

**Prisons &
Probation**

Ombudsman
Independent Investigations

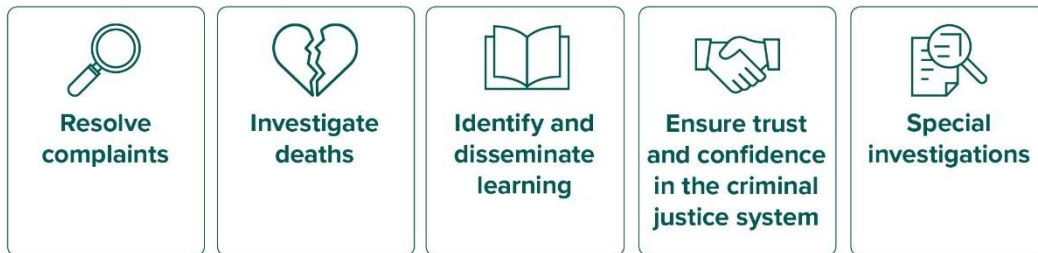
Independent investigation into the death of Mr Michael Marsh, a prisoner at HMP Exeter, on 23 November 2021

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



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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.

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

Mr Michael Marsh died in hospital of a hypoxic brain injury (when the brain does not get enough oxygen) caused by a cardiac arrest, on 23 November 2021, after he was found hanging in his cell at HMP Exeter five days earlier. He was 33 years old. I offer my condolences to his family and friends.

Mr Marsh was a troubled man who appeared to struggle in prison. He isolated himself in his cell and staff started suicide and self-harm monitoring, known as ACCT, a few days after he arrived at Exeter. I am concerned that some aspects of the ACCT procedures were not correctly implemented, including that they were closed at a case review that did not have proper healthcare input.

I am concerned that the control room did not effectively communicate the nature of the emergency, which meant that not all staff were immediately aware of the seriousness of the situation.

I am concerned that the keywork process was not as effective as it should have been in offering additional support to Mr Marsh, which the Governor will need to address. Staff also did not undertake regular wellbeing checks, in line with national instructions.

It is also concerning that prison staff initially notified the next of kin of a different prisoner who had the same name as Mr Marsh.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman

June 2023

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Summary

Events

1. On 4 October 2021, Mr Michael Marsh was convicted of sending digital communications causing fear or anxiety. He was remanded to HMP Exeter. He had a history of substance misuse and mental health difficulties but declined medication.
2. On 8 October, prison staff intercepted a letter of suicidal intent from Mr Marsh to his mother and started suicide and self-harm prevention procedures (known as ACCT). Over the next three weeks, Mr Marsh self-isolated and barely left his cell. He told staff that he had received threats from other prisoners for being in a relationship with an ex-sex offender. On 31 October, an officer conducted a wellbeing check and recorded that Mr Marsh appeared well and did not report any concerns.
3. On 2 November, a supervising officer (SO) chaired an ACCT review. Healthcare staff did not attend but before the meeting, they told the SO that Mr Marsh refused to take his medication that morning. However, the information related to another prisoner with the same name. The SO recorded that Mr Marsh continued to self-isolate but engaged well and did not report any thoughts of suicide or self-harm. Attendees stopped ACCT monitoring and made a Challenge Support Intervention Plan (CSIP) referral.
4. At 8.20pm on 18 November, an officer conducting a roll check found Mr Marsh hanging by a ligature. He radioed a medical emergency code and entered the cell. Staff attended, cut the ligature and started cardiopulmonary resuscitation (CPR). In the meantime, a control room operative requested that all available staff attend but did not specify that it was an emergency code. At 8.21pm, healthcare staff arrived and assisted officers. At 8.28pm, paramedics arrived and took over resuscitation. At 8.56pm, they took Mr Marsh to hospital by ambulance.
5. At 3.41am on 23 November, a hospital doctor pronounced that Mr Marsh had died.

