SHERIFFDOM OF LOTHIAN AND BORDERS AT EDINBURGH

[2018] FAI 35

2B-1152-17

DETERMINATION

BY

SHERIFF GORDON LIDDLE

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

ALLAN STEWART MARSHALL

APPEARANCES

For the Crown: James O'Reilly, Senior Procurator Fiscal Depute
For Scottish Ministers on behalf of the Scottish Prison Service: Springham QC; McLeod QC
For Prison Officers Association: Gillies, Solicitor; O'Hagan, Solicitor
For Marshall Family: Jackson, Advocate

Edinburgh, 9 August 2019

[1] The sheriff, having resumed consideration of the evidence, the productions, the joint minutes of agreement and the submissions presented at an Inquiry under section 26 of the Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016

Finds and determines:

(1) In terms of section 26(2)(a) that Allan Stewart Marshall (date of birth 22 August 1984) died on 28 March 2015 within the High Dependency Unit, Edinburgh Royal Infirmary, Little France, Edinburgh.

(2) In terms of section 26(2)(b) that the accident which led to the death of Allan Marshall occurred approximately between 07:48 hours and 08:28 hours on 24 March 2015 within the Segregation and Reintegration Unit (SRU), Her Majesty's Prison, Edinburgh.

(3) In terms of section 26(2)(c) that the cause of death was: 1a, hypoxic-ischaemic brain injury due to out-of-hospital cardiac arrest during physical restraint in a man with coronary artery atheroma.

(4) With reference to 26(2)(d) that the cause of the accident that led to the death of Allan Marshall was the continual physical restraint of Alan Marshall between 07:48 hours and 08:28 hours whilst he was suffering from an episode of Excited Delirium Syndrome that included him forcefully resisting the restraint at times during the said period.

Reasonable precautions

(5) With reference to section 26(2)(e) there were precautions that could reasonably have been taken and had they been taken might realistically have resulted in the death or any accident resulting from the death being avoided, as follows:

(i) It would have been a reasonable precaution to have Mr Marshall referred to NHS Prison Healthcare staff in advance of his removal from association particularly as the removal was not an emergency removal.

(ii) It would have been a reasonable precaution that, it having been suspected by prison staff that Mr Marshall may have been under the influence of drugs,

for him to have been monitored in terms of GMA079A/14[1] and to have been immediately referred to NHS Prison Healthcare and, in any event, before being placed under any restraint. Taking that precaution might have interrupted the chain of events that led to Mr Marshall's restraint, cardiac arrest and death.

(iii) It would have been a reasonable precaution that, when Mr Marshall presented with warning signs of psychosis at various junctures and in particular on 24 March 2015, for him to have been assessed by NHS Prison Healthcare services within the prison as soon as practicable and, in any event, before being moved or placed under any restraint. Taking that precaution might have interrupted the chain of events that led to Mr Marshall's restraint, cardiac arrest and death.

(iv) It would have been a reasonable precaution to have had Mr Marshall assessed by NHS Prison Healthcare Services immediately following removal from association as soon as he arrived in SRU (all in terms of Prison Rule 95) and before he was offered a shower, by leaving him in his designated cell in the SRU until he had been assessed. Taking that precaution might have interrupted the chain of events that led to Mr Marshall's restraint, cardiac arrest and death.

(v) It would have been a reasonable precaution to have desisted from restraining Mr Marshall when he was exhibiting warning signs associated

[1] Supplementary Production 4/8A

with Excited Delirium such as possessing unexpected strength and endurance, apparently without fatigue and showing an abnormal tolerance of pain and for SPS staff to have de-escalated, retreated and contained Mr Marshall securely, then to consider other courses of action such as seeking the assistance of NHS Healthcare staff to assess his condition.

(vi) It would have been a reasonable precaution to have desisted from restraining Mr Marshall when he was exhibiting unusual strength and endurance such as to cause injury to staff, to have retreated to consider other courses of action which may have included the deployment of protective clothing to facilitate restraint of Mr Marshall more efficiently and while upright.

(vii) It would have been a reasonable precaution to immediately investigate Mr Marshall's vital signs and start CPR as soon as it was known that his breathing was compromised such that a code blue message was to be sent.

