Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Marchant a prisoner at HMP Elmley on 26 March 2016

A report by the Prisons and Probation Ombudsman
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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*

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 Colin Marchant died on 26 March 2016 of a heart attack while a prisoner at HMP Elmley. He was 55 years old. I offer my condolences to Mr Marchant's family and friends.

Mr Marchant had a number of health conditions, including ischaemic heart disease, high blood pressure, and high cholesterol. He had previously had four heart attacks. Healthcare staff at Elmley appropriately managed Mr Marchant's heart conditions and quickly referred him to hospital when his condition deteriorated. I am satisfied that the care that Mr Marchant received was equivalent to that he could have expected to receive in the community. However, I am concerned that Mr Marchant was restrained for hospital stays in January and February 2016 without fully considered risk assessments, which took into his account his condition at the time.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2016**

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Summary

Events

1. On 27 February 2015, Mr Colin Marchant was released on licence from a prison sentence. On 9 July 2015, he was recalled to HMP Elmley after breaching his licence conditions. Mr Marchant had a number of health conditions, including ischaemic heart disease, high blood pressure, and high cholesterol. He had previously had four heart attacks. He received medication for his conditions.

2. On 18 January 2016, Mr Marchant was admitted to hospital after he complained of chest pain. A cardiologist diagnosed a heart attack and Mr Marchant had surgery to insert a stent. He returned to prison on 20 January.

3. On 12 February, Mr Marchant had breathing difficulties. A prison doctor diagnosed heart failure and sent him to hospital by emergency ambulance. In hospital Mr Marchant briefly refused treatment but, after support from the prison chaplain, agreed to resume treatment. His condition improved slightly and the hospital discharged him on 26 February.

4. Mr Marchant refused to be admitted to the prison's healthcare inpatient unit and signed a disclaimer about this. A nurse created care plans and nurses saw Mr Marchant daily to take observations and monitor his heart condition.

5. At 11.33pm on 24 March, officers radioed a medical emergency when they were concerned about Mr Marchant's breathing. A nurse gave him oxygen. Paramedics arrived and tests showed Mr Marchant was having a heart attack. He was taken to hospital but remained in a critical condition and died at 10.45am on 26 March.

Findings

6. Prison healthcare staff managed Mr Marchant's heart condition well during his time at the prison and appropriately referred him to hospital when his condition deteriorated. The clinical reviewer was satisfied that the standard of healthcare that Mr Marchant received in prison was at least equivalent to that he could have expected to receive in the community.

7. Restraints were not used when Mr Marchant was admitted to hospital in March. However, we are concerned that he was restrained for hospital admissions in January 2016, when he had a heart attack, and in February 2016, when he had heart failure, without any healthcare input into the risk assessments to indicate how his conditions affected his risk of escape at the time.

Recommendation

- The Governor and Head of Healthcare should ensure that 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 Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Marchant's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Marchant's clinical care at the prison.

11. We informed HM Coroner for Mid Kent and Midway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Marchant's ex-partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Marchant's ex-partner said that the prison chaplain had contacted her when Mr Marchant refused treatment in hospital but did not consider this contact was handled well. She asked whether Mr Marchant's health was managed appropriately and whether healthcare staff responded quickly enough when his condition deteriorated.

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

14. Mr Marchant's ex-partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Elmley

15. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided good care for prisoners with the most acute needs, though general access to healthcare services remained a problem. They also found that prisoners sometimes missed routine external hospital appointments because of competing prison priorities for escort staff.

Independent Monitoring Board

17. 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 October 2015, the IMB reported that long-term chronic diseases were monitored by well trained healthcare staff. However, they were concerned about the number of prisoners who did not attend healthcare appointments.

Previous deaths at HMP Elmley

18. Mr Marchant was the fifth person to die from natural causes at Elmley since January 2015. We have raised the issue of the insufficiently justified use of restraints before.

Key Events

19. On 5 November 2014, Mr Colin Marchant was sentenced to 16 months in prison for sexual offences and sent to HMP Elmley. On 27 February 2015, he was released on licence, but he was recalled to Elmley on 9 July when he breached his licence conditions.