Findings

6. Some mandatory requirements of ACCT procedures were not completed in line with national instructions. The assessment and first case review were not completed within expected timescales. The ACCT procedures were closed at a case review which was not multidisciplinary and before all of the issues raised in the support plan had achieved their intended outcome.
7. Prison and healthcare staff responded promptly to the emergency. However, we are concerned that the control room did not effectively communicate the severity of the situation.
8. The clinical reviewer considered that the care Mr Marsh received at HMP Exeter was equivalent to that which he could have expected to receive in the community. However, he found that healthcare staff had mistakenly made entries for another prisoner of the same name in Mr Marsh's medical record. This impacted on the quality of information provided to ACCT case reviews.

9. We are concerned that the next of kin identified by the prison was incorrect and that the Governor initially broke the news to the wrong person.
10. We are also concerned that prison staff did not undertake regular wellbeing checks, in line with local and national instructions.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:
 - ACCT assessments and first case reviews are completed within expected timescales;
 - a case co-ordinator is appointed at the first case review, who should lead all subsequent case reviews whenever possible;
 - healthcare staff are invited and contribute to all case reviews where their support is relevant;
 - ACCT monitoring does not stop until all support actions have been completed and risk is no longer considered raised; and
 - staff record, share and consider all relevant information about risk, and start ACCT procedures when indicated.
- The Governor should ensure that control room staff are made aware of and understand their responsibilities during medical emergencies, including that staff correctly communicate the nature of an emergency.
- The Head of Healthcare ensure that healthcare staff record actions and decisions about a prisoner's care in the correct medical record.
- The Governor should ensure that prison staff correctly identify and inform the appropriate next of kin as soon as possible when a prisoner dies or becomes seriously ill.
- The Governor should ensure that staff conduct wellbeing checks and keywork sessions for all prisoners identified as vulnerable, in line with national and local policy.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the findings with them.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Exeter, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
 12. The investigator obtained copies of relevant extracts from Mr Marsh's prison and medical records.
 13. The investigator interviewed six members of staff between 26 and 27 January. NHS England commissioned a clinical reviewer to review Mr Marsh's clinical care at the prison. They jointly interviewed healthcare staff. All the interviews were conducted remotely because of the restrictions in place during the COVID-19 pandemic.
 14. We informed HM Coroner for Exeter and Greater Devon of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
 15. The Ombudsman's family liaison officer contacted Mr Marsh's family to explain the investigation and to ask if they had any matters that they wanted us to consider. They asked the following questions:
 - Were there any issues with Mr Marsh receiving letters from his family?
 - How often was he supposed to be checked and were these checks carried out?
 - Did Mr Marsh have a mental health assessment and what support, including medication, did he get for his mental health?
 - Did paramedics experience a delay getting to Mr Marsh?
- We have addressed these concerns in the report and in separate correspondence.
16. Mr Marsh's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
 17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Exeter

18. HMP Exeter holds up to 561 adult men and young offenders, and serves the courts of Devon, Cornwall and Somerset. Practice Plus Group provides primary health services and Devon Partnership NHS Trust provide mental health care.

HM Inspectorate of Prisons

19. In March 2021, HMIP carried out a Scrutiny Visit at HMP Exeter. Inspectors reported that levels of self-harm had increased during the COVID-19 pandemic and that the quality of many ACCT documents was poor. They found that although most prisoners did not have meaningful contact with staff and that keyword sessions occurred infrequently, daily wellbeing checks for prisoners assessed as vulnerable generally took place.
20. The most recent full inspection of Exeter was in November 2022. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State setting out significant concerns. The Chief Inspector's letter highlighted that levels of self-harm were higher than at any comparable prison and 44 per cent higher than the year before their previous inspection. The Chief Inspector also found that the provision of mental healthcare was not good enough, with too few staff to provide adequate support.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for 2021, the IMB reported that a high number of ACCTs had been started during the reporting year. They found that most ACCT reviews took place on time and that there had been strenuous efforts to ensure that they are multi-disciplinary.
22. The IMB also reported that there had been a steady increase in violent incidents that tended to coincide with the relaxation of COVID-19 restrictions.

Previous deaths at HMP Exeter

23. Mr Marsh was the tenth prisoner to die at Exeter since November 2019, and the fifth to take his own life since then. We have previously made recommendations about the medical record keeping and communicating medical emergencies.