Defects in the system of working

[2] With reference to section 26(2)(f) there were defects in the system of working which contributed to the death or any accident resulting in the death:

(i) SPS prison officers are not medically trained or qualified to make clinical assessments. In terms of their training relating to the four medical conditions that may be triggered by or exacerbated by the use of force; namely positional asphyxia, excited delirium, psychosis and sickle cell disease, they are provided

with specification of the warning signs or symptoms associated with each of the conditions. On the hypothesis of fact that each prison officer was aware of the warning signs in each case where they were required to make a value judgement on what they observe. Having observed Mr Marshall's behaviour the officers were first of all required to consider whether the behaviour was abnormal. That is a subjective assessment that might have differed from officer to officer. Each officer was then instructed to require something of a medical triage. If it was considered by the officer that Mr Marshall's behaviour was abnormal the officer was then to consider whether the behaviour may be due to mental illness or drug abuse. Prison officers are not medically qualified to make such a preliminary medical assessment. These assessments are the gateway to medical intervention in terms of the instructions. It is only when both criteria are deemed by the officer to be present that the officer is instructed to urgently seek advice from health care staff before C&R techniques are employed, if possible. Officers are then directed that if a medical emergency occurs de-escalation of control and restraint techniques must happen at once and medical advice must be sought immediately. Failure by the officers involved with Mr Marshall to identify or to act upon the fact that he was exhibiting abnormal behaviour that may have been due to mental illness or drug abuse led to Mr Marshall being placed in the shower area in the SRU and then being subjected to the restraint that led to his cardiac arrest and subsequent death. The system was defective in that it placed responsibility in the hands of prison officer to make multiple judgements they

were not equipped to make. The system was further defective in that it instructed officers to de-escalate techniques at once if a medical emergency occurs but there was no specific instruction in relation to what constituted such a medical emergency. A medical emergency did occur. It occurred from when Mr Marshall was suffering from excited delirium but officers were unaware of it having occurred. It then became too late to prevent Mr Marshall sustaining a cardiac arrest. In terms of the instruction, a medical emergency may already have arisen on the criteria for psychosis when hands were first placed on Mr Marshall in the shower area or before that when he was first placed under restraint in Glenesk Hall to go to the SRU and at the SRU.

(ii) The system of training of prison officers in relation to the four medical conditions that may be triggered by or exacerbated by the use of force was defective. The information purported to have been delivered during annual training was not, on the evidence, successfully imparted to some or all of the prison officers involved in the restraint of Mr Marshall. As a result, the officers failed to identify the conditions Mr Marshall presented with, which could have led to the restraint not occurring or officers not persisting with the restraint to the point of Mr Marshall's cardiac arrest.

(iii) It was a defect in the system of working that there was no requirement for a prison officer to create a log when there was observation of, or a report of, warning signs associated with psychosis in a prisoner and to ensure that the note was kept, recorded and passed on in the handover to the next shift. This defect

meant that knowledge or information gleaned during one shift would not necessarily come to the attention of staff on a subsequent shift or to prison management, thus creating a risk of death through ignorance of a potentially life threatening condition having arisen.

Other facts which are relevant to the circumstances of the death

[3] With reference to section 26(2)(g) there were other facts which are relevant to the circumstances of the death:

(i) As at 24 March 2015 prison officer staff at HMP Edinburgh were not aware or were not sufficiently aware of the warning signs associated with positional asphyxia, psychosis and/or excited delirium syndrome to identify those signs and act appropriately.

(ii) At the time of Mr Marshall's restraint the chain of command and responsibility among the prison officers involved was not clear leading to confusion among prison officers, lack of leadership and lack of instruction.

Recommendations

[4] With reference to section 26(1)(b) of the Act the following recommendations are made:

(i) It is recommended that SPS bring the C&R manuals used for the training of prison staff up to date and that the content and delivery of training provided is kept under regular review. In that regard, it is recommended that SPS give

urgent consideration to revising all versions of the C&R Manual to include the information and advice contained in GMA 048A/16 and the information contained in Annex A.

(ii) It is recommended that SPS give consideration to reviewing the instruction in the C&R Manual (or elsewhere) relating to psychosis such that observation of any warning signs associated with psychosis is a trigger to require urgent healthcare advice being sought.

(iii) It is recommended that SPS give consideration to ensuring that there is consistency within the instructions contained in Governors & Management Advice (GMA), and all volumes of the C&R Manuals to ensure that there can be no confusion about the circumstances to trigger a requirement for seeking NHS Prison Healthcare advice.

(iv) It is recommended that SPS give consideration to the introduction of a system of working that ensures prison staff members have read and understood any instruction that is contained within a GMA directed at them.

