

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Marc Marshall on 26 June 2019, following an incident at Inner London Crown Court

**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 Marc Marshall died in St Thomas' Hospital on 26 June 2019. He had been admitted on 29 April after he drank some acid in the dock at Inner London Crown Court when he was sentenced. He was 55 years old. I offer my condolences to Mr Marshall's family and friends.

Although Mr Marshall had a recent history of serious self-harm, court staff were not aware of this and I am satisfied that court staff could not have predicted Mr Marshall's actions.

However, I am concerned that Mr Marshall was able to take a dangerous substance into the dock with him. I consider that the dock officer made an error of judgement when she allowed Mr Marshall to take his flask into the dock after he had declined to take a sip test.

Serco, who are responsible for security in court docks, have since amended their standard operating procedures. Defendants are no longer allowed to bring their own drinks into court docks. I hope this is effective in preventing similar incidents in future.

In hospital, Mr Marshall was in the custody of HMP Thameside. I have made recommendations to Thameside about liaising with hospitals when prisoners are in their care and appropriately supporting staff after a prisoner dies.

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**

**April 2020**

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# Summary

## Events

1. On 26 March 2019, Mr Marc Marshall was convicted of fraud at Inner London Crown Court. He was bailed to return on 29 April for sentencing.
2. On 29 April, Mr Marshall returned to court. When he entered the building, he and his bag were searched. Mr Marshall was carrying a drink flask and was asked to take a sip test (drink some of the liquid) to ensure that the liquid was safe. He did so without issue.
3. CCTV footage shows that while waiting in a communal area of the court, Mr Marshall removed his shoe and took something out of it. This was not witnessed by anyone at the time.
4. Mr Marshall then went into the court's dock area. He and his possessions were searched again before he entered the court room and he left his possessions outside the dock. The court adjourned. After speaking to his legal adviser, Mr Marshall went into a toilet. He took his flask with him.
5. When he returned to the dock, Mr Marshall was searched again. As he was to be sentenced and potentially taken to prison, he had his possessions with him. The dock officer noticed that he had a flask with him and asked him to take a sip test. Mr Marshall said that he was not thirsty. The officer did not insist and allowed him to take the flask into the dock. Mr Marshall and the officer entered the dock and put Mr Marshall's belongings on the floor.
6. Mr Marshall was sentenced to two years and four months imprisonment. He picked up his flask and drank from it, then shouted, "Acid ... acid." The dock officer pressed the alarm and poured water onto Mr Marshall's face. Other staff responded and called an ambulance. In line with advice from the ambulance service, they continued to pour water onto Mr Marshall until ambulance staff arrived and took over. They took Mr Marshall to hospital.
7. If Mr Marshall had gone to prison after he was sentenced, he would have gone to HMP Thameside. Staff from Thameside therefore took over security for Mr Marshall while he was in hospital.
8. Mr Marshall remained in hospital on life support until 26 June, when life support was withdrawn. He died later that morning.

## Findings

### Assessment of risk

9. This is an exceptional case and Mr Marshall had clearly planned his actions.
10. Mr Marshall had previously attempted to hang himself in prison and had stabbed himself when he was arrested to avoid being taken into police custody. If he had been attending court from prison or police custody he would have been risk assessed and accompanied by risk assessment paperwork but, because he was coming to court from the community, there was no assessment system in place

and his previous history of serious self-harm was not known to court staff. We are satisfied that court staff could not have been expected to foresee Mr Marshall's actions.

11. We accept that the numbers of people attending courts across England and Wales every day would make it impossible for court staff to risk assess everyone. We do, however, wonder whether it would have been possible for the probation officer who completed Mr Marshall's pre-sentence report to have alerted court staff that he might be at high risk of suicide or self-harm.

### **Court entry security**

12. Mr Marshall went through security measures on entering court. He passed through a metal detector, he was searched, and his drinks flask was checked. Security staff conducted these checks correctly. Once out of sight of staff, he added a soluble form of sulphuric acid to the water in his flask. We did not find any evidence that court security staff did not carry out their duties correctly and we are satisfied that they could not have been expected to find what Mr Marshall had hidden in his shoe.

### **Court dock security**

13. Serco staff searched Mr Marshall in the court dock area. They did not carry out a wand search in line with their standard operating procedure. (If they had done so, a wand search would not have detected the powder that Mr Marshall had concealed and would not have prevented what happened.)
14. We consider that the dock officer showed an error of judgement in allowing Mr Marshall to take his flask into the dock after he had declined to take a sip test. We accept, however, that the standard operating procedures in place at the time did not state explicitly that defendants could not take drinks into the dock with them.
15. In the light of Mr Marshall's death, Serco have amended procedures so that defendants are not allowed access to their property in the dock. It has also been made clear that defendants may not take any liquids into the dock with them.

