked Officer F if DM had finished but Officer F said DM was still using it. Officer F shouted to DM twice to ask if he had finished and there was no reply. Officer E advised Officer F to wait until he had locked Prisoner 1 in cell No. 8. He then joined Officer F, who was by the window, and they went towards the toilets together. They saw DM hanging from the grille gate beside the toilet. Officer E believed both grille gates were open. The two officers supported DM's weight. Officer E was talking to DM and they shouted for help and for the ligature knife.

THE STAFF'S RESPONSE TO THE EMERGENCY

Prison Custody Officer H

3.24 Officer H was one of the regular custody officers based at Southampton. In his written report, Officer H said that at about 10:45 he heard Officer F shout from within the cells male side. He ran into the office to get keys, then back to the

gate, which he unlocked. Other officers had joined him and proceeded to the male cell toilets. Officer H heard someone shout for a ligature knife and he ran back to the office to get it then returned to the cell block and gave the knife to Officer J. Officer E, Officer F and Officer K were working in the small area outside Cell 6 so, having handed over the knife, Officer H returned to the main cell gate and locked it. Paramedics arrived within minutes.

3.25 In an undated statement, Officer H explained that the cells officer held one set of keys. A second set was kept securely elsewhere. He obtained the second set and opened the gate. Officer K and Officer J entered the cell area.

Prison Custody Officer K

3.26 According to his escort record, Prisoner 6 was escorted to court at 10:33 by Officer C and Officer K and returned at 10:45 to be discharged at 10:47.

3.27 In his written report, Officer K said that about 10:40 he heard shouts for help from the custody area. He ran down to the area with Officer J to find the cells officer, Officer F, holding DM, who had tied a shoe lace around his neck and to a gate. Whilst Officer J ran back for a ligature knife, Officer K managed to untie the shoe lace from around the gate and DM's neck. DM was then laid down. He was unconscious but had a pulse and was breathing. He was placed in the recovery position.

3.28 In his interview for the internal investigation, Officer K said he was sitting in the office when he heard shouts for help. He ran round to the gate to the cells area but it was locked. An officer opened it and he ran towards the shouting in the toilet area where he found Officer F holding DM up and shouting for the knife. Officer J ran back for the knife but meanwhile Officer K was able to untie the lace from the gate and they lowered DM to the floor. The lace seemed to come away from his neck. Officer K did not need to unpick a knot.

3.29 Someone said to get DM into a cell and they manoeuvred him into a cell a few feet away. He was placed on his back in the cell. He had a pulse and was breathing, though in strained gasps. Officer K checked his airways and felt a pulse in his neck and his heartbeat. They placed DM in the recovery position. As well as Officer K, Officer J and one other person were with DM, and Officer C came at one point. They were talking to DM, but he was not responsive. He was breathing up to the point the paramedics took over.

Prison Custody Officer J

3.30 In her written report, Officer J said that at about 10:35 she heard shouts from Officer F in the cell block. She and Officer K ran round to the toilet area. On the way, she heard Officer F shout for the ligature knife, so she went back to the staff area to get it. When she returned to the cell area Officer K had already undone the ligature. DM was breathing but unresponsive. She and Officer K put him in the recovery position and stayed with him until the ambulance arrived at 10:45. Officer F was with them for a time then went for a break because of the shock of finding DM in that position.

3.31 In her interview for the internal investigation, Officer J said that in response to the shouts from Officer F, she, Officer K, Officer C, and another officer ran round to the cell block gates but had to wait for them to be opened before they could enter. She did not recall who opened the gate. When they reached DM, Officer J assumed the local staff would have the ligature knife as they would know where it was kept, but it was apparent nobody had it. Officer J ran back to the office shouting '*where's the knife'* as she didn't know where it was. The Acting Senior Custody Officer passed her the knife but when she got back with it, Officer K had untied the knot while Officer F held DM's weight.

3.32 Officer J told the current investigation she stayed with DM until the paramedics arrived.

Acting Senior Custody Officer (ASCO)

3.33 The ASCO told the current investigation that he stood with DM's solicitor outside the gate to the cell area while the solicitor spoke to DM, then escorted the solicitor through the locked door, and 'buzzed' him out of the two doors to the lobby where the signing-out book was. ASCO then walked back towards the office and heard Officer F shout for help. He said that Officer E or Officer F opened the gate from inside the cell block.

3.34 In his interview for the internal investigation, ASCO said he let the solicitor out of the custody suite and went back to the office. At about 10:40 he heard Officer F shouting for help. He ran into the cells area and Officer K, Officer F and Officer E were by the toilets. DM was hanging from the grille gate, but Officer F and Officer E were supporting his weight. ASCO assisted them. Officer K then undid the shoe lace. They laid DM on the floor. ASCO could see he was breathing and was told he had a pulse. They opened Cell 6 and carried DM in there and placed

him in the recovery position. ASCO left the cell block to go back to the office and shouted to Prison Custody Officer G to call an ambulance.

THE ASSISTANCE GIVEN TO DM WHEN HIS SELF-HARM WAS DISCOVERED

Prison Custody Officer F – the cells officer

3.35 In his written report, Officer F said that he and Officer E lifted DM up to relieve the pressure around his neck and they called for help. ASCO and Officers K and Officers J came to help. Officer K released the lace. They laid DM on the floor and checked for a pulse and his breathing. Both were evident, so they moved DM into Cell 6 and placed him in the recovery position. They checked to make sure he was still breathing and had a pulse. ASCO went for an ambulance. Officer F said that he and Officer K stayed with DM until the paramedics arrived and took over. Officer F then left the cell block.

3.36 In his interview for the internal investigation, Officer F said that he supported DM's weight from his left side and Officer E supported his right side. They called for help and officers came to assist. Officer K undid the knot attaching the lace to the gate, they lowered DM to the floor and someone removed the lace from DM's neck. Officer E and Officer K both checked and found that DM had a pulse and was breathing. They then moved DM into Cell 6 and Officer F believed the officers had again found he had a pulse and was breathing. They put DM into the recovery position and stayed with him until the senior officer, ASCO, told them to leave. ASCO, Officer K and Officer C remained in the cell.

3.37 In an undated witness statement, Officer F said that when they found DM the gate was against the wall (i.e. open) and DM was in a crouching rather than a slumped position.

Prison Custody Officer E

3.38 In his written report, Officer E said that he and Officer F lifted DM up to relieve pressure on his neck. Colour started to return to his face. Officer K removed the lace from the gate and DM's neck. Officer E said he checked, and found a pulse in his left wrist. DM also opened his eyes. They manoeuvred him into Cell 6. Much more colour had returned to his face. They placed him in the recovery position. Officer E tried to place DM's arm under his head for support, but DM

removed it twice so Officer E laid his arm gently on the floor. Officer E then left the cell. DM had a pulse, eye movement and moved his arm twice.

3.39 In his interview for the internal investigation, Officer E said that when they found DM he was sure both grille gates were open. DM was slumped, hanging from the gate. As they picked him up to support his weight, Officer E was talking to DM and could see blood going back into his face. When the lace was released and they lowered DM to the floor, Officer E checked for a pulse and was sure it was a strong pulse. DM's left eye opened but he was not talking.

3.40 Officer E said he continued to talk to DM to give him encouragement. They manoeuvred him into Cell 6 and somebody said he was breathing. They put DM in the recovery position and Officer E held his head. Officer E put DM's arm up to support his head but twice DM moved his arm away. Officer E then lowered DM's head to the floor. DM had a pulse, was breathing and getting colour back into his face. Officer E then went to give assistance in the office.

3.41 Officer E told the current investigation that they moved DM basically for reasons of decency. In the cell he was out of sight and there was a bit more room.

Prison Custody Officer K

3.42 In his written report, Officer K said that while Officer J ran back for the ligature knife, he had managed to untie the shoe lace from around DM's neck and the gate. DM was then laid down. He was breathing and had a pulse but was unconscious. They placed him in the recovery position and called the ambulance.

3.43 In his interview for the internal investigation, Officer K said the lace seemed to come away with ease from around DM's neck. He did not have to unpick a knot. Someone said let's get him into a cell, which was about four to five feet away. Officer K placed his arms under DM's armpits and they manoeuvred him into a cell. DM was placed on his back on the floor for them to assess him. He had a pulse and was breathing though not normally. His breathing was more of a strained gasp but he was taking breaths. Officer K checked his airway to make sure he had not swallowed his tongue and it was clear, and he checked his pulse on his neck. He also had a hand on his chest and felt his heartbeat. He, Officer J and someone else placed DM in the recovery position. They continued to monitor him. Officer C came in at one point. They were talking to DM but he

was not responsive. He was breathing up to the point the paramedics took over. Officer K then came out of the cell.

3.44 Officer K told the current investigation that when they got DM down on the floor he was unconscious. They moved him into the nearest cell, for more room, for safety and to give him some dignity. They laid DM down. They were talking to him but got no response. Officer K put on gloves from the pouch on his belt and checked DM's airway. He was breathing, though it was gasping, they found a pulse on his neck and his wrist, and Officer K felt his heartbeat. He could not recall if DM had colour in his face.

Prison Custody Officer J

3.45 In her written report, Officer J said that when she returned to the cell area with the ligature knife, Officer K had undone the ligature, DM had a pulse and was breathing but unresponsive. Officer J and Officer K put him in the recovery position and stayed with him until the ambulance arrived. Officer F was with them for a short time then went for a break because of the shock of finding DM in that position.

3.46 In her interview for the internal investigation, Officer J said that when she and other officers reached DM, it became apparent nobody had the ligature knife, so she ran back to the office shouting for it. The senior officer passed her the knife and she went back round. When she got back DM was down on the floor and Officer K was wearing gloves and seemed to be checking DM's airway. Officer J checked his pulse.

3.47 They moved DM slightly, into a nearby cell for his dignity. At that point they did not know how serious it was. They all agreed DM was breathing, though in gasps, not normally. They put him in the recovery position and Officer J was feeling for a pulse all the way through. She quickly lifted DM's eyelids to see if his eyes were focusing and not rolling. At this point there were herself, Officer K and Officer F but Officer F was beginning to look shocked and left, and Officer C came down for a couple of minutes. The paramedics arrived and took over DM's care. Officer J and Officer K and three paramedics remained at the scene.

Prison Custody Officer C

3.48 The escort records indicate that at 10:33 Officer C escorted Prisoner 6 to court with Officer K, and that they returned at 10:45. The PER says Prisoner 6 was discharged at 10:47.

3.49 In her interview for the internal investigation, Officer C said she was sorting the property of Prisoner 6 so he could be released. She heard that an ambulance had been called and went into the cell block with Officer J, whose colleague was in the cell with Officer F. DM was on the floor in the recovery position with Officer K kneeling beside him. Officer C and Officer J were standing by the cell door. Officer C asked if DM was breathing and Officer K said he could feel a breath.

Prison Custody Officer G

3.50 Officer G was the desk officer on the day, entering information about events and prisoner movements on the computer system. In her written report she said that at 10:50 she was asked to call an ambulance. She was told that a prisoner had tried to hang himself and was breathing but unresponsive. She gave these details to the ambulance control and stayed on the phone until the ambulance arrived.

AN AMBULANCE ATTENDED AND DM WAS TAKEN TO HOSPITAL

3.51 The Ambulance Trust's record of the 999 call says it was made at 10:50 and the ambulance crew were on the scene at 10:55. The ambulance patient record says the ambulance crew were notified at 10.52 and the crew were at the patient's side at 10:59. They left the scene to take DM to hospital at 11:26 and arrived at 12:29.

Access for the ambulance

3.52 A transcript of the 999 call provided by the Ambulance Trust records that Officer G said that the staff at the court security gates could show the ambulance the way to the back door to the custody suite, that crew should ask the security staff to telephone the magistrates' court so the custody staff could open the back door for them, and that they would not be able to use a mobile phone inside because they were underground and had no signal.

3.53 A report by the Building Services Manager for the Southampton Courts says that an ambulance pulled into the combined courts car park at about 11:00. Security at the gatehouse had not been told an ambulance was coming, so spoke with the crew when they arrived and established they were for the magistrates' court. The Building Services Manager received a phone call from the Acting Senior Custody Officer later at about 15:00 or 15:30 that day to say there had been an incident. The report says the officer said it was his first day as supervisor.

The ambulance crew's patient record

3.54 The ambulance staff's report says that on arrival staff were unaware that an ambulance had been called but directed them to the custody suite. (From other evidence I understand that it was staff at the court precincts security gate, not in the custody suite, who were unaware that an ambulance had been called.)

3.55 On reaching DM, the ambulance staff found him to be

'*lying right lateral, cyanotic, grey in colour, agonal breathing (?4 per min).'*

Custody staff estimated a three-minute gap when DM was alone prior to being cut down.

3.56 The ambulance team started compressions at 10:59, a defibrillator was attached and indicated PEA (pulseless electrical activity insufficient to support life). Oxygen was administered. DM's condition, treatment and response were recorded.

3.57 The ambulance team's report comments that a prison officer was insistent on handcuffing the patient prior to leaving the scene. En route to the hospital, DM's pulse weakened, and he suffered further cardiac arrest. A paramedic applied compressions, while a prison officer attempted to remove handcuffs. Uninterrupted compressions and ventilations continued while he was transferred to a resuscitation unit at the hospital. Spontaneous circulation returned at 12:24.

Statement by a member of the ambulance crew

3.58 One of the paramedics who was part of the ambulance crew who attended to DM in the custody suite, recognised him some time later when she was called to take a patient from a nursing home to hospital. She spoke to DM's mother

about her recollection of what happened in the custody suite and, on 14 April 2016, she made a statement about it. The paramedic said she remembered the incident because for several reasons it had stuck in her mind.

3.59 From referring to the ambulance handover report, she said that the ambulance received the call at 10:52 when they were driving along Burgess Road (which is close to the courts). She remembered arriving at the court and since it was an urgent call she would have expected someone to be at the entrance, waiting, and ready to direct the ambulance in, but nobody was there. They had to stop and ask where to go. The person they spoke to did not know where the patient was, so the ambulance had to wait until they found out.

3.60 They were then directed to drive through to a big metal door. They had to wait for this to be unlocked, which took about a minute, which the paramedic said was a long time in such an urgent situation. She felt that the staff seemed relaxed and were not acting with due urgency.

3.61 The statement says that the ambulance crew were told the patient had been put in the recovery position and was breathing, but when they arrived at the cell DM was certainly not breathing and was blue, indicating that he was in cardiac arrest. He was also alone. The handover report indicated that they arrived at the patient at 10:59.

3.62 One of the paramedic's colleagues, who was the clinical lead, applied defibrillation pads which gave a reading of PEA (pulseless electrical activity) meaning that there was some electrical activity within the heart, but the heart was not producing sufficient output to support life. This confirmed he was in cardiac arrest, so time was crucial. The clinical lead started chest compression and the paramedic controlled the oxygen bag to breathe for the patient. The custody staff were unable to say how long DM had been in cardiac arrest. The paramedic went to get the stretcher. When she returned, DM's heart was attempting to beat and he had low breaths.

3.63 Two members of the custody staff accompanied DM to hospital. One insisted on handcuffing herself to DM during the journey. The paramedic drove the ambulance. The other custody officer sat next to her in the passenger seat. The handover report said they left the scene at 11:26. During the journey to the hospital the paramedic's colleague shouted, '*He has arrested again'*. The paramedic heard her colleague say *'Can you please get these cuffs off*.'

3.64 The paramedic says that during the journey the custody officer travelling in the front of the ambulance asked whether DM would be OK and made a disparaging remark that he was selfish and the staff would get the sack if he died. In her statement the paramedic said:

'I felt shocked and disgusted at the attitude of the staff. There was never any sense of urgency the whole time we were there, and all they were interested in was how it might affect them if DM died. That is one of the reasons why the incident has stayed in my mind so clearly.'

