

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Marsh a prisoner at HMP Channings Wood on 24 June 2018

A report by the Prisons and Probation Ombudsman

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*



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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 David Marsh died on 24 June 2018 of a heart attack at HMP Channings Wood. He was 75 years old. I offer my condolences to his family and friends.

We agree with the clinical reviewer that Mr Marsh received a good standard of care for his chronic health conditions at Channings Wood. Staff could not have anticipated or prevented his sudden death. However, I am concerned that when Mr Marsh went to hospital, he was restrained without a fully considered risk assessment taking his poor health and limited mobility into account.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2019

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Summary

Events

1. On 28 October 2008, Mr David Marsh received an indeterminate sentence for public protection. He transferred to HMP Channing Woods on 2 December 2009 and had remained there. He had a complex medical history: he had a cardiac pacemaker, high blood pressure and Type 2 diabetes.
2. Healthcare staff developed care plans to manage his conditions. They reviewed him frequently and adjusted his medication as necessary.
3. On 4 June, a prison GP diagnosed a urine infection and prescribed a course of antibiotics. However, there was no improvement and on 9 June, a nurse noted that he had low oxygen saturation levels, an elevated heart and breathing rate and low blood pressure. An ambulance was called and paramedics took him to hospital. Two officers escorted him and he was restrained by an escort chain.
4. Mr Marsh's condition did not improve and he remained in hospital. He deteriorated further and on 24 June, he died from a heart attack due to heart disease.

Findings

5. Mr Marsh had significant health problems. Healthcare staff appropriately monitored his conditions. When his condition deteriorated, they assessed him promptly and sent him to hospital quickly. We are satisfied that Mr Marsh received a good standard of care at Channings Wood, equivalent to that which he could have expected to receive in the community.
6. When Mr Marsh was restrained by an escort chain on 9 June, we are not satisfied that the prison fully took into account Mr Marsh's medical condition and lack of mobility when assessing his risk.

Recommendations

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Executive Director of Public Sector Prisons South should ensure that guidance to establishments about the use of restraints reflects the legal position.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Marsh's prison and medical records.
9. The investigator interviewed one member of staff by telephone on 9 August 2018.
10. NHS England commissioned a clinical reviewer to review Mr Marsh's clinical care at the prison.
11. We informed HM Coroner for Plymouth and Torbay of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
12. The investigator contacted Mr Marsh's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Channings Wood

14. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds over 700 men. Care UK provides health services at the prison. There is one permanent GP, with locum GPs running additional clinics. Nurses are on duty every day and there is an out of hours GP service.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Channings Wood was conducted in October 2016. Inspectors reported that, overall, the prison had deteriorated since their last inspection. They noted that the healthcare unit was clean and tidy and that staff were caring and professional. They said that there were gaps in record-keeping and a lack of care-planning for prisoners with complex health needs. Inspectors noted that there were no nurse-led clinics for prisoners with long-term conditions and no effective recall system to maintain ongoing care. Such prisoners were managed through the GP. Inspectors noted that this affected GP waiting times which, at six weeks, were too long.

Independent Monitoring Board

16. 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 the year to August 2017 the IMB reported that, despite staff shortages and poor morale, prisoners were overall treated fairly and humanely. The Board recognised that since the change in healthcare provider in March 2017, there had been a gradual but marked improvement in healthcare provision.

Previous deaths at HMP Channings Wood

17. Mr Marsh's death was the thirteenth death at Channings Wood since January 2015. Of those deaths, eight were from natural causes. There are no similarities between Mr Marsh's death and the previous deaths, although we have made previous recommendations about the use of restraints on ill and infirm prisoners which the prison has accepted. There has been one death since Mr Marsh's which is under investigation.

Key Events

18. On 27 October 2008, Mr David Marsh received an indeterminate sentence for public protection for sexual offences, with a minimum tariff to serve of two years and eight months before he could be considered for parole. His applications for parole had been unsuccessful as Mr Marsh refused to engage with the process and made it clear that he wanted to stay in prison.
19. Mr Marsh progressed through his sentence and had been at HMP Channings Wood since 2 December 2009. He had several long-term conditions: he had had a cardiac pacemaker fitted, high blood pressure, Type 2 diabetes, poor eyesight and reduced mobility. (He had to use a walking stick.)
20. Healthcare staff saw Mr Marsh frequently and regularly reviewed and monitored his conditions.
21. On 4 June 2018, a nurse examined Mr Marsh and noted that he was disorientated. She completed his observations and noted these were all within the normal range but he told her he had not taken any medication for two weeks. She arranged an appointment with a prison GP. A prison GP completed the examination and suspected a urine infection. He prescribed a course of antibiotics and arranged for a urine test, the results of which were normal.
22. On 8 June, a nurse noted that there was no improvement and Mr Marsh was again confused. She booked an appointment for a blood test and discussed this with another nurse who referred Mr Marsh for social care and a GP review. The next morning, she checked on Mr Marsh. She noted that he had low oxygen saturation levels, an elevated heart and breathing rate and low blood pressure. She arranged for him to be transferred to hospital. Two officers escorted him to the Hospital and he was restrained using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
23. Hospital staff diagnosed a urinary tract infection and gave Mr Marsh intravenous antibiotics. Mr Marsh's condition deteriorated and he died on 24 June.

