Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Madison Sefton-Marshall, a prisoner at HMP Featherstone, on 15 June 2018

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 I oversee can improve their work in the future.

Mr Madison Sefton-Marshall died in hospital on 15 June 2018 of upper gastrointestinal bleeding, caused by liver disease, after collapsing in his cell at HMP Featherstone. Mr Sefton-Marshall was 50 years old. I offer my condolences to Mr Sefton-Marshall's family and friends.

Mr Sefton-Marshall had a number of serious long-term health conditions which were appropriately managed by the prison. I am satisfied that, overall, the clinical care he received was equivalent to that which he could have expected in the community.

Mr Sefton-Marshall was being monitored under suicide and self-harm prevention procedures (known as ACCT) at the time of his death and I am concerned that staff did not respond with sufficient urgency when they could not obtain a response from him during a check on his wellbeing. There was also a significant delay before an emergency ambulance was called. This was unacceptable.

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 **September 2020**

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Summary

Events

1. On 3 March 2006, Mr Madison Sefton-Marshall was sentenced to a minimum of three and half years' imprisonment under an IPP sentence. This meant he was required to remain in prison until the Parole Board was satisfied that he no longer posed a danger to the public.

2. On 31 October 2016, he was transferred to HMP Featherstone. It was noted at his reception health screen that he had liver disease and enlarged veins in his oesophagus which were prone to bleeding, and a history of strokes, substance misuse and anxiety.

3. During his time at Featherstone, Mr Sefton-Marshall was regularly reviewed for his health concerns, and was under the supervision of specialists at the local hospital. He was taken to hospital as an emergency admission on several occasions.

4. Mr Sefton-Marshall also had a long history of drug misuse in the community and in prison. Emergency medical codes were called at Featherstone on a number of occasions after he collapsed as a result of drug use, including one occasion in March 2018 when a nurse recorded that his heart had stopped briefly.

5. On occasions he was suspected by prison and healthcare staff of faking illness in an attempt to be taken to hospital and it was thought that he was being bullied to do this by other prisoners. As a result, he had a reputation among some staff for 'crying wolf'.

6. Mr Sefton-Marshall also had a history of self-harm, and was monitored under suicide and self-harm prevention procedures (known as ACCT) in January 2018 and again from 31 May, and at the time of his death he was being observed once an hour under ACCT procedures.

7. At 8.00pm on 15 June, an officer was unable see Mr Sefton-Marshall or get a response from him during an ACCT check. He called for help and three officers entered the cell and found Mr Sefton-Marshall unconscious on the floor. An ambulance was called at 8.23pm.

8. At 8.52pm, the ambulance crew arrived and took Mr Sefton-Marshall to hospital. At 10.07pm, the hospital pronounced that Mr Sefton-Marshall had died.

Findings

Clinical care

9. We agree with the clinical reviewer that, overall, the healthcare Mr Sefton-Marshall received at Featherstone was equivalent to that which he could have expected to receive in the community. He was regularly reviewed for his serious health concerns and appropriately referred to external specialists when necessary.

10. However, we share the clinical reviewer's concern that there was one occasion three days before his death when healthcare staff failed to follow up clinical observations as they should have done.

Emergency response

11. We are concerned that prison staff did not respond with sufficient urgency when they could not get a response from Mr Sefton-Marshall on 15 June. We consider that the two officers on the scene should have entered the cell without waiting for a third officer to arrive and that staff should have called a medical emergency code as soon as they saw him unresponsive on the floor of his cell. As a result of these delays, there was a significant delay of at least 30 minutes before an emergency ambulance was called.