3.65 The statement goes on to say that the staff did not seem to realise how crucial timing was in that situation and how serious DM's condition was. She said there was no way of knowing when DM went into cardiac arrest. When someone goes into cardiac arrest you have about five or six minutes to act. If DM had been ventilated and given CPR sooner, then his outcome could have been better. Whilst the staff told the ambulance crew when they arrived that DM was breathing, the paramedic says he clearly was not and had gone into cardiac arrest.

3.66 The paramedic was invited to comment on a draft of the parts of the investigation report that referred to her statement. We know that she received our invitation but we have not received any further response.

At the hospital

Prison Custody Officer C

3.67 In her interview for the internal investigation, Officer C said that she went in the ambulance with Officer J and Officer K followed behind. DM's parents came to see him in the resuscitation unit. A hospital police liaison officer was present when DM came back from a CT scan. DM's mother visited DM at about 17:30. Officer C had understood her to tell Officer J that DM had called her at 06:30 that morning saying he was intending to *'do something'* and that she had relayed this to the police. (DM's mother told us that she had not spoken to the police.) After that, the escort staff handed custody of DM over to officers from Winchester prison.

Prison Custody Officer J

3.68 In her interview for the internal investigation, Officer J said that DM was not in handcuffs in the resuscitation area at the hospital, as he was wired up. DM's mother arrived about 12 noon. Officer J said she had explained to a female registrar that visitors were not allowed in custody. The registrar seemed disgusted at this fact, stating. 'DM … *died today*.' She asked Officer J to telephone someone in authority. She contacted the Senior Custody Officer at the Eastleigh base, who asked the Area Business Manager, who said no to a visit. The Registrar insisted. Officer J wanted to avoid a confrontation and DM's mother came in. Officer J telephoned the senior custody officer at the vehicle base to say what had happened and the senior officer said his mother could visit but there must be only one visitor at a time and the escort staff must stay in the room.

Prison Custody Officer K

3.69 In his interview for the internal investigation, Officer K said the Acting Senior Custody Officer said he was to go to the hospital. He went to the Crown Court for the keys to his van and back to the magistrates' court to retrieve DM's property, then drove to the hospital. There was only room for two escorts in the resuscitation room so he stayed outside, then relieved Officer C so she could have a break. When a nurse asked if DM's mother and father could visit, the escorts refused at first, but were challenged by the nurse and DM's parents came in and stayed a couple of minutes. They were asked again about a family visit when DM was in intensive care. Officer J had telephoned the base and was told one person could visit. Officer K and Officer C left the room to make space while DM's mother visited.

DM's mother – Mrs M

3.70 DM's mother told us she heard what DM had done through a phone call from his solicitor at about 11:20 when she was out shopping. She then received a call from a doctor who said she needed to get to the hospital urgently. When she got there, DM was in intensive care. Two escort staff refused her access and told her to get out. She then went to the police. The police liaison officer contacted GEOAmey and told them she was entitled to see her son. The liaison officer went with her to the hospital. Mrs M was very upset and said DM could have died without her seeing him. When she did see him there was no privacy.

Transfer of custody

3.71 At 17:00 on Monday 16 March the escort and custody service handed custodial responsibility for DM to Winchester prison.

The staff's response to the account given by the paramedic

3.72 When the investigation interviewed custody staff we were aware in general terms of the content of the paramedic's statement but we did not have a copy of it. We put it to the staff on duty at the time that the paramedic had said that there was no one in the cell with DM when they arrived, she had criticised staff as having an unsympathetic attitude and she had said that one officer had made a particularly disparaging comment.

3.73 The Acting Senior Custody Officer (ASCO) said he went out to the main garage door to let the ambulance in as he was the only one with a key to the front door. The crew came in with all their gear and started CPR and tried to insert a line in DM. As far as ASCO remembered, he left two officers in the cell with DM. He thought the officers might have moved out of the cell to let the ambulance crew in with all their equipment. He remembered that as they came running in he had called out *'Get out, now. The ambulance crew are here.'* Later he had gone back out with one of the paramedics to get a trolley and when they got back DM had a mask on with a tube down his throat and someone was pumping air.

3.74 Officer E said that he was not aware of any disparaging comment by a member of staff. He said he had already left the cell block when the ambulance crew arrived.

3.75 Officer K said he was in the cell with DM when the paramedics arrived. He could not remember whether anyone else was there. He said he was not aware of any disparaging comment made about DM. He did not know who the paramedic was talking about but said it certainly wasn't him.

3.76 Officer J said she, Officer K and Officer C were in the cell with DM when the paramedics arrived. We told Officer J what the paramedic claimed that one of the officers had said on the way to the hospital. Officer J said she had no recollection of hearing anyone say that or saying it herself. She said she would not say something like that.

3.77 Officer C said that when the paramedics arrived she was outside the cell, to the left-hand side. She recalled that Officer K had been crouched down with DM all the time. She could not remember whether anyone else was there. She said they might have moved out of the cell to allow the paramedics access once they knew they were coming in. Officer C said that she was in the back of the ambulance with DM and she said categorically that she had not made the remark alleged.

INCONSISTENCIES IN THE EVIDENCE ABOUT WHAT HAPPENED

3.78 There are a number of areas where the account of what happened that day given by different members of staff or by the same member of staff on different occasions are not consistent. That is not unexpected, and it does not show that anyone is lying. Memory of a shocking event, or of earlier events that did not seem important at the time, is not always reliable, and I am aware that it is now more than four years since March 2015.

3.79 The investigation has given particular consideration to three areas where there is conflicting evidence.

3.80 On two occasions in October 2015 the cells officer, Officer F, is reported to have claimed to have seen DM in the toilet cubicle immediately before he opened the gate to admit Officer E and Prisoner 1. That would have reduced by a few minutes the time during which DM was able to leave the cubicle and tie a ligature. Officer F made no such claim in his previous statements and interviews, and when the conflict was pointed out to him in November, he reverted to what he had said earlier and said that his belief in October that he had seen DM was an honest mistake, due to the passage of time and intervening events.

3.81 The second conflict is that the account given by the cells officer and Officer E places them both at the scene when DM was discovered. They have both described why Officer E was in the cell area, returning a prisoner from a legal visit, which is consistent with the visitors' record. Officer E and Officer F say that they both supported DM's weight before other officers arrived. The two officers from Manchester, Officer K and Officer J, say emphatically that only Officer F was present when DM was found and that Officer E entered with other officers. Officer E says equally emphatically that this is wrong.

3.82 I have examined carefully both these conflicts of evidence. If witnesses were not telling the truth, then I would want to discover the reason for this and whether evidence was being concealed.

Conclusion

3.83 The situation at the time was highly charged and distressing and events moved quickly. I conclude that - as Officer F subsequently confirmed – the account he gave initially was correct. As to the question of Officer E's position, this makes no significant difference to my findings, and I am inclined to conclude that in the heat of the emergency the Manchester officers were mistaken.

The evidence of the paramedic

3.84 The evidence of the paramedic causes concern and in some respects it conflicts with the evidence of the custody staff. The paramedic says that precious time was lost while the security gate enquired where the ambulance was required, that the custody team showed no sense of urgency, that DM was alone in the cell when the ambulance crew arrived, that he was blue and in cardiac arrest so not breathing. She also says that a member of staff made a disparaging remark about DM on the way to hospital.

3.85 I must take into consideration that the paramedic's statement was made 13 months after the event. She has not commented on the extracts we sent her from the draft report, which included the custody staff's response and my observations on the conflicting accounts. Clearly the incident had made a powerful impression on her, but memory is not always accurate even immediately after an event and it becomes less reliable with the passage of time. I am also aware that the paramedic's statement gives an account which DM's mother understandably finds distressing since it suggests that her son was treated shabbily, by staff who did not care about him, and, more important, that his severe disabilities and premature death might have been avoided. That is a heavy burden to carry.

Conclusion

3.86 The ambulance crew reached DM within seven minutes of receiving the call, which was two minutes after the 999 call. The time taken could have been reduced if the security gate had been primed to prepare for the ambulance's arrival and a custody officer on hand to open the vehicle dock. The instructions

given by the custody desk officer that the ambulance should ask the security gate officer to telephone the custody suite for the vehicle dock to be opened do not show an appropriate sense of urgency. Undoubtedly some time could have been saved if someone had taken responsibility for securing a clear passage through the security gate and into the vehicle dock.

3.87 From the evidence I have obtained I do not think it likely that the staff abandoned DM and left him alone in the cell, which was the impression the paramedic formed. I think it more likely that Officer K and Officer C stepped aside to give access to the paramedics. The clinical reviewer to the investigation advises that the actions of the staff in checking DM's airway, pulse and breathing were appropriate, but she cannot say whether moving him into a cell was detrimental. I believe that the staff who attended DM did their best within their competence.

3.88 I note there was no defibrillator at the court. HMIP has noted in a thematic review based on the inspection of 97 court custody suites that none had defibrillators. We recommend that consideration should be given to locating defibrillators accessible to court custody staff and ensuring that all staff are competent to recognise the circumstances when they should be used and to use them.

CHAPTER FOUR:

LIAISON WITH DM'S FAMILY AND SECURITY MEASURES AT THE HOSPITAL

4.1 DM's mother told the investigation she was very upset by the custody staff preventing her seeing her son at the hospital. He might have died without her seeing him. The police liaison officer and the Family Liaison Officer from Winchester prison helped her. Mrs M said that no one from GEOAmey got in touch with her. DM's solicitor and a governor at Winchester prison told her she could visit the courts to see where DM had hanged himself. The visit was on 6 May 2015 at 08:00 before the prisoners arrived. The Winchester prison Family Liaison Officer and the solicitor went with her. It was an upsetting experience. She said there was no way that a member of staff could see down the corridor to the gate where DM had hanged himself. Mrs M felt that the GEOAmey manager she met there treated her coldly, and

'She didn't ask how [DM] was or even offer us a drink although members of staff had drinks.'

4.2 Mrs M's visit to the custody suite was requested on her behalf by the Family Liaison Officer at Winchester prison and was arranged by the GEOAmey Regional Manager and the HMPPS Contract Delivery Manager. The Regional Manager's note of the visit says that she showed Mrs M Cell 12, the corridor to the toilets and the grille gate. When Mrs M became visibly upset, the managers withdrew to give her privacy while she sat in a cell with the people accompanying her. The Regional Manager said that Mrs M asked why DM had been left with his shoe laces and she had replied that she was not able to answer that question at the time.

4.3 The PECS Contract Delivery Manager's note of the visit says she understood that the visit was only to visit the site and not an opportunity to ask questions of GEOAmey. Mrs M was understandably distressed. She asked why DM had been left with his shoe laces. Mrs M went to sit in a cell and the Family Liaison Officer advised the managers to give her some time there. The liaison officer told them DM'S condition was unchanged. They considered whether they should offer Mrs M a cup of tea but felt this risked seeming too sociable and making light of the matter.

4.4 In responding to the draft of this report, HMPPS told me there was discussion between the HMPPS Prisoner Escort and Custody Service (PECS) and Winchester Prison to agree how to liaise with DM's family. It was agreed that the Police

Liaison Officer (PLO) and the prison's Family Liaison Officer (FLO) would take responsibility for being the point of contact. In their reports after Mrs M's visit to the court, the GEOAmey Manager and the PECS Contract Delivery Manager both said they had asked the Family Liaison Officer for advice about how they should interact with DM's mother.

Observations and conclusions

4.5 Liaising with a family after a tragedy such as this is a sensitive responsibility. In my view no one has a greater claim to know what happened and how it could have happened than family members whose lives have been so profoundly damaged by an event of this kind.

4.6 I believe that the two managers acted with good intentions, but what they intended as a respectful distance was experienced by Mrs M as cold and uncaring.

4.7 I am aware that in 2008 a report by the Prisons and Probation Ombudsman about the death of a man in a Crown Court (not Southampton) recommended that PECS and HM Court and Tribunal Service be asked to develop a family liaison policy.

4.8 I am not aware that this has been done. Serious self-harm is, thankfully, rare in custody suites but we recommend that, in conjunction with PECS, custody and escort contractors develop a policy for family liaison and that a senior member of staff should be designated as Family Liaison Officer with training for that role.

THE POTENTIAL FOR FAMILIES TO HELP TO PREVENT SELF-HARM

4.9 When a person is taken into custody they are removed from the relationships and resources in the community to whom they might turn in distress. DM's mother said she had not passed on information to the police as she was not named as next of kin and expected them to be unwilling to talk to her about him (see paragraph 2.14.)

4.10 The instructions for the suicide and self-harm warning form make clear that third parties, such as friends or family, may provide relevant information. Official agencies need to ensure that adherence to data protection obligations to protect the privacy of prisoners does not prevent staff from being receptive to information that may be critical to prisoners' safety.

4.11 We recommend that GEOAmey and HMPPS consider how friends and families of prisoners at risk can be encouraged and enabled to pass on any concerns about risk of self-harm. Protocols may be required as to how to reconcile the requirements of privacy and the requirements of safe custody that may be in conflict.

THE CONTRACTOR'S PROCEDURES FOR PRISONERS IN HOSPITAL

Standard Operating Procedure (SOP) 010 hospital and bedwatch (September 2013)

4.12 SOP 010 sets out the procedures to be followed when the contractor has custody of a prisoner taken to hospital. A GEOAmey officer must be nominated as Officer in Charge for each period of duty when a prisoner is transferred to hospital, and this officer must inform the Operational Support Centre who they are and ensure an entry is made in the prisoner's PER detailing them as the current officer in charge. The Operational Support Centre (OSC) is a central hub responsible for notifying operational issues. I am told they can provide support as required to the person who has contacted them and can escalate issues if required.

Restraints

4.13 The procedure says that custody officers must be aware that a prisoner may feign illness or deliberately injure themselves in order to be moved to a hospital, where the opportunities for escape are high. Other than in certain exceptional circumstances restraints must be applied at all times. The preferred method of restraint is handcuffs, but where these are deemed unsuitable, escorting chains must be applied, for example during a toilet visit.

4.14 Restraints must be removed only if essential for the administration of essential medical treatment, including when resuscitation equipment is being used, and following a request from a senior medical officer treating the prisoner. Where officers have concerns, they must contact the Operational Support Centre (OSC) for guidance.

4.15 SOP 010 was revised in August 2017. It makes clear that escort staff must comply immediately with a request to remove restraints where that is necessary for life-saving treatment to be administered.

Visits

4.16 The procedure says that visits to prisoners in hospital who are not subject to Prison Rules must be permitted only on the authority of the Operational Support Centre (the OSC). Visits must comply with hospital rules and procedures. In addition, visitors must provide their name and address, they must be searched, there must be no physical contact between a visitor and the prisoner, and no items must be passed to the prisoner.

4.17 A maximum of two visitors is permitted for a maximum of one hour unless hospital rules require fewer visitors or a shorter visit, or escorting officers consider it necessary to limit the number of visitors or duration of the visit because of concerns about security or other risks.

Person Escort Record

4.18 The PER for DM does not name an officer in charge. It says DM arrived at the hospital at 11:30. An entry for 15:00, three hours after DM's admission to the Intensive Care Unit says that the Area Business Manager authorised that one family member may visit and no closeting chain is required.

Observations and conclusions

4.19 The ambulance record indicates that DM's handcuffs may have impeded resuscitation. In the use of restraints, it is necessary to achieve a balance of security, medical access and decency when escorting a prisoner to hospital in an emergency. DM had already suffered cardiac arrest when he was moved to the ambulance. In my view permission should have been sought from a senior manager to remove handcuffs as a precaution in case a further arrest occurred. I welcome the revised procedure introduced in 2017 which makes clear that preservation of life is paramount.

4.20 In this case it was custody officers who made the initial decisions about restraints and visits and they felt had no proper authority to exercise discretion.

4.21 We recommend that there should be in place a procedure for the Operational Support Centre to escalate the incident to a duty senior manager whenever a serious incident of illness or other harm occurs, and for that manager to take responsibility for ensuring that families are notified at the earliest opportunity,

and for authorising the appropriate balance between compassion and security based on the circumstances of the particular case. The contractor should have been on the front foot, with a senior manager anticipating the need for decisions about restraints and facilitating access for family.