20. At an initial health screen in July, a nurse noted that Mr Marchant had ischaemic heart disease, high blood pressure and high cholesterol. He had previously suffered four heart attacks. A doctor reviewed him and re-prescribed his medications, which included aspirin, clopidogrel (to prevent blood clots), bisoprolol, perindopril erbumine (for high blood pressure), isosorbide monoitrate (to widen blood vessels), glyceryl trinitrate spray (GTN – used to treat angina), ezetimibe and atorvastatin (to lower cholesterol).

21. Mr Marchant said that he also had chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), asthma, chronic kidney disease, arthritis and depression. Healthcare staff treated Mr Marchant's health conditions appropriately with medication and reviewed him regularly. There was little of significance in his medical record for the next six months.

22. On 6 January 2016, Mr Marchant was concerned about a tooth abscess, as he said a previous abscess had caused a heart attack. A nurse gave him paracetamol and a prison GP prescribed an antibiotic the same day. The GP referred him to the dentist. There was no record whether Mr Marchant saw the dentist.

23. About 8.00am on 18 January, Mr Marchant told a nurse that he had had pain in his chest and arm for two hours, and had vomited twice. He said the pain was heavy and had not stopped after he had used a GTN spray. She took Mr Marchant's observations and arranged an emergency ambulance to take him to hospital. Officers used an escort chain to restrained Mr Marchant.

24. In hospital, a cardiologist confirmed that Mr Marchant had had a heart attack and that if his heart function did not improve, they would consider fitting an implantable cardioverter-defibrillator (a device similar to a pacemaker). Mr Marchant had an angioplasty (a surgical repair or unblocking of a blood vessel) and surgeons inserted a stent. On 20 January, Mr Marchant returned to the prison. The hospital arranged a follow-up appointment for 14 April.

25. On 21 January, in line with the hospital's discharge summary, a prison GP changed Mr Marchant's medication from clopidogrel to ticagrelor (which reduces the risk of a stroke or heart attack). The next day, another GP reviewed Mr Marchant and increased the dose of atorvastatin as hospital staff had noted a rise in his cholesterol level.

26. On 31 January, a prison GP reviewed Mr Marchant, who felt short of breath on exertion and had occasional nosebleeds. The GP considered that his ticagrelor prescription caused the nosebleeds, but did not need amending. He advised Mr Marchant to report further breathlessness or pain.

27. On 3 February, a locum GP reviewed Mr Marchant and advised him to try to lose weight to reduce his cholesterol level. On 6 February, Mr Marchant reported shortness of breath. A nurse noted he appeared pale but he did not have signs of cyanosis (blue discoloration of the skin due to inadequate oxygenation of the blood) or chest pain. She told Mr Marchant to rest and referred him to see the GP.

28. On 8 February, a prison GP examined Mr Marchant and requested an urgent blood test. The next day, another GP reviewed the blood test results, which contained a very high level of brain natriuretic peptide (BNP – an amino acid secreted by the heart in response to excessive stretching of the heart muscle cells). The GP referred Mr Marchant to a cardiologist and for an echocardiogram (an ultrasound test to evaluate the heart's structure).

29. At approximately 4.00pm on 12 February, a nurse and a prison GP examined Mr Marchant, who was finding it difficult to breathe and could not complete sentences. He did not have any chest pain. The GP diagnosed heart failure and sent Mr Marchant to hospital by emergency ambulance. Officers used handcuffs to restrain Mr Marchant.

30. Mr Marchant was admitted to hospital, but on 18 February, he told hospital staff that he was refusing all treatment. Hospital staff told him that he was in cardiogenic shock (a condition where the heart cannot pump enough blood to meet the body's needs) and that, if he continued to refuse treatment, he would die. They assessed him as having mental capacity to make decision about his treatment.

31. A prison chaplain phoned Mr Marchant's ex-partner, who he had named as his next of kin, and asked her to visit the hospital to help persuade Mr Marchant to accept treatment. She declined, as she was unsure that the contact from the chaplain was genuine. After this, the chaplain visited Mr Marchant to encourage him to resume treatment, and Mr Marchant agreed.

32. Mr Marchant's condition improved slightly and, on 26 February, he returned to the prison. The hospital reported that the echocardiogram had showed that Mr Marchant's left ventricle was dilated and he had moderate to severe mitral regurgitation (leakage of blood back into the left ventricle). When he got back to the prison, Mr Marchant refused to be admitted to the prison's inpatient unit and signed a disclaimer. He later said this was because the inpatient unit was too noisy. Mr Marchant had care plans, which required nurses to take his clinical observations every day and monitor for deterioration in his heart disease.

