Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Marc Walker, a prisoner at HMP Nottingham, on 16 February 2024

A report by the Prisons and Probation Ombudsman

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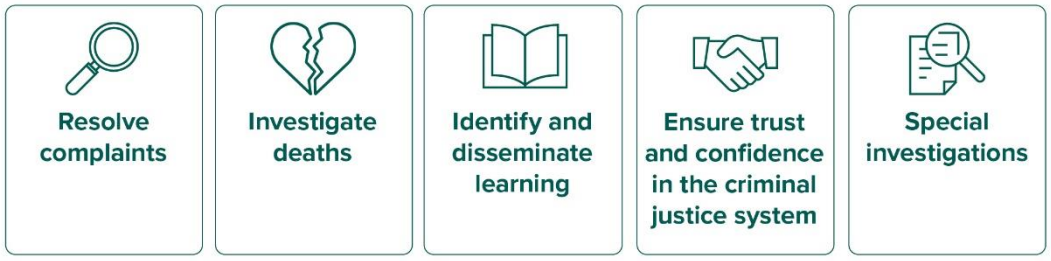
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In January 2024, Mr Marc Walker was sentenced to 34 weeks imprisonment for theft. Following brain surgery, he died in hospital of a high-grade glioma (a brain tumour) on 16 February 2024, while a prisoner at HMP Nottingham. He was 38 years old. We offer our condolences to Mr Walker's family and friends.

4. The Ombudsman office wrote to Mr Walker's next of kin, his father, to explain the investigation and to ask if he had any matters he wanted us to consider. While we note his concern that prison officers were by Mr Walker's bedside while he was in hospital, this was in line with national prison policy which requires at least two members of prison escort staff to be present when prisoners are in hospital. The evidence also indicates that there were times when the officers appropriately stepped away for decency purposes. We also note that escort officers did not remain with Mr Walker when he was taken to a separate room and his life support was turned off on the day he died.

5. NHS England commissioned an independent clinical reviewer, to review Mr Walker's clinical care at HMP Nottingham. The clinical review is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Walker received at Nottingham was, in part, of a good standard and equivalent to that which he could have expected to receive in the community. For example, she found that a National Early Warning Score (NEWS2) assessment was appropriately completed, staff attending the emergency response were appropriately trained in immediate life support and healthcare staff maintained good communication with the hospital. However, she found that an internal communication was not sent to the GP operating at the prison to highlight Mr Walker's headaches and a reception screen was not undertaken when he returned to prison from hospital on 8 February. The clinical reviewer concluded that this did not have an impact on Mr Walker's death.

7. The clinical reviewer made four recommendations about issues which were not directly relevant to Mr Walker's death but which the Head of Healthcare at Nottingham will want to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Walker's care. We did not identify any significant non-clinical learning related to his death and we make no recommendations.

Governor to note

9. While we appreciate that the prison provided CCTV footage of the emergency response and body-worn camera footage of Mr Walker in the ambulance on 9 February, body-worn cameras were not activated for the emergency response when the code blue was called as we would have expected in line with policy. The Governor will wish to consider this.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

11. Mr Walker's family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly.

12. At an inquest held on 6 January 2025, the Coroner concluded that Mr Walker died of natural causes.

Adrian Usher **September 2024**
Prisons and Probation Ombudsman

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