CHAPTER FIVE:

THE CLINICAL REVIEW BY DR CRAISSATI

This part of the investigation's report was prepared by Dr Jackie Craissati, a Director of Psychological Approaches CIC and a Consultant Clinical & Forensic Psychologist.[1] *Dr Craissati has expertise in services relating to the criminal justice pathway for individuals with mental health problems, and in the safe management of individuals who pose a risk of serious harm to themselves or to others.*

THE SCOPE OF THIS REVIEW

5.1 As clinical reviewer, working to the Article 2 Compliant investigation in the case of DM, I have restricted my review to DM's mental health difficulties, with particular reference to the three days leading up to the incident.

5.2 I have had sight of all the documentation available to the full investigation, including the prison health records (SystmOne) and the hospital medical records. Additionally, I have had telephone liaison with the manager of Hampshire Liaison and Diversion Service (HLDS), and a face to face meeting with managers of a long-standing and well-regarded prison healthcare and community Liaison and Diversion Service operating elsewhere in the south of England.

DM's MENTAL HEALTH BACKGROUND

Prison records

5.3 The medical records from prison (SystmOne) span from 2010 to 2015, during which time DM was in and out of prison on a number of occasions. During that period, it seems that DM was placed on an ACCT on four occasions:

- 30 March 2011 to 21 April 2011
- 24 April 2012 to 11 May 2012
- 14 May 2012 to 14 May 2012

[1] Psychological Approaches CIC is a not for profit community interest company focused on work with individuals with complex mental health needs – often associated with a history of offending and social exclusion – for whom services may be difficult to access, and sometimes poorly equipped to meet their needs.

- 28 June 2012 to 15 July 2012

5.4 The majority of DM's healthcare contacts related to the management of his detoxification from prescribed drugs (for example, diazepam), from illegal drugs (mostly opiates), or managing alcohol withdrawal. He was also maintained on a methadone prescription initially, although this changed to Suboxone in later years. Both drugs are prescribed substitutes for opiate dependent users.

5.5 However, there are a few records relating to incidents of self-harm or suicidal thoughts. The main events include:

- In March 2011, DM was noted to be low in mood, he appeared very distressed and expressed a wish to kill himself. He reported to the healthcare professional that he had recently threatened to jump off a bridge.

- In April 2012, DM reported feeling very low, with suicidal thoughts. He said that he had recently been in Accident and Emergency, Southampton General Hospital, for slashing his arm. The healthcare professional noted that he had 14 stitches in his arm.

- In June 2012, DM self-harmed by cutting his hand. No further details are available.

5.6 In January 2015, DM reported to prison healthcare professionals that he had been in a psychiatric hospital in Basingstoke a few months previously, for a period of around four months. He reported at that time that his last suicide attempt had been three months previously. DM's mother apparently confirmed this account (although the dates do not tally), stating that DM was resident in a psychiatric ward for four to five weeks in February 2014 due to suicidal thoughts.

The observations of DM's solicitor

5.7 DM was well known to his solicitor, who observed that in the year prior to the serious incident, DM appeared to be trying to turn his life around. For the most part he was living with his partner, who also had a problem with alcohol. It was the impression of others that DM was motivated to be a good father to his young son, although the situation was not straightforward as social services were concerned about his partner's use of alcohol. The situation apparently became destabilised following an incident in November 2014. DM's partner

called the police as he was threatening suicide – trying to climb out of the window at his partner's flat – and in the course of being restrained, he hit a police officer. In the view of DM's solicitor, this was the point at which DM's mental health began to deteriorate.

Relevant hospital medical records

5.8 DM appeared to be a frequent user of ambulance services, and in presenting to the Accident and Emergency department. His contacts with such services appeared to be brief, and little follow-up appeared to be sought by him or offered by services. There are no mental health records contained within the bundle of his medical records provided to the investigation, and we are therefore unable to confirm the reported admission to a psychiatric ward in 2014, or whether DM had previously had any sustained contact with a community mental health team.

5.9 Relevant information of note includes:

- 11 June 2013
  Medication prescribed by neurologist following the onset of epileptic seizures; a subsequent MRI brain scan found no abnormalities.

- 2 January 2014
  Ambulance called as DM was threatening to jump off a bridge; he was found to be intoxicated, and was taken to hospital. Previous self-harm attempts noted.

- 24 July 2014
  Same day admission and discharge for gastric bleeding and alcohol dependence; co-morbid diagnosis of depression.

- 18 October 2014
  Presentation at A&E with self-harm – cut to left forearm with a knife; '*no suicidal ideation*' at that time.

- 2 January 2015
  Ambulance attended as DM intoxicated, very emotional and '*collapsing*'. Records refer to previous admission to hospital in October 2014 and decline in mental state since that time. DM attended A&E with vomiting,

having threatened to jump from a bridge, intoxicated; diagnosed as 'suicide risk'.

5.10 The final hospital record of relevance prior to the serious incident, is that relating to the Friday evening, 14 March 2015, three days prior, when the police took DM to hospital in response to a suspected overdose. The A&E discharge record states that the diagnosis was '*mixed overdose*' – with secondary diagnoses of depression and alcohol use - and refers to an unknown quantity of substances having been ingested, most probably benzodiazepines (minor tranquilisers such as diazepam). The record states that DM reported he had taken 100-150 tablets of diazepam and there was suspicion that he had stored the tablets in his rectum (although DM later denied that this was the case). One tablet of ecstasy was also found on him. He was noted to be drowsy, and was given intravenous fluids and kept under observation for a few hours before being discharged back into police custody.

Conclusion

5.11 For an individual who has had frequent contact with health services, both in prison and in the community, there is a surprising lack of detail in the medical records. It may be that some records – such as the mental health team – are missing from the bundle. There is also some suggestion that DM preferred to seek help in the moment, and may not have welcomed offers of ongoing support. Nevertheless, it is disappointing that the records suggest a lack of curiosity on the part of healthcare services in seeking possible ways forward to support DM in achieving longer term stability in his life.

5.12 The records suggest that DM may have suffered from fairly persistent and pervasive psychological difficulties, particularly in terms of his ability to manage his emotional distress at times of particular stress. It is also clear that he struggled throughout his adult life with substance misuse, although this fluctuated over time in severity, and also in terms of which particular substance – for example alcohol or opiates – was most problematic for him. It is not possible to discern, with hindsight, whether DM's emotional difficulties were largely a consequence of long term substance misuse, or whether they preceded it.

5.13 As a result of the above difficulties, DM appears to have experienced suicidal thoughts fairly regularly; these periods of emotional crisis were quite often short lived and fluctuating. His acts of self-harm – of which there were a number –

were diverse in terms of method. That is, he appears to have had a history of cutting, overdose, head banging, as well as threats to throw himself out of a window and off a bridge.

MENTAL HEALTH OF DM FROM SATURDAY 14 TO MONDAY 16 MARCH 2015

5.14 DM was noted to be agitated when arrested on 14 March, and initially reacted aggressively.

5.15 DM is taken to hospital when it is suspected that he has ingested substances. See medical record above for more details.

5.16 At this time, nursing and paramedical professionals, as well as Forensic Medical Officers, were available to the police for persons in their custody. In addition, MENDOS was the service offered by Southern Health NHS Trust and Southampton City Council, providing assessment and advice for those with mental health problems. MENDOS operated with two practitioners visiting police custody and the Southampton courts, from Monday to Friday working hours only. MENDOS staff were not available in the court on the Monday 16 March during the morning hours that DM was detained there.

5.17 DM was regularly monitored in police custody by the police health practitioner over the course of the next two days. His risk assessment identified him as a vulnerable adult with self-reported depression and panic attacks; he stated that he is drug dependent and takes methadone, which is due, and mirtazapine. He confirmed that he has epilepsy for which he is prescribed Epaline. It is not clear whether he took mirtazapine over the weekend; he did not take his Epaline which is said to be at home.[1] He is reported to have '*thoughts of suicide, no current thoughts*'.

5.18 On DM's return from hospital, he was assessed as low in mood and placed on level one observations (half hourly checks). On the Sunday evening (15 March

[1] Methadone: a synthetic opiate manufactured for use as a substitute for heroin in the treatment of heroin addiction. DM was provided with a dose of methadone on the evening of 15th March. Symptoms of withdrawal from methadone might commence within about 12 hours, but are typically moderate and 'flu like'.

Mirtazapine: an antidepressant medication prescribed to treat major depression, but also general anxiety conditions. Depending on a range of factors, changes following the sudden cessation of the drug are unlikely to be noticed for several days.

Epaline: a treatment to significantly reduce or improve symptoms related to epileptic seizures. Again, it would take a few days of not taking the medication before any risk of seizure might increase.

2015) he was administered a dose of methadone. His mood and distress fluctuates throughout this time, with episodes of banging his head against his cell wall, but other times he is calmer. His self-harm risk is rated as fluctuating between low and medium.

5.19 DM was reviewed by the health practitioner early on Monday morning (16 March 2015 at 05:23) as he had head-butted the wall again: his self-harm risk was rated as high, the reviewer noting that he appeared to be very distressed, stating he had been off alcohol for five weeks without support and that he had personal problems. He remained on level one observations.

5.20 DM was tearful and distressed when handed over to the escorting staff. He told one member of staff that his son had been taken away from him, and that he was barred from seeing him and his girlfriend, and that he wanted to kill himself.

5.21 The Person Escort Record form (PER) noted the risks as DM having banged his head, that he was a heroin addict, a drug addict, that he had concealed heroin and a lighter internally, and that he suffered from panic attacks. No mention was made of his current prescribed medication, his admission to A&E on Saturday, or his risk of self-harm having been assessed as high early that morning.

5.22 On arrival at the court, DM was noted to state that if he did not get off the vehicle soon, he might fit; he was then observed to slump in his chair with his arm and leg tapping. He returned to normal within a minute and made no mention of a fit. Reference is made by staff to the fit probably being faked.

5.23 The Suicide and Self-Harm Warning Form was completed on arrival at the Court, but appears to be incomplete. The free text clearly describes DM's report that he would kill himself that day, the reasons being his son having been taken away from him. No entries are made under Section 5, which details the actions taken in order to ensure the prisoner's safety.

5.24 DM reported that he is suicidal to his solicitor, but appeared calmer at the end of the interview. He banged his head on his cell wall. Staff, on an informal basis, spend a reasonable amount of time talking with him, trying to keep him calm, with some intermittent success. On receiving his sentence of 12 weeks in court, DM returned to the court cells and appeared on the surface to be fairly calm, although he did not have any detailed discussion with anyone prior to asking to use the toilet.

Conclusion

5.25 Although adequate assessment and care appears to have been provided in police custody, the communication of risk appears to have been limited. I would have expected there to be mention of the hospitalization two nights previously, and the assessment of harm to self as high only a few hours prior to transfer. It would also have been good practice to identify the medication that had been administered and that which had not been given. (The Hampshire Constabulary have commented on a draft of this report - see paragraphs 9.38 and 9.39 below.)

5.26 The escort staff appear to have concluded that DM was faking his seizure in the van. Although this is quite possible – and they did attend to him at the time – their assumption that the seizure was fake and did not need to be communicated to the court staff as a matter of concern was overly confident. It is very difficult for the lay person to determine the veracity of a seizure without knowing the individual's seizure pattern; given that DM was on prescribed epilepsy medication, more caution should have been applied.

5.27 The custody staff at the court did not appear to take the risk of self-harm seriously, on the basis that DM was familiar to many of them, and he had previously threatened to harm himself and had not done so, except to bang his head. There appeared to be no effort made to enquire further. Some staff assumed that DM was '*attention seeking*' and therefore there was no risk of serious harm to self.

5.28 The Suicide and Self-Harm Warning Form did not demonstrate any robust consideration of the options available to manage the risk. Clearly some staff spent time talking with DM, but this was on an informal basis, not as part of a clear action plan. In my view:

- It would have been reasonable to assess DM's risk of self-harm as moderate and fluctuating.

- Cell sharing should have been considered as a desirable option that may well have alleviated DM's distress.

- Basic observations - six observations per hour (irregularly delivered) - would probably have been a reasonable plan in the circumstances; clearly these observations should have been recorded.

- Removing DM's shoe laces would have been an extreme response in this situation, and unlikely to be warranted. However, a key indicator for considering this option would have included knowledge of a history of repeated or recent use of ligatures to self-harm. There was no indication that the court staff had considered this.

As is available in prisons, it would be helpful for there to be a Samaritan phone available in court cells for those in distress. For some, basic reading materials, such as magazines, may assist with distracting the prisoner in the short term.

POST INCIDENT INTERVENTION BY STAFF

5.29 Once DM was discovered, the staff appear to have acted promptly and appropriately. They referred in their evidence, appropriately, to 'ABC' (checking the airway is clear, that the individual is breathing, and that there is a pulse (circulation). If any of the three elements are compromised, then CPR should be commenced. In DM's case, the staff assessed all three elements as present, and they placed him in the recovery position.

5.30 Is not possible to determine, from the interview evidence, whether any problems occurred as DM was moved to the cell that may have subsequently compromised DM's airway, breathing or circulation. At the time the ambulance staff arrived, DM was assessed as requiring CPR.

5.31 Although it is common sense to remain with an individual in DM's situation, and to stay on the phone to emergency services, until the ambulance arrives, often no clear guidance on this matter is provided in relevant policies and procedures. This is the case in GEOAmey. Furthermore, there was no portable telephone handset available in the custody area that allowed the staff member on the phone to convey direct observations of DM to the emergency services operator. I understand that this has changed since these events and that cordless phones are now provided in all courts.

5.32 I note that the aftercare provided to the staff - who were involved in what was undoubtedly a traumatic incident - was rather limited and variable.

<u>Conclusions and recommendations</u>

5.33 GEOAmey policies and procedures should be updated to provide clear guidance on when to stay with an individual. Mobile telephone handsets, which I

understand have now been provided, are necessary to facilitate on going contact with emergency services.

5.34 Consideration should be given to locating defibrillators accessible to court custody staff and ensuring that all staff are competent to recognise the circumstances when they should be used and to use them.

5.35 There should be clear guidelines regarding the aftercare of staff involved in serious – and potentially traumatic – incidents. Although it may not always be appropriate to offer the 'hot' and 'cold' debriefing that is usual in the prison system, there should be provision for relatively informal support provided by line managers and/or other appropriate senior staff. This should be offered immediately after the event, and at regular and fairly frequent intervals thereafter, in response to individual staff needs. This support should be made available to all staff involved, regardless of (and separate to) any possible disciplinary measure as a result of the incident.

KEY CHANGES SINCE MARCH 2015

5.36 Hampshire Liaison and Diversion Service (HLDS) has been in place since April 2015, and is provided by Solent NHS Trust and Southern Health NHS Foundation Trust, commissioned by NHS England. The multi-disciplinary team provides a seven-day week service, from 9.00am to 9.00pm, and a telephone advice service between 9.00pm and 9.00am. A practitioner is based in each of the three police custody suites across Hampshire, and the team attend court in the morning every day. If an individual is identified as vulnerable in the police cells, and is in contact with the team, they will liaise with the court staff, as well as including risk information for the escort team. In many instances, an individual can be followed up by the HLDS team member in the court cell having previously been seen in the police cell.

5.37 HLDS may advise the police or the court custody staff on levels of observations, risk management in custody and on release. The advice given is based on individualized assessments of risk, as requested by police and court staff. The team have access to health records in the county, so that background information is available for those individuals who have prior contact with health services; however, this access is dependent upon the individual providing consent.

5.38 From a broader perspective, NHS England has increased funding since 2014 for the further development of LDS, with the aim that there is a complete criminal justice pathway of liaison and diversion in every area of England and Wales. There is one single service specification, but core and emergency hours are determined by local commissioners, as are the specific details of the service. For example – in comparison with HLDS above – another long standing LDS in south east England offers different core hours, but in other respects a very similar service. However, this other service uses a routine screening form, administered by police and court staff; if any history or risk of self-harm is noted on this screen, a LDS mental health practitioner always undertakes a brief face to face assessment of the prisoner.