33. On 10 March, a nurse from a hospice assessed Mr Marchant. The nurse noted that his life expectancy was short and likely to be weeks or months. The prison started an application for compassionate release.

34. At 11.33pm on 24 March, officers called a code blue medical emergency (which indicates that a person has breathing difficulties) when Mr Marchant was breathing very fast. A nurse responded and gave Mr Marchant oxygen while waiting for an ambulance. Paramedics arrived and an electrocardiogram (ECG – a test to check the heart's rhythm) showed that Mr Marchant was having a heart attack.

35. The paramedics took Mr Marchant to hospital. He was not restrained. Mr Marchant remained critically ill and died at the hospital at 10.45am on 26 March.

Contact with Mr Marchant's family

36. Mr Marchant had named his ex-partner as his next of kin, but when he was recalled to prison in July 2015 she had decided that she did not want any further contact with him. The prison was unaware of this, which is why the chaplain had contacted her in February when he was in hospital. As Mr Marchant had named his ex-partner as his next of kin, the chaplain and a Supervising Officer visited Mr Marchant's ex-partner and informed her when he died. His ex-partner said that she did not want to act as his next of kin. In line with national policy, the prison arranged and contributed to the cost of Mr Marchant's funeral.

Support for prisoners and staff

37. After Mr Marchant's death, a prison manager debriefed the staff who had been involved in the emergency response on 24 March to offer support. The staff care team also offered support.

38. The prison posted notices informing staff and prisoners of Mr Marchant'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 Marchant's death.

Post-mortem report

39. A post-mortem concluded that Mr Marchant died from an acute myocardial infarction (a heart attack).

Findings

Clinical care

40. The clinical reviewer considered that healthcare staff at the prison appropriately managed Mr Marchant's heart condition. There was good liaison with the hospital and good care plans, which ensured healthcare staff effectively monitored Mr Marchant. Healthcare staff quickly referred him to hospital when his condition deteriorated.

41. The clinical reviewer considered there were no opportunities to prevent Mr Marchant's death and that the care he received in prison was at least equivalent to that he could have expected to receive in the community. We are satisfied that Mr Marchant received good care at Elmley.

Restraints, security and escorts

42. 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 the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a 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 suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

43. When Mr Marchant went to hospital on18 January, he was assessed as a medium risk to the public and a low risk of escape. The risk assessment recommended that officers should use an escort chain to restrain him. (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.) The security assessment noted that Mr Marchant was "suffering from heart attack". An operational manager agreed that he should be restrained. There was no formal healthcare input into the risk assessment. The next day, restraints were removed.

44. When Mr Marchant went to hospital on 12 February with heart failure, he was assessed as a low risk to the public and of escape. The risk assessment recommended that officers should restrain Mr Marchant with handcuffs. A senior prison manager agreed this. Again, there was no formal healthcare input into the risk assessment. Five days later, a manager decided that officers should remove the handcuffs, due to Mr Marchant's heart condition.

45. When Mr Marchant went to hospital in March, a prison manager instructed officers not to restrain him due to his limited mobility and his heart condition.

46. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. In the absence of any healthcare contribution to the risk assessments in January and February, there is

no evidence of any consideration of how Mr Marchant's condition impacted on his risk of escape, as the 2007 High Court judgment requires. We cannot therefore be assured that the use of restraints was justified. In January, the restraints were removed after one day but in February Mr Marchant was handcuffed in hospital for five days.

47. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate and considered input into the risk assessment process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that 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.

Family liaison

48. Prison Rule 22 requires prisons to inform the next of kin at once if a prisoner becomes seriously ill or dies. Prison Service Instruction 64/2011 states that prisons must ensure that a member of staff engages with the next of kin of prisoners who are either terminally or seriously ill.

49. Mr Marchant had nominated his ex-partner as his next of kin. It appears that she had told Mr Marchant that she did not want any further contact with him but prison staff were unaware of this. When Mr Marchant refused treatment in February, a chaplain telephoned her as Mr Marchant's health was in grave danger if he did not accept treatment soon. While there appears to have been some confusion in the communication, we believe this was reasonable in the circumstances, as the situation was urgent. It was not until after Mr Marchant died, that the prison learnt that the relationship was over and his ex-partner said she did not want to act in the capacity of next of kin. We consider that there was appropriate family liaison.

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