Assessment, Care in Custody and Teamwork

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and

interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

25. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

26. On 4 October 2021, Mr Michael Marsh was convicted of sending digital communications causing fear or anxiety and remanded to HMP Exeter. Before he arrived at the prison, a member of staff from the police, court liaison and diversion service (PCLDS) contacted the mental health team and requested a mental health assessment for Mr Marsh.
27. A nurse conducted an initial health screen and noted that Mr Marsh reported a history of substance misuse, a previous admission to a psychiatric hospital and a diagnosis of personality disorder. He also noted that Mr Marsh did not report any thoughts of suicide or self-harm and that he had made a mental health referral.
28. Shortly afterwards, Mr Marsh refused to leave the Reception area unless staff located him under Prison Rule 45. (If staff think a prisoner would be in danger, for example, because of the offence they committed such as sexual offence, they can allocate them a place on a separate wing away from the main population for their own safety.) Mr Marsh said he needed protecting as his partner was a convicted sex offender. However, staff did not deem his offence as suitable for Prison Rule 45 and they had to forcibly escort him from Reception. They located him in a safer cell (a cell specifically designed to minimise ligature points) and charged him with breaching prison rules.
29. On 5 October, a mental health nurse, conducted an assessment through Mr Marsh's cell door due to his aggressive behaviour the previous day. He told her that he was worried about people putting something in his food or assaulting him for being in a relationship with an ex-sex offender. He also said that he was prescribed olanzapine (an antipsychotic) in the community but felt that there was "no point" in taking it as it "did not make a difference". She concluded that he displayed no evidence of a psychotic illness.
30. A substance misuse worker visited Mr Marsh to provide harm reduction advice, as part of the induction process. However, he was lying on his bed, with his head covered and refused to engage.
31. On 6 October, a substance misuse worker, visited Mr Marsh and made a further attempt to have a harm reduction conversation with him, but he said he was not interested.
32. On 8 October, staff in the correspondence offices submitted a security intelligence report (SIR) stating that they had intercepted what looked like a letter of suicidal intent from Mr Marsh to his mother. In the letter, Mr Marsh said that he had had no electricity (in his cell) for two days, no money for the prison shop, that staff would not let him move wing and that he would "rot away from starvation". At 2.10pm, prison staff started ACCT procedures and set his observation requirement at one an hour.
33. At around 9.20am on 10 October, an officer visited Mr Marsh to conduct an ACCT assessment, but he refused to engage. She reviewed his prison record and completed the 'key information' part of the ACCT. She did not record why the

assessment did not take place within 24 hours of the ACCT starting, as required by national policy.

34. At 2.45pm, a Supervising Officer (SO) was named as the case co-ordinator and chaired a first ACCT case review, which several members of staff, including a nurse and, a substance misuse worker, attended. The SO noted that Mr Marsh was self-isolating in his cell due to a concern that other prisoners knew about his “messed up sexual thoughts” and that he had barely eaten anything for two days. The nurse recorded that Mr Marsh became upset when discussing his intrusive thoughts and agreed to see a psychiatrist. Attendees set his observation requirement at two conversations a day with hourly checks at night. They also agreed several care support actions, which included mental health intervention and for Mr Marsh to apply for a place on the Vulnerable Prisoners’ Unit under Prison Rule 45.
35. On 11 October, a mental health nurse recorded that staff discussed Mr Marsh at a multidisciplinary team meeting (MDT) and concluded that he did not require secondary mental health support as he had no formal diagnosis of mental illness and denied any thoughts of suicide and self-harm.
36. On 13 October, a prison GP reviewed Mr Marsh’s community medical summary and sent a task to the mental health team, saying that Mr Marsh was prescribed olanzapine (although it was possible that he had not been taking it) and asked if they would like the prescription to continue. A consultant psychiatrist replied directly to the prison GP asking her to prescribe olanzapine for paranoid disorder. However, she did not see the task for two weeks due to a period of annual leave.
37. On 15 October, a SO chaired an ACCT case review which several members of staff attended, including a nurse. He noted that the review took place in Mr Marsh’s cell and that he said, “I will smother myself with a pillow tonight” but did not give a reason. Attendees increased his observation requirement to four an hour and agreed to review him again the next day. There is, however, no record that this took place.
38. On 17 October, a SO chaired an ACCT case review which a nurse attended. He noted that Mr Marsh did not engage well but did open up slightly after encouragement. He recorded that Mr Marsh said he would continue to stay in his cell as he had intrusive thoughts about children and that other prisoners knew about them. Mr Marsh also said that he had thoughts about hanging or suffocating himself. Attendees decided to keep his observation requirement unchanged.
39. On 20 October, a SO chaired an ACCT case review which a member of prison staff and a nurse attended. She recorded that although Mr Marsh was forward thinking and said he had no plans to end his life, he continued to report intrusive thoughts. She noted that he had had another Rule 45 application declined and remained in self-isolation. Attendees agreed that ACCT monitoring should continue, but reduced his observation requirement to once every two hours, with two quality conversations a day.
40. On 21 October, the consultant psychiatrist visited the wing to review Mr Marsh, but he refused to attend. She recorded that wing staff said his door had a sign on it, saying “in- isolation”, so she requested for the appointment to be re-scheduled. At interview, she told us that at first, she thought that Mr Marsh may have been

