police ombudsman FOR NORTHERN IRELAND

Statutory Report

Public Statement in accordance with Section 62 of the Police (Northern Ireland) Act 1998

REPORT INTO THE DEATH OF PAUL SOMERVILLE ON 31 JANUARY 2012

1.0
INTRODUCTION

1.1 At approximately 13:20hrs on 27 January 2012, while being transferred to HMP Maghaberry, Mr Paul Somerville exited the rear of a moving police vehicle, on Church Street, Maghera. Paul Somerville sustained a serious head injury as a result and tragically died from his injuries on 31 January 2012.

1.2 On 27 January 2012 the Police Service of Northern Ireland (PSNI) referred concerns about the duty of care afforded to Paul Somerville whilst in police custody. This referral to the Police Ombudsman was made in accordance with the agreed protocol between the Police Ombudsman for Northern Ireland and the Chief Constable under Section 55 (4) of the Police (Northern Ireland) Act 1998.

1.3 There was no public complaint in relation to this matter.

1.4 This public statement is made in accordance with Section 62 of the Police (Northern Ireland) Act 1998 and it also fulfils our Statutory obligations to comply with Regulation 20 of the Royal Ulster Constabulary (Complaints etc.) Regulations 2000.

2.0
CIRCUMSTANCES

2.1 On 26 January 2012, the Department of Justice, Offender Recall Unit (ORU) issued the PSNI and Paul Somerville with a determination that Paul Somerville's Determinate Custodial Sentence had been revoked and he was being recalled back to prison. The decision to revoke Paul's licence was based on reports from the Probation Office and a recommendation from the Parole Commissioners for Northern Ireland. The PSNI were requested to make the necessary arrangements for Paul Somerville's arrest and return to HMP Maghaberry.

2.2 On 27 January 2012, at 10:19hrs two response Constables (Police Officer's 1 & 2) attached to call-sign GM71 were detailed to facilitate the arrest and transportation of Paul Somerville to HMP Maghaberry. As GM71 was busy with other duties it was not until 12:20hrs before they attended Paul Somerville's homes address. Paul was allowed to collect a number of personal items and contact his Probation Officer before police arrested him at 13:15hrs.

2.3 Following Paul Somerville's arrest by Police Officer 2, he was placed in the cellular compartment of the PSNI vehicle, namely, a Volkswagen (VW) Transport Cell Van. Whilst travelling through Maghera on Church Street, Police Officer 2 made a radio transmission at 13:23hrs reporting Paul Somerville had attempted to escape from custody by jumping from the rear of the vehicle, and landing on the road. Police Officer 2 further requested the attendance of an ambulance as Paul Somerville had sustained a head injury. Paul Somerville was treated at the scene by staff from the nearby Maghera Medical Centre, until the arrival of the ambulance. He was subsequently conveyed to Antrim Area Hospital for

further treatment.

2.4 At 13:53hrs on 27 January 2012, the Duty Inspector covering G District contacted the on call Deputy Senior Investigation Officer (DSIO) from the Police Ombudsman's Office and provided details of the incident. It was related that Paul Somerville had sustained a head injury and he was presently receiving treatment at Antrim Area Hospital, however, the severity of the injuries were not known at the time. The Police Ombudsman DSIO requested to be kept updated on the condition of Paul Somerville.

2.5 The Duty Inspector further outlined that police were in attendance at the scene and were conducting enquires. As a precautionary measure the Police vehicle involved was conveyed to the Forensic Science Northern Ireland (FSNI) laboratory in Carrickfergus, to be secured for examination if required.

2.6 A decision had been made by a Duty Sergeant that there was no requirement for the scene to be secured. This was based on the initial belief that Paul Somerville's injuries were not serious and no other vehicle had been involved. When it became apparent that Paul Somerville had sustained a serious head injury the Duty Sergeant reassessed the need to secure the scene but had determined that there was no evidential value in doing so.

2.7 On 31 January 2012, the Police Ombudsman's Office was informed that despite medical treatment, Paul Somerville had tragically died as a result of his injuries.

3.0
INVESTIGATION

3.1 Once it had become apparent that Paul Somerville had sustained life threatening injuries, the Police Ombudsman commenced an independent investigation.