Recommendations

- The Head of Healthcare should ensure that there are clear processes for staff to follow in response to any NEWS score that falls into the category of medium to high risk.
- The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency, subject to a risk assessment, in order to help preserve the life of a prisoner.
- The Governor should ensure that all staff are aware of their responsibilities when dealing with emergency situations and the calling of emergency medical codes.
- The Governor should initiate a fact-finding investigation into the following and inform the PPO of the outcomes and whether any disciplinary action has been taken:
    - the actions of two officers in not entering Mr Sefton-Marshall's cell when they could not obtain a response from him; and
    - the actions of a custodial manager in not calling a code blue medical emergency code as soon as Mr Sefton-Marshall was found unresponsive on the floor of his cell.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Sefton-Marshall's prison and medical records. The investigator initially had some trouble obtaining documents relating to Mr Sefton-Marshall as the prison initially failed to respond to emails and telephone calls. The investigator raised this with the Governor, who instructed staff to co-operate. Following the Governor's intervention, the prison co-operated fully with all requests.

14. The investigator interviewed four members of staff at Featherstone on 18 September 2018.

15. NHS England commissioned a clinical reviewer to review Mr Sefton-Marshall's clinical care at the prison.

16. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

17. The investigator wrote to Mr Sefton-Marshall's brother to explain the investigation and to ask whether he had any matters the family wanted the investigation to consider. Mr Sefton-Marshall's brother asked us to consider the circumstances surrounding his brother's death. He also said that there were some items of property which he did not receive, and expressed his concern that the funeral directors had not released Mr Sefton-Marshall's ashes to him. The prison told us that all property was returned to Mr Sefton-Marshall's brother. They also said that the delay in returning the ashes was due to the funeral directors not having Mr Sefton-Marshall recorded as the client, but once the Governor intervened, the ashes were released.

18. Prior to issuing the initial report, the investigator disclosed relevant parts of the report to the prison to give them the opportunity to comment. The prison had no further comments to make.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

20. Mr Sefton-Marshall's brother received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Featherstone

21. HMP Featherstone is a medium security, Category C prison, holding around 650 convicted men. Healthcare services are provided by Care UK. There are no healthcare services during the evening.

HM Inspectorate of Prisons

22. The most recent inspection of Featherstone was conducted in November 2016. Inspectors reported that there was "a shocking worsening of standards" since the previous inspection in 2013, and that staff and prisoners spoke openly about what they perceived to be a lack of leadership and direction in the prison.

23. Inspectors judged that primary healthcare services were reasonably good, despite staff shortages, but the range of services offered had reduced. They also observed that too many prisoners experienced long delays accessing external hospital appointments.

Independent Monitoring Board

24. 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 2017, the IMB said that the prison's new health management team had employed a business manager, leading to a more efficient running of the healthcare department. There were no vacancies in the department, an improvement on the previous year.

25. The Board recognised the improvement in staffing levels at the prison and noted that relationships between staff and prisoners were much improved as a result.

Previous deaths at HMP Featherstone

26. Mr Sefton-Marshall's death was the fourth to occur from natural causes at Featherstone since the start of 2016. On each previous occasion, we have made recommendations about family contact following a prisoner's death.

Assessment, Care in Custody and Teamwork

27. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 risk and how best to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm.

Psychoactive Substances (PS)

28. Psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the

influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm. PS comes in a variety of chemical compositions, with 'spice' and 'mamba' being two of the more common names generally applied.

29. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

30. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

31. On 3 March 2006, Mr Madison Sefton-Marshall (convicted as Mr Hugh Brown) was sentenced to a minimum of three and half years' imprisonment for robbery under an IPP sentence. This meant he was required to remain in prison until the Parole Board was satisfied that he no longer posed a danger to the public. He had a history of strokes, mental health problems, including a diagnosis of an emotionally unstable personality disorder, and intravenous and other drug use.

32. Mr Sefton-Marshall spent time at several prisons before transferring to HMP Featherstone in 2016.

Background to Mr Sefton-Marshall's health concerns

33. In September 2012, a hospital gastroenterologist recorded that Mr Sefton-Marshall had had hepatitis C for over twenty years but had not received anti-viral therapy. Hepatitis C is a viral infection in the blood which can cause liver cirrhosis (irreversible scarring of the liver) and liver cancer. In June 2014, he was diagnosed with liver cirrhosis.