isolating due to COVID-19, but subsequently, she became aware that he was isolating out of choice.

41. On 26 October, a Custodial Manager (CM) chaired an ACCT case review and noted that he was the only member of staff able to attend due to low staffing levels. He noted that healthcare staff offered a verbal contribution, but there is no written record of the information provided. Mr Marsh told the CM that he did not feel that he needed to be on an ACCT. The CM recorded that he would keep the ACCT in place so that a multidisciplinary discussion could take place first.
42. On 29 October, prison staff moved Mr Marsh to standard cell on the same wing. Prison location records show that it was classified as a “general move”.
43. On 31 October, an officer conducted a wellbeing check and recorded that Mr Marsh appeared well and did not report any concerns. The next day, an officer saw Mr Marsh for a keywork session but he did not want to engage.
44. On 2 November, a SO chaired an ACCT case review which a prison chaplain, attended. Healthcare staff did not participate, but a clinical administrator, reviewed Mr Marsh’s medical record and told the SO that he had refused his medication that morning. However, at interview, the Head of Healthcare told us that the entry was made in error and related to a different prisoner, also called Mr Marsh. The SO recorded that Mr Marsh continued to self-isolate but did not report any thoughts of suicide or self-harm. Attendees agreed to stop ACCT monitoring and to make a Challenge Support Intervention Plan (CSIP) referral. (CSIP is a national case management model for managing prisoners who are violent or pose a risk of being violent. It can also be used to support victims or potential victims of violence.) Later that morning, the SO made a CSIP referral.
45. On 6 November, the Acting Head of Residence, asked Mr Marsh why he had closed his door shortly after it was opened for a domestic period. He said that he wanted to leave his cell but did not provide a reason. Later that day, a CM reviewed Mr Marsh’s CSIP referral and concluded that the case should progress to CSIP as it would provide more appropriate support.
46. On 10 November, a SO conducted an ACCT post-closure review and noted that although Mr Marsh did not report any thoughts of suicide and self-harm, he continued to isolate. Later that day, the consultant psychiatrist recorded that Mr Marsh failed to attend a review for a second time and discharged him from her psychiatry clinic.
47. On 15 November, a prison offender manager visited Mr Marsh to conduct a CSIP review. He recorded that he explained his reason for wanting to talk to Mr Marsh, but that Mr Marsh declined to engage. He added that Mr Marsh did not raise any concerns and that he re-scheduled the review for 19 November.

Events of 18 November

48. At 9.30am on 18 November, an officer conducted a wellbeing check and recorded that Mr Marsh gave him a ‘thumbs up’ but declined to engage further.