(v) It is recommended that SPS give consideration to separating out from the C&R Manual, the training module relating to the four medical conditions that may be triggered by or exacerbated by the use of force and delivering that training separately from C&R training.

(vi) It is recommended that SPS give consideration to either including specific training on the use of feet as a C&R technique within the C&R Manual or, alternatively, specifically disallowing the use of feet within any restraint.

(vii) It is recommended that SPS give consideration to introducing a system of working whereby there is always at least one staff member within a removal team who is a designated first responder and that there is a designated duty for that officer to respond and administer CPR when an appropriate situation arises.

(viii) It is recommended that SPS devise and put in place a clear policy to provide that prisoners presenting with symptoms of EDS or psychosis must be kept secure and not be placed under physical restraint until they have been assessed by healthcare professionals and it having been deemed safe for the prisoner to be restrained.

(ix) It is recommended that SPS immediately introduce a policy provision to ensure that all code blue alerts are audio recoded, preserved and, in the event of a death, not destroyed until there has been a FAI determination issued.

(x) It is recommended that SPS give consideration to introducing a system of working whereby it can be ensured that information contained in GMAs is both received and understood by all intended recipients.

(xi) It is recommended that SPS give consideration to introducing a system of evaluation whereby it can be effectively established that the information contained in training provided to prison officer staff has been successfully imparted to the recipient.

(xii) It is recommended that SPS introduce a policy that, in any case involving police investigations, no operation debrief shall be conducted until the police

have concluded their investigations and finished taking statements from SPS witnesses.

(xiii) It is recommended that SPS introduce a system whereby there is a formal handover on changes of shift and a written account of any unusual prisoner activity or presentation to be kept and presented to the FLM on the following shift at shift handovers.

NOTE:

Introduction

[5] On 2, 3, 4, 5, 6, 10, 11, 12, 13, 16, 17, 18 July, 19, 20, 22, 27, 28, 29, 30 November and 4, 6, 7, 10, 11, 12, 13, 14 and 18 December 2018, an Inquiry under the Fatal Accidents and Sudden Deaths etc. (Scotland) Act (The 2016 Act) was held at Edinburgh Sheriff Court into the death of Allan Stewart Marshall. The circumstances of the death had previously been investigated by the procurator fiscal who presented evidence to the court in the public interest.

[6] Evidence was led by the Procurator Fiscal Depute from the following witnesses (whose designations are stated as they were at the time of the deceased's cardiac arrest) in order of their testimony:

RR, prisoner and cellmate

Gordon Mellis, Front Line Manager, prison officer, SPS

Stuart Wilson, prison officer, SPS

Kara Scobie, prison officer, SPS (KS)

Kenneth Mason, prison officer, SPS

John Nicol, prison officer, SPS

Justin White, prison officer, SPS

Brian Doyle, prison officer, SPS

NW, prisoner

RM, prisoner

DM, prisoner

Eric Baskind, British Self Defence Governing Body Limited

Trevel Henry, Conflict Prevention and Management

Matthew Sim, prison officer (FLM), SPS

Dean Golding, prison officer, SPS

Dr Robert Ainsworth, Forensic Pathologist

Rev. Sheena Orr, prison chaplaincy advisor, SPS

Dr Hazel Torrance, forensic toxicologist

Lesley McDowall, Health Strategy and Suicidal Prevention Manager, SPS

KQ, registered nurse, NHS

JW, registered nurse NHS

Dr Miles Behan consultant cardiovascular surgeon

Gillian Walker, SPS National Resilience Manager, Operations Directorate

Louise Sonstebo, Scottish Police Authority, Forensic Services

Dr Neil Nicol, Consultant in Emergency Medicine

David Grant, prison officer, SPS

Kevin O'Hara, prison officer, SPS

Paul Hay, Staff Training Manager, C&R instructor, SPS

James Hardie, prison officer, SPS

Charles Kivlin, prison officer, SPS

David McAdam, SRU Manager, SPS (Split evidence)

Dr Jacqueline Elizabeth Scott, Consultant Psychiatrist

Steven Banks, prison officer, SPS

Brian Fraser, prison officer, SPS

The legal framework

[7] The Inquiry was held under section 1 of the 2016 Act. The purpose of the Inquiry was to establish the circumstances of the death and to consider what steps, if any, might be taken to prevent other deaths in similar circumstances. This was a mandatory Inquiry in terms of section 2(1) and (4) of the Act as Mr Marshall was in legal custody at the time of the accident resulting in his death.