### **Clinical care**

16. While Mr Marshall was in hospital, Thameside healthcare staff telephoned for daily updates. Sometimes the calls were not answered, and when they were, the information was provided by whoever picked up the phone. There was no structured approach to liaising with hospital staff.

### **Support for staff**

17. After Mr Marshall died, no debrief was held for prison staff who had been involved in his care in hospital. They were not directly informed of support available to them.

## Recommendations

- The Head of Operations at Serco should ensure that court search procedures are carried out in line with Standard Operating Procedures.
- The Director General of Probation should consider whether there should be a mechanism for probation officers to inform court staff if they consider an offender may be at high risk of suicide or self-harm.
- The Head of Healthcare at HMP Thameside should establish a protocol for obtaining consistent, regular updates from a senior member of the appropriate medical team when a prisoner is in hospital.
- The Director of HMP Thameside should ensure that, following any death in custody, a debrief is held and that staff are offered support.

## The Investigation Process

18. The investigator issued notices to Inner London Crown Court staff and HMP Thameside staff involved in Mr Marshall's care informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
19. The investigator obtained copies of relevant extracts from Mr Marshall's prison and medical records. He discussed Mr Marshall's care with police investigating officers and had access to witness statements. He also obtained information from senior staff in Her Majesty's Courts and Tribunal Service (HMCTS), Serco, HMP Thameside, and the Chair of the Independent Monitoring Board (IMB) and the Lay Observers Secretariat.
20. The security officer who had been in the dock with Mr Marshall had, at the time of writing, not returned to work. The investigator contacted her requesting an interview, but she did not reply.
21. NHS England commissioned an independent clinical reviewer to review Mr Marshall's clinical care.
22. We informed HM Coroner for Inner South London District of the investigation. He provided us with a copy of Mr Marshall's death certificate. We have sent the Coroner a copy of this report.
23. One of the Ombudsman's family liaison officers contacted Mr Marshall's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any specific issues. We have sent a copy of this report to Mr Marshall's family. They raised some issues, which have been addressed in separate correspondence.

## Background Information

### HMP Thameside

24. HMP Thameside is a local prison which holds up to 1,232 male prisoners who have either been convicted or are on remand. It is managed by Serco. Healthcare is provided by Oxleas NHS Trust. A dedicated healthcare unit has inpatient facilities for 20 prisoners.

### Inner London Crown Court

25. Inner London Crown Court is in Southwark and has 10 courts. Security for entering court is the responsibility of Her Majesty's Courts and Tribunals Service (HMCTS). Security for defendants in the dock is the responsibility of Serco Prisoner Escort and Custody Service (PECS).

### HM Inspectorate of Prisons (HMIP)

26. The most recent inspection of HMP Thameside was in May 2017. Inspectors reported that, overall, HMP Thameside was a relatively good prison, and they identified an unusually high number of examples of good practice that other establishments could learn from. However, they reported that healthcare services were not sufficient to meet demand, and they noted that significant staff shortages had affected the delivery of health services.
27. HMIP have not yet inspected Inner London Crown Court. This will form part of the next inspection they undertake in London courts.

### Independent Monitoring Board

28. 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 June 2019, the IMB reported that while there were still areas of concern, healthcare provision had improved, and that healthcare staffing levels had risen.

### Lay Observers

29. Lay Observers monitor the welfare and access to justice of people being brought to court and held in court custody. They are appointed by the Secretary of State under the Criminal Justice Act 1991 to provide independent oversight of how people detained in court cells and cellular vehicles are cared for and their access to justice. Their April 2019 report on the Inner London Crown Court commented on problems with risk assessments for defendants brought to court from prison.

### Previous deaths at HMP Thameside

30. Mr Marshall was the sixth prisoner in the care of HMP Thameside to die since 2017. There has since been a further death. The circumstances of Mr Marshall's death are not comparable to any of these.
31. We have not investigated any previous deaths at Inner London Crown Court.