34. In May 2015, Mr Sefton-Marshall was transferred to HMP Bristol. In September, the hepatology department at Bristol Royal Infirmary assessed him as having a life expectancy of 4-14 years. In January 2016, Mr Sefton-Marshall started a course of anti-viral medication. In June, an ultrasound scan revealed that his liver disease had not deteriorated.

35. In August 2016, Mr Sefton-Marshall was diagnosed with oesophageal varices (abnormal enlarged veins in the oesophagus which tend to cause bleeding and are commonly found in people with serious liver disease). He was due a further review, but he refused to attend as he wanted to transfer to Featherstone to improve his chances of parole.

HMP Featherstone

36. On 31 October 2016, Mr Sefton-Marshall was transferred to HMP Featherstone and New Cross Hospital in Wolverhampton took over the supervision of Mr Sefton-Marshall's long-term conditions.

37. A nurse reviewed Mr Sefton-Marshall at a health screen when he arrived at Featherstone. He recorded that he had had a stroke in 2012, and that, in addition to his liver disease and oesophageal varices, he had a history of ascites (abnormal accumulation of fluid in the abdominal cavity, often caused by liver cirrhosis). The nurse also noted that he had used heroin and crack 11 years previously, and that, after his wife and two children were killed in a car crash in 1990, Mr Sefton-Marshall had attempted suicide and been diagnosed with anxiety.

38. On his admission, Mr Sefton-Marshall was taking several prescribed drugs, including amiloride, ramipril and propranolol (for high blood pressure); atorvastatin (to lower cholesterol); clopidogrel (to reduce the risk of stroke or heart disease); lansoprazole (to reduce stomach acid); quinine sulphate (to

prevent leg cramps); and tramadol (an opioid pain killer to treat moderate to severe pain).

39. On 20 December, a nurse responded to a code blue emergency called after officers suspected that Mr Sefton-Marshall had had a stroke or heart attack. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff to attend and the control room to call for an ambulance.) The nurse noted that Mr Sefton-Marshall's observations were normal and no further action was required.

40. On 24 December, Mr Sefton-Marshall was taken to hospital following a stroke. He was left with right-sided weakness but no cognitive impairment.

41. When he returned to Featherstone on 4 January 2017, he required a walking frame and an en-suite cell and he was relocated to houseblock 7 which had en-suite facilities. An officer noted that he did not fit the criteria for this houseblock because he had had an adjudication for using 'mamba' (a form of PS). He remained on houseblock 7 until July.

42. On 10 January 2017, a hospital report said that Mr Sefton-Marshall had undergone a successful procedure in which rubber bands were placed around the varices in his oesophagus to prevent bleeding. Over the next couple of months, he continued to have difficulties and was referred back to New Cross for further treatment. On 24 May, a review revealed no significant varices.

43. On 27 March, a nurse examined Mr Sefton-Marshall after reports of a swollen abdomen and a pitting oedema (swelling body tissues caused by fluid accumulation). She detected a large amount of ascites and sent him to the hospital for this to be drained. Spironolactone was added to his prescription to reduce excess fluid.

44. On 23 May, two substance misuse workers reviewed Mr Sefton-Marshall after he asked to engage with the substance misuse team. He told them that he needed to engage in order to satisfy the Parole Board's expectations of him. They informed Mr Sefton-Marshall that he was not suitable for the service.

45. In the early hours of 18 July, Mr Sefton-Marshall collapsed in his cell. An officer noted that there was a pool of blood next to where he lay. He recorded that ambulance staff suspected a stroke and that the blood had been coughed up by Mr Sefton-Marshall. He was sent to hospital but was discharged a few hours later without treatment.