Contact with Mr Marsh's family

24. On 24 June, the prison appointed a prison manager as the family liaison officer. Mr Marsh did not have a nominated next of kin. After Mr Marsh died, she traced his son to break the news of his father's death and to offer her condolences and support. Channings Wood arranged and paid for Mr Marsh's funeral, which was held on 14 August 2018.

Support for prisoners and staff

25. After Mr Marsh's death, the family liaison officer emailed the staff who escorted Mr Marsh to hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support. She told them that the staff care team could also offer support.

26. 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 his death.

Post-mortem report

27. The post-mortem examination established that Mr Marsh had died from myocardial infarction (a heart attack) due to coronary artery atherosclerosis (a narrowing of the arteries).

Findings

Clinical review

28. The clinical reviewer concluded that Mr Marsh's care was equivalent to that which he could have received in the community. He said that the healthcare team regularly reviewed and monitored his chronic health issues. He said that Mr Marsh's health appeared to have suddenly deteriorated in his final days, without a clear reason or diagnosis.
29. We are satisfied that Mr Marsh's clinical care and treatment at Channings Wood was of a high standard, and was at least equivalent to that which he could have expected to receive in the community.

Restraints

30. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account a prisoner's health and mobility.
31. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about a prisoner's ability to escape and review this as circumstances change.
32. In Mr Marsh's case, the security risk assessment noted that he posed a high risk to the public but later contradicted itself and noted that he was a medium risk to the public. The Head of Security said that the discrepancy was due to human error or a lack of time to complete the form fully. The assessment also noted that Mr Marsh's risk of reoffending was high. It noted that his risk of hostage taking, escape and external assistance was low.
33. On 9 June 2018, a prison manager authorised the use of an escort chain for Mr Marsh's transfer to hospital. She said that she had to consider the public's perception of sending a man in custody into the community. The medical assessment stated that there was no objection to the use of restraints. She said that that was her first consideration, and the second was Mr Marsh's limited mobility so on that basis, she authorised the use of an escort chain.
34. The risk assessment noted that Mr Marsh could only move short distances and used a walking stick. He needed help for all his care needs and had very poor vision. It is difficult to see how the use of restraints was justified in his circumstances, not least because he was also escorted by prison staff.
35. When Mr Marsh was admitted to hospital, another risk assessment was completed. The security assessment noted that all his risk factors were "normal" and that Mr Marsh was a risk to children. The Head of Security noted that Mr

Marsh was seriously ill, restraints were unnecessary and two escort officers should remain with Mr Marsh.

36. The Head of Security said that it was considered an emergency to escort Mr Marsh to hospital by ambulance. He said that national instructions required prisoners to be restrained for all emergency, out of normal hours or unscheduled escorts, unless their condition was life-threatening. He gave us a copy of the guidance to which he referred. It was not in fact national policy but local guidance in the form of an email from the Office of the Executive Director for Public Sector Prisons South on 8 May 2018. It said that:

“Escort paperwork should be clear and include commentary on cuffing arrangements. The routine use of escort chains on escort should cease- where an ambulance is used a standard cuff must be applied as soon as possible after arriving at hospital.”

37. The email guidance does not confirm what the Head of Security said and it does not alter the legal position that restraints must be proportionate to the risk posed.
38. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity. It is difficult to understand how the prison concluded that restraints were necessary for an elderly and infirm man, with limited mobility, and who was escorted by two prison officers. Too much weight was given to Mr Marsh’s original offences rather than his actual risk at the time. We are concerned that we must repeat a recommendation that Channings Wood previously accepted and agreed to implement. We also make a recommendation about any guidance:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Executive Director of Public Sector Prisons South should ensure that guidance to establishments about the use of restraints reflects the legal position.

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