5.39 A new national PER (Personal Escort Record) is now in use. This provides more detailed guidance for the staff in completing it, which is of relevance to this investigation. For example, there is a section on health and social care details that includes a section in which all currently prescribed medication must be described. The section on self-harm is more detailed, demanding a more rigorous – but non specialist – enquiry into the prisoner's history of self-harm, concerning behaviours, and contextual risk factors. There is also an appropriately detailed section on the actions undertaken to ensure safety.

5.40 The GEOAmey Self-Harm and Suicide Prevention procedures (SOP 063, 26/6/18) provide detailed guidance on most of the above issues. The procedures may need to be reviewed and updated in light of the recommendations raised in this report.

TRAINING FOR STAFF

5.41 GEOAmey provide a six week training course for new staff, with two modules of particular relevance to this clinical review:

- Module 3 on Interpersonal skills, which is delivered over the course of about half a day in Week 1 of the course, and half a day in Week 5.
- Module 4 on Safer Custody, of which one element is Mental Health Awareness (2 ½ hours in Week 2); there is a further half day on suicide and self-harm in Week 4.

There is also a one day refresher course (Employee Refresher 3) that contains updates on procedures in relation to the risk of self-harm, as well as updates on

mental health awareness. These are two topics of nine that are delivered on that day.

5.42 GEOAmey have to cover a large range of topics in their initial course, and it is understandable that there is limited time for the above topics. There are also limitations to the amount of information that can be absorbed during an intensive course. However, I question whether there is sufficient attention paid to the development of skills in managing a range of behaviours that are challenging, including those linked to instability of mental health, substance misuse, poor emotional self-control, threats to self and others, aggression, and poor cooperation. That is, developing skills in listening, exploring, and responding to, complex issues in a busy and fast moving environment. The module on mental health awareness – including the refresher course – appears to be unnecessarily focused on a range of diagnoses and their indicators, rather than on responding to shared characteristics and the communication of distress. It may be that closer working with local liaison and diversion teams offers opportunities for increased skills development, as well as utilising supervision and mentoring opportunities.

CONCLUDING REMARKS

5.43 Court cells are a busy environment, in which custody staff deal with large numbers of individual prisoners passing through for short periods of time. A significant proportion of the individuals under the care of the custody staff present with a range of behavioural problems, or experience mental health difficulties; this may include a complex combination of personality difficulties, low mood (or agitation) and substance misuse. For those individuals with a history of self-harm, differentiating between chronic risk (of low harm behaviours) and acute risk (of suicide) can be difficult. This is particularly so when defendants may provide unreliable or inconsistent self-report and/or refuse consent for staff to seek further information.

5.44 Identifying and assessing the risk of self-harm in such an environment is dependent upon a ***culture of curiosity and concern*** being promoted among custody staff. This requires leadership and training, as custody staff are not alone in experiencing feelings of frustration and occasional cynicism in the face of behaviour that may be challenging. A culture of curiosity and concern then needs to be combined with the provision of simple procedures for ensuring that staff are supported to make simple enquiries, communicate concerns, and to keep basic records. Such procedures and routines help to counteract the risk of

inadequate scrutiny or inaccurate assumptions being made by hard worked staff in a difficult environment.

5.45 The updated Person Escort Record contains, in my view, the right level and focus of questioning in relation to self-harm risk. However, although it is clear that all GEOAmey staff receive an initial training in mental health awareness and suicide/self-harm risk, it is not clear whether this is sufficiently targeted on those behaviours likely to be encountered in a prisoner population. For example, in DM's case, he presented with the following characteristics which are all associated with an elevated risk of suicide:

- He had previously self-harmed.
- He had drug and alcohol problems.
- He had suffered a recent distressing life event.
- He clearly threatened to take his life that day.

5.46 Traditional modes of training delivery – including the initial and refresher trainings – could be supplemented by more creative learning opportunities including modelling behaviours, opportunities for reflective practice, learning lessons bulletins, and input from the local liaison and diversion teams.

CHAPTER SIX:

THE CUSTODY SUITE AT SOUTHAMPTON MAGISTRATES COURT

6.1 The custody suite is located in the basement of the magistrates' court. All external and internal access points are locked and controlled. It contains a secure vehicle dock, an office, four cells for legal visits, and a secure inner cell area behind a locked gate, with holding cells for defendants who are detained in custody before or after their appearance in court. Women and juveniles are held separately from men. Prisoners are brought to the custody suite from police or prison custody to await their hearing and those who are sentenced to prison are held in the custody suite until they can be transported to prison. The custody suite does not hold prisoners overnight.

The cells

6.2 We visited the custody suite in September 2017. There was information for prisoners on the outside of the cell doors, about their rights and how to make a complaint. The inside of the cells was bare, with high ceilings, no natural light, a bench seat, and a cell bell. There was no noticeboard or other information inside the cell. There was no information about the Samaritans and no facility for prisoners to have access to a phone. We understand from the transcript of the 999 call that there is no mobile phone signal accessible in the custody suite.

6.3 We asked custody officers if there was any means of distraction for prisoners who were held in the cells. Officer C told us that, when she was the cells officer, she would hand out newspapers or magazines. We were told that at one time prisoners could have cigarettes, but the suite had been no smoking since 2007 and this could be a source of stress. The acting senior officer said that an officer could go and talk to a prisoner if they had enough staff. Officer J, who was seconded from Manchester, said that in her home area prisoners could ask for a pencil and paper.

The configuration of the male cell area

6.4 There are 15 cells for male adult prisoners, arranged in three parallel ranks: cells 1 to 6 face a corridor; at the end of this corridor are two toilet cubicles for male adult prisoners; cell 6 is the cell closest to the toilets; cell 1 is the cell closest to a window in the office that faces the corridor to the toilets; cells 7 to 11 and 12 to

15 face each other with a corridor between; cell 12 is closest to the office and the access gate to the cells area.

6.5 A third corridor runs along the back of cells 12 to 15. These three corridors are linked by corridors running at right angles at each end. One corridor runs beside the office from the secure gate to the cell area. The other runs across the far end of the cell area and has two grille gates with horizontal metal bars, one at the end of the central corridor, and one adjacent to the toilet cubicles set back slightly from the end of the corridor for cells 1 to 6. It was to this gate, which was unlocked at the time, that DM attached a ligature.

6.6 We observed that the area outside the toilet in the interconnecting corridor is a blind spot where staff seeking to watch a prisoner from outside cell number 1 would not be able to see.

The office

6.7 The office has a window facing the corridor containing cells 1 to 6 and a counter outside the cells area where admission and discharge processes are conducted. We were told that the layout of the office was the same as it had been on the day of the incident. We noted that it would not have been easy for staff in the office to have access to the observation window that looks towards the toilet area. A chair, a bin and a filing cabinet were in the way. Even if there was ready access to the observation window, staff would not have been able to see a prisoner in the toilet or at the grille gate beside it.

6.8 There was a whiteboard in the office where the prisoners for the day were listed and information about them could be highlighted. We noted a sheet of paper listing potential risks, each one being assigned a code number. Staff are expected to put the number of the identified risk next to the name of the prisoner.

6.9 One computer terminal is available for staff who work in this area. Some of the staff we spoke to felt this was not enough to allow staff ready access and they hoped tablets would be introduced to address the problem.

6.10 During our visit to the custody suite in 2017, we were told that the staff did not carry ligature knives as prison staff do. Two ligature knives were kept in the first aid box but when we visited there was only one, and a pair of old-style anti-ligature scissors was on a shadow board. Instructions on how to use the ligature

knife were posted on a wall in the office. We note that GEOAmey's policy on ligature knives was changed in April 2015 as a direct result of DM's self-harm. The new policy required the cells officer to carry a ligature knife. The policy subsequently changed again. Since June 2018 all custody officers are issued with personal ligature knives and required to carry them when they are on duty.

6.11 We observed a mental health worker coming into the staff office and being briefed about the prisoners in custody that morning. We were told that the mental health services are located locally and can be called on at any time if staff have concerns (see Hampshire Liaison and Diversion Service, paragraphs 5.36 to 5.38 above). That was not the case in March 2015.

The grille gates

6.12 When the grille gates are locked, they stop access to the interconnecting corridor. There is no mechanism to fix the grille gates open against the wall.

What staff told us

6.13 We asked present and former members of the custody team to tell us whether the grille gates were supposed to be locked or open when the custody suite was in use. We were given conflicting answers.

Prison Custody Officer E

6.14 Officer E left the company in early 2016. He had worked at courts in the area, including Southampton, for 11 years and had been senior custody officer at another court and on occasion at the Southampton Magistrates' Court. Officer E told us that normally the gates would be locked but sometimes they would be used to give access to the toilets for male adults if there were juveniles in the single row of cells (Cells 1-6), or if they wanted to avoid a particular prisoner going past another prisoner's door, or if there were female prisoners in the cells on that corridor, which might happen if they did not have enough staff to cover the female cell area.

6.15 In his interview on 23 March for the internal investigation, Officer E said he was sure that on the day of the incident the gates were unlocked but he could not recall a reason for that.

Prison Custody Officer C

6.16 Officer C has worked as a custody officer at Southampton Magistrates' Court since 2006. She said that the gates were supposed to be locked to cut off access to the interconnecting corridor. It was always practice now to be sure they were locked. They would only be opened if there was an incident at the other end of the cell block and the corridor was needed for access to the toilets.

6.17 In her fact-finding interview on 16 March 2015 for the internal investigation, Officer C said she came on duty at 08:00, opened the cell block and checked the alarms, completed the board and waited for the prisoners to arrive.

6.18 We asked Officer C about the checks she had made in the cell block. She explained that she checked the affray alarm and the toilet facilities, that the cell buzzers were working and that there were copies of the prisoners' rights in the cells. She could not remember whether she checked on the day whether the gates were locked.

Prison Custody Officer F – the cells officer

6.19 Officer F was dismissed by GEOAmey in November 2015 as a result of disciplinary proceedings following DM's self-harm. He did not respond to the current investigation's request to interview him. In his written report on the day of the incident, Officer F said he took over the cells from Officer C at 09:20 when the prisoners had already arrived.

6.20 In his fact-finding interview on 24 March, Officer F said that he came on duty at 09:00 as he did every day. He was nominated cells officer. By the time he got to work the opening checks had been completed and he signed for the cell keys and went into the cell block where he went to speak to DM as he had been briefed that he was banging his head on the cell walls. We do not know whether Officer F checked the grille gates or what instructions he was following.

Acting Senior Custody Officer (ACSO)

6.21 The incident report prepared by ASCO on the day of the incident does not say whether the grille gates were locked. In his interview for the internal investigation, ASCO says he came on duty at 07:00, completed some paperwork and his opening and closing checks but he does not specify what these were. In his interview for the present investigation, ASCO said that as acting senior officer

he would check all the cells to make sure they were clean and nothing had been left there. He would lock the cells, and check all the fire alarms and the locks, and go up to the courts to check all the alarms were working there.

6.22 We asked ASCO about the grille gates adjacent to the toilet area. He said they were always open, but he didn't know why. He said some people said both were supposed to be locked and when he made enquiries the GEOAmey Health and Safety officer for the courts on the south coast said he could lock one and leave one open, so ASCO would shut one and keep one open. The left-hand side was locked so if a prisoner was out to go to the toilet he could not go running round the corridors with a PCO chasing. The other one, by the toilets, was open and pushed back against the wall. There was nothing to fix it against the wall. As far as ASCO was aware there was no protocol written down about the gates.

The findings of the internal investigation

6.23 The investigation concluded that the officer in charge did not ensure that the grille gates located beside the toilet area were closed and locked on the day of DM's self-harm, and that this was in breach of SOP 083, the Standard Operating Procedure on Custody Area Pre-Checks. Paragraph 2 stipulates that all gates and doors are locked and secured at all times when the custody area is in use. Further, the investigation concludes that if the grille gate had been locked it would have been more difficult for DM to tie the ligature without being observed.

<u>Conclusion</u>

6.24 The grille gate beside the toilet cubicle was open on the day of the incident and it should have been locked. It was not clear which officer was responsible for completing the custody area checks. There was confusion among the staff about whether the gate was supposed to be locked. The acting senior officer apparently acted on oral advice that was not authoritative and he did not exercise responsible oversight.

CHAPTER SEVEN:

POLICIES AND PROCEDURES FOR THE SAFE CARE OF PRISONERS BY THE PRISONER ESCORT AND CUSTODY CONTRACTORS

7.1 The prisoner escort and custody contractors are responsible for the safety and security of large numbers of people who may pose risks to themselves or to others. It is a challenging task. In 2015 escort and custody services for England and Wales were responsible for 768,082 prisoner movements. Many prisoners are vulnerable, especially because of substance abuse and/or mental health issues or a propensity to self-harm.

7.2 HMPPS Prisoner Escort and Custody Service (PECS), which monitors the performance of the escort contractors has provided the following information about the incidence of self-harm among prisoners under escort or in custody suites. This indicates that self-harm is relatively rare.

	Number of Prisoners escorted or held in custody - national	Number of Prisoners escorted or held in custody - Southwest/ South east region	Instances of self-harm - national	Instances of self-harm - regional	Instances of self-harm – Southampton MC	All reportable Incidents - Southampton MC
2015	768,082	145,041	435	78	5	13
2016	674,688	122,899	610	120	7	18

IDENTIFYING AND MANAGING RISK

7.3 Risks may be identified in the information accompanying a prisoner, but that information is often generalised and limited. Each prisoner is in the care of the escort and custody service for only a matter of hours. There is not sufficient time for the custody staff to build sustained relationships, to explore in depth the issues that may be affecting an individual's state of mind, nor to put in place enduring means of support.

7.4 In March 2015, the custody staff in Southampton relied entirely on their own resources, apparently without ready access to mental health support or the means to enable prisoners to obtain relief through distraction or expert counselling. As indicated in Chapter Five of this report, since April 2015 the Hampshire Liaison and Diversion Service (HLDS) now provides a service seven

days a week to the police stations and the courts. If that service had been in operation at the time it is likely that DM would have seen a mental health worker in the police cells, who would have access to records about his history, who would have provided risk information for the escort team and possibly visited DM at the court.

Recommendation

We recommend that the managers responsible for the Southampton court custody suite work with the Hampshire Liaison and Diversion Service to ensure that the service is well understood by custody staff and used effectively.

STANDARD OPERATING PROCEDURES (SOPs)

7.5 Standard Operating Procedures (SOPs) provide guidance and instructions to escort and custody staff on the processes to be followed by the Contractor and individual staff members. They are consistent with the policies of the Prison Service, and the Contractor is required to comply with any requirements in Prison Service policies that touch on their work. The investigation has examined the SOPs that are relevant to the care of DM, both in the version that was in force at the time, and in their latest form. Relevant changes since the incident are noted. We have also examined whether the procedure in force at the time was followed in the present case. Where appropriate, I have referred to some SOPs elsewhere in this report. This chapter examines the procedures directly concerned with keeping prisoners safe whilst they are in the care of the escort and custody service.

7.6 Standard Operating Procedures (SOPs) are in place with the objective of reducing risk by:

- recording and sharing information through the Prison Escort Record so that the custody service, and in turn, other agencies are aware of risks indicated by the prisoner's history or by recent events.

- a systematic framework for the assessment and support of prisoners considered to be at risk of suicide or self-harm.

- protocols applying to the care and management of all prisoners in the custody of the escort and custody service.

- protocols for maintaining a safe and secure environment.