Summary of events

[8] There were reliability and credibility issues with many of the prison officer witnesses. This is a summary of matters that were easily acceptable and where there was little room for ambiguity. There will be a further discussion of the more controversial evidence later in this determination.

[9] Allan Stewart Marshall was born on 22 August 1984. At Perth Sheriff Court, on 2 March 2015 he was placed on remand in Her Majesty's Prison, Edinburgh, to await trial. He was put in a cell in the remand hall (Glenesk Hall) of the Prison of Edinburgh.

[10] On 11 March 2015 RR, a prisoner, was placed in the same cell as Mr Marshall. After a few days together Mr Marshall told RR that he believed in God and the devil. He said "if you invite the devil into your house he'll come in. If you told him not to come in he wouldn't". Some days later they were both moved to cell G3/13. RR had prescription drugs openly available within the cell for his own use. Mr Marshall made no mention to RR of any drug dependency. RR never saw Mr Marshall take any drugs.

[11] On Thursday 19 March 2015 RR noticed Mr Marshall start to act strangely and discuss things that were going wrong for him and were on his mind. Mr Marshall began talking about a film that included images of a prisoner's "dirty protest".

[12] About 00:30 hours on Sunday 22 March 2015 RR was awoken by Mr Marshall within their cell. Mr Marshall told RR to look out the window whereupon he showed RR what he described as a moving star. RR considered the object to be an aeroplane coming in to land at Edinburgh airport and saw that Mr Marshall had drawn on the window in an attempt to plot its movement. RR returned to bed and Mr Marshall continued to look out of the window. About 02:30 Mr Marshall again wakened RR and asked him to come to the door where he was. Mr Marshall said "everyone wants me to go outside, everyone is shouting at me". When RR said there was no one there, Mr Marshall pointed at the intercom and said "they'll be listening, can you hear that music?", although it was silent. RR noticed that Mr Marshall was jumping backwards and forwards and dancing from

side to side directly in front of the door. RR was awakened again around 05:00. On this occasion Mr Marshall said "you're not going to believe me, I've just prayed to God and that star has disappeared". RR suggested that Mr Marshall should go to bed and sleep and he did so.

[13] RR remained awake. At about 08:15 he was allowed out of the cell by prison officer Steven Banks. He asked if he could be moved to another cell and told prison officer Banks he had been kept up all night. He said something along the lines of "there's something wrong with him [Mr Marshall], you'll need to keep an eye on him." He told prison officer Banks what Mr Marshall had been doing, about the star/plane incident and dancing at the door. He requested that Mr Marshall be not told of his request to be moved. The request was accommodated and RR was later moved to another cell. Mr Marshall asked RR why he was being moved and he lied and said that he did not know why. RR also mentioned to prison officer Kara Scobie that Mr Marshall had been freaking him out and he was glad to have moved cells. No report relating to Mr Marshall's behaviour was made by prison officer Banks after receiving the information and request from RR. No action was taken by him or anyone else within SPS in relation to the behaviour of Mr Marshall. No document was produced to the Inquiry recording RR's report to prison officer Banks. There was no religious counselling offered to Mr Marshall and no medical advice was sought.

[14] During the early hours of Tuesday 24 March 2015, Mr Marshall became agitated within his cell. He was violent. He smashed items of furniture and sanitary fittings. He smeared urine and excrement on the walls and on the observation window within his

cell. He got some excrement on his body. A decision was made by prison night staff not to deal with Mr Marshall at that time. A decision was made to wait until the day shift arrived because there would be greater resources to deal with Mr Marshall. No NHS Prison Healthcare assistance was considered or requested by the night staff. Mr Marshall was observed more often but it is disputed on the evidence whether a formal observation regime was put in place.