46. On 18 August, a nurse recorded that healthcare staff attended to Mr Sefton-Marshall following a code blue call. She noted that his observations were normal and that officers suspected that he had placed himself on the floor. The nurse recorded that it was an inappropriate code blue and the ambulance was stood down. Three days later, healthcare staff again responded to a code blue call for Mr Sefton-Marshall. The nurse recorded that his observations were normal and asked officers to monitor him in his cell.

47. On 12 September, Mr Sefton-Marshall referred himself to the mental health team. A nurse noted that he asked about interventions around coping and anxiety due

to his bereavements and his own physical and sexual abuse as a child. Two days later, a mental health nurse reviewed him. He noted that Mr Sefton-Marshall decided to disengage from the service.

48. On 15 September, a nurse examined Mr Sefton-Marshall after he collapsed on the wing. He observed that his pupils were dilated, his speech was slurred and incoherent, and that he was unsteady. The nurse diagnosed PS misuse and asked officers to monitor him and report any concerns.

49. On 26 September, a nurse noted that Mr Sefton-Marshall had pain in his upper abdomen. Two days later, he was taken to hospital but discharged without treatment. On 23 October, a GP saw Mr Sefton-Marshall and observed some tenderness in his abdomen and some mild swelling. He diagnosed lower back pain and increased Mr Sefton-Marshall's dose of tramadol.

50. On 16 October, an officer noted that Mr Sefton-Marshall was restricted to his cell due to suspicions of illicit substance misuse. Two days later, an officer noted that he appeared under the influence of something and was restricted to his cell for the rest of the day. On 21 October, Mr Sefton-Marshall tested positive for PS during a mandatory drug test (MDT). On 30 October, an officer asked a nurse to check on Mr Sefton-Marshall because he was not responding to verbal commands. The nurse recorded that his pupils were non-reactive but he was maintaining his own airways and was rousable. After a few seconds Mr Sefton-Marshall began to talk and denied using PS.

51. On 24 November, a GP reviewed Mr Sefton-Marshall. He agreed to stop his tramadol medication and replace this with gabapentin (for persistent pain). The GP noted that this was tradeable and he advised Mr Sefton-Marshall that gabapentin was habit-forming and posed a risk of overdose, especially if mixed with other medication or illicit substances.

52. In January 2018, Mr Sefton-Marshall complained of stomach pain, diarrhoea and blood in his stools. On 4 January, a GP reviewed him and noted that he had neuropathic pain and a soft abdomen, but his ascites was no worse. He doubled Mr Sefton-Marshall's gabapentin dose and wrote to his consultant gastroenterologist at the hospital.

53. On 30 January, a nurse responded to a code blue for Mr Sefton-Marshall. She noted that his observations were normal and he had no acute symptoms. The nurse noted that he appeared to be faking illness to get taken to hospital.

54. The next day, an officer saw Mr Sefton-Marshall making cuts to his arm. The officer called a code red emergency. (This is an emergency code used in cases of bleeding.) A nurse responded and noted that Mr Sefton-Marshall had two superficial cuts to his forearm. An ACCT was opened but was closed two weeks later.

55. On 15 February, a GP reviewed Mr Sefton-Marshall following complaints of abdominal pain. The GP sent him to hospital for an urgent assessment. He was discharged the same day.

56. On 25 February, Mr Sefton-Marshall told an officer that he was being threatened by prisoners to give them medication. The next day, a GP noted that Mr Sefton-

Marshall was not suitable for in possession medication because of being bullied. He also noted that Mr Sefton-Marshall had been seen by his consultant gastroenterologist two weeks earlier and was due for a further review.

57. On 13 March, an officer informed Mr Sefton-Marshall that the Parole Board had refused him release or a transfer to open conditions. He noted that Mr Sefton-Marshall was disappointed but appeared to have expected this news.

