Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rafal Sochacki at Westminster Magistrates Court on 21 June 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Rafal Sochacki died of cardiovascular collapse caused by hyperthermia (severe heat stroke) and hypertensive heart disease in a court cell at Westminster Magistrates' Court on 21 June 2017. He was 43 years old. I offer my condolences to his family and friends.

The circumstances of Mr Sochacki's death are very disturbing. On the way to court he spent 50 minutes parked in an unventilated escort vehicle and was then held for nearly five hours in an unventilated court cell on one of the hottest days of 2017. The court's air conditioning was not working and police estimated that the temperature in Mr Sochacki's cell was between 34ºC and 40ºC at the time of his death.

I am very concerned that there were inadequate contingency plans when the court's air-conditioning failed. Staff were aware that the temperature in the cells was excessively hot and it is unacceptable that Mr Sochacki and other detainees were left in those conditions for hours.

Our investigation also found deficiencies in the way staff managed Mr Sochacki during his transfer to and time in a cell at Westminster Magistrates' Court. We found some apparent non-compliance by Serco staff in delivering their contracted service and we have drawn this to the attention of both Serco and those responsible for the management of their contracts at HMPPS and HMCTS.

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

Sue McAllister CB
Prisons and Probation Ombudsman **March 2019**

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Summary

Events

1. On 19 June 2017, Mr Rafal Sochacki, a Polish national, was arrested and taken to Wood Green Police Station. On 21 June, Serco prisoner escort services took him to Westminster Magistrates' Court, where he was due to appear. 21 June was one of the hottest days of 2017, and the temperature in London exceeded 30ºC.

2. During the journey, which took two and a half hours, Mr Sochacki remained locked in a cell in an escort vehicle. The escort vehicle stopped for just under an hour at Charing Cross Police Station to pick up more detainees, during which time the ventilation system was turned off.

3. When Mr Sochacki arrived at Westminster Magistrates' Court at about 10.00am he was taken to a court cell, which was not ventilated, as the court's air-conditioning was not working. (Mobile air-conditioning units had been brought in as a temporary measure.)

4. At around lunchtime, Mr Sochacki's behaviour deteriorated. He became noisy and started acting bizarrely. At about 2.45pm, Mr Sochacki was found unresponsive in his cell. Staff tried to resuscitate him but he was pronounced dead at 4.15pm.

5. The post-mortem investigation found that the cause of Mr Sochacki's death was cardiovascular collapse caused by hyperthermia (an excessively high body temperature) and hypertensive heart disease.

Findings

6. Escort staff did not check if the air-conditioning in the escort vehicle cell in which Mr Sochacki travelled was working properly. We could not establish whether his cell was ventilated on 21 June, although we have seen evidence that the vehicle's air conditioning was not working in July.

7. When the vehicle stopped at Charing Cross Police Station, for just under an hour, an officer did not check Mr Sochacki, as she should have done. As the escort vehicle engine had been turned off, Mr Sochacki's cell was not ventilated.

8. When he arrived at Westminster Magistrates' Court, Mr Sochacki was suffering from the effects of heat. Apart from asking how he was, staff took no action to make him feel more comfortable or to check on his welfare.

9. Due to a breakdown in the court's air-conditioning, there was no ventilation in Mr Sochacki's court cell and the contingency measures to alleviate the hot temperatures had no effect on the temperature in the court cells. The police estimated that the temperature in Mr Sochacki's cell was between 34ºC and 40ºC at the time of his death. This was significantly higher than the maximum cell temperature of 26ºC specified in the "Court Standards and Design Guide" (November 2007). We consider that this was unacceptable.

10. We are concerned about the way an officer recorded his interactions with Mr Sochacki, in particular when they were recorded.

11. We are concerned that there was no defibrillator available in Westminster Magistrates' Court.

12. We understand that HMPPS and HMCTS is responsible for investigating the health and safety aspects of escort vehicles and court cells which carry or hold detainees and those in custody.

Recommendations

- The Chief Executive of HMPPS and the Head of Operations at Serco should ensure that all escort vehicle crews carry out a thorough check of vehicles, including their ventilation and air-conditioning both before and after use.
- The Head of Operations at Serco should complete a full review of the time required to check escort vehicles, taking their differing sizes into consideration, and implement changes to ensure that vehicle crews have adequate time to check vehicles thoroughly before and after use.
- The Chief Executive of HMPPS and the Head of Operations at Serco should ensure that adequate ventilation is always maintained on escort vehicles, including when a vehicle is stationary.
- The Chief Executive of HMPPS and the Head of Operations at Serco should ensure that in line with SOP 009, vehicle escort officers record all welfare checks for detainees in their care during transfers, including when the escort vehicle is stationary.
- The Head of Operations at Serco should ensure that an investigation is completed into the actions of an officer while the escort vehicle was parked at a police station, and that the conclusions are shared with this office and the Coroner within six weeks of the date of this report.
- The Head of Operations at Serco should ensure that detainees received into their custody at court are told their rights in their own language, and that staff check on their welfare and respond appropriately if they exhibit any symptoms of distress.
- The Chief Executives of HMCTS and HMPPS should ensure that robust and adequate contingency plans are in place in the event of any future breakdown of the court building's air-conditioning which might result in the temperature of detainees' cells exceeding 26℃.
- The Head of Operations at Serco should ensure that all staff record their interactions with detainees promptly and accurately in relevant documentation and on electronic systems.
- The Head of Operations at Serco should ensure that an investigation is completed into the manual and electronic records about Mr Sochacki on 21 June, including the timing of entries made by an officer, and that the conclusions are shared with this office and the Coroner within six weeks of the date of this report.