[15] Prison office Matthew Sim was the day shift first line manager (FLM) in Glenesk Hall on 24 March 2015. He received a verbal handover from the night staff. He was told that Mr Marshall (cell 13) had been displaying strange behaviour since around 05:00 and that he had smashed up his cell. He subsequently received a report from prison officer Farquhar that Mr Marshall had allegedly covered himself in excrement and barricaded his cell door. At about 08:15 FLM Sim attended at Mr Marshall's cell. He could not initially get the cell door open because of debris behind it. He noticed excrement smeared on the inside of the observation window in the door. He spoke to Mr Marshall and asked him to clear debris from behind the door. According to FLM Sim, the response he received did not make much sense to him. Mr Marshall quoted the Bible and was saying prayers. FLM Sim thought that Mr Marshall seemed to be praying to members of his family. Mr Marshall said "you're going to come in and get me" and "what's going to happen when I come out?" FLM Sim formed the impression that Mr Marshall was afraid. He persuaded Mr Marshall to clear debris from the back of the door so that it could be opened. When the cell door was opened he observed Mr Marshall to retreat diagonally to the rear of the cell. He tried to persuade

Mr Marshall to come out of the cell and reassured Mr Marshall he would not be hurt. Mr Marshall invited FLM Sim to take off his shoes and socks and come into the cell. Mr Marshall then said "look at your face, you're going to do something". FLM Sim then told Mr Marshall that if he did not come out of the cell he would come back and get him, which persuaded Mr Marshall out of the cell. FLM Sim did not then consider seeking assistance from NHS Prison Healthcare personnel.

[16] FLM Sim had already decided to have Mr Marshall moved to the Segregation and Reintegration Unit (SRU) and had contacted the unit. That constituted a planned removal from association in terms of Prison Rule 91. He instructed two prison officers, namely prison officer Kara Scobie and prison officer Steven Banks, to escort Mr Marshall to the SRU. Prison officer Dean Golding arrived from the SRU and assisted. Mr Marshall was compliant during the transfer and was escorted by the use of 'come along' holds involving only light contact with his wrists and shoulders. FLM Sim led the way. They had to descend three flights of stairs. Mr Marshall stopped briefly on a landing to look at his reflection. None of the prison officers escorting him made anything of that. On arrival at the SRU they were met by FLM David McAdam and were directed to cell 6. At about 07:29 Mr Marshall was placed briefly in cell 6 by the escorting officers. SRU prison officer Justin White, prison officer Brian Doyle and prison officer John Nicol were waiting and took over.

[17] A verbal exchange took place between Mr Marshall and FLM McAdam. At that time FLM McAdam formed the view that Mr Marshall might have taken some substance because his eyes were glazed. He thought that Mr Marshall seemed quite vacant. He did

not seem to FLM McAdam to be communicating in any way and just did not seem right. Mr Marshall agreed to have a shower which resulted in him compliantly being escorted to the shower area, with no hands on him. Sometime just before 07:30, at the entrance to the shower area, Mr Marshall was handed a towel, clean clothing, shampoo and soap. Before entering he said "do you know the words of the Lord's prayer?" and "do you want to stab me in the heart?" The four prison officers present did not respond other than coaxing Mr Marshall into the shower area. Three prison officers entered behind him. Shortly thereafter the prison officer who had been waiting outside also entered the shower area. At about 07:32 all four prison officers exited the shower area and the door was locked with Mr Marshall inside. No NHS Prison Healthcare personnel were requested to attend.

[18] Mr Marshall did not take a shower. He was checked on by officers from time to time. About 07:38 prison officer Doyle spoke to Mr Marshall through the glass partition and tried to encourage Mr Marshall to take a shower. Shortly afterwards, prison officers slightly opened the shower area door and spoke to Mr Marshall. Prison officers returned to check on Mr Marshall at about 07:45. During the time he was locked in in the shower area, Mr Marshall was heard to recite prayers, quote scripture, sing what were thought to be hymns or chants and make satanic references. The prison officers considered that to be "strange behaviour". Mr Marshall was observed to be sitting behind the door. Prison officers spoke to him through the glass partition urging him to take a shower but he refrained from doing so.

[19] Prison officer Nicol went to the office and reported to FLM McAdam that Mr Marshall had not showered and appeared to be hiding behind the door. It was decided by prison staff that Mr Marshall should be returned to his cell, he not having showered. Although there is a chain of command, it is unclear from the evidence which prison officer made that decision. It constituted a planned removal in terms of the Prison C&R Manual[2]. In a restraint it is the responsibiliy of the FLM in charge to observe and not get involved in the restraint. At 07:48, FLM McAdam and prison officers White, Doyle and Nicol opened the shower area door with the intention of removing Mr Marshall from the shower area to cell 6. They had all put on protective gloves before entering. When the door was opened Mr Marshall retreated to the wall adjacent to the door, placing himself in a constricted space between a sink and a toilet compartment partition. He displayed fear. He asked if they had come to stab him through the heart and said that God would protect him. That struck some of them as bizarre. He raised his hands above his head in what was described as a martial arts stance and raised one of his legs. All of the officers present considered that to be strange behaviour. None of them suggested that they should retreat and seek assistance from NHS Prison Healthcare staff before advancing on Mr Marshall. None of them suggested to anybody that a medical emergency had arisen. FLM McAdam was ostensibly in charge of the removal team. Prison officer Doyle, accompanied by FLM McAdam and prison officers White and Nicol, advanced towards Mr Marshall and laid hands upon him. Mr Marshall

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violently resisted the restraint being exercised upon him and a struggle ensued. He shouted, swore and recited prayers.