3.2 Police Ombudsman Investigators attended the scene and liaised with the Police Sergeant who had been coordinating the initial Police investigation. They were informed by police officers who attended the scene immediately after the incident that they had identified two witnesses who had been working on the church hall opposite the scene. The witnesses had informed the police officers, they had observed the police vehicle travelling along Church Street, Maghera with the rear door open. They also witnessed a male jumping from the vehicle and landing heavily on the road. Despite several personal requests by Police Ombudsman investigators these witnesses declined to make formal statements in relation to the incident.

3.3 Despite extensive enquiries at the scene and both media and roadside appeals by Police Ombudsman Investigators, no other witnesses were identified who observed Paul Somerville exiting the rear of the police vehicle.

3.4 Police Ombudsman enquiries established that there was no CCTV footage of the incident or along the route the police vehicle had taken.

3.5 Police Ombudsman Investigators interviewed Police Officers 1 & 2. Both related that whilst returning to Magherafelt, instructions were received via radio transmissions to attend the address of Paul Somerville in relation to

his recall to prison. On arrival at the address they explained the reason for the return to prison to Paul Somerville and gave him time to gather his belongings. Paul's parents were also made aware of his recall to prison and his mother returned home and spoke with Paul and the Police Officers present.

3.6 Paul also telephoned his Probation Officer to advise her of his recall to prison. The Probation Officer asked to speak with one of the officers present and subsequently spoke with Police Officer 2 advising the officer of her concerns in explaining the full details to Paul, as it may have inflamed the situation. Police Officer 2 advised the Probation Officer that Paul was calm and compliant. After a short conversation with Police Officer 2 the Probation Officer again spoke with Paul, advising him to remain calm and to go with the police. The Probation Officer then received a call from the Duty Sergeant where she outlined her concerns regarding Paul's arrest and reaction to such an arrest.

3.7 Police Officer 2 subsequently arrested Paul Somerville and he was placed in the rear of the police cell van. Due to his compliant behaviour both officers stated there was no need to use handcuffs or any restraints.

3.8 Once Paul Somerville had been placed in the cell compartment of the police vehicle, Police Officer 1 stated that she locked the cell door, stating during interview, *'……. you can see a dead bolt going across so Police Officer 2 would stand on my left hand side and I simply said here that's locked isn't it, I could see myself. He said yeah and I then tugged at the door twice and it appeared to be locked and you then close the outer door down.'*

3.9 Police Officer 2 stated he observed Police Officer 1 close the cell door and commented in interview *'…The door was closed and then I observed Police Officer 1, reach up with the key and close the secondary lock. I was standing behind her I'm slightly taller than her and the lock is a bit*

elevated anyway I could clearly see the second bolt of the lock as she turned the key the bolt head went into the receiver in the door frame and so I could see that he was locked in and then pretty much the boot door was closed down yeah that's us were going to head now and the door, the inner door was closed and then the boot lid was closed down as well…'

3.10 Paul's mother who observed the officers place Paul into the vehicle provided a statement to Police Ombudsman investigators. In it she stated that she observed Police Officer 1 go forward to the cage at the back of the van insert something into the lock and then said to her colleague something to the effect "*I never remember what way this turns*" or "*I can never remember what way this goes*".

3.11 Both officers said as they travelled through Maghera a loud bang was heard. Police Officer 1 pulled over and stopped in the forecourt of a nearby garage, which was the first safe place to stop the vehicle. Police Officer 1 remained in the police vehicle, whilst Police Officer 2 went to investigate the rear of the vehicle, he found the rear vehicle and cell door open, Paul Somerville was not in the vehicle. He closed both of the doors and on looking down the road saw Paul Somerville lying at the side of the road. He immediately went to his assistance. When Police Officer 2 failed to come back Police Officer 1 exited the vehicle and became aware of the incident further back along the road and assisted accordingly.

3.12 Police Officer 2 said on reaching Paul Somerville he could see he had sustained injuries and made a radio transmission informing his control of the situation and requested an ambulance. He remained with Paul Somerville and assisted the medical staff from the nearby medical centre, who had appeared quickly on the scene and were providing first aid. He then accompanied Paul Somerville to Antrim Area Hospital in the ambulance.