49. At 5.07pm, staff moved Mr Marsh to a cell on A Wing after an intelligence report indicated that two prisoners had allegedly assaulted him in the shower on C Wing. There is, however, no record that staff conducted a wellbeing check or spoke to Mr Marsh about the alleged assault.
50. Prison records indicate that Mr Marsh's cell bell was activated and reset twice between 6.58pm and 7.35pm. An officer told the investigator that he was the only officer on the wing and remembered giving Mr Marsh a toilet roll. He said that Mr Marsh thanked him and that he carried on with his duties.
51. At 7.45pm, CCTV footage shows that the officer approached Mr Marsh's cell door to conduct a roll check but it is not clear whether he opened the cell door observation panel due to the obscure camera angle. At interview, he told us that he saw Mr Marsh standing in his cell and that he was moving.
52. At 8.20pm, the night patrol officer looked through Mr Marsh's cell door observation panel to conduct a roll check and saw him hanging by a ligature made from bed linen and attached to the cell window. He radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties) and entered the cell. Around 10 seconds later, the officer arrived with several members of staff and cut the ligature. The officers laid Mr Marsh on the floor and started cardiopulmonary resuscitation (CPR). In the meantime, an officer in the control room radioed for "staff assistance" to A Wing.
53. At 8.21pm, a nurse arrived on the wing with a Healthcare Assistant (HCA) and asked her to collect an emergency medical bag in case it was needed. She then went into the cell, saw staff conducting CPR and shouted "code blue" to HCA, who handed her the bag and went to collect an oxygen cylinder. The nurse requested that staff move Mr Marsh out on the wing landing for easier access and assisted with the resuscitation effort.
54. At 8.24pm, an ambulance arrived at the prison. At 8.28pm, the first paramedics arrived at Mr Marsh's cell. Paramedics took over the resuscitation effort and, at 8.34pm, established that Mr Marsh had a pulse. At 8.56pm, paramedics transferred Mr Marsh by ambulance to the Royal Devon and Exeter Hospital. Two officers escorted Mr Marsh to hospital, without using restraints.
55. On 19 November, a nurse spoke to hospital staff who informed her that Mr Marsh had brain damage and was unlikely to survive. Healthcare staff remained in daily contact with the hospital for updates on Mr Marsh's condition.
56. At 3.41am on 23 November, a doctor pronounced that Mr Marsh had died.

Contact with Mr Marsh's family

57. On 18 November, the governor attended the prison in response to the incident and requested contact details for Mr Marsh's next of kin. Mr Marsh had not named a next of kin so staff looked through his prison record and found a letter from a Mrs Marsh, who appeared to be his mother. Later that night, a SO and the governor visited her address to break the news, but it quickly became apparent that she was the mother of the other Mr Michael Marsh who was in prison at Exeter. The governor subsequently contacted the prison and asked staff to check Mr Marsh's

phone records. They found a contact number, which was for the correct Mr Marsh's mother, and the governor broke the news to her by phone.

58. At 9.40am on 19 November, the prison appointed an officer as the family liaison officer (FLO) and a second officer as his deputy. The FLO recorded that the governor offered to arrange for Mr Marsh's mother's transport to the hospital, but she said she would prefer to make her own way there. He also noted that the governor asked if she would like a member of staff to meet her at the hospital, but she was unsure.
59. At 7.45am on 22 November, a prison manager asked a SO, if she could attend the hospital to offer support to Mr Marsh's family as it was likely that his life support equipment would be turned off and the allocated family liaison officers were off duty. However, when she arrived at around 8.30pm, the nurses looking after Mr Marsh said that his family visited yesterday and said they would not return. At 11.22am, the SO phoned Mr Marsh's mother and she confirmed that the family had said their goodbyes and would not be returning.
60. On 23 November at 10.55am, the SO phoned Mr Marsh's mother to offer her condolences and an officer provided ongoing support. Mr Marsh's funeral took place on 20 December and the prison contributed towards the cost, in line with national instructions.

Support for prisoners and staff

61. On 19 November, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. On 23 December, the prison manager spoke to the officers present at the hospital when Mr Marsh died to offer support.
62. The prison posted notices informing other prisoners of Mr Marsh's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Marsh's death.

Post-mortem report

63. The post-mortem examination found that Mr Marsh died of a hypoxic brain injury (when the brain does not get enough oxygen), caused by a cardiac arrest that was caused by hanging. Post-mortem toxicology analysis found low levels of tetrahydrocannabinol (from cannabis). The pathologist was unable to conclude if Mr Marsh had used cannabis before or after he was sent to prison. No other illicit medications were detected. However, the pathologist noted that the interval of time of nearly 81 hours between staff finding Mr Marsh hanged and the blood sample being taken meant that many drugs, including psychoactive substances, might have already been eliminated from his body.