[20] The struggle was violent. During the initial struggle, three officers sustained injury. One officer sustained a broken wrist and two others were bitten by Mr Marshall. Mr Marshall sustained a significant number of injuries, including an open facial injury resulting from violent contact with the floor. That was claimed by prison officers to have been self-inflicted. Prison officers did not quickly overcome Mr Marshall. They said that he struggled with unexpected and significantly increased strength, described by some prison officers as super-human. He displayed significantly increased pain threshold and long endurance. He was hot and sweaty to touch. A general request for assistance from other prison officers was sent soon after a protracted struggle became apparent. Prison officers from elsewhere in the prison responded. The restraint was joined by a number of other prison officers, some of whom relieved the original ones. The first of the prison officers came running at about 07:50. Another request for assistance was sent. Prison officers responded. From then on, prison officers came and went. Some left to later return. Among the prison officers arriving to assist, was FLM Brian Fraser. At one point during the restraint, FLM McAdam asked FLM Fraser to take charge in his stead. FLM Fraser agreed to do so and took charge. During the restraint feet were placed upon Mr Marshall within the shower area by FLM Fraser and prison officer Kivlin. That part of the restraint continued from about 07:48 until 08:17 when Mr Marshall was dragged face down and feet first by prison officers out into the corridor area of the SRU.

[21] In the corridor there is camera surveillance. Determination of what happened in the corridor is therefore less reliant on oral evidence since it can be viewed. Once in the corridor, Mr Marshall was revolved and dragged feet first along part of the corridor in a southerly direction. Sporadic resistance to being held prone onto the floor can be observed. It can be observed that a number of prison officers were involved in controlling and moving Mr Marshall. At about 08:20 Mr Marshall was still seen to be mobile and attempting to raise his body off the floor. He was prevented from doing so by five prison officers placed one at his head and one on each limb. The control and restraint skilled witnesses who gave evidence said it was difficult to identify the force being applied to Mr Marshall as being any recognised and taught control and restraint hold. As is commented on by the skilled C&R witnesses, Mr Henry and Mr Baskind, who gave evidence to the Inquiry, as well as those prison officers involved in holding Mr Marshall down, two prison officers used their feet to exert downward pressure on Mr Marshall. One was FLM Fraser, who used his feet in total on about ten or more occasions during the restraint. Spoken to by prisoners who were present in adjacent cells and some of whom had a limited view of part of the restraint, Mr Marshall was heard to scream, shout "get off me" and shout "I can't breathe".

[22] The last point on the video at which resistance by Mr Marshall to being held down can clearly be observed is at about 08:23. The use of feet by FLM Fraser was intermittently employed up until then.

[23] Prison officer Kivlin suggested that plastic handcuffs might be employed and might assist in the restraint. They were brought to the scene. It is not clear who

authorised that. Prison officer Grant gave the plastic handcuffs and a cutter for removal to prison officer Banks. Prison officer Golding had one of Mr Marshall's arms and prison officer Kivlin had the other. Beginning about 08:25, they assisted prison officer Banks in his applying the plastic handcuffs to Mr Marshall whilst Mr Marshall was facing downwards on the floor with his hands and arms held behind his back. In this exercise, prison officer Kivlin placed a foot on the shoulder area of Mr Marshall whilst applying the plastic handcuff to his outstretched arm. By 08:25 the handcuffs had been applied. Mr Marshall did not strain against the handcuffs. He was limp. According to their evidence, at first some of the prison officers were apprehensive that Mr Marshall may be faking unconsciousness and they continued to restrain him. It was eventually accepted that Mr Marshall had stopped breathing. The first loop of the plastic handcuffs was cut off by prison officer Banks at about 08:27. The second loop was cut off and the cuffs removed at about 08:28. Within about one minute a 'code blue' general alert was issued by one of the prison officers. That is an alert to inform all personnel that there is a medical emergency involving someone not breathing. Unhelpfully, the recording having been destroyed by SPS, it is not known exactly what the precise time or terms of the alert were.