SHARING INFORMATION

SOP 053: The Person Escort Record (October 2013)

SOP 033: Collection, Transfer and Delivery – Police Establishments (March 2014)

7.7 The Person Escort Record (PER) is a form in which the authorities who have custody of a detained person record information about the prisoner, risks to be taken into account, changes of circumstances and significant events. The PER is the principal instrument through which agencies, and members of staff within the escort and custody service, share information about a prisoner's history and well-being in order to minimise the risk of harm to the prisoner or others. The PER is passed on from the police to the escort and custody service and where appropriate to a prison. The electronic version of the Person Escort Record (the EPER) is held and maintained only by the escort and custody service.

7.8 Guidance on the Person Escort Record is contained in HMPPS Prison Service Order (PSO 1025 issued in 2012) and GEOAmey's Standard Operating Procedure (SOP) 053.

7.9 I am aware that a new Person Escort Record form is being developed (see paragraphs 9.38 to 9.50 below). The structure of the form is designed to prompt more effective risk assessment.

Transfer of custody

7.10 SOP 033 gives instructions on collecting prisoners from the police. Paragraph 1.2 says that GEOAmey officers must familiarise themselves with prisoners' documents and assess any immediate risks. They must ensure that the police give them specific and relevant information indicating a potential self-harm or attempted suicide. To supplement the entry on the PER a full verbal brief including a report of events in police custody must be part of the handover (transfer) procedure wherever possible. Paragraph 3.1 of SOP 053 says that an officer signing when receiving a prisoner is confirming that the risks associated with a prisoner are understood.

7.11 The PER completed by the police for DM does not say that they took DM to hospital the previous night after he claimed he had taken an overdose of pills. With the papers I have seen, there was no record available to the escorts that DM was given methadone on Sunday evening to mitigate withdrawal, and I have not seen any instructions about this for the information of the custody service or other agencies to whom DM might have been transferred. These and other events are recorded systematically on the police custody record but that is not passed on to other agencies. There is no record of any events on the PER for the time DM was in the custody of the police.

7.12 The PER risk indicator says that DM banged his head on a police van *'in 2015'* but does not say whether that was during the present period in custody or on a previous occasion. No indication is given of the level of risk recorded by the police. The escorting officers, Officer A and Officer B, say that when they enquired about DM's banging his head they were told that it was because of an allergy to a police blanket but that he was all right now that he had his own. The officers saw a blanket in DM's property which seemed to substantiate the explanation, and the investigation is aware that DM had a history of a skin sensitivity.

Observation

7.13 The escort staff who received DM into their custody observed the requirements of the policy. My investigation extends only to the actions of the escort contractor, but there was salient information in the records of DM's time in police custody and a recent assessment of high risk of self-harm that was not recorded on the PER. (The Hampshire Constabulary have commented on a draft of this report – see paragraph 9.38 and 9.39.)

Information recorded by the escort and custody officers

7.14 There are inconsistencies between the risks recorded by the police and those recorded on the EPER by the custody service. The police form records risks of suicide/self-harm (banging his head on a van door in 2015) and concealing weapons or other items (based on concealment of heroin and a lighter in 2009), but there were no risks identified for escape, violence or any other risk to other people. Health risks identified were medical (drug addict) and mental (panic attacks). The EPER records risks of drugs, escape, medical, suicide, violence and weapons without any explanatory comment. I do not know the reason for the differences.

7.15 Paragraph 2.1 of SOP 055 gives a non-exhaustive list of events to be recorded in the EPER. It includes toilet visits, all visits to the prisoner by a custody officer, and all checks at irregular intervals. Paragraph 2.2 gives a non-exhaustive list of events to be recorded in the paper PER. This does not expressly include visits and checks by custody officers, but refers to 'any significant events as detailed in the PER instructions'.

7.16 From 08:50, when DM arrived at the courthouse, until 10:50 when his self-harm was discovered, the electronic record and the PER have entries for admission procedures and DM's movements to and from a legal visit and the court. There are no records of any conversations with officers, that he was banging his head in the cell, or that a custody officer sat with him in the cell.

Conclusion

7.17 The internal investigation noted non-compliance with SOP 053 paragraph 2.1 in that the officer in charge did not ensure that DM's toilet visit and his second legal visit were entered in the PER and EPER. I note in addition that there is no record of the several visits before DM went to court that the custody staff say took place nor that he was heard by several officers to be banging his head in the cell.

RISK OF SUICIDE AND SELF-HARM

SOP 063 Self-harm and suicide prevention March 2014

7.18 SOP 063 outlines staff responsibilities in ensuring prisoners' safety by reducing their risk of self-harm and suicide.

The suicide and self-harm warning form

What the procedure requires

7.19 Section 2 is about the Suicide/Self-Harm Warning Form. It requires that the officer opening the form must ensure that the prisoner has been notified and understands the reason. A warning form must be commenced whenever a prisoner who is not already subject to a Prison Service self-harm prevention plan:

- attempts suicide
- commits an act of self-harm, however minor
- makes direct threats to injure self or take own life
- raises a GEOAmey employee's concern about the potential to commit an act of self-harm or suicide
- is the subject of information a GEOAmey employee receives from other sources indicating the prisoner's potential for self-harm or suicide
- is known to have committed an act of self-harm within the last month and this has been detailed on the PER. Where it is known but not detailed on the PER, the GEOAmey employee must challenge the documentation and update the risk predictor as Risk changed and detail why
- has committed an act of intentional self-harm which has happened in police, court or escort custody during the episode of arrest, including when the prisoner has made a ligature but not used it.

7.20 The officer opening the warning form must ensure that an entry is made in the prisoner's PER and the Daily Occurrence Book or Blackberry. Care must be taken to ensure the correct entry is made: for example, cause for concern or detail of self-harm. Sections 1 to 6 of a warning form must be completed by the employee who first became aware of a prisoner being at risk of suicide or self-harm. The warning form must be used in conjunction with the PER, with the reason for commencing the warning form being annotated on the PER. GEOAmey staff must detail on-going observations and events on the record of events pages of the Prisoner Escort Record (PER). The officer in charge must ensure that suicide/self-harm warning forms are completed correctly and a copy, along with any supporting documentation or risk assessment from a third party, is attached to the PER and transfers with the prisoner, with a copy retained at the court.

Conclusion

7.21 The escort officer to whom DM disclosed an intention to end his life correctly recorded her concerns on the PER and opened a warning form at the first opportunity. She noted that there were no forms on the escort vehicle. Good

practice requires that the forms should be kept on an escort vehicle. In this case, the journey to the court was very short but that will not always be so. The form provides a structured method of identifying, assessing and sharing information about risk and the safeguards put in place to reduce it. Completion of the form should not be delayed until arrival at the vehicle's destination.

7.22 There were departures from the procedure. No measures were recorded in Section 5 of the form to keep DM safe. There were no records of observations on the record of events in the Person Escort Record. The Acting Senior Officer was not able to say whether DM had been told that a warning form had been opened. The warning form was not noted in the Daily Occurrence Book.

7.23 The internal investigation concludes that the officer in charge did not ensure that Section 5 of the suicide and self-harm warning form was completed, referring to whether DM was to be located with another prisoner, frequency of cell checks, other support, referral to a medical practitioner or any other action. The internal investigation finds that the officer in charge made these decisions but did not ensure they were recorded on the form.

7.24 I am not satisfied that the officer in charge gave proper consideration to how DM should be supported, to frequency of cell checks, or whether a medical practitioner was required. The staff in the custody suite reacted to DM's banging his head, but without any assessment of risk, or reflection on how best to help him. Officer C showed care and consideration in spending time with DM and listening to his worries, but this was not part of a coordinated plan led by the officer in charge and understood by all the staff on duty.

Briefing all staff

7.25 Paragraph 1.2 states that the officer in charge must ensure that all staff who may come into contact with the prisoner are briefed on the risk of self-harm. The briefing must be detailed on the prisoner's PER, and on the staff daily briefing sheet.

7.26 The entry in the EPER timed at 08:45 says that a warning form was completed. It says nothing about DM's stated intention to kill himself, but only that he banged his head then calmed down.

7.27 The warning form was in fact not completed until about 09:10 when the staff were already going about their duties. The Manchester officers came to the

custody suite only after 09:30 and say they heard a prisoner banging his head but did not know at that point who it was. The risk was not displayed on the white board where the prisoners for the day were listed. Officer C, Officer E, Officer J and Officer K, did not refer to knowledge of a warning form in the written reports that they wrote on the day.

Conclusion

7.28 I have not seen evidence of a systematic briefing of the staff about DM's risk of self-harm as identified by the escorting officer, or indeed what measures staff should adopt to support him. The EPER said only that a warning form was opened because DM was banging his head in the van. In the course of the morning, DM told the cells officer, the acting senior officer and Officer C that he feared he would lose access to his son, but I am not persuaded that the reason for his particular distress on that day was properly appreciated, or made known to all the staff on duty on the day.

7.29 The impression I have formed is that there was conversation among the staff about DM banging his head. Some staff believed they knew him of old, and did not take his distress seriously. Officers dismissed it as familiar behaviour *'to gain attention*'.

Cell-sharing

7.30 Paragraph 1.8 of the guidance on suicide and self-harm refers to SOP 018 on cell allocation and states that a decision to place a prisoner for whom there is a self-harm warning form in a single cell must be annotated in the PER and Daily Occurrence Book with the reason for the decision.

7.31 The procedure on cell allocation dated July 2014 states that prisoners who have suicide/self-harm warning forms must, wherever possible, be allocated to share a cell unless a Cell Sharing Risk Assessment (CSRA) specifies single cell allocation.

7.32 Officers told the investigation that DM asked to share a cell. The escorting officers told the investigation the suggestion was dismissed. The acting senior officer told the internal investigation that DM was not suitable for cell-sharing because of his risk markers, and told the current investigation there was no one suitable for DM to share with. There are no records showing how the request was considered.

Conclusion

7.33 I am not persuaded that cell-sharing was considered properly, nor that either DM's risks as stated by the police, nor the status of the other prisoners that day would have prevented it.

7.34 The internal investigation concluded that the decision not to locate DM with another prisoner did not contribute to his attempt to take his own life as the act of self-harm was committed outside his cell.

7.35 I do not agree. The policy is in place because cell-sharing may act as a safeguard. Locating DM with another prisoner might not have prevented his self-harm, and I acknowledge that officers spent time talking with DM before he went to court, but location with another prisoner might have altered his mood, prevented his head-banging, and distracted him from self-destructive feelings.

7.36 Moreover, had DM not taken the opportunity of a toilet visit to tie a ligature he might have found some other means to self-harm if he had been left alone in a cell. Health and safety inspections have identified possible ligature points in the cells (see paragraph 8.16)

Removal of items that may be used for self-harm

7.37 DM used a shoe lace as a ligature. His mother asks why his shoe laces were not removed when he was known to be threatening to kill himself.

7.38 Paragraph 1.3 of SOP 063 states that where a SASH warning form has been commenced, the officer in charge must consider removal of items including shoe laces where in their opinion there is a current risk that the prisoner may use them to commit an act of self-harm.

7.39 The procedure goes on to say that the removal of any items from the prisoner will be by exception. Items will not normally be removed. Removal of items must only take place following a documented and recorded risk assessment detailing why the removal of items was considered necessary.

7.40 The acting senior custody officer told us that in all his experience there had been only one extreme occasion when he had removed a prisoner's shoes and laces because he was in the process of using them for self-harm. He said the police

would normally put prisoner's belts in a property bag and sometimes shoe laces or a cord from a track suit.

7.41 Mr L attended one of our interviews to support a witness. Mr L is a vehicle escorting officer, who has also worked as a police officer and in the ambulance service. Mr L told us that he had known of only one case of someone trying to harm themselves with a shoe lace, but in his experience it was much more common to use other items of clothing, which were not obviously potential ligatures and not included in the list of clothing items to be considered for removal.

7.42 Officer J, who was seconded from Manchester, said that she believed that in her area the police would remove shoe laces where a prisoner was considered to be at risk of self-harm.

7.43 HMPPS Guidance on preventing suicide and self-harm, (Prison Service Instruction 64-2011) emphasises engagement with the prisoner in planning how they will be supported. This includes considering and agreeing whether any items a prisoner might use to self-harm should be removed from them. Removal of items should be kept to a minimum and never be automatic.

Conclusion

7.44 Contrary to the procedure, there is no evidence that any consideration was given to removing DM's shoe laces or other items of clothing.

7.45 I cannot be certain that proper consideration would have meant that the laces were removed or that, if they were, DM would not have devised another means of self-harm. Deprivation of everyday possessions may make a prisoner feel still more despondent and there are many ways that someone resolved to harm themselves may do so. I note the thrust of the HMPPS guidance that the decision should be taken in collaboration with the prisoner as part of energetic engagement by staff showing that they are on the prisoner's side in their determination to help protect him.

Informing the court

7.46 Paragraph 1.5 of SOP 063 says that the officer in charge must inform the Court Management as soon as possible if they have concerns regarding a prisoner's

vulnerability or risk, or any changes in them. Such notification must be annotated in the Court Daily Occurrence Book.

Conclusion

7.47 There is no evidence that the officer in charge informed the court of their concerns about DM's vulnerability. It is likely that custody staff were in touch with the court to arrange for DM's case to be heard early, but there is no record of this and I do not know what reason was given. Contrary to SOP 063 there was no reference at all to DM in the Daily Occurrence Book until his act of self-harm.

Observation of a prisoner at risk

7.48 Paragraph 3.1 of SOP 063 says that where a suicide/self-harm warning form has been opened the prisoner must be observed and checked a minimum of six times per hour, or more frequently dependent, on risk. The checks must be at irregular intervals with no discernible pattern or may be a constant watch. The level of supervision must be entered in the prisoner's PER. The officer in charge is responsible for ensuring compliance.

7.49 The GEOAmey employee carrying out an observation and check on a prisoner must ensure that the prisoner is alert and responsive and that the response is annotated on the prisoner's PER and must enter details of observations and events on the continuation sheets of the Person Escort Record along with their own name as the officer making the entry.

Conclusion

7.50 I am satisfied that officers were with DM for much of the half hour between the end of his legal visit and his appearance in court, but contrary to SOP 063 there is no record of this in the PER.

SUPERVISING PRISONERS

SOP 018 Separation, Segregation and Cell Allocation

SOP 032 Checking of prisoners – September 2013

Checking prisoners in their cells

7.51 SOP 032 says that GEOAmey staff *'are responsible for the continuing care of all prisoners whilst in the custody of GEOAmey'* and the officer in charge is responsible for making sure that checks are made on prisoners '*to ensure that their general welfare and wellbeing is being maintained*'.

7.52 If the PER indicates that a prisoner has mental health issues, the officer in charge must ensure an assessment is carried out to determine if they must be checked irregularly a minimum of six times per hour. Details of the assessment carried out and the decision regarding the minimum number of checks to be carried out each hour is annotated in their PER and officers made aware at the briefing.

7.53 The officer in charge must make sure that prisoners who are not subject to special arrangements or risks are physically checked at irregular time intervals, no less than once an hour, and prisoners off bail at least six times an hour.

7.54 The officer in charge must ensure that prisoners who are subject to special arrangements or whose welfare has been identified as at risk (including those for whom there is a suicide/self-harm warning form) are checked at irregular time intervals at least six times per hour, or more as otherwise directed by medical or other appropriate advice.

7.55 The officer in charge must ensure that all checks on prisoners are annotated in the Blackberry and/or in the prisoner's PER which must include any significant remarks in relation to the prisoner's behaviour, actions or demeanor.

7.56 The internal investigation accepted that DM was supervised by officers who attended his cell, but these visits were not recorded on the PER as checks on DM, and this was in breach of SOP 032 Paragraph 1.1.6

Conclusion

7.57 DM was both the subject of a warning form and was reported to have mental health issues. From the evidence I have seen I am satisfied that in the half hour or so that DM was in a cell before he went to court, officers were with him for much of the time. The cells officer and the senior officer both attended his cell and Officer C sat with him for several minutes. None of the officers recorded their observations at the time, and I have seen no evidence that consideration was given to whether to seek medical advice when DM was banging his head.