58. The next day, an officer called a code blue emergency after he found Mr Sefton-Marshall unresponsive in his cell. A nurse noted that he was unresponsive and slumped against his cell wall. She recorded that at one point he stopped breathing but started again as she was about to begin cardiopulmonary resuscitation (CPR). An ambulance crew arrived but shortly afterwards Mr Sefton-Marshall became responsive and the crew decided not to take him to hospital. Healthcare staff asked officers to monitor Mr Sefton-Marshall at 15-minute intervals and to call a code blue if they had any concerns.

59. On 18 March, an officer called a code blue emergency after he discovered Mr Sefton-Marshall on his cell floor. He noted that nurses responded and confirmed that he was under the influence of PS. A nurse recorded that Mr Sefton-Marshall appeared normal and advised officers to observe him. Officers and healthcare staff reported no further PS episodes for the next couple of months.

60. On 10 April, a GP discussed Mr Sefton-Marshall's upcoming appointment with his consultant gastroenterologist at the hospital and noted that he was waiting for a liver transplant. The next day, the hospital asked if they could change Mr Sefton-Marshall outpatient's appointment that afternoon to an inpatient one, but were told this was not possible at such short notice. On 23 April, a GP recorded that Mr Sefton-Marshall had been seen by the consultant gastroenterologist recently, who advised that he should be considered for release on medical grounds and that he would need a liver transplant.

61. On 22 May, a GP recorded that Mr Sefton-Marshall's pain was not being controlled and increased his daily gabapentin dose to 900mg. On 27 May, a nurse saw Mr Sefton-Marshall after he complained that his liver pain was getting worse. He noted that Mr Sefton-Marshall's NEWS score was 0. (The National Early Warning Score, or NEWS, is a predictive tool used to gauge the medical condition of a patient – 0 equates to no risk.)

62. On 31 May, Mr Sefton-Marshall asked to be placed on an ACCT due to his low mood. The next day, a nurse saw him and noted that a noose had been found in his cell. He told her he had intended to use it before staff prevented him doing so. Later at an ACCT review, Mr Sefton-Marshall said that his mental health was suffering due to an upcoming court case where he was the alleged victim of sexual assault at the hands of his step-mother. He also said that the death of his wife and children was affecting him. Mr Sefton-Marshall was initially placed on two ACCT observations per hour.

63. On 4 June, a nurse sat in on an ACCT review with Mr Sefton-Marshall. He said that he had been having nightmares and hearing the voices of his dead father and his step-mother telling him to hang himself. Mr Sefton-Marshall said that he wanted to go to a psychiatric hospital but the nurse noted that he did not meet

the criteria for this. His ACCT observations were increased to three per hour. On 6 June, an ACCT review noted that he did not mention self-harm or suicide and his observations were reduced to one per hour.

64. On 7 June, a nurse responded to a code blue call for Mr Sefton-Marshall. She noted that he was alert and orientated with no clinical concerns. The nurse recorded that a code blue had been called because he had fallen over.

65. On 8 June, a nurse saw Mr Sefton-Marshall because officers became concerned about marks on his neck. He told her that he had put a ligature around his neck during the night but did not currently have any thoughts of self-harm or suicide. He was kept on one ACCT observation per hour.

66. Later, a psychosocial worker noted that an ACCT review had taken place earlier and requested a further ACCT review with her present. She noted that Mr Sefton-Marshall presented well but she asked officers to increase his observations due to his behaviour. She noted that officers were reluctant to do so but observations were increased to two per hour. On 12 June, a further ACCT review recorded that Mr Sefton-Marshall had no thoughts of self-harm and his observations were reduced to one per hour.

67. On 12 June, a nurse saw Mr Sefton-Marshall after he reported coughing up blood. He noted that there was no evidence of this on examination. The nurse performed Mr Sefton-Marshall's clinical observations and recorded that his blood pressure was low and his body temperature was slightly low. The nurse noted that Mr Sefton-Marshall's NEWS score was 5. (This equates to a medium risk requiring further monitoring.) Later that day, a nurse attempted to review Mr Sefton-Marshall's observations but he was in the shower. Later, she saw him collecting his medication and noted that he "appeared as his usual self". His NEWS scoring was not reviewed.