Findings

Assessment of the risk of suicide and self-harm

64. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and to take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

ACCT procedures

65. Mr Marsh was monitored under ACCT procedures on one occasion at Exeter. While there were some positive aspects in the way staff operated ACCT procedures, we are concerned that some aspects were poorly managed. PSI 64/2011 requires the ACCT assessment to be completed within 24 hours of the start of ACCT procedures and the first case review to be held within 25 hours. Mr Marsh's assessment took place around 43 hours after the procedures were initiated, and the first case review was over two days after they were started.
66. PSI 64/2011 also instructs that a case co-ordinator must be appointed at the first case review. The case co-ordinator should lead all case reviews, where possible, to promote consistency in managing the ACCT plan, assessing risk and care planning. Case co-ordinators should therefore try to plan ACCT case reviews for times when they are working. A SO was named as case co-ordinator but attended only half of the ACCT case reviews.
67. PSI 64/2011 states that the case co-ordinator must ensure that healthcare staff are always invited to attend all case reviews where they are relevant to supporting the prisoner (or provide a written contribution if attendance is not possible).
68. While there were healthcare staff at most of Mr Marsh's case reviews, there was no one present at his closing case review. A healthcare administrator provided an update based on a review of the medical record, but she mistakenly provided information about another prisoner who shared the same name. (The update provided also stated that the prisoner had not taken his medication that morning, which if it was correct would not indicate progress or a reduction in risk.) One of Mr Marsh's support plan issues related to his mental health and he had recently refused a psychiatrist assessment. Our view is that it would have been appropriate for a healthcare member of staff to attend the case review to provide input about these issues.
69. PSI 64/2011 also states that ACCT procedures can be closed when the risk of harm has reduced to a level where it is no longer considered raised, and all support actions have been completed with their intended outcome achieved.
70. One of Mr Marsh's support actions was to apply for protection under Prison Rule 45. This had been marked as completed in his ACCT document and an application had been submitted. However, prison staff refused Mr Marsh's application and he continued to live on a standard residential wing. While the support action (to submit an application) had been completed, its intended outcome (for Mr Marsh to feel

safe, stop isolating and begin to associate with his peers and engage in prison life) had not as he continued to isolate in his cell due to fears for his safety. We appreciate that CSIP procedures were initiated with the aim of addressing Mr Marsh's isolation issues and agree that this is an important document that was valid in the circumstances. However, CSIP should not be used to replace the risk assessment, care planning and monitoring that ACCT procedures provide for prisoners at risk of suicide and self-harm.

Events of March 2022

71. Mr Marsh had some continuing risk factors for suicide and self-harm in the time after the ACCT procedures were stopped. He continued to self-isolate and declined to engage in a CSIP assessment. He again declined a review with the psychiatrist. An intelligence report indicated that Mr Marsh had been assaulted by two prisoners and he moved wings as a result. There is no evidence that anyone checked on Mr Marsh's wellbeing after the wing move or spoke to him about the alleged assault.
72. We are concerned that each of these factors were treated in isolation. There is no evidence that anyone considered whether, either individually or together, they might increase Mr Marsh's risk of suicide and self-harm or considered restarting ACCT procedures. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:

- **ACCT assessments and first case reviews are completed within expected timescales;**
- **a case co-ordinator is appointed at the first case review, who should lead all subsequent case reviews whenever possible;**
- **healthcare staff are invited and contribute to all case reviews where their support is relevant;**
- **ACCT monitoring does not stop until all support actions have been completed and risk is no longer considered raised; and**
- **staff record, share and consider all relevant information about risk, and start ACCT procedures when indicated.**

Emergency response

73. Exeter's local policy instructs staff to use a code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for all healthcare staff to attend with the appropriate medical equipment.
74. An officer responded quickly when he found Mr Marsh hanging. He used an appropriate medical code and entered the cell without delay. Additional staff arrived

swiftly and the control room called an ambulance immediately, in line with Prison Service instructions. However, we are concerned that attending staff were not fully aware of the seriousness of the situation.