- The Chief Executive of HMCTS should ensure that a defibrillator is available in the detainee custody suite in Westminster Magistrates' Court in case of emergency.

The Investigation Process

13. The investigator issued notices to staff at Westminster Magistrates' Court, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

14. The investigator visited Westminster Magistrates' Court on 23 June 2017. He obtained copies of relevant extracts from Mr Sochacki's court custody records.

15. The investigator interviewed ten members of staff and two detainees.

16. We informed HM Coroner for London Inner West of the investigation and have sent her a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Sochacki's family to explain the investigation. They did not have any specific questions.

Background Information

Westminster Magistrates' Court

18. Westminster Magistrates' Court is a magistrate's court in Marylebone, London. In addition to acting as a normal magistrates' court, the senior District Judge of England and Wales sits at the court and all extradition and terrorist related cases pass through it.

19. The court buildings opened in September 2011, replacing the City of Westminster Magistrates' Court. The court has eleven court rooms and the basement custody suite contains 40 cells. The cells have no external windows and are ventilated by the building's air-conditioning system.

20. The court is run by Her Majesty's Courts and Tribunal Service (HMCTS). HMPPS manage the custody suite and detainee cells on behalf of HMCTS. The building's maintenance is managed by MITIE Facilities Management Ltd on behalf of HMCTS Estates Directorate. The maintenance of the court's air-conditioning system is managed as part of the MITIE Facilities Management Contract.

21. Serco manages the transfer of detainees from police to court custody on behalf of Her Majesty's Prison and Probation Service (HMPPS).

HM Inspectorate of Prisons

22. In October 2015, Her Majesty's Inspectorate of Prisons (HMIP) published a thematic review of court custody in England and Wales based on their inspection of 97 courts in eight court areas. Westminster Magistrates' Court has not been inspected by HMIP and did not form part of the thematic review.

23. In their thematic review inspectors reported that the court custody conditions were some of the worst they had inspected. They noted that court custody was an accident waiting to happen.

24. They said that the treatment of detainees and the conditions in custody suites were very low priorities for the different organisations involved and that no single organisation exercised any effective leadership for court custody provision at local or national level. They noted that the management of court custody operations is spread between several organisations which do not always communicate effectively with each other. Inspectors noted that each organisation involved in court custody worked to different imperatives. For example, HMCTS was concerned primarily with efficient case management, while the custody contractors were focused on security and timely delivery of detainees to court. Inspectors concluded that while these were important, they were given much greater priority than the basic conditions in which detainees were held.

25. HMIP noted that no organisation had a good overall picture of the situation. They said that they could find almost no one at local or national level who accepted

overall accountability for the treatment of detainees and the conditions in custody suites or saw it as their responsibility to address HMIP's recommendations.

26. Inspectors noted that little importance was placed on detainees being given information about their rights in court custody. They were most concerned about the lack of any meaningful risk assessment or interaction when detainees arrived in court custody. They noted that staff were often reluctant to talk with detainees to help clarify concerns. This meant that serious risks, including risks that detainees might lapse from sleep into coma, or become ill while in custody, were not managed.

27. The first aid equipment was often insufficient for the type of emergencies likely to occur. The inspectors noted that none of the courts inspected had defibrillators.

28. HMIP recommended that Ministers insist that HMCTS develop and publish a strategy with clear performance measures to improve detainee treatment and custody conditions rapidly, including identifying named individuals at local and national level to be responsible for court custody conditions and treatment.

Key Events

Background

29. Mr Rafal Sochacki was a Polish national who lived in the United Kingdom. On 19 June 2017, he was arrested under a European warrant to face extradition proceedings to Poland. He was taken to Wood Green Police Station.

30. A healthcare professional assessed Mr Sochacki and prescribed him paracetamol and ibuprofen for historic leg pain. Mr Sochacki raised no other medical complaints and his clinical observations were within an acceptable range. He was assessed as being fit for detention in police custody and for future transfer.

31. On 19 June, a duty solicitor visited Mr Sochacki. Her statement to the Coroner said that the police station was "extremely hot". It also said that during her interview with Mr Sochacki, they were both perspiring heavily and that Mr Sochacki asked for water several times.

32. We have not investigated these or other issues raised by the duty solicitor in her statement to the Coroner, as they fall outside of the remit of this office. However, a copy of the statement has been sent to the Independent Office for Police Conduct for their consideration.