Events of 15 June 2018

68. On 15 June, at approximately 8.00pm, Officer A was working alone on Mr Sefton-Marshall's houseblock. In interview, he said that he went to check Mr Sefton-Marshall in line with his ACCT observations but could not see him and could not get a response from him. He informed a custodial manager (CM) who was in charge of the prison at the time. The CM told Officer A to seek assistance from the officer in the adjacent houseblock so they had three officers to open the cell.

69. Officer B responded to this request. He and Officer A said it took him about a minute to get to Mr Sefton-Marshall's cell. He told the investigator that the CM gave them permission to unlock Mr Sefton-Marshall's cell but they decided to wait until she arrived. He said that they had no specific concerns about the risk Mr Sefton-Marshall might pose, but preferred to be cautious. He also said he would never enter a cell without three officers present.

70. Officer A also said that they waited for the CM before unlocking the door. He said Mr Sefton-Marshall was very unpredictable because he used a lot of illicit substances, so he was wary of opening his cell without a third officer present. He said he had known Mr Sefton-Marshall throughout his time at Featherstone and believed that he was terminally ill. He described him as 'frail' and not very

'nimble'. He said that Mr Sefton-Marshall had changed in the week before his death and seemed very 'zoned out' and slow at responding to what was going on around him.

71. In interview both officers said that Mr Sefton-Marshall had a reputation for 'crying wolf' because he had sometimes pretended to collapse when there was nothing wrong with him in order to be taken to hospital. (They said it was thought that he was being bullied by other prisoners who wanted him to bring illicit substances back into the prison.)

72. Both officers said that the CM arrived a couple of minutes after Officer B, although the CM told the investigator that she arrived at about the same time as Officer B so there was no delay in opening the cell. The CM also said that she did not regard it as an emergency at that time; it was just that they could not see Mr Sefton-Marshall.

73. The CM said they then tried to open Mr Sefton-Marshall's cell but he was lying behind the door and obstructing it. They managed to open the door sufficiently to enable Officer B to get inside. This took a couple of minutes. Officer B said that as soon as he got into the cell he saw that Mr Sefton-Marshall was unconscious and said that they needed to call a code blue emergency. He moved Mr Sefton-Marshall to allow the others to get into the cell. The CM said that when she checked she found a pulse and signs of breathing so they placed Mr Sefton-Marshall into the recovery position.

74. The CM then asked Officer A to phone the control room from the office and ask them to call an ambulance. The CM accepted in interview that it was a mistake not to call the code blue on the radio, but she said that she told Officer A to say it was a code blue emergency over the phone. Officer A said that he would not have used the term 'code blue' on the phone but would have said that an ambulance was needed. He said he could not remember if he said it was an emergency or not.

75. The control room log records that an ambulance was called at 8.23pm. At 8.42pm, it records that the ambulance was contacted because the prisoner had deteriorated. At 8.46pm, the log records that the incident was upgraded to a cardiac arrest and reclassified as an emergency by the ambulance service. The log records that the ambulance arrived at 8.52pm.

76. The ambulance service log records that at 8.26pm, the ambulance was called out for a male who had collapsed in a cell with slow breathing and a faint pulse. At 8.44pm, the log records that an emergency ambulance was required for a potential cardiac arrest.

77. The CM said they monitored Mr Sefton-Marshall while they waited for the ambulance. Other officers joined them, and she asked an officer to fetch the defibrillator. She said that shortly afterwards they could no longer feel a pulse so she instructed Officer B and another officer to start CPR. An officer then returned with the defibrillator and they connected this to Mr Sefton-Marshall.

78. When the ambulance crew arrived, they took over Mr Sefton-Marshall's care but let officers continue with chest compressions. In a statement taken by the police

after the event, a paramedic said that "there were two male prison officers inside the cell performing very good CPR". Once the paramedics had assessed Mr Sefton-Marshall, they took him to New Cross Hospital in Wolverhampton.