Ligature knife

7.58 The procedure was amended in April 2015 to require that the cells officer must be equipped with a ligature knife. It was amended again in June 2018, so that now all staff carry ligature knives.

Observation

7.59 At the time of the incident it was not the Contractor's policy for the cells officer to be equipped with a ligature knife. Moreover, not all the staff on duty knew where to find it. Although in this case the lace was untied by a custody officer, a ligature knife immediately available to the cells officer would have reduced the time when DM's airways were blocked. I note that the policy was changed quickly as a direct result of what happened to DM, and that from June 2018 all custody officers have been required to carry ligature knives.

Supervising prisoners outside their cells

7.60 An amendment in October 2015 to SOPs 018, 032 and 063 provides that a prisoner out of their cell must be observed and supervised by a custody officer at all times. It specifies that an officer escorting a prisoner to a toilet visit must not get distracted and remain behind the prisoner at a 45-degree angle and no further than a reactionary gap distance away from the prisoner during movement. During a toilet visit the officer must provide necessary privacy, but maintain the security level required for the welfare of the prisoner. The officer must remain within the direct vicinity of the toilet area but within a communicable (talking) distance of the prisoner at all times, and must not get distracted.

Conclusion and recommendation

7.61 There was no instruction in force in March 2015 stating expressly that a prisoner out of their cell to use a toilet must be kept within sight at all times. The policy was revised in October 2015.

7.62 The configuration and sightlines of the cell block at the Southampton Magistrates' Court are particularly challenging. A single officer supervising a prisoner using the toilet is unable to do anything else at the same time. Had the cells officer not left his post observing DM to speak with the solicitor and then to admit another prisoner, all movements into and out of the cell block would have been stopped for the duration of DM's toilet visit. We recommend that PECS and GEOAmey reviews the number of custody officers required in the custody suite and how they are deployed.

CHAPTER EIGHT

OPERATIONS IN THE CUSTODY SUITE

Staffing levels and the roles and responsibilities of staff

SOP 021 Staffing levels – December 2013

8.1 Section 1 says that the officer in charge (usually a senior custody officer) must ensure that sufficient staff to maintain security and facilitate the smooth running of the courts are planned for and requested. Factors to be considered include the number of female officers available, young persons, multi-handed cases, increased risk due to known violent or escape risk prisoners, the need to facilitate visits and maintain security of visits.

8.2 The Acting Senior Officer (ASCO) said there were usually six members of staff on duty at the magistrates' court in the morning, but he would put in for two to four extra staff every day. Although they would receive a day in advance a list of prisoners expected from the prisons, they did not know how many would come from the police station. If the extra staff were not needed, he would tell the office they were not necessary. If they had too few staff, they might have to delay legal visits or escorting a prisoner to court.

8.3 ASCO said the staff had to cover legal visits, admission and discharge procedures, food and drink for the prisoners, the cells area, data entry on the computer, and escorts in court. The cells officer had to let prisoners and escorts in and out for legal visits and to court and to cover toilet visits and, at the time in question, the cells officer had discretion as to whether to let prisoners and escorts in at the gate while a prisoner was out of cell using the toilet (see paragraphs 7.60 and 7.61 above – the explicit requirement to remain within sight of a prisoner out of his cell was not introduced until October 2015)

8.4 ASCO said that he would usually prefer to send two escorts with a prisoner to court for security.

8.5 Officer E told us that when there were not enough staff to cover the separate female cells, they would use Cells 1 to 6 for women prisoners.

The staff complement on the day

8.6 On 16 March 2015, in addition to the acting senior officer, the five prison custody officers on duty who normally worked at the magistrates' court were:

- Officer H, who had little involvement in the care of DM and did not respond to the investigation's request to interview him. Officer H left his job in August 2016.

- Officer G, who recorded prisoner movements on the electronic escort record. Officer G did not respond to our request to interview her. Officer G left her job in January 2016.

- Officer E, who was employed in the custody service for 11 years from 2005 including seven years as senior custody officer at another magistrates' court and occasionally as senior at Southampton Magistrates' Court. Officer E left in February 2016.

- Officer C, who has worked as a PCO since 2006 and was still employed at the magistrates' court at the time of our investigation.

- Officer F, the cells officer, who was dismissed in November 2015 in connection with his supervision of DM (see paragraph 6.19).

8.7 Vehicle staff Officers J and K, who were temporarily seconded to the area from Manchester, came back to the custody suite from the Crown Court, at about 09:30 and assisted with legal visits and court escorts.

- Officer J has worked for the escort and custody service, based in Manchester, for some 17 years, on the vehicles, in courts and escorting young people.

- Officer K worked as a Prison Custody Officer based in Manchester for about four years until June 2017. He usually worked on the vehicles but assisted in the courts.

8.8 Vehicle staff Officers A and B, temporarily seconded to the area from Mansfield, were sent to work elsewhere after delivering prisoners and opening the suicide and self-harm warning form about DM.

- Officer A has worked for 12 years as a Prison Custody Officer, mainly in vehicles but at times assisting in the courts. She said that it was unusual for her to be asked to work out of her home area but in Southampton they were short of female escorts.

- Officer B worked as a Prison Custody Officer from 2004 until September 2017. For the first eight years she worked in a Crown Court. She transferred to working on the vehicles in about 2013.

The Acting Senior Custody Officer (ASCO)

8.9 The Acting Senior Custody Officer worked for successive escort and custody contractors from 2003 until April 2015 when he left the service. He started off driving vehicles, became a senior custody officer in the Transport and Vehicle base for some four years, then resigned from that role to return to being an escort. In February 2015 he was asked to go and act up at the magistrates' court when they had no senior officer. He said there was no special training for the senior officer role.

Vehicle staff and court staff

8.10 Longstanding members of staff had worked for successive contractors and some were trained by a previous contractor. Staff told us that the six-week initial training course was the same, whether staff were then assigned to the vehicles or in the courts. Officer B said that she had done a bit of shadowing when she first moved on to the vans. Mr L, who accompanied one of the witnesses to an investigation interview, worked as an escorting officer on the vehicles. Mr L said that all the PCOs received the same training but on the vehicles, the PCOs' specialism was

'*really the transportation documentation, as opposed to the nitty-gritty of court work. We're all familiar with it, but in reality we're not the specialist Court Officers, we're there to assist them in carrying out their work.'*

Access to medical support

8.11 The Acting Senior Custody Officer told us that the custody staff can obtain medical advice from a helpline. He said he would have had to telephone the Vehicle Base to obtain the number.

8.12 The investigation has seen a report of an incident that occurred in the custody suite at Southampton Magistrates' Court in May 2015. On that occasion, at 10:00 the Acting Senior Custody Officer requested a doctor through the medical contractor to administer prescribed medication to a prisoner. At 11:17 the medical service called to say that a doctor would come from North London but would be at least two hours.

Observation

8.13 It is not clear why the telephone number for the medical Helpline was apparently not immediately available at the custody suite. It is a cause for concern that in the case of another incident, apparently the closest available medical practitioner was some 120 miles away.

Mental health support

8.14 Dr Craissati's clinical review (paragraphs 5.36 to 5.38 above) explains the system of support from mental health practitioners which since April 2015 has been provided by the Hampshire Liaison and Diversion Service (HLDS). We were told that in March 2015 the custody staff were not able to call on immediate mental health advice.

THE MANAGEMENT OF THE COURT CUSTODY SUITE

Health and safety inspections

22 October 2013

8.15 An inspection was conducted in October 2013 by a GEOAmey Health and Safety Adviser, the then Senior Custody Officer and the Accommodation and Security Manager for the court from Her Majesty's Courts and Tribunal Service (HMCTS).

8.16 Various hazards were identified, mainly as a result of poor maintenance but some, including potential ligature points in cells, as a result of design. There is no specific reference to the grille gates adjacent to the toilets, but unspecified non-security doors were observed unlocked and unsecured. It is noted that Standard Operating Procedure 083 paragraph 1.1.2 stipulates that all gates and doors must be locked and secured before prisoners arrive.

8.17 The report states that self-harm is a serious hazard but can only occur within the cells, as at all other times prisoners are escorted by an officer. The only controls in place are said to be that, where a prisoner has been identified on the PER as a self-harmer or suicide risk, the cells officer checks the prisoner six times within the hour, and in exceptional circumstances, there may be permanent watch.

December 2014 and June 2016

8.18 The reports of inspections in 2014 and 2016 again state that self-harm can occur only in a cell, and that if a risk is identified on the PER there will be a minimum of six checks an hour.

8.19 As before, there is no specific reference to the grille gates adjacent to the toilets, but unspecified non-security doors were observed unlocked and unsecured and, as before, it is noted that SOP 083 paragraph 1.1.2 stipulates that all gates and doors must be locked and secured before prisoners arrive.

Monitoring reports by the HMPPS Contract Delivery Manager

January 2015

8.20 The Contract Delivery Manager in HMPPS Prisoner Escort and Custody Service monitors the contract on behalf of HMPPS. A report of a visit on 2 January 2015 is highly critical of the operation of the custody suite at that time.

8.21 The report states that the senior custody officer for the court had recently been dismissed and, consequently, there was no leadership, and morale was very low, with staff feeling negative and reluctant to take ownership of roles and responsibilities. Consequently, the suite was disorganised and there were few systems in place.

8.22 An experienced senior custody officer from another court was running the suite at the time of the visit. He had instigated improvements but was not based at the site regularly so had not had the opportunity to put all the required systems in place.

8.23 The overall recommendation was to ensure that a strong, competent senior officer is recruited and that all systems are reviewed and correct.

8.24 Among deficiencies identified were that daily checks were completed spasmodically, with no individual taking responsibility; the briefing sheet was not printed daily and shared and signed by all PCOs in accordance with the requirement. There were no filed copies of cell sharing risk assessments, which were never used because the number of cells meant there was rarely a need to share. However, it was said to be understood by staff that this facility can be used when custody officers feel that it would be of benefit to 'buddy' a prisoner with another. Some PERs had no events detailed. Paperwork was generally not well maintained, and files were not in good order.

8.25 The Occurrence book was all electronic with no paper version on site. (Our investigation noted that the Occurrence book for 16 March 2015 gives little detail about the events of the day, recording only key check, opening and closing checks, the arrival and departure of vehicles, and that at 10:50 a prisoner tried to hang himself in the cell block toilet.)

8.26 To the deficiencies identified in this monitoring visit we would add that we observed at paragraph 3.23 above that there was no entry in the visitors' book for certain legal visits. In response to the draft of this report the solicitor acting for DM's mother says that in her experience this requirement is now strictly enforced.

Observation

8.27 The report in January 2015 presents a disturbing picture. The description of an absence of systems, oversight, and leadership, corresponds with - and may explain - deficiencies that our investigation has identified in the operation of the custody suite on the day of DM's self-harm, in particular, a substantial disregard of many of the procedures that we have examined in Part Seven of this report. The report suggests that these deficits were endemic at this time.

June 2015

8.28 The report of a site visit on 29 June found significant improvements: there was a newly appointed Senior Custody Officer (SCO); all cells were checked daily and checks documented; the handover of prisoners was thorough, and the welfare of prisoners was checked through a conversation on arrival. PERS were completed to a good standard; briefing sheets were signed and filed. There was a vulnerable prisoner with mental health issues who was known to staff. The staff monitored her on an increased level and annotated her PER and the Occurrence book accordingly.

8.29 After closing checks, all doors in the custody suite were left open for cleaning purposes and the suite relocked during opening checks. Control gates/doors were not left open when the suite was in use.

8.30 The report notes that staff complements were sometimes inadequate, and the SCO said he rarely received help if he requested it. It was noted that the separate area for female prisoners was rarely used even if they were present. Instead staff stated that, for ease, female prisoners were placed in a different corridor in the male section.

8.31 Three PERS were checked against the electronic GEOTrak system and the information tallied.

8.32 SOPs were available electronically with the more commonly used ones printed off and filed. Any amendments were cascaded in the daily briefing,

Liaison with the court

8.33 In September 2017, the investigation spoke with the Acting Operations Manager for the Southampton Magistrates' Court.

8.34 Her understanding was that, as Operations Manager, she was responsible for the court buildings and health and safety. GEOAmey was responsible for the cell area, areas of transit and docks. GEOAmey would report any damage to the areas they are responsible for, and the court service was responsible for repairs. It had recently been agreed that the Court Custody Manager (formerly called the Senior Custody Officer) would have a conversation every morning with the Court Delivery Manager about operational matters. We were told that there would also be a monthly inspection of the cells by the Court Delivery Manager.

8.35 The Operations Manager said she would expect the custody service to share with the court any concerns they have about someone at risk of self-harm. Given that DM was processed first in court on the day of the incident, she thought this would probably have been arranged with the Delivery Manager or legal adviser before the court sat. If information about a prisoner's health is given to the delivery manager, it is passed on to the legal adviser.

8.36 The Deputy Justice's Clerk told us in September 2017 that the custody service is short staffed. There are some days when there are not enough staff to supervise the court properly. They are contracted to staff four courts a day. The

GEOAmey Area Business Manager has confirmed to HMCTS that only one member of staff is required to escort prisoners in the dock, but sometimes the custody staff consider two are required, which reduces the availability of staff for duties elsewhere. Sometimes van staff assist. The Clerk assumes there is a risk assessment to ascertain levels of staffing in court, but the court is not always aware why one member of staff is appropriate one day and two another. Sometimes an apparently low-risk prisoner comes to court with two escorts.

8.37 We spoke to a magistrate who was appointed Chair of the Bench shortly before the incident. She was not made aware of the incident at the time or afterwards and she understood the magistrate who presided at DM's hearing was not aware of DM's self-harm until the present investigation.

8.38 The Chair of the Bench said she would expect information from the custody services about any concerns before a prisoner is brought into court. This usually comes via the Usher or Legal Adviser. They are sometimes told if a prisoner is coming down from drugs or is fractious, and they might bring the case forward to reduce the time the prisoner waits in the cells, but they have no control over how much information they receive.

8.39 The magistrates go through the court list each day at a pre-briefing with the Legal Adviser and enquire whether any defendants have seen the mental health team. Following any intervention by the mental health and liaison service, magistrates will ask if they have any concerns and may adjourn for more information. There is no written protocol for sharing information about prisoners with the Magistrates' Court.

8.40 There is now a prompt card on the bench to advise magistrates what to do if they have concerns about a vulnerable defendant with a mental health or learning disability and how the situation should be managed. This reminds magistrates to enquire whether a person has seen the Liaison and Diversion Service, and options if they are concerned as to whether a defendant is fit to plead, and sentencing options.

8.41 The magistrates are not responsible for the cells area and have no managerial role about what happens in the court building. It is no longer a requirement for new magistrates to visit the cells as part of their induction, but the Chair thinks that they should.

8.42 The Chair also said the Court Users' Groups had been a useful cross-discipline forum for discussing and resolving issues, but they no longer operated.

Observations

8.43 It may be that awareness of the need for liaison between the custody suite and the court has been heightened since the events with which this investigation is concerned. I am pleased to say that, in response to the draft of this report, the solicitor acting for DM's mother has commended a recent case concerning a vulnerable young woman, in which there was constant communication between the Court and the custody suite and the solicitor witnessed a caring approach by the custody staff.

8.44 The solicitor for DM's mother also commented that, at the time of writing, the intercom system permitting entry of solicitors to the custody suite at Southampton Magistrates' Court, had been broken for some time. This has meant that solicitors have to use their mobile telephones to arrange entry to the custody suite for legal visits, and instead of the door being released electronically, a member of the custody staff has to open the door manually. This is an extra duty for staff, diverting them from their other tasks and, in particular, reducing their availability to attend to the people in their custody. I have drawn this to the attention of GEOAmey, with the expectation that it would soon be fixed, but it nonetheless serves to illustrate the importance of cooperation between the court, who are responsible for repairs, and the custody staff responsible for the prisoners in their care.