Transfer to Westminster Magistrates' Court

33. 21 June 2017, was one of the hottest days in central London for over forty years. (The temperature at Heathrow was formally recorded to be 34.9℃.)

34. At 6.30am on 21 June, Officer A, an escort vehicle driver, completed a routine check of the escort vehicle, including its ventilation system. He told the investigator that he checked that the ventilation fans were working and saw that the temperature was set to its lowest level, 16℃. He said that cool air blew out of the vent above the escort officer's seat, but that he did not check the temperature further back in the vehicle or the ventilation in each cell compartment. He turned the ventilation off before checking the rest of the vehicle. Officer B, the prisoner escort officer that day, helped Officer A to check the rest of the vehicle. Officer A signed the check sheet to indicate that there were no issues with the escort vehicle. (At 6.15pm, Officer B signed the check sheet on behalf of Officer A to confirm that no issues had been raised about the vehicle's condition or operation during the day.)

35. At 6.55am, Officer A signed the person escort record to confirm that Mr Sochacki had been taken into the custody of Serco for his transfer to Westminster Magistrates' Court.

36. The escort record noted that Mr Sochacki had no previous custodial history and was not a risk to himself or others. Officer A told the investigator that Mr Sochacki appeared fine when he was collected from Wood Green Police Station. Although English was not Mr Sochacki's first language, the officer said that Mr Sochacki understood what was said to him. Mr Sochacki asked the officer about his mobile phones. The officer told him that the police had kept them.

37. At 7.22am, Mr Sochacki was put into a cell in the escort vehicle. Another detainee was put in another cell. At 7.30am, Officer B noted that although Mr Sochacki spoke poor English, he told her that he was okay. At 7.39am, she recorded that she offered Mr Sochacki water which he did not take. During the next 20 minutes, the officer checked Mr Sochacki twice and noted that he was looking out of the window and that all was okay.

38. At 8.10am, Mr Sochacki asked Officer B if his mobile phones were with the rest of his property. The officer told him that the police had taken them as evidence and she noted that he appeared concerned. Mr Sochacki was checked again at two further ten-minute intervals. She noted on both occasions that all was fine.

39. At 8.32am, the escort vehicle arrived at Charing Cross Police Station to pick up two more detainees. Officer A parked the vehicle in the police station's open court yard and left to organise the escort of detainees from the police station. Officer B remained with the escort vehicle and recorded that Mr Sochacki was okay.

40. Officer A said that when he parked at the police station, he turned the vehicle's engine off. He said that he did not know if the ventilation system on the escort vehicle would have remained working during this time. However, he said that when the escort vehicle was parked and the engine was turned off, the ventilation at the back of the vehicle stopped working. Officer B said that when the escort vehicle was parked at the police station, the side door to the vehicle was left open to allow a flow of air into the vehicle. Mr Sochacki remained in his cell on the vehicle during this time.

41. Officer B said that she remained in the vehicle, waiting for the new detainees to arrive and that she checked on and talked to Mr Sochacki during this time. She said that she did not offer Mr Sochacki or the other detainee in the escort vehicle a comfort break as she did not know long Officer A would be. She said that while parked at the police station, Mr Sochacki raised no concerns and did not ask for water or a comfort break. (She made no entries in Mr Sochacki's escort record during the 50 minutes that the escort vehicle was parked at the police station.)

42. At 9.21am, the escort vehicle left Charing Cross Police Station for Westminster Magistrates' Court, with two more detainees on board.

43. At 9.23am, Mr Sochacki asked Officer B for some water. She gave him two small sealed plastic cups of water. Two minutes later, Mr Sochacki told her that there was water coming into his cell. She noted that the cell's internal door window had steamed up and she told Mr Sochacki that she could not do anything until they arrived at Westminster Magistrates' Court. She noted that he was otherwise okay.

44. Although she did not note it in the escort record, Officer B told the investigator that Mr Sochacki patted the back of his neck with some of the water and put some on his feet. She said that she joked with him, saying, "Are you hot stuff?", and said that he laughed at this. She told the investigator that she could understand why Mr Sochacki put water on the back of his neck, but not on his feet as he was wearing shoes and socks.

45. Officer B recorded that she checked Mr Sochacki three more times, at ten-minute intervals, and noted that all was okay. At 9.51am, the escort vehicle arrived at Westminster Magistrates' Court. She noted that all was okay and that Mr Sochacki had no concerns.

46. Officer A told the investigator that during the journey from the police station to Westminster Magistrates' Court, he could not recall speaking to Officer B about the temperature in the rear of the escort vehicle. Officer B said that she had not experienced any heat discomfort on the escort vehicle during the journey, and she said that the air-conditioning was on.