79. At 10.07pm, the hospital pronounced Mr Sefton-Marshall had died.

Events following Mr Sefton-Marshall's death

80. A paramedic said in his police statement that while CPR was being performed, Mr Sefton-Marshall moved slightly and he "found an empty Bic biro pen, without the ink in it. It had tin foil on the end of the biro with a black residue on the end". He said that he gave the pen to a member of prison staff.

81. In interview, Officer A said that he saw what appeared to be a homemade 'bong' (a pipe used for smoking drugs) in Mr Sefton-Marshall's cell when they were lifting him onto the bed. He described it as an old asthma inhaler with foil on it, and said that it was covered with burn marks and had a smoky smell. He said that they left it because it was effectively a potential crime scene. He said he did not see anything like a pen, but that pens were often used to administer illicit substances.

82. The prison told us that after Mr Sefton-Marshall was taken to hospital, his cell was sealed and treated as a potential crime scene pending inspection by the police. The police subsequently conducted a forensic examination of the cell and removed the Bic biro pen, but there was no mention of an inhaler.

Contact with Sefton-Marshall's family

83. On 28 December 2016, a prison manager visited Mr Sefton-Marshall while he was in hospital. She asked whether he wanted anyone to be informed but he said there was no one to inform. The prison manager noted that Mr Sefton-Marshall's brother was his next of kin but that he had not visited him at Featherstone.

84. On 15 June 2018, at 9.30pm, a prison manager telephoned Mr Sefton-Marshall's brother to inform him that his brother had been taken to hospital. He noted that the number he had was out of service so he was unable to speak to him.

85. The prison manager obtained an address for Mr Sefton-Marshall's brother through the police. After Mr Sefton-Marshall's death, the prison manager contacted HMP Sudbury and asked them to send family liaison officers to his brother's address to inform him of the death. At 2.30pm on 16 June, family liaison officers from HMP Sudbury went to Mr Sefton-Marshall's brother's home and informed him of his brother's death.

86. The prison appointed an officer as Mr Sefton-Marshall's family liaison officer. At 3.30pm, she telephoned his brother to introduce herself and offer support. She maintained regular contact with Mr Sefton-Marshall's brother.

87. On 25 June, the family liaison officer facilitated a visit to Featherstone for Mr Sefton-Marshall's brother. While at the prison, Mr Sefton-Marshall's brother spent some time in the cell and spoke to a prison manager and the Governor.

The prison manager gave Mr Sefton-Marshall's property to his brother and then took him home.

88. Mr Sefton-Marshall was cremated on 26 July. The prison paid for the full cost of the funeral in line with national guidance.

89. On 16 August, Mr Sefton-Marshall's brother contacted the investigator to express his concern that the funeral directors had not released his brother's ashes to him. The investigator informed the Governor who contacted the funeral directors. Mr Sefton-Marshall's brother later confirmed that he received his brother's ashes on 30 August.

Support for prisoners and staff

90. After Mr Sefton-Marshall's death, 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. The staff care team also offered support.

91. The prison posted notices informing other prisoners of Mr Sefton-Marshall'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 Sefton-Marshall's death.

Post-mortem report

92. A toxicology report revealed that Mr Sefton-Marshall had gabapentin (which he had been prescribed) and PS in his system. The toxicologist recorded that PS has been associated with sudden unexpected deaths but he could not determine whether this played an active part in Mr Sefton-Marshall's death.

93. The post-mortem concluded that Mr Sefton-Marshall died from massive upper gastrointestinal bleeding caused by ruptured oesophageal varices and alcoholic liver cirrhosis. The pathologist concluded that PS had not contributed to Mr Sefton-Marshall's death.