## Key Events

32. On 26 March 2019, Mr Marc Marshall was convicted of fraud. He was released on bail, to return to Inner London Crown Court on 29 April for sentencing.
33. Mr Marshall had been in prison before. In 2011, he had been found hanging in his cell and required hospital treatment. Records show that he was diagnosed with depression and could display impulsive behaviour. He was most recently released in 2014. When police arrested Mr Marshall for the latest offences, he stabbed himself in the neck to try to prevent himself being taken into their custody.
34. On 29 April, Mr Marshall returned to Inner London Crown Court. Her Majesty's Courts and Tribunals Service (HMCTS) are responsible for security arrangements in court buildings, and Mitie provide security for the Inner London Crown Court under contract. As well as passing through metal detectors and other physical security measures, people bringing drinks into courts are required to take a sip test (drink some of the liquid in front of security staff) to ensure that the liquid is safe.
35. At 9.03am, Mr Marshall arrived at the court building. A Court Security Officer searched his bag. He saw a metal drinks flask and asked Mr Marshall to take a sip test, which he did. He was satisfied and allowed Mr Marshall to proceed. He passed through the archway metal detector, which activated so he was searched with a hand-held metal detector. This did not discover any barred articles, so he was allowed to enter the court building.
36. CCTV footage shows that after leaving the entrance search area, Mr Marshall went into the toilet, then came out and sat down in a communal area of the building. He took off his shoe and appeared to remove something from it and put it in his trouser pocket. It does not seem that anybody witnessed him doing so at the time. He then went into another toilet, taking his flask with him, before coming out and going to the waiting area for Court 10.
37. Serco are responsible for security in court docks. At the time, Serco's policy was that after a search, defendants attending court from bail could have reasonably sized property with them in the docks. Larger pieces of luggage were left in a secure area outside the docks.
38. A PCO was the member of Serco staff who was the dock officer for Court 10. When the court usher called for Mr Marshall to be brought to the court, the PCO asked him to place all his belongings on a chair by the door to the dock and gave Mr Marshall a rub-down search. She and Mr Marshall then entered the dock at 10.14am. They left Mr Marshall's belongings, including his flask, on the chair outside the door.
39. At 10.45am, the judge called a recess. Mr Marshall left the dock to consult with his legal advisers. At 11.02am, Mr Marshall went into the toilet, taking his flask with him. At 11.06am, he re-entered the court area.
40. As he was to be sentenced, the PCO asked Mr Marshall to collect his belongings and escorted him to the court holding area by the dock. As she searched him and

his property, she saw that Mr Marshall was now holding his flask. She told him that he was not allowed to take his own drink into the dock. She asked him what it was, and he said it was water. She offered him a cup to pour some into for a sip test, but he said that he was not thirsty. She did not pursue the issue. They then entered the dock. Mr Marshall took his property, including the flask, into the dock and put it on the floor. The PCO stood to his right (next to the staff alarm).

41. At the end of the proceedings, the judge sentenced Mr Marshall to two years and four months in prison. The PCO began completing the necessary court documentation. At this point, Mr Marshall picked up his flask and put it to his mouth. He then dropped it to the floor, put his hands to his face and shouted, "Acid! Acid!"
42. The PCO pressed the dock alarm, then poured jugs of water from the court over Mr Marshall's head and face. Other court staff, responding to the alarm, joined her. Another PCO took the flask from Mr Marshall's hands, and in doing so some splashed onto his wrist. He used one of the courtroom telephones to call for an ambulance. Once the ambulance had been despatched, a PCO was put through to paramedics, who advised that staff should continue to pour cold water onto Mr Marshall. They did so. The PCO had been splashed with some of the liquid, and left to run cold water over her arm.
43. London Ambulance Service records showed that they received the emergency call at 11.34am. They arrived at the court at 11.45am and found Mr Marshall conscious and breathing, but very distressed. They provided medical aid to Mr Marshall. Ambulance staff also assessed the PCO and found three small acid burns to her arm. She declined pain relief medication, and was advised to keep applying cold water to the burns.
44. Paramedics transferred Mr Marshall to the ambulance and, at 11.55am, left the court and took him to hospital. They were accompanied by three Serco escort staff (one in the ambulance and two in a vehicle following). No physical restraints were applied to Mr Marshall. Paramedics found a note written by Mr Marshall in his pocket which said that he would drink acid to end his life if he was given a custodial sentence.
45. If Mr Marshall had been taken to prison following his sentencing, he would have gone to HMP Thameside. Consequently, that afternoon, staff from HMP Thameside took over from Serco staff in providing security for Mr Marshall in hospital.
46. Mr Marshall was sedated and ventilated. Healthcare staff in Thameside contacted the hospital daily (with one exception) and obtained regular updates on Mr Marshall. They also visited the hospital on two occasions to discuss his care with hospital staff.
47. Mr Marshall's life support machine was switched off on 26 June. He died that morning.