Westminster Magistrates' Court

47. Within a few minutes of arriving at Westminster Magistrates' Court, Mr Sochacki was taken off the escort vehicle. Officer B told the investigator that Mr Sochacki looked "sweaty in the face". She said that Mr Sochacki told her that he was okay, nodded, smiled and said goodbye to her as he left the vehicle. She said that she did not notice any sweat marks on Mr Sochacki's clothes. She told the investigator that when she removed the empty water cups, the cell looked damp but that there was no visible sign of water.

48. An officer helped to escort Mr Sochacki from the escort vehicle to the court's custody suite reception. He said that Mr Sochacki was sweating heavily when he left the escort vehicle and that his clothes were soaking wet. He asked Mr Sochacki if he was okay and he replied that he was, but told the officer that the escort vehicle had been hot. The officer told the investigator that the escort vehicle was hot.

49. At 10.02am, Mr Sochacki arrived in the custody suite's reception area. CCTV footage shows that Mr Sochacki was sweating heavily, as large wet patches can be seen on his grey tracksuit. Officer A, who was already in the reception area, told the investigator that when Mr Sochacki arrived in reception, he appeared wet, and had drips of water on his front, as if he had been in a shower. He said that he jokingly asked Mr Sochacki, "Is it hot enough for you?" and said that Mr Sochacki responded by smiling as if to say, "What do you think?"

50. An officer booked Mr Sochacki into the court's custody and reviewed his paperwork. She told the investigator that she noticed the wet patches on Mr Sochacki's clothing and that he was wet. She told Officer A that Mr Sochacki looked really hot and asked if he was withdrawing from alcohol, or if he was aware of any issues which court staff should be aware of. Officer A told her that Mr Sochacki was just very hot as he had been on an escort vehicle for nearly three hours. She said that Mr Sochacki did not say anything, but smiled as he walked past her to be taken to the court cells. She did not speak to Mr Sochacki.

51. An officer took Mr Sochacki to the court's cells. At 10.04am Officer C took Mr Sochacki, who he said was soaking wet, to his cell and offered him a drink. Mr Sochacki asked for a coffee and told the officer he was okay. The officer did not ask why Mr Sochacki was so wet. He told the investigator that he assumed that he had been sweating on the escort vehicle as it was a hot day. An officer who was with Officer C said that they asked Mr Sochacki if he was okay as he was "soaked". He said that Mr Sochacki told him that he was and said that it was the

weather, the conditions in the escort vehicle and that he had been on the escort vehicle for about four hours.

52. Officer D described Mr Sochacki as “drenched” when he arrived in the court cells. The officer asked him if he was okay and he told her he was. She said that Mr Sochacki did not seem bothered.

53. At 10.27am, an officer took Mr Sochacki to a private room nearby to speak to his legal representative. The representative said that Mr Sochacki was “sweating heavily” and his sweatshirt was “dark all down the front and under the arms from sweat”. He said that Mr Sochacki said that he was fine but said that the officer who had brought him to the room appeared to linger around, appearing to be concerned about Mr Sochacki’s welfare. He said that Mr Sochacki did not appear ill. After the legal visit, Mr Sochacki was taken back to his cell. Several minutes later, he was moved to another cell.

54. Officer E checked Mr Sochacki at around 11.30am, and noted that he was alert and raised no issues. At 12.00pm, Mr Sochacki was taken to see his legal representative again and was returned to his cell ten minutes later. He checked Mr Sochacki at around 12.30pm, and noted again that he was alert and raised no issues. He said that for his half hourly checks between 11.30am and 2.00pm, he looked through Mr Sochacki’s cell door observation panel but did not open the cell door.

55. At around midday, Officer D said she gave Mr Sochacki some food and coffee in his cell. She described him as being nice and quite happy. Officer C said he offered Mr Sochacki more food at around 12.30pm. Mr Sochacki smiled and said that he was fine. He did not ask for a drink. (We have not seen the welfare records for 21 June of staff interactions with detainees, such as food requests, as Serco told us that they were missing.)

56. At 1.00pm, Officer E noted on the manual checklist, but not the electronic checklist, that he had checked Mr Sochacki, and that he was alert and had raised no issues. He noted the same when he checked Mr Sochacki again at 1.30pm and 2.00pm. However, he told the investigator that at the 2.00pm check, Mr Sochacki was acting differently, walking around his cell and sweating.

57. A court custody manager told the investigator that at around 1.50pm, Officer E told him that Mr Sochacki was behaving bizarrely. He opened Mr Sochacki’s cell door and tried to speak to him. He said that Mr Sochacki ignored his questions and was trying to remove the fixed bench at the back of the cell. He said that because Mr Sochacki looked hot, he checked his escort paperwork to see if there was any further information recorded about his health. He said that he did not consider that Mr Sochacki needed to be observed more frequently at that time.

58. Officer D said that at around 2.00pm, the officers who were covering the lunch period in the court cells said that Mr Sochacki was acting strangely and was hitting the cell door. Officer C also said that after lunch, staff reported that Mr Sochacki had been banging on his cell door and singing, but that when he returned from lunch Mr Sochacki was not making any noise. He said that when he checked on Mr Sochacki, he said that he was okay.