Findings

Clinical care

94. The clinical reviewer concluded that, overall, the care Mr Sefton-Marshall received at Featherstone was equivalent to that which he could have expected in the community. We agree with the clinical reviewer that healthcare staff regularly monitored Mr Sefton-Marshall for his many serious health concerns. They also appropriately referred him to external specialists as necessary.

95. Mr Sefton-Marshall placed a lot of demands on all staff at Featherstone because of his complex health concerns, self-harming and illicit substance misuse, but we are satisfied that healthcare staff always attended promptly when required, and followed up with further reviews and monitoring.

96. However, we share the clinical reviewer's concerns that healthcare staff neglected to follow up after Mr Sefton-Marshall recorded NEWS score of 5 on 12 June. We make the following recommendation:

The Head of Healthcare should ensure that there are clear processes for staff to follow in response to any NEWS score that falls into the category of medium to high risk.

Emergency response

97. Prison Service Instruction (PSI) 24/2011, *Management and Security of Nights*, gives instructions for entering cells at night. The PSI says that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and a cell should be opened with a minimum number of staff (according to local risk guidelines) present. However, the PSI goes on to say that the preservation of life must take precedence over this. Where there is, or appears to be, a threat to life, staff may open and enter cells on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room.

98. PSI 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. A code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.

99. We are very concerned by the lack of urgency shown by staff when Officer A could not see Mr Sefton-Marshall or get a response from him when he tried to conduct an ACCT check at 8.00pm. This should have been treated a serious matter for a prisoner being monitored under suicide and self-harm procedures, but the CM said she did not consider it an emergency at the time and we are concerned that she and the two officers may have been influenced by Mr Sefton-Marshal's reputation for 'crying wolf'.

100. Although the CM said that she arrived at the same time as Officer B, we accept the officers' accounts that they waited a couple of minutes before she arrived. We consider that once Officer B had joined Officer A they should have entered

the cell immediately to check on Mr Sefton-Marshall's well-being, without waiting for the CM. Mr Sefton-Marshall had no history of violence to staff or prisoners at Featherstone and both officers were aware that he had serious health problems.

101. We are also concerned that, although Mr Sefton-Marshall was unresponsive and barely breathing, none of the staff called a code blue emergency. We consider that staff should have radioed a code blue emergency as soon as they pushed the cell door open slightly and saw Mr Sefton-Marshall unresponsive on the floor at about 8.06pm. This would have triggered the control room to call an emergency ambulance immediately. As the CM acknowledged at interview, it was a mistake for her to have told Officer A to phone the control room instead of radioing an emergency code since this led to a confused message.

102. We are also concerned that, although the officers opened the door and saw that Mr Sefton-Marshall had collapsed at about 8.06pm, the control room was not asked to call an ambulance until 8.23pm. The CM said she could not explain why there was such a long delay before the control room was contacted.

103. It appears that the call for an ambulance was not upgraded to an emergency until 8.42pm or 8.46pm when further calls were made after Mr Sefton-Marshall's condition deteriorated. As a result, the paramedics did not arrive until 8.52pm, by which time Mr Sefton-Marshall had stopped breathing.

104. We cannot say whether the outcome would have been different for Mr Sefton-Marshall if an emergency ambulance had been called at 8.06pm, but it seems likely that paramedics would have reached him earlier than they did if staff had called a code blue as soon as they found Mr Sefton-Marshall unresponsive.

105. We make the following recommendations:

The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency, subject to a risk assessment, in order to help preserve the life of a prisoner.

The Governor should ensure that all staff are aware of their responsibilities when dealing with emergency situations and the calling of emergency medical codes.

The Governor should initiate a fact-finding investigation into the following and inform the PPO of the outcomes and whether any disciplinary action has been taken:

- **the actions of two officers in not entering Mr Sefton-Marshall's cell when they could not obtain a response from him; and**
- **the actions of a custodial manager in not calling a code blue emergency code as soon as Mr Sefton-Marshall was found unresponsive on the floor of his cell.**

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