Safety and Security

8.45 The Regional Security and Safety Officer for the South West Region of HM Courts and Tribunals Service (HMCTS) said that his audits take account of custody suites, but the cell area is controlled by GEOAmey and he must seek permission before entering. Information is exchanged via his opposite numbers in GEOAmey.

8.46 In the case of DM's self-harm, GEOAmey provided little information. He requested a copy of the internal investigation report but this was not provided. He said it was made clear that his presence was not welcome to speak to the staff to make sure they were OK after such a traumatic event.

8.47 His knowledge of the incident was therefore limited, and his only input had been to ask why there had been confusion over directing the ambulance, as the custody service had not told the court it was expected.

Aftercare for staff

8.48 We asked the custody staff whether they received support from their employer after DM's self-harm. Staff who were away from their home area found it more difficult to carry on operating as if nothing had happened, but some spoke well of the support they received from managers later at their home base. Support from managers and a counselling service was not always readily available when staff tried to access it. It was clear that some staff had experienced lasting distress. (Dr Craissati has commented on the need for aftercare for staff in her clinical review for the investigation – see paragraph 5.35.)

CHAPTER NINE:

KEEPING PRISONERS SAFE IN CUSTODY SUITES

9.1 Many prisoners in the care of the escort and custody service are vulnerable, especially because of substance abuse and/or mental health issues or a propensity to self-harm. Nonetheless, self-harm is not a common occurrence in court custody units. There were five recorded instances of self-harm at Southampton Magistrates' Court in 2015, and regional and national figures for that year indicate reported incidents of self-harm for less than 1 in 1500 prisoners in the care of the escort and custody service, though an increase the following year (see Table at paragraph 7.2 above). Across the whole population of prisoners in custody suites, the incidence of self-harm is low, but the consequences, as in this case, can be disastrous. Identifying those most at risk is challenging, and staff may become complacent. That is why it is necessary to have simple systems embedded in the management of the custody suite operations that are followed as a matter of routine.

INFORMATION-SHARING AND RISK ASSESSMENT IN PRACTICE

THE PERSON ESCORT RECORD – SOUTHAMPTON MAGISTRATES' COURT

9.2 PSO 1025 paragraph 1.5 says:

> *'The PER is the key vehicle for ensuring that information about the risks posed by prisoners …transferred within the criminal justice system is always available to those responsible for their custody. It is a standard form, agreed with and used by all agencies involved in the movement of prisoners. The form highlights the risks posed by and the vulnerability of prisoners on external movements, provides assurance that the risks and weaknesses have been communicated to those who are responsible for the prisoner and provides a record of events during a prisoner's movements.'*

9.3 In order to test the effectiveness of the processes for communicating and managing risk of suicide and self-harm, the investigation examined the escort records for the six prisoners, in addition to DM, who were held in the custody suite on 16 March 2015.

Prisoners with risk indicators for self-harm

9.4 In addition to DM, four other prisoners had risk indicators on their PER for suicide and self-harm.

Prisoner 1

9.5 The EPER lists risk types medical, suicide and violence. The PER says that in 2015 Prisoner 1 banged his head on a wall and placed a police officer in a choke hold. There is no evidence of any consideration by the custody staff of risk of suicide or self-harm.

9.6 Prisoner 1 was placed in a cell at 08.50. A legal visit is recorded from 09.35 to 09.45. The solicitors' visiting records and the evidence of Officer E and the cells officer indicate that Prisoner 1 had another legal visit that ended about 10.45 but this is not recorded on the escort records. Checks or delivery of food and drink are recorded in the morning at approximately hourly intervals. In the afternoon there is no check recorded for a period of 2 hours and 15 minutes from 13.15 until 15.30.

Comment:

9.7 Police entries on the PER indicated a risk of suicide or self-harm but there is no indication that any consideration was given to this in the custody suite. A second legal visit was not recorded. If the records are to be believed, Prisoner 1 was left alone in his cell without any check in the afternoon for a period of over two hours.

Prisoner 3

9.8 The handover details in the PER says Prisoner 3 was handed over to Officer B at 08.08 for the two-person vehicle, and that Officer B handed Prisoner 3 over at the court. However, the EPER says Prisoner 3 travelled on the six-person vehicle and this appears to be correct.

9.9 The EPER and the PER for Prisoner 3 list risk types drugs, suicide and violence. Medical risks are listed as depression and that Prisoner 3 is on '*Certrallen*' (probably referring to the anti-depressant Sertraline) and has been seen by the doctor. Details of the risk of self-harm entered by the police on the PER are said to be that Prisoner 3 *'has suicidal thoughts every day – son has been taken away – no thoughts of sh*'. (We were unable to establish whether the confusion over

the handover of Prisoner 3 extended to a confusion about the risk of self-harm, which is strikingly similar to what DM said about his distress at the time.)

9.10 The EPER says Prisoner 3 was placed in Cell 11 at 08.48 and had a legal visit from 10.08 to 11.20. He was escorted to court at 12.10 and returned at 12.46. He was given food and drink at 13.00 and was handed over for escort to prison at 14.25. There are no other records of interaction or checks.

9.11 There is no reference in the record of events to any consideration of risk. After admission procedures, no further checks or refreshments in the custody suite are recorded on the PER.

Comment:

9.12 Prisoner 3 was said to be at risk of self-harm and the entry by the police is ambivalent about how imminent the risk is. There are anomalies in the records. The EPER and the PER have the prisoner travelling on different vehicles. Most striking is that there is no evidence that any consideration was given in the custody suite to a risk of self-harm and the recorded checks do not even meet the requirement that all prisoners be checked at least once every hour, let alone the requirement for prisoners at risk to be checked a minimum of six times an hour. If the records are to be believed, Prisoner 3 remained alone in his cell without any check by staff for 1 hour and 20 minutes on arrival, for 50 minutes between his legal visit and court appearance, and for 1 hour and 25 minutes while waiting for transfer to prison.

Prisoner 8

9.13 Risk types are listed on the EPER and the PER as drugs, medical, suicide and violence. The PER cites an instance of non-lethal self-harm and addiction to cannabis, and medical risks are detailed as asthma, depression and anxiety.

9.14 The EPER says Prisoner 8 was placed in Cell 12 at 08.49 (but that was the cell where DM was apparently located) until a legal visit from 10.11 to 10.37 from which he returned to Cell 15, where he remained until taken to court at 11.41. After the admission procedures at 08.49, there is no record in either the PER or the EPER of any checks or of any consideration given to risk of self-harm.

Comment:

9.15 There is apparently an error in recording Prisoner 8's location. The police indicated a risk of suicide or self-harm but there is no indication that any consideration was given to this in the custody suite. If the records are to be believed, Prisoner 8 was left alone in his cell without any check by staff for 1 hour and 10 minutes after admission, then for a further hour until he was taken to court.

Prisoner 7

9.16 Prisoner 7 was escorted from another police station in a different vehicle and arrived at Southampton Magistrates' Court at 11.40. The EPER states 'No special risks'.

9.17 By contrast with the EPER, the risk indicator in the PER lists risks of violence, escape and suicide/self-harm. Prisoner 7 is said to have jumped from a bridge seven months ago, taken an overdose, and driven into a tree. He is also said to be dyslexic and to have allergies, spinal problems, and asthma and psychosis problems and to be taking anti-depressants.

9.18 After a drink and admission procedures at the custody suite at 11.45, there is no record of any check, refreshment or other interaction until Prisoner 7 was taken to court at 15.05. He was released at 15.36. There is no indication of any consideration of a risk of self-harm.

Comment:

9.19 There is a glaring discrepancy between the risks recorded on the EPER and the PER. There is no evidence of any consideration of Prisoner 7's propensity to self-harm. If the records are to be believed, Prisoner 7 was left alone without refreshment or interaction for 3 hours and 20 minutes.

Prisoners with other risk types listed

9.20 The escort records for all four other prisoners in the custody suite that day give similar cause for concern.

9.21 Prisoner 2 was in the custody suite from 08.47 until 14.20. After admission procedures, no checks, refreshments or visits are recorded on the PER. The EPER

records a legal visit from 11.40 to 12.00 and lunch at 13.00 but no other checks, indicating that there was no check for nearly three hours from his admission.

9.22 Prisoner 4 was in the custody suite from 08.51 to 17.20 except for his appearance in court from 15.50 to 16.13. The EPER lists risk factors for drugs, medical, violence and weapons. The PER lists risk types drugs, concealing drugs, and asthma, and a medical assessment/care plan is said to be enclosed. The EPER records a legal visit from 10.00 to 10.20 and delivery of refreshment or checks at 11.00, 12.00, 13.00, 14.00, 15.00 and 17.15. No checks or refreshments are recorded on the PER.

9.23 The EPER for Prisoner 6 records medical risk without any explanatory comment. The PER lists medical risks as heroin user, paranoid psychotic episodes, bi-polar. Prescribed medication is said to be enclosed and there is an accompanying Detained Person's Medication Form in which a doctor has recorded administration of medication in police custody. Prisoner 6 was placed in a cell at 08.48. There is no record of any further check or interaction until he was taken to court at 10.33, 1 hour and 45 minutes later.

9.24 No risk types are recorded on the EPER for Prisoner 5. The PER lists a sex offence in 2008 and medical and mental health risks from Type 1 diabetes, high blood pressure and depression. After standard admission procedures at 08.53 there is no record of any check or interaction until a legal visit at 12.31. The PER but not the EPER says Prisoner 5's sugars were checked at 13.00 when he returned from the legal visit. No further check or interaction is recorded until he was escorted to court at 14.35.

Conclusion

9.25 These records indicate wholesale breaches of the requirements stipulated in the standard operating procedures for risk assessment and information sharing:

- There is no evidence that any consideration was given to assessing the risks of self-harm indicated on the escort records of four prisoners in addition to DM.

- The presumption that a prisoner assessed to be at risk of self-harm will share a cell: there is no indication that cell-sharing was ever considered.

- The requirement that a prisoner said to be at risk of self-harm should be checked at irregular intervals a minimum of six times an hour and that those checks should be recorded in the PER and EPER with details.

- The requirement that if a prisoner is recorded as having mental health risks, consideration should be given to whether he should be checked six times an hour.

- The requirement that all prisoners should be checked at irregular intervals not less than once every hour.

9.26 Other prisoners in the custody suite will have been aware that a serious incident had occurred. Such an event may make other prisoners more vulnerable. There is no evidence of any special attention to ensuring that other prisoners in the custody suite were not distressed.

9.27 We cannot say whether the absence of entries in the Person Escort Records for these prisoners indicate alarming deficiencies in care or failure to keep records.

9.28 Maintaining records is not a pointless bureaucratic process. It is an important tool in planning and delivering care. The requirement to record, systematically, performance of the measures in place for the safe care and management of prisoners is to ensure that members of the custody team perform those tasks, that they know what their colleagues have done, what remains to be done, when checks are required, and any changes in the mood or condition of those detained.

9.29 It is possible that the records do not wholly reflect the times that the cells officer, who was based inside the cells area, checked or spoke with the prisoners there. We are satisfied that before DM went to court custody officers spent time talking with him which was not recorded in his records. Inconsistencies and errors in the records do not inspire confidence that they provide an accurate account.

9.30 It is also possible that this was an exceptional day in which normal procedures went awry because of what happened to DM. However, some of the inconsistencies, the failure to consider risk indicators, and the absence of recorded checks occurred before the emergency, and the breaches identified are depressingly similar to those identified in the Contract Delivery Manager's report from January 2015 (see paragraphs 8.20 to 8.26).

PERSON ESCORT RECORD - THE NATIONAL PICTURE

CONCERNS EXPRESSED BY HM INSPECTORATE OF PRISONS (HMIP) ABOUT THE EFFECTIVENESS OF THE PERSON ESCORT RECORD

9.31 In 2012, at the request of the Independent Advisory Panel of the Ministerial Board on Deaths in Custody, HM Inspectorate of Prisons published a thematic review on *'The use of the person escort record with detainees at risk of self-harm'* (HMIP 2012). Their research focused on the use of the PER by the police and by prisons and YOIs, but focus groups included staff from the escort and custody service, and some of HMIP's observations are transferable to the escort and custody service. Their findings also demonstrate that the custody service is not always well served by the information passed on by the police. The Inspectorate recommended a multi-agency approach to improving the utility of the Person Escort Record.

9.32 The Inspectorate found that police officers often lacked understanding of how information about risk of self-harm was used. A risk of self-harm might be recorded because of an entry on the Police National Computer but there was often a lack of contextual information indicating the nature or date of the concern. In particular, there was often little information about what had happened in the immediate period of custody and what the prisoner themselves said about their present mood. Moreover, there was no system of quality assurance to identify these deficits and to promote good practice.

9.33 The review identifies the two key issues emerging from the review as:

- maintaining quality in large-scale processes where risks might be infrequent but serious for the individuals concerned, and

- ensuring that communication between operational staff involved is effective and informed by a good understanding of each other's needs.

9.34 HMIP recommended:

- The National Offender Management Service (now HMPPS) should establish mechanisms to encourage PECS, police services, prisons and the PECS contractors to work together regionally to improve the quality and flow of information about self-harm, through quality assurance, provision for

notifying police national computer markers, consistency in the use of self-harm warning forms, staff training, and convening an inter-agency forum to steer improvements and resolve any problems.

- The inter-agency forum should create opportunities for operational staff and managers working in police custody, escort, courts and prisons to have a regular structured meeting to learn about each other's work and understand the importance of generating accurate and comprehensive information about self-harm.

- The Ministerial Board on Deaths in Custody should commission work to develop the coverage of courts by mental health diversion teams and strengthen joint working between court and prison mental health services.

- Staff training should encourage police, court custody and escort staff to talk with detainees, particularly when concerns have been identified, as part of the process of actively monitoring their mood. It should equip staff to recognise and ask about any significant evidence of increased risk of self-harm, record it, and note it on the PER, and it should provide staff with basic awareness of how information about risk of self-harm is used.

9.35 HMIP emphasise that a PER is not a risk assessment tool but is a prompt for a risk assessment to take place. The PER is designed to convey information about assessed risks to those who may need to know about them.

Observations and conclusions

9.36 The PERs we examined illustrate the defects in the use of the PERs identified by HMIP. In the PER received by the custody service for DM the entry about self-harm was vague. It included no information about what happened in the immediate period of custody or what DM himself said about his present mood (see paragraphs 7.11 - 7.12 above). In PERs for other prisoners the information was more informative but there was no evidence that the custody staff took it into account (see paragraphs 9.4 - 9.19).

9.37 The PERS we examined also suggest – perhaps contrary to HMIP's view that risk is infrequent - the prevalence of complex vulnerabilities among the people who pass through the custody service's care. This makes evaluating degrees of risk a challenging task, but in the case of DM and the other prisoners in the custody

suite on the same day there was no indication of any kind of systematic risk assessment at all.

Hampshire Police

9.38 The Hampshire Constabulary told the investigation that they acknowledged that in 2015 the PER system was not as good as it could have been. The Force Solicitor says that this was identified after 2015 and in 2016 there was a significant improvement in the quality of PER completion, with custody refresher courses for all custody staff, updated policies and procedures and a focus on improving the completion of forms.

9.39 In the particular case of DM, Hampshire Police acknowledge that the PER completed by the police did not have as much information as might have been expected, but they note that risks, including a risk of self-harm, were recorded, and that DM made known his distress to the escort staff. The police say that, whilst it is regrettable that all the relevant information was not captured in the PER, in their view this made no difference to the tragic outcome.

THE PILOT PROJECT FOR IMPROVEMENTS IN THE PERSON ESCORT RECORD

9.40 HMPPS is leading a multi-agency project to improve the format and use of the Person Escort Record. The project began in 2015. We understand that the intention is to provide an improved form covering more information and, in particular, that it should be dynamic, with a 'Red Flag' page to highlight heightened risk, not only in relation to self-harm, but including, for example, risk of violence, or signs of mental disorder. A Suicide and Self-Harm Warning form is included as an integral part of the new PER booklet. There is a new health and social care page for health risks, social care needs, other vulnerabilities and details of medication. The front cover page requires entries to show whether a Suicide/Self-Harm Warning Alert has been completed, whether an HMPPS ACCT document is enclosed, and whether a Red Flag page has been completed.