75. At interview, an officer told the investigator that upon receiving the code blue, he raised a general alarm on the radio network and broadcast “code blue alpha landing”. However, prison radio records show that he did not confirm it was a code blue. An officer told us that he responded to a code blue, but statements from healthcare staff say they responded to a general alarm and were not aware of the seriousness of the situation until they entered the cell and saw officers doing CPR. While we consider that the apparent miscommunication did not affect the outcome for Mr Marsh, it is crucial that staff understand their roles in a medical emergency. We therefore make the following recommendation:

The Governor should ensure that control room staff are made aware of and understand their responsibilities during medical emergencies, including that staff correctly communicate the nature of the emergency.

Clinical care

76. The clinical reviewer concluded that the clinical care that Mr Marsh received at HMP Exeter was equivalent to that which he could have expected in the community. Healthcare staff reviewed him frequently, his care was discussed at MDT meetings and a psychiatrist attempted to review him on two occasions. Substance misuse staff also offered him support and attended the first ACCT case review. However, the clinical reviewer did identify one area for improvement, namely clinical record keeping.
77. The clinical reviewer found that two case notes entered on Mr Marsh’s medical record related to a different Mr Marsh. This meant that healthcare staff provided incorrect clinical information to prison staff prior to the closing ACCT case review. We therefore make the following recommendation:

The Head of Healthcare should ensure that healthcare staff record actions and decisions about a prisoner’s care in the correct medical record.

Family contact

78. Prison Rule 22 requires that when a prisoner dies or becomes seriously ill, the Governor should tell their next of kin “at once”. Although we are satisfied that the Governor contacted Mr Marsh’s mother once he realised that they had gone to the wrong address, we are concerned that he informed the wrong person in the first instance. We consider that it is likely to have caused unnecessary distress.
79. Prison records show that a letter for the other Mr Marsh had been incorrectly put in Mr Marsh’s file. While we appreciate that it is crucial to act quickly when identifying a prisoner’s next of kin, it is vital that staff cross reference information such as a prison number to ensure as far as reasonably possible that the information is correct. We therefore make the following recommendation:

The Governor should ensure that prison staff correctly identify and inform the appropriate next of kin as soon as possible when a prisoner dies or becomes seriously ill.

Keyword delivery and wellbeing checks

80. The Prison Service's COVID-19: National Framework for Prison Regimes and Services (updated August 2021) sets out five regime stages that prisons will move up or down, depending on local conditions. Stage one being regimes operating with minimum control measures in place and stage five being complete lockdown. All areas of the regime are subject to exceptional delivery models (EDMs) and these vary depending on the stage at which the prison is operating.
81. During the time that Mr Marsh was at Exeter, the prison was subject to stage four regime delivery. Exeter's Wellbeing and Keyword Delivery Model (January 2021) states that stage four regimes are expected to deliver keyword or wellbeing checks in line with the keyword EDM. Specifically, when unable to deliver full keyword sessions during the recovery period, prisoners identified as vulnerable must be seen daily and an entry made in the prisoner's case note record. Prisoners being supported by CSIP or ACCT measures are regarded as vulnerable at Exeter and would therefore require a daily wellbeing check.
82. Mr Marsh was eligible for a daily wellbeing check for 42 days, but only five wellbeing checks and one keyword session were recorded as taking place. We are also particularly concerned that staff did not record whether they conducted a welfare check following intelligence to indicate that Mr Marsh had been assaulted while in the shower. While we appreciate the additional pressures placed on prisons in the wake of the pandemic, we consider that staff should have made a more concerted effort to ensure that Mr Marsh received a daily wellbeing check. This is also a missed opportunity to identify any increase to the risk of suicide and self-harm. We make the following recommendation:

The Governor should ensure that staff conduct wellbeing checks and keyword sessions for all prisoners identified as vulnerable, in line with national and local policy.

Learning lessons

83. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend the following:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest

84. At the inquest, which took place on 5 May 2026, the Coroner concluded that Mr Marsh deliberately ligatured himself but the evidence presented did not adequately explain whether or not he intended to take his own life.

**Prisons &
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