59. The court custody manager told the investigator that after lunch, at about 2.15pm, he and two officers visited Mr Sochacki, who refused to drink a cup of water offered to him. He said that Mr Sochacki became frustrated that he told him to drink water and pushed the cup at him. He said that he poured a cup of water on Mr Sochacki's back to cool him as he was not allowed to leave the cell door open for security reasons and because of Mr Sochacki's unpredictable behaviour.

60. Officer D said that after lunch, she and the court custody manager checked on Mr Sochacki. The officer told the investigator that Mr Sochacki was "making a picking and pulling motion" at his clothes. She said that Mr Sochacki said that he was okay but she described him growling and not making much sense. She said that she felt uncomfortable leaving Mr Sochacki in his cell so she asked Officer E to check on him again with her. She said that Mr Sochacki was still picking at his clothes and that they cleared up the spilt water.

61. A detainee in the neighbouring cell said that Mr Sochacki was banging his cell door, screaming and shouting at the top of his voice and that this had continued for about half an hour. He described Mr Sochacki as "going crazy" and said that other detainees were shouting at him to be quiet. He said that he later heard staff say that Mr Sochacki was going to faint and, although he could not see him, assumed he must have felt unwell.

62. At 2.30pm, Officer E noted in the electronic records that he had checked on Mr Sochacki again and all was well (although the manual check sheet does not record this check). He said that he noticed that Mr Sochacki was acting bizarrely during his 2.30pm check and, given his behaviour, took the decision to check on him at five-minute intervals. (The court custody manager said that he was told later in the day about the increase in observations.) The officer said that he started the checks at five-minute intervals at 2.30pm. However, the electronic records showed that he recorded the 2.30pm check electronically at 2.41pm, and that Mr Sochacki was "alert with no issues" at this time.

63. Officer E said in his Serco incident statement that he stayed next to the cell and checked on Mr Sochacki at around 2.35pm. He said that Mr Sochacki still looked unwell, was sweating heavily and was not moving around his cell as much as he had been.

64. The investigator has been unable to establish with any clarity the sequence of events, described above by staff, shortly before Mr Sochacki was found, due to staff's inconsistencies in their timings of events and of what exactly happened and when.

65. However, at 2.44pm, CCTV shows that a court forensic medical examiner left the reception area with the court custody manager and went towards the court cells. It shows that at 2.45pm, the medical examiner saw another detainee in a cell close to Mr Sochacki's. At the same time, the court custody manager checked on Mr Sochacki and saw him sitting in the corner of his cell, looking unresponsive. He went into the cell and took Mr Sochacki's basic observations. Mr Sochacki was unresponsive and he called the medical examiner, who arrived at Mr Sochacki's cell at 2.46pm. The medical examiner said that when he arrived, Mr Sochacki was slumped on the cell bench, was not breathing and he was unable

to find a pulse. He started cardiopulmonary resuscitation (CPR), assisted by the court custody manager and Officer E.

66. At 2.47pm, a prison custody officer called an ambulance. Paramedics arrived between 3.03pm and 3.22pm, and tried to resuscitate Mr Sochacki for an hour.

67. At 3.31pm, as paramedics were treating Mr Sochacki, Officer E made several retrospective entries on the electronic cell checklist. He noted that at 2.30pm (although in the manuscript record, the time is indicated as 1.30pm), Mr Sochacki looked unwell and was to be checked every five minutes and that he had told the court custody manager about this. At 3.32pm, he noted that at 2.35pm, Mr Sochacki still looked unwell and that the doctor was aware and at 3.33pm, he noted that at 2.40pm, the court forensic medical examiner had gone to Mr Sochacki's cell and had started CPR with the court custody manager and him.

68. At 4.15pm, paramedics pronounced Mr Sochacki dead. During their attempts to resuscitate him paramedics noted that he was hyperthermic, with a temperature of 39.6℃, which later reduced to 37.3℃. (Hyperthermia is the condition of having an abnormally high body temperature, defined as a temperature greater than 37.5–38.3 °C (99.5–100.9 °F). The normal human body temperature is around 37ºC.)

Events and additional information received after Mr Sochacki's death

69. At around 5.00pm, Officer E updated the electronic record and recorded that between 3.00pm and 5.30pm, Mr Sochacki was alert and had raised no issues.

70. One of the detainees who joined the escort vehicle at Charing Cross Police Station said that the escort vehicle was warm but not hot, and added that it was nothing that "you could not bear". He said that the cells in the court were warm but that he did not feel hot. The other detainee who joined the escort vehicle described the vehicle as "not being so hot".

71. An officer told the investigator that the court's air-conditioning system had not worked for many weeks and that on 21 June, the custody suite was very hot. She said that the officers working in the custody suite had told her that when they opened the cell doors, the heat from the cells "hit them in the face" and they described it as being "very, very hot".

72. Officer D said that on 21 June, the cells in the court were "ridiculously hot" and you could feel the heat when the cell doors were opened. She said that the air-conditioning had not been working for a couple of months and that the portable air-conditioning units that had been brought in as a temporary measure just blew hot air around.