Recording risk of self-harm

9.41 In the version of the pilot PER that we have seen we found that the relationship between the risk indicator page, the Suicide and Self-Harm Warning form and the Red Flag page was not altogether clear.

9.42 The risk indicator page, which is the first document inside the booklet, is unchanged from the one in use in 2015. Whilst asking for details of current and relevant risk against a number of risk areas, including suicide and self-harm, the form provides very little space to encourage inclusion of detail.

9.43 The guidance says that a suicide and self-harm warning form should:

'*only be opened if staff believe there is a current risk of self-harm. To ascertain this it is essential to speak to the individual*.'

9.44 The Red Flag page is to be completed to draw attention to

'*any known risk factors or vulnerabilities which impact on the safety or well-being of the person whilst in your care*.'

Staff are required to enter known risk factors or vulnerabilities

'based on the information contained within the body of the PER document'

and to record and highlight any incidents, vulnerabilities or risk factors indicating a heightened risk during the period in custody. The Red Flag page has ample space for free text comments explaining the cause for concern.

9.45 We can envisage that a prisoner might have a history of self-harm insufficient to warrant completion of a warning form or the Red Flag page, but nonetheless requiring custody staff to be alert to the possibility of an increasing risk. There is a significant difference in the level of concern indicated by a single act of self-harm in the distant past and repeated or recent incidents. Moreover, those completing the Red Flag page will often be prompted by information from elsewhere in the PER. Therefore we suggest that the risk indicator page might usefully prompt more emphatically the need for information about the date, nature and source of the concern, and it would be helpful if the design of the page could encourage this by providing more space.

Health and Social Care

9.46 In a section for 'Other Vulnerabilities' the Health and Social Care page asks, 'Does the person meet the definition of a person at risk?' Guidance sets out criteria and thresholds for a person to be considered to be a person at risk. It

might be helpful for this section of the guidance to be called 'Definition of a Person at Risk' rather than just 'Person at Risk' so that it matches the form.

9.47 We understand that the form is being piloted in five prisons in the South/Central area, in some police stations in that area and in courts served by those police stations and prisons. A Project Working Group has members from the police, the pilot agencies, the escort contractors and PECS. An evaluation in 2016, with advice from a psychologist, found that the form improved the quality of information but this relied on there being good guidance and training. There have been some changes as a result of the evaluation. The latest version will go to a smaller working group of users and when a final version is ready it will go for ratification to each of the public agencies involved.

Observations and conclusions

9.48 We welcome the project to improve the quality of the information transferred through the Person Escort Record. However, the deficiencies in the use of the PER that were evident from the cases we examined were not solely attributable to lack of space or the absence of prompts to staff to record relevant information.

9.49 We agree with the evaluation of the pilot project that guidance and training are critical, so that staff in all the agencies that use the form have an understanding of the purpose of the form, the needs of each of the agencies concerned, and the sources of information that they should refer to in completing the form. The redesign clarifies areas of risk and will give more opportunity for risk information to be transferred effectively but it will require knowledgeable users, with an understanding of the process and what information needs to be included, and the time to use the form effectively. The Project Group will need to be satisfied that it will be practicable for the more complex form to be used intelligently when it becomes routine and is no longer under the microscope as a pilot. We wonder whether it might be helpful to incorporate an algorithm signposting which sections of the form should be completed.

Recommendation

9.50 We invite the Project Group on the Person Escort Record to consider the defects in the use of the PER that we found in this investigation; to consider our comments on the pilot form and in particular:

- the importance of entries about suicide or self-harm on the Risk Indicator page stating the nature and date of incidents giving rise to concern and the source of the information considered to indicate a risk; and

- ensuring that there is clear guidance to staff about when an entry for suicide and self-harm on the risk indicator page should prompt completion of a warning form and/or the Red Flag page.

COURT CUSTODY SUITES – THE FINDINGS OF HM INSPECTORATE OF PRISONS

9.51 In October 2015, HMIP published a thematic review on court custody calling for urgent improvements (HMIP 2015). The review identified serious deficiencies which the Inspectorate found to be widespread. Southampton Magistrates' Court was not among the 97 courts inspected but the list of concerns is not inconsistent with what we have learned about the Southampton Magistrates' Court in March 2015.

9.52 In the Introduction to the thematic review the Chief Inspector says:

'*… despite, in many cases, the best efforts of custody staff, we found a dangerous disregard for the risks detainees might pose to themselves or others. Court custody is an accident waiting to happen.'*

In particular,

'Of most concern is the lack of any meaningful risk assessment when detainees arrive in court custody or are released. Custody staff often received very vague information about risks in person escort record forms and were often reluctant to talk with detainees to help clarify concerns. A few custody staff did attempt to ask detainees how they were feeling, or about what had happened when they had harmed themselves before, but it was often clear that they lacked training in risk assessment.'

9.53 It was noted that decisions about how vulnerable detainees would be cared for were usually made on the basis of information in PER forms from the police or from prisons, whose content was often incomplete or vague (HMIP 2015, paragraph 1.6).

9.54 Cell sharing risk assessments were often completed after detainees had left the court or not done at all (HMIP 2015, paragraph 1.6).

9.55 Custody staff usually checked on detainees at the required intervals, but at some courts there were sometimes too few staff to be able to do so sufficiently frequently to meet safety and security requirements (HMIP 2015, paragraph 1.6).

9.56 Most custody staff were friendly and polite to detainees but generally interacted with them little after admission other than looking through the window or hatch in the cell door at the required intervals (HMIP 2015, paragraph 7.9).

9.57 There was no systematic risk assessment. Some staff said that concerns would have been discussed with the detainee on the cellular vehicle, but the vehicles lacked the privacy to explore sensitive issues (HMIP 2015, paragraph 7.22).

9.58 In many courts, custody staff brought in newspapers and magazines from home to give to detainees, but sometimes there was nothing available to help pass the time (HMIP 2015, paragraph 7.9).

9.59 At many, but not all courts, Senior Custody Officers conducted a morning briefing with custody staff. Sometimes, information was provided about detainees' risk, but at others the briefing was concerned with telling staff what duties were being assigned to them. Some custody staff made commendable efforts to engage with detainees in assessing and managing risk, but many lacked the skills and facilities to follow this through properly (HMIP 2015, paragraph 7.23).

9.60 Each courthouse had access to healthcare advice from a contractor, but the service was used very little even when there was a clear need for advice (HMIP 2015, paragraph 1.11).

9.61 HMIP considered that three yearly refresher training in first aid was too infrequent to maintain adequate skill levels given the low level of reported incidents (HMIP 2015, paragraph 8.2).

9.62 Recommendations about health care in the first eight court custody inspection reports included:

- Court custody staff should be trained to identify and appropriately refer detainees who may be experiencing mental health or substance use-related problems.

- There should be access to mental health services for detainees appearing to have mental health problems.

- All detainees who require prescribed medications while in court custody should have access to it.

- All detainees should have access to mental health support at all times that the courts are open. There should be clear processes agreed with the courts and mental health trusts for the provision of Mental Health Act assessments (HMIP 2015, paragraph 8.10).

9.63 Other observations by HMIP were:

- No courthouses had automated external defibrillators and first aid kits were usually inadequate (HMIP 2015, paragraph 1.11).

- Access to mental health services varied, being excellent in some areas but difficult to obtain in neighbouring areas. Most custody staff told the Inspectorate they would like to acquire better skills in working with detainees who had mental health problems (HMIP 2015, paragraph 1.11).

- There was some concern about staffing levels in court custody. In one court there was no senior custody or deputy senior custody officer on duty. When problems arose, no effective leadership was exercised, putting detainees at potential risk. Although there appeared to be sufficient custody officers to care for detainees during the inspection, at most courts custody staff relied on assistance from vehicle crews, some of whom did not know the custody suites or their facilities sufficiently well (HMIP 2015, paragraph 7.26).

- A consistent theme of court custody inspections was that no single organisation had an overview of the whole picture and, as a consequence, problems often remained unresolved (HMIP 2015, paragraph 1.1).

- Contract management processes focused largely on timeliness and security rather than detainee care (HMIP 2015, Introduction, page 6). At a strategic level, there was little collective attention given by the various organisations to detainee care and safety. The organisations concerned with court custody had different imperatives. For example, HMCTS was

concerned with efficient case management, and custody contractors with security and timely delivery. HMIP found that these were given greater importance than the basic conditions in which detainees were held (HMIP 2015, paragraph 1.1).

- Detainees might spend eight or 10 hours in a tiny cell with no natural light, and sometimes no heating, that might be filthy or covered in graffiti, on a hard wooden or plastic bench with nothing to do. HM Courts and Tribunals Service (HMCTS) managers were often unaware of conditions in the cells or how long prisoners might spend there (HMIP 2015, Introduction page 6).

9.64 The Chief Inspector recommended that Ministers required HMCTS to develop and publish a strategy with clear performance measures for the rapid improvement of detainee treatment and custody conditions to include:

- the identification of named individuals at local and national level responsible for court custody conditions and treatment;

- the establishment of effective and regular structures at local and national level to coordinate the work of all the organisations with a role in court custody, including the Lay Observers;

- the inclusion of health care in court custody in England in NHS England offender health commissioning arrangements (Introduction page 7).

9.65 In inspections of particular court custody suites HMIP has recommended among other things that

- HMCTS local managers should visit court custody suites regularly, to monitor standards and to resolve or escalate any issues as appropriate.

- HMCTS and the PECS contractor should work together to establish clear joint arrangements to ensure that Lay Observers' concerns are understood and addressed effectively.

- There should be clear procedures for safeguarding vulnerable detainees, including those released from court, and custody staff should be briefed about how and when to use them. (paragraph 5.12)

Observations and conclusions

9.66 Some of the problems identified by HMIP across a number of other courts resemble issues that have emerged from our investigation: the absence of risk assessment for vulnerabilities and cell-sharing; staffing deployment to meet safety and security requirements in compliance with standard operating procedures; a lack of liaison between the custody service and the court; the need for defibrillators. We have made recommendations elsewhere in this report about some of these matters.

9.67 Action has been taken to ameliorate some of the problems identified by both HMIP and this investigation. Access to mental health care through the Liaison and Diversion Service is a crucial advance, but risk assessment by the custody staff remains fundamental. HMIP identifies three elements necessary for meaningful risk assessment:

- Where relevant information is known by the custodial agencies it should be passed on in the PER in specific terms. We have referred to this above at paragraphs 9.43 and 9.49.

- Staff need to have the expectation, the skill and the time to draw information from the people in their care. Our clinical reviewer speaks of the need for a culture of curiosity and concern. This requires leadership, training and guidance on preventing suicide and self-harm, and interpersonal skills. Paragraphs 5.41 to 5.42 above comment on the form and focus of mental health awareness training.

- HMIP observes that the priorities of the court service and the custody service focus mainly on efficient throughput rather than care of those in custody. They recommend that there should be performance measures focusing on treatment and conditions in custody with named individuals responsible, and that HMCTS local managers should visit court custody suites regularly to monitor standards and resolve problems. We agree.

Recommendation

9.68 We recommend that HMPPS and HMCTS review and report on their progress in implementing the recommendations on Court Custody made by the Inspectorate in 2015. We recommend specifically that:

- HMCTS local managers should have access and a responsibility to visit court custody suites regularly to monitor conditions and resolve problems.

- automated external defibrillators should be provided in all courthouses, accessible to the custody and court staff, who should be instructed in their location and use.

- HMPPS ensures that performance requirements for contractors, and contract monitoring, include measures focusing on treatment and conditions for those in custody, a requirement for regular liaison with HMCTS staff, and an understanding that HMCTS have a responsibility to monitor standards.

- that where magistrates wish to visit custody suites to see the conditions in which people appearing before the courts are held, HMCTS, HMPPS and the contractors facilitate this.

ANNEX:

NOTE ON THE INVESTIGATION PROCEDURE

Article 2 of the European Convention on Human Rights

1. I am required to conduct the investigation in compliance with Article 2 of the European Convention on Human Rights. Article 2, which safeguards the right to life, can require the State to mount an independent investigation when someone in custody suffers life-threatening self-harm.

2. In compliance with Article 2, the investigation will be independent, open, transparent and even-handed, and will provide an opportunity for DM, or those who can represent his interests, to participate in the investigation.

3. My objective is to ensure as far as possible that the full facts are brought to light and that lessons learned may save others from similar suffering.

4. The investigation will not consider any question of criminal or civil liability.

The investigation team

5. I will be assisted in the investigation by an Assistant Investigator, and by the Personal Assistants to Article 2 Investigations.

6. The investigation may commission a suitably qualified health professional to provide clinical advice.

The investigation process in outline

7. The investigation will examine documents, establish relevant lines of inquiry, prepare a chronology, and identify relevant witnesses. Interviews with witnesses will be held in private. They will be recorded and transcribed. Documents and transcripts will be made available to the interested parties to enable them to participate in the investigation but are not for publication. Documents and interview transcripts may be quoted or referred to in the investigation report, which will be a public document and will be made available on the website of the Independent Advisory Panel on Deaths in Custody. Unless there are exceptional circumstances, individuals will not be named in the final report.

8. The investigation wishes to meet representatives of DM's family at an early stage to consult them about how DM's interests may be represented in the investigation.

9. Introductory visits and meetings may also be held with others, including the other interested parties.

The interested parties

10. The interested parties known to the investigation at present are DM, through his representatives, Her Majesty's Prison and Probation Service, and GEOAmey, who are the contractors who provide the escort and custody service at Southampton Magistrates' Court.

11. Anyone else who considers they have a special interest in the proceedings or outcome of the investigation may ask me to consider granting interested party status.

Evidence

12. The investigation requests interested parties and anyone who holds documents that may be relevant to supply those documents to the investigation. The investigation may request further documents and/or oral evidence from the interested parties or other persons whom it considers hold relevant material.

13. The investigation makes a presumption that relevant documentary and oral evidence will be shared with interested parties, and with others where that is necessary for the conduct of the investigation. However, there are some circumstances where, exceptionally, documentary evidence may be redacted or withheld.

14. The terms of the investigation's commission stipulate that the Secretary of State may require redaction of documents on the basis of security, relevance or other sensitive matters before onward transmission to interested parties or others.

15. Where a witness or any other person considers that any part of a document, transcript, statement or other material they have provided should not be disclosed, he or she should inform the investigation of the reason for this view when the document or statement is provided. If any material which the investigation considers relevant is redacted by the Secretary of State or withheld

at the reasonable request of a witness, the investigation will disclose to the interested parties the fact that material has been redacted or withheld and the reason for this.

16. The investigation may undertake interviews with witnesses it considers relevant. Witnesses will be provided with a written explanation of the investigation, terms of reference and the purpose of the interview. The investigation will have regard to the need for witnesses to have the means and opportunity to obtain support and representation if necessary. All the persons approached will be directed to the issues about which it is considered they may have relevant evidence. They will be supplied with copies of documents that are relevant. Interviews with witnesses will be recorded and transcribed.

Draft report

17. The investigation report will be made available in draft to the interested parties in confidence so that any factual inaccuracies may be addressed and any comments considered before final submission to the Secretary of State.

18. Any person who may be criticised in the investigation report will be given advance disclosure of the criticisms and be given the opportunity to respond before the report is finalised.

Final report

19. The Investigation Report will be presented simultaneously to the parties, subject to appropriate redaction if necessary. It will be a public document and will be published on the website of the Independent Advisory Panel on Deaths in Custody but without the documentary and witness evidence.

20. The final report will not contain the proper names of any persons unless the investigation considers that, exceptionally, any individuals need to be named for the purposes of Article 2, for example, because that person has been involved in serious wrongdoing. If I am minded to name any individuals in the report for this or other reasons I am required to write to the Secretary of State in advance giving reasons.

Barbara Stow
Lead Investigator