### **Contact with Mr Marshall's family**

48. Hospital staff contacted Mr Marshall's family when he arrived there. On 30 April, Thameside appointed an officer as family liaison officer and he remained in contact with Mr Marshall's family while Mr Marshall was in hospital. In line with Prison Service guidance, Thameside offered a financial contribution to the cost of Mr Marshall's funeral.

### **Support for staff**

49. Serco held a debrief for the dock officers after the incident.
50. There is no record of a debrief being held for prison staff after Mr Marshall died.

### **Analysis of the liquid**

51. Analysis of the bottle Mr Marshall drank from showed positive traces of sulphuric and hydrochloric acid.

### **Cause of death**

52. Mr Marshall's death certificate records that he died of multi-organ failure due to mediastinitis (inflammation of the chest cavity), a broncho-oesophageal fistula (an abnormal connection between a bronchus and the oesophagus) and oesophageal injury following acid ingestion. No post-mortem examination took place.

# Findings

## Assessment of risk

53. Mr Marshall had a note on him saying that he would drink acid if he was given a custodial sentence. He had smuggled the soluble acid into the court. Mr Marshall's actions were obviously pre-planned.
54. If a prisoner is transferred from police or prison custody to court, they are risk assessed and this information is given to court security staff. If someone is coming into court from bail, no such assessment takes place. HMCTS court entry security staff, and subsequently Serco court custody officers do not, therefore, have any indications as to whether someone in the dock may be volatile, vulnerable or violent.
55. When police originally went to arrest Mr Marshall, he had stabbed himself in the neck to try to prevent being taken into custody. Neither HMCTS nor Serco staff were aware of this.
56. Ministry of Justice published figures show that over 100,000 people were received into Crown Courts in England and Wales in the first quarter of 2019. Large numbers of people attend courts each day, a great many of whom are not arriving from custody. We accept that it is not possible for courts to individually risk assess all these people. This was an exceptional event. In the circumstances, we are satisfied that Inner London Crown Court could not have anticipated Mr Marshall's actions.
57. Having said that, a probation officer completed a pre-sentence report on Mr Marshall. We assume they would have been aware that Mr Marshall self-harmed seriously when he was arrested and could have ensured that court staff were aware of this when he appeared for sentencing. We, therefore, recommend:

**The Director General of Probation should consider whether there should be a mechanism for probation officers to inform court staff if they consider an offender may be at high risk of suicide or self-harm.**

## Court entry security

58. It appears that Mr Marshall had hidden a soluble form of sulphuric acid in his shoe. Once out of sight of any security staff, Mr Marshall removed it from his shoe and subsequently added it to the water in his flask when he went into the toilet.
59. The policies for search operating procedures for courts are based on the level of risk and what is considered reasonably practicable, bearing in mind that court buildings are open to the public and have a high footfall rate. Guidance on searching arrangements in courts is set out in HMCTS Security and Safety Operating Procedure 4b, *Court Security Officers – Powers of Search*. Court Security Officers (CSOs) have the power to search anyone seeking to enter or in a court building and any article in their possession. It is HMCTS policy that every person accessing the building through public entrances must be subject to a security search. The initial search must be carried out by passing through an

Archway Metal Detector (AMD). Any baggage must be visually searched. The guidance explains that further searches, including the removal of footwear, may be made in the context of the AMD giving a positive reading for metal.

60. Specific guidance on procedures for liquids is contained in HMCTS Security and Safety Operating Procedure 4b(i). This states that people bringing unsealed containers with liquid should be asked to take a sip test to demonstrate that it is not a harmful substance.
61. Mr Marshall passed through the AMD when entering court. The detector activated, so a CSO searched him with a hand-held metal detector. Mr Marshall did not have any metal item that was not allowed. CCTV footage confirms that his bag was searched and that he took a sip test from his flask, and again there were no apparent issues. While CCTV footage indicates that the hand-held metal detector search was somewhat cursory, there is nothing to suggest that court security officers had any reason to have searched him further.

### **Court dock security**

62. Once defendants have entered court, they are the responsibility of Serco Prisoner Escort Custodial Service (PECS). Guidance on search procedures for PECS staff is contained in Serco Standard Operating Procedure (SOP) 033 – *General Searching*. The SOP stipulates that for prisoners coming into the dock from being on bail (known as off-bail), Serco staff will conduct a scan by a hand-held metal detector (known as a wand) and a Level A rub down search. Full searches are only made on the authority of the Duty Director, when there are grounds for thinking that there may be contraband hidden about the body.
63. Mr Marshall was subject to a wand search when entering the building. He was not, though, given a wand search by Serco staff in line with SOP 033. While the wand search would not have detected the powder Mr Marshall had brought into court, and would not therefore have prevented what happened, the search procedures were not in line with the SOP. We make the following recommendation:

**The Head of Operations at Serco should ensure that court search procedures are carried out in line with Standard Operating Procedures.**

64. Guidance on searching off-bail defendants is contained in Serco's Standard Operating Procedure (SOP) 055 – *Duties of a Dock Officer*. At the time Mr Marshall appeared in court, the policy was that off-bail defendants entering the dock would be searched and their personal items checked. Their property would then remain with them in the dock (apart from any large bags or suitcases). The SOP stated that no "*drinks or food is to be accepted by the officer or prisoner into the dock*". This is an ambiguous sentence that could be read as meaning that prisoners cannot take any food or drink with them into the dock, or as only prohibiting people already in the dock from accepting drinks from someone outside.
65. Under the terms of the SOP, Mr Marshall was allowed to take his property into the dock and he took his flask with him. The PCO told him this was not allowed, which shows that she interpreted SOP 055 as meaning he was not allowed to

take drink into the dock with him. She then queried what the liquid was and asked him to take a sip test, which demonstrates that she was aware that liquids could pose a potential hazard.

66. When Mr Marshall declined to take a sip test on the grounds that he was not thirsty, we consider that the PCO's suspicions should have been aroused as this was not a good reason for not taking the test. We accept that she assumed that he would have taken a sip test when he entered the court, but he had not been subject to close supervision since then and had had the opportunity to doctor the liquid (as he had done). We consider that the PCO should either have insisted that Mr Marshall take a sip test or that he leave the flask outside the dock, and that in not doing so, she made an error of judgement.
67. We recognise, however, that SOP 055 did not say unequivocally that prisoners could not take liquids into the dock and for that reason, we have not made a recommendation for action be taken against the PCO.
68. In May 2019, after Mr Marshall had appeared in court, Serco amended SOP 055. Defendants now have their property searched prior to entering the dock, after which it is sealed in transparent bags. These are then brought into the dock, but the property is placed at the end of the dock opposite to the defendant, with the dock officer between it and them. All items in the defendant's pockets are placed in a sealed property bag. The defendant is not allowed to access any of their property during their time in the dock. The SOP has also been amended to say explicitly, "*No liquids can be brought into the dock. If the prisoner wants a drink during the hearing, water should be requested from the usher.*"
69. We consider that these amendments are sensible and we do not, therefore, make any further recommendation.

### **Emergency response**

70. Serco have contingency policies in place for staff to react to incidents in court docks, including self-harm incidents. As soon as the PCO realised what Mr Marshall was doing, she raised the alarm and poured water on him. Other staff reacted to the alarm and continued to administer water to his burns. The Serco internal investigation confirmed that staff involved in the emergency response were first aid trained. An ambulance was called without delay and the PCO who called the ambulance spoke to paramedics to check what treatment should be provided. He was told to continue administering water, which staff did until the ambulance crew arrived and took over Mr Marshall's care.
71. Two PCOs received burns to their arms. A PCO was treated by the paramedics when they arrived. A PCO received a minor burn that he treated with water. We commend their calm and competent response to this distressing situation, while suffering minor injuries themselves.

### **Clinical care**

72. Mr Marshall went directly from court to hospital and remained there. The healthcare team at Thameside would have been responsible for Mr Marshall's care if he was discharged from hospital. It was, therefore, necessary for them to monitor his progress.

73. While Mr Marshall was in hospital, healthcare staff telephoned for daily updates and visited him on two occasions. This was appropriate to keep abreast of his condition and to be prepared to make any necessary arrangements if Mr Marshall became well enough to transfer to Thameside.
74. The clinical reviewer said, however, that the monitoring was made by telephone calls to the hospital, and asking whoever answered for an update. There was no structured approach or any regular dialogue with hospital staff about Mr Marshall's condition. The clinical reviewer recommended that a formal process should be put in place. We agree and make the following recommendation:

**The Head of Healthcare at HMP Thameside should establish a protocol for obtaining consistent, regular updates from a senior member of the appropriate medical team when a prisoner is in hospital.**

### **Support for staff**

75. When Mr Marshall was taken to hospital, Serco's senior manager at the court held a debrief for staff who had been involved in the emergency response. Support was offered for any staff who felt that they might need it.
76. There is no record that after Mr Marshall died, a debrief was held for prison staff who had been involved in his escort while he was in hospital. The death of a prisoner can be upsetting for those who were involved in his or her care, and support should be offered. While the care team at Thameside were available to provide support if required, it was not offered in a formal way. We make the following recommendation:

**The Director of HMP Thameside should ensure that, following any death in custody, a debrief is held and that staff are offered support.**

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