73. Officer C said that staff had complained about the heat in the cells in the custody suite for over a month. He said that although other prisoners had complained about the heat in their cells, Mr Sochacki had not done so. The officer said that the air-conditioning system in the building had never worked properly.

74. Another officer said that the "heat that [came from] the cell [was] ridiculous", that the heat in the cells was greater than the temperature in the corridor and that some detainees took their shirts off because of the heat.

75. The court custody manager said that the cells were “ridiculously hot” but there was no maximum allowable cell temperature and no procedure for getting detainees out of the cells or for leaving the cell doors open.

76. After the incident, the investigator spoke to a Detective Sergeant from the Metropolitan Police, who told him that at 9.00pm on the 21 June, the temperature in Mr Sochacki’s cell was 30ºC and that it was thought the temperature was between 34ºC and 40ºC when he was found.

77. The investigator visited Westminster Magistrates’ Court on the morning of 23 June 2017. He spoke to a detainee, who complained to him about the heat of his cell. In a record made after the visit, Mr Cameron noted that the detainee was stripped to the waist and that the cell was “very hot and very uncomfortable”. The investigator said that he was told that the cells were cooler the day he visited than they had been on 21 June.

Contact with Mr Sochacki’s family

78. Mr Sochacki’s sister, who lives in the United Kingdom, was informed of his death by authorities from the Polish Embassy.

Post-mortem report

79. A consultant forensic pathologist carried out a post-mortem examination and concluded that the cause of Mr Sochacki’s death was cardiovascular collapse caused by hyperthermia and hypertensive heart disease.

80. The pathologist said that Mr Sochacki had an enlarged heart, which had the potential to cause sudden death. He noted that it was likely to have contributed to Mr Sochacki’s death, but the prevailing circumstances at the time also needed to be taken into account. These included that the temperature was extremely high, which was compounded by a failure in the air-conditioning in a relatively confined area.

81. The pathologist noted that the symptoms of heat stroke varied, but included unusual behaviour, nausea, muscle cramps and difficulty in breathing. He noted an element of hyperthermia as Mr Sochacki had a body temperature greater than 39℃. He concluded that the signs of hyperthermia are subtle and can present the same as heart failure.

Findings

Temperature of escort vehicle

82. 21 June 2017, was one of the hottest days for over four decades in central London, with temperatures over 30℃. When Mr Sochacki arrived at Westminster Magistrates' Court, after a journey of over two and a half hours in a closed cell in an escort vehicle, he was sweating heavily and his clothes were visibly wet. He told several court custody officers, who had commented on his wet clothing, that he was hot because of the hot weather and the conditions on the escort vehicle.

83. It was not possible to establish the exact temperature of Mr Sochacki's cell in the escort vehicle on 21 June. On 14 July, the investigator arranged with the Serco Transport Manager to inspect the escort vehicle, including its air-conditioning system, on 20 July. However, on 20 July the Manager told the investigator that the inspection could not take place as the escort vehicle had been taken to the garage for a MOT, that the keys had been lost and that it would take two weeks for them to be replaced. As a result, the investigator was unable to inspect the vehicle to determine whether the air-conditioning was working.

84. The investigator saw records that the escort vehicle's air-conditioning had been reported as not working on 6 July. On 14 July, during an inspection/service by Pullman Fleet Services, an engineer noted that the escort vehicle's air-conditioning belt was missing and that this had been reported. The engineer signed to confirm that the escort vehicle was "fit for the road". That day, the escort vehicle passed its MOT inspection.

85. On 18 July 2017, a Pullman Fleet Services engineer reported that the escort vehicle's roof fan was not working and that a fuse had been replaced. A worker from Pullman Fleet Services confirmed that when the escort vehicle had its MOT inspection, it was found that a mechanical failure of the air-conditioning belt and tensioner on the engine block had caused issues with the air-conditioning system on the escort vehicle, and the faulty parts were replaced the next day. We have been unable to establish when the fault occurred and how long the problem had existed.

86. Given the numerous technical issues and our lack of expertise in relation to the operation of air-conditioning units on escort vehicles, the investigator asked the Health and Safety Executive (HSE) to assist in our investigation or investigate independently. However, the HSE declined and said that the circumstances of Mr Sochacki's death fell outside of their remit. We have been unable to identify another organisation whose remit is to investigate the health and safety aspects presented in this case. We are very concerned that no organisation appears to be responsible for investigating the health and safety aspects of escort vehicles and court cells which carry or hold detainees and those in custody.

87. Although we do not know what the temperature of Mr Sochacki's escort vehicle cell was, we believe, based on other evidence both factual and anecdotal, that it is likely that he experienced excessive temperatures on his way from Wood Green Police Station to Westminster Magistrates' Court.

88. We are particularly concerned about the 50 minutes that Mr Sochacki remained in the escort vehicle while it was parked at Charing Cross Police Station, during which time the air-conditioning was not working as the engine was switched off.

