Prisons & Probation Ombudsman
Independent Investigations

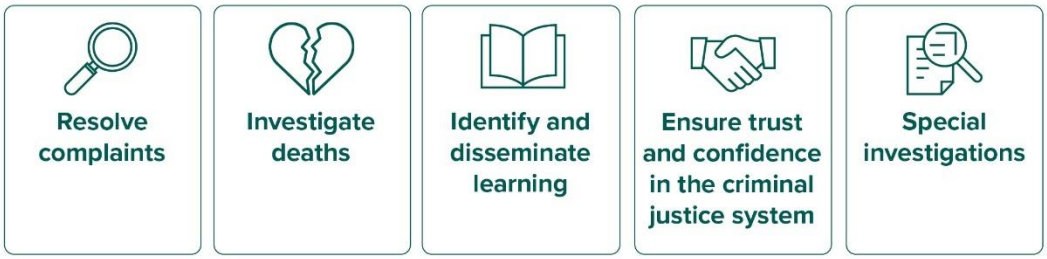
# Independent investigation into the death of Mr David Marsh, a prisoner at HMP Lincoln, on 19 October 2025

**A report by the Prisons and Probation Ombudsman**

## 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 September 2025, Mr David Marsh was sentenced to 14 years imprisonment for sexual offences. He died in hospital of a heart attack on 19 October, while a prisoner at HMP Lincoln. He was 70 years old. We offer our condolences to Mr Marsh's family and friends.

4. The Ombudsman's office wrote to Mr Marsh's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Marsh's clinical care at HMP Lincoln.

6. The PPO investigator investigated the non-clinical issues relating to Mr Marsh's care.

7. We did not find any non-clinical issues of concern.

8. The clinical reviewer concluded that the clinical care Mr Marsh received at Lincoln was equivalent to that which he could have expected to receive in the community. However, she identified two areas of concern.

9. Mr Marsh had an electrocardiogram (ECG, a test to check the heart's rhythm) on 25 September, but there was no evidence that the results were reviewed by a GP. The clinical reviewer considered this particularly concerning as Mr Marsh's post-mortem examination found he had scarring of the heart, indicating he had had previous heart attacks. She also found that Mr Marsh did not have any care plans in place for his long-term conditions, including heart disease and diabetes. We recommend:

   **The Head of Healthcare should ensure there is a robust process in place for ECG results to be reviewed by a GP or appropriately qualified registered healthcare professional.**

   **The Head of Healthcare should ensure robust processes are in place for the timely creation of care plans for prisoners with diagnosed long term conditions.**

10. We shared our initial report with HMPPS and the prison's healthcare provider, Nottinghamshire Healthcare NHS Foundation Trust. They found no factual inaccuracies. Nottinghamshire Healthcare NHS Foundation Trust provided an action plan which has been annexed to this report.

**Adrian Usher** **March 2026**
**Prisons and Probation Ombudsman**

## Inquest

At the inquest, held on 20 April 2026, the Coroner concluded that Mr Marsh died from natural causes.

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