Volkswagen Transport Van Door and Cell Door

3.13 The Volkswagen police vehicle was examined by a forensic scientist from the FSNI. The scientist was asked by Police Ombudsman investigators to establish how the cell door and the rear door of the vehicle could have been opened, and to establish how Paul Somerville was able to exit the vehicle whilst in transit.

3.14 Following his examination of the vehicle, the scientist, commented that the vehicle's rear door was a hatch door opening upwards and the external door release catch was located just below the number plate whilst the internal door release catch was located slightly higher. The vehicle was fitted with an 'open door' warning light on the driver's dashboard, which was operating correctly.

3.15 The cell door locking mechanism consisted of two latch bolts, upper and lower, which were operated by a single lever on the outside of the door and a dead bolt operated by the cell key with the key hole located on the outside of the rear door. The dead bolt and upper latch bolt are housed within the same unit. There is no door handle inside the vehicle in the cellular area. The dead bolt is put into position by inserting the relevant key at the 12 o'clock position and turning the key anti-clockwise to the 9 o'clock position. The key is then turned back clockwise to the 12 o'clock position, where it can be removed. It was further identified that if the key was turned but not to the full 9 o'clock position, the dead bolt would give the impression that it had fully extended when it had not.

3.16

3.17 The cell door mechanism was designed so that when the door is closed the spring loaded latch bolts would retract and then fall/lock into the relevant recess in the floor. When this was done the door cannot be opened without turning the door handle at the rear. It was established that if the latch bolts did not engage then the door can be opened with little or no pressure and without using the door handle.

3.18 When the dead bolt is engaged the door cannot be opened even if the latch bolts are not engaged properly.

3.19 On testing the cell door the scientist concluded that the cell door latch bolts did not always engage, even when the door was slammed, this was due to distortion/misalignment of the door and the door frame.

3.20 During a test the scientist entered the cell compartment and the cell door was closed. The dead lock was not applied for the test. The vehicle door was then closed. The scientist was able to open the cell door using little force. The gap between the cell door and the vehicle door was sufficient for the scientist to reach round and open the vehicle rear (hatch) door and exit the vehicle, in a very short period of time and using very little effort in the task.

3.21 The scientist concluded that in order for Paul Somerville to have been able to exit the vehicle one of the following three scenarios must have occurred:

1. The rear cell door had not been closed.
2. The rear cell door had been closed but the latch bolts were not engaged or fully engaged and the key operated dead bolt mechanism had not been used.
3. The rear cell door had been closed but the latch bolts were not engaged or fully engaged and the key operated dead bolt had been used but the bolt was not extended sufficiently to engage fully.

3.22 The scientist commented that in all three above scenarios Paul Somerville would still have had to reach and activate the rear latch for the rear door of the vehicle. This would, in the opinion of the scientist, indicate a deliberate action by Paul Somerville, as the rear latch door could not have opened accidentally.

3.23 Throughout the tests conducted it was established that the force used to close the cell door was not a factor as to whether the latches were engaged. It was further concluded that simply pulling the door would result in the operator determining whether the door was secured correctly.

3.24 Following receipt of a report from the FSNI scientist, regarding the door/lock of the police vehicle involved, both police officers 1 & 2 were further interviewed. During the interviews the findings in the report were put to them. Police Officer 1 maintained she had locked the cell door and checked that the door was closed properly.

3.25 Police Officer 2 accepted that based on the scientific findings the cell door could not have been locked/closed properly.

Vehicle Service History

3.26 The service history of the vehicle was examined. It was established that on 23 January 2012, the vehicle was taken to Gough Barracks, Armagh to undergo a service. Enquiries with the vehicle mechanics at Gough Barracks established this was a routine service of the vehicle. A routine service does not include the cellular compartment of the vehicle. The Motor Transport (MT) workshop supervisor based at Gough PSNI provided a statement and related that on the day of the service he was contacted by the Motor Transport Co-ordinator for Magherafelt, requesting that the cell door be checked as a police officer had reported a fault regarding the closing of the rear door. It was established that this additional request was not entered onto the vehicle's service sheet.

3.27 Police Ombudsman Investigators also spoke to the mechanic who conducted the service of the vehicle involved. This individual provided a statement and stated that he recalled carrying out the service of the cellular vehicle and was further requested to take a look at the cell door of the vehicle, which was noted as being misaligned with the door frame. This was rectified and checked with the door closing correctly.