Checking the escort vehicle

89. The Ministry of Justice's (MOJ) contract for the provision of prisoner escort and custody services requires Serco to "thoroughly inspect and search all vehicles internally and externally, particularly the saloon, before and after each journey".

90. Serco's Standard Operating Procedure (SOP) 008 on the duties of a vehicle escort driver says that the driver of the escort vehicle is responsible for the safety of the vehicle and passengers on board. It requires the driver to check the vehicle's systems and condition, including the heating and ventilation, and report any defects before using the vehicle. A similar check to confirm the air-conditioning is working is also required at the end of the day.

91. Although the SOP does not specify the length of time needed to carry out the checks, Serco's bid document to the Ministry of Justice to provide prisoner escort and custody services dated January 2011, states that escort vehicle crews should be given 20 minutes at the start and end of each day to check escort vehicle checks.

92. Officer A said that the expectation was that two officers would take 15 minutes to check an escort vehicle. A prison custody officer told the investigator that 15 minutes was not enough time to check everything on the pre-use escort vehicle checklist and to check whether the ventilation was working properly.

93. On 21 June, Officer A noted no defects to the escort vehicle, including its ventilation system. However, he did not check that the ventilation was working in each of the individual cell compartments, assuming that if air was coming from the unit above the escort's seat, it would also come from the ventilation vents in each of the cells.

94. Checking that a vehicle is roadworthy and safe is essential to ensure the safety of passengers on board. It is critical that vehicle checks are carried out thoroughly and that adequate time is given for escort vehicle crews to do so. Given that the checks were not completed as they should have been on 21 June, we make the following recommendation.

The Chief Executive of HMPPS and the Head of Operations at Serco should ensure that all escort vehicle crews carry out a thorough check of vehicles, including their ventilation and air-conditioning both before and after use.

The Head of Operations at Serco should complete a full review of the time required to check escort vehicles, taking their differing sizes into consideration, and implement changes to ensure that vehicle crews have adequate time to check vehicles thoroughly before and after use.

Ventilation of stationary escort vehicles

95. Officer A switched off the escort vehicle's engine when he arrived at Charing Cross Police Station to pick up more detainees. The officer did not re-start the engine until the escort vehicle left 50 minutes later.

96. Two officers confirmed that when the escort vehicle was parked, and the engine switched off, the air-conditioning stopped working. One officer said that when there was no ventilation, the vehicle could get very hot. He said that when parked in a secure area, the main door to the vehicle could be left open to aid ventilation but that cell doors could not be opened during this time. Officer B said that when the escort vehicle was parked at the police station, she left the door open to allow a free flow of air.

97. The cell compartments in the escort vehicles are sealed units, apart from a small gap at the bottom of each cell compartment door, and are reliant on ventilation delivered through a vent at the top of the cell. The escort vehicle cells have a window in the cell door and to the exterior of the vehicle.

98. Given the temperature in central London on 21 June, the cell would have heated quickly without any ventilation, and this would have been compounded if the escort vehicle had been parked in direct sunlight. This is evidenced by the build-up of condensation on the cell door window, which Officer B noted when the escort vehicle left the police station. Mr Sochacki was sweating heavily when he arrived at Westminster Magistrates' Court 30 minutes later and told court staff that the vehicle had been very hot. Even though the external door to the escort vehicle was open while it was parked, this would not have provided a sufficient flow of air to individual escort vehicle cells. We make the following recommendation.

The Chief Executive of HMPPS and the Head of Operations at Serco should ensure that adequate ventilation is always maintained on escort vehicles, including when a vehicle is stationary.

Welfare checks on escort vehicle

99. Serco SOP 009 on the duties of a vehicle escort officer requires that "the escorting officer will check the prisoners on board at intervals not exceeding ten minutes".

100. Officer B checked Mr Sochacki at regular ten-minute intervals during the journey from Wood Green Police Station to Charing Cross Police Station and noted these in the escort records. However, no welfare checks were recorded between 8.32am to 9.21am when the escort vehicle was parked at Charing Cross Police Station. Further checks took place when the vehicle left at 9.21am and at 9.23am.

101. Officer B said that she remained on the escort vehicle when it was parked at Charing Cross Police Station. She said that she had never recorded welfare checks during these times. She said that neither Mr Sochacki nor the other detainee on the vehicle made any requests while the escort vehicle was parked. She did not offer the detainees comfort breaks but noted when she checked Mr

Sochacki shortly after departure from the police station at 9.23am that he had asked for a drink of water, which she gave him.

102. We are concerned that the officer failed to record any welfare checks for Mr Sochacki while the escort vehicle was parked at Charing Cross Police Station and while Mr Sochacki remained in his cell. This is particularly worrying given the temperature that day and that the officer was aware that while parked, the air-conditioning in the vehicle was not working. We make the following recommendation.

The Chief Executive of HMPPS and the Head of Operations at Serco should ensure that in line with SOP 009, vehicle escort officers record all welfare checks for detainees in their care during transfers, including when the escort vehicle is stationary.