3.28 Police Ombudsman Investigators spoke to the MT Co-ordinator at Magheralfet, while he declined to make a statement he did provide an account. The MT Co-ordinator related that he took the vehicle down to

Gough Barracks from Magherafelt PSNI on 23 January 2012 for a service. On the morning of 24 January 2012, he was informed by a Police Constable, from Magherafelt Police Station (Police Officer 3), that there was a fault with the cell door; he then contacted the MT workshop supervisor at Gough Road asked him to have a look at this fault.

3.29 Police Officer 3 provided a statement for the Police Ombudsman investigation. It was related that on 19 January 2012 he was a passenger in the police vehicle (VW) and as the vehicle left Magherafelt Police Station the rear cell door opened. Police Officer 3 was unsure if the door had been closed properly and there were no further problems throughout the day. On 24 January 2012 he reported the incident to the MT Co-ordinator and asked if the cell door could be checked. When the vehicle was subsequently returned from Gough Barracks the MT Co-ordinator tested the cell door before informing Police Officer 3 that it appeared to be working.

4.0
CONCLUSIONS

4.1 The Police Ombudsman investigation focused on the issue of whether the PSNI and in particular whether the police officers who drove Paul Somerville from his home in Maghera on 27 January 2012 had afforded him the appropriate duty of care and whether the actions or inactions of either officer amounted to misconduct.

4.2 **Finding One: The Police Ombudsman has found that the vehicle the police used to convey Paul Somerville from his home to Maghaberry Prison did not afford him the appropriate duty of care.**

4.3 The police vehicle in question – a Volkswagen Transport Cell Van – only has a small viewing hatch which, given its location would not have made it practical for a police officer to carry out the proper level of supervision of Mr Somerville throughout the proposed journey. The Police Ombudsman has concluded that the specification of such vans did not allow for the supervision required.

4.4 **Finding Two: The Police Ombudsman has found that the police officers involved did not ensure the cell door was closed properly.**

4.5 Irrespective of the faults with the van's locking system, forensic evidence indicates that the cell door could not have opened if the 'dead bolt' had been applied correctly. The Police Ombudsman has therefore concluded that Police Officer 1 failed to do this, which gave Paul Somerville the opportunity to get out of the van. He has recommended that this officer and Police Officer 2, who was the arresting officer and had responsibility for Mr Somerville's safety, both be disciplined.

5.0
RECOMMENDATIONS

5.1 **Recommendation One**

5.2 The Police Ombudsman has recommended that two police officers face disciplinary sanction for their failure in ensuring the cell door of a vehicle in which they were transporting a prisoner was not fully locked. This recommendation was accepted by the PSNI and both Police Officer 1 and 2 received the recommended disciplinary sanction on 27 June 2013. However, both Officers subsequently appealed the disciplinary sanctions and their appeal was upheld on 4 September 2013.

5.3 **Recommendation Two**

5.4 The Police Ombudsman has recommended that a potential fault in the latch bolt locking mechanism of Volkswagen Transport Cell vehicles could represent a risk to health and safety and should be brought to the attention of the PSNI. The PSNI has acted upon this recommendation. It has fixed display notices to vehicle cell compartments, informing officers of the need to ensure that doors are fully locked. Furthermore a 'blanking' panel was placed over the vehicle's rear door so as to prevent it being opened from the inside.

5.5 **Recommendation Three**

The Police Ombudsman has recommended that in addition to the routine inspection of police vehicles for general road worthiness and safety, those vehicles used for transporting prisoners must be inspected to ensure the safety of any modifications made to them, including the integrity of any reinforced materials, their doors, windows and locking mechanisms are all fit for purpose. These inspections, and any faults which are reported, must all form part of the vehicle service record. This recommendation has been adopted by the PSNI.

5.6 **Recommendation Four**

The Police Ombudsman has recommended that the police review the specifications of the Volkswagen Transport cell vehicles to better allow for the appropriate monitoring of prisoners. The PSNI has now fitted all its Transport cell vans with clear Perspex to allow for easier monitoring and observations of detainees. While the cell door design is still widely used across the UK and fitted to new vehicles by the manufacturers, the PSNI intend sharing the findings of this case with other forces.

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