The Head of Operations at Serco should ensure that an investigation is conducted into the actions of Officer B while the escort vehicle was parked at the police station, and that the conclusions are shared with this office and the Coroner within six weeks of the date of this report.

Court cells

Arrival in custody suite

103. Serco SOP 054 states that all prisoners who come into the care of Serco should be told about their status and rights in their first language. Mr Sochacki's first language was Polish and he should therefore have been given a prisoner's rights and complaints form in Polish. This did not happen and CCTV shows that he was taken straight to his cell without being checked in at the custody suite's reception desk or given this information in any language.

104. Serco did not provide the court custody suite's welfare sheets for 21 June, and told the investigator that they were missing. Mr Sochacki was wet with sweat when he arrived at Westminster Magistrates' Court, and although some officers asked Mr Sochacki if he was okay, as he was sweating heavily, no one checked on him further, offered him the opportunity to refresh himself, to change his clothing or checked how hot his cell was or how to mitigate that. We make the following recommendation.

The Head of Operations at Serco should ensure that detainees received into their custody at court are told their rights in their own language, and that staff check on their welfare and respond appropriately if they exhibit any symptoms of distress.

Cell temperature and contingency plans

105. The Court Buildings Standards and Design Guide dated November 2007 states that there should be a maximum cell temperature of 26℃. Serco SOP 048 requires the court custody manager to ensure that defective cells are not used and that the custody court manager should record any defects which cannot be remedied immediately and report them to the HMCTS court manager.

106. On 21 June 2017, Westminster Magistrates' Court's air-conditioning was not working, not only in the court rooms but also in the court's basement custody suite, where court defendants were kept in sealed cells with no natural ventilation. This had been reported to HMCTS and the investigator was told that the air-conditioning had not been working in the court building for several weeks.

107. HMCTS had brought portable air-conditioning units to alleviate the hot temperatures in the custody suite. Although the portable air-conditioning units provided some relief to staff in the custody suite, they provided no relief to defendants held in the court cells because of the location and design of the cells and because the cell doors were not left open for security reasons. Consequently, Mr Sochacki and other prisoners were held behind sealed cell doors in excessively hot and humid cells.

108. According to the police, the temperature in Mr Sochacki's cell was 30ºC at 9.00pm on 21 June, and they estimated that the temperature was between 34ºC and 40ºC when he died. The temperature in the cell was therefore significantly higher than the maximum allowable temperature of 26ºC. This was unacceptable.

109. The investigator witnessed these conditions himself during his visit to the cells two days after Mr Sochacki's death and staff also described such conditions, with one saying that opening a cell door was like opening an oven door.

110. The contingency arrangements brought in to alleviate the excessive heat during that time were insufficient and inadequate. Although the mobile air-conditioning units had been installed and provided some relief to staff working in the custody suite, they did nothing to alleviate the very high temperatures that Mr Sochacki and other prisoners experienced in the court cells that day. We make the following recommendation:

The Chief Executives of HMCTS and HMPPS should ensure that robust and adequate contingency plans are in place in the event of any future breakdown of the court building's air-conditioning which might result in the temperature of detainees' cells exceeding 26ºC.

Discrepancies in documentation

111. Serco SOP 054, 1.1.2 states that "Court custody staff will check all prisoners on a regular basis. This must be once in every period of 30 minutes".

112. The investigator could not establish the sequence of events in the hours before Mr Sochacki's death because staff gave differing accounts of what happened and there were inconsistencies in the recording of Mr Sochacki's half hourly checks in Serco records.

113. Despite arriving at court just before 10.00am, Mr Sochacki's first check was not recorded until 11.30am, although he was seen during this time. Although Mr Sochacki's behaviour appears to have deteriorated from around lunchtime, the custody paperwork does not reflect this, and instead continues to record that there were no issues or concerns. Many entries which were made retrospectively are at odds with what appears to have been the likely sequence of events. For example, Officer E said that he started the five-minute checks of

Mr Sochacki at 2.30pm. However, the computer records show that the check of 2.30pm was recorded electronically at 2.41pm, and that he noted incorrectly that Mr Sochacki was "alert with no issues". Considering these considerable inaccuracies, we make the following recommendations:

The Head of Operations at Serco should ensure that all staff record their interactions with detainees promptly and accurately in relevant documentation and on electronic systems.

The Head of Operations at Serco should ensure that an investigation is completed into the manual and electronic records about Mr Sochacki on 21 June, including the timing of entries made by Officer E, and that the conclusions are shared with this office and the Coroner within six weeks of the date of this report.

Defibrillator

114. We are concerned that no defibrillator was available to staff either in the custody suite or in the wider court building when attempts were made to resuscitate Mr Sochacki. We are unable to say whether this might have affected the outcome for Mr Sochacki. However, we make the following recommendation:

The Chief Executive of HMCTS should ensure that a defibrillator is available in the detainee custody suite in Westminster Magistrates' Court in case of emergency.

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