[24] Mr Marshall suffered a cardiac arrest and stopped breathing at some point around 08:24. At 08:28:50, Mr Marshall was turned over onto his back. His eyes were rolled back into his head. His ears were blue and he was not breathing. There were at least twelve prison officers present at the scene. Some of them were trained in first aid. None of them immediately commenced CPR chest compressions. Medical staff arrived

on the scene at about 08:29:40. They had difficulty gaining access to Mr Marshall due to the number of prison officers in the immediate vicinity and restraint being maintained by some of them. The nurses asked what had happened in order to get a clear focus for immediate treatment. None of the prison officers said anything at all in response. Nurse KQ was very surprised to get no response from any prison officer. Chest compressions were commenced by the nursing personnel. A defibrillator was attached to Mr Marshall. The machine directed that no shocking should take place. The nurses carried out chest compressions. Two of the officers then assisted with chest compressions. Chest compressions continued until about 08:44. At some point a pulse was detected. Laboured breathing was observed. Paramedics arrived about 08:57 and Mr Marshall was removed to hospital under escort.

[25] At Edinburgh Royal Infirmary Mr Marshall initially attended at the Accident and Emergency Department. He was moved to the high dependency ward where he was placed in an induced coma and monitored. Over the following days, several attempts were made to reduce his sedation but without success.

[26] On 28 March 2015 a C.T. scan was conducted which revealed irreversible hypoxic brain injury. The medical decision was taken to withdraw medical care. At 20:03 on 28 March 2015 Mr Marshall's life was pronounced extinct.

Background information

Prison Rules

[27] Statutory rules apply to prison staff members, including prison officers of all rank. These rules are contained in the Prison and Young Offenders Institutions (Scotland) Rules 2011. Authority for the use of force is provided in Rule 91, which provides as follows;

> "**Control of prisoners**
> 91(1) In the control of prisoners, an Officer must seek--
> (a) To influence behaviour by example and leadership; and
> (b) To enlist the willing cooperation of prisoners.
> (2) An Officer may only use force against a prisoner when it is necessary to do so taking account of all the circumstances of the situation and the force used must be:
> (a) Proportionate to the risk posed by the prisoner in that situation: and
> (b) no more than necessary for the purpose of that situation.
> (3) Where an Officer uses force against a prisoner that Officer will keep a written record of that use of force.
> (4) An Officer will not deliberately provoke a prisoner."

[28] Rule 95 is concerned with Removal from Association and makes provision for the governor of a prison to order in writing that a prisoner must be removed from association with other prisoners. Such an order may only be made by the governor where the governor is satisfied that removal from association was appropriate for one of three purposes, namely

> "(a) maintaining good order or discipline;
> (b) protecting the interests of any prisoner;
> (c) ensuring the safety of other persons."

Documents

Scottish Prison Service Control & Restraint Manuals

[29] At the time of the accident and at the time of the hearing there were three Scottish Prison Service Control and Restraint Manuals in existence. They are modular. They comprise training modules. The first, Volume 1[3], is available to SPS staff through electronic means. C&R Phase 1 Refresher sets out a Session Plan for an annual refresher course. Volume 2[4] is a more comprehensive document, intended for the use of trainers during the one-day annual refresher courses that take place and are attended by all prison officers. It contains the information in Volume 1 and also includes notes to trainers in the form of training directions. Volume 3[5] is used by trainers for new recruits at national level. It contains fuller and more detailed information on some of four specified medical conditions, mentioned in each volume, that are associated with restraint. The importance of the extended information in Volume 3 is discussed by the C&R expert witnesses. The vast bulk of all three volumes concerns control and restraint techniques and training on the use of restraint in a variety of situations. All three were published on the same date, namely 2 August 2012. All were in force at the time of the restraint leading to the death of Mr Marshall. None had been amended or modified at that time, nor as at the end of the evidence in this Inquiry on 18 December 2018. The prison officers involved in the restraint of Mr Marshall were all trained from Volume 2[6] of the Manual. The Inquiry was particularly interested in the parts of the Manual

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[6] Production 23

relating to the use of restraint and Rule 91 (supra), the use of plastic handcuffs and the module relating to medical conditions that may be "triggered by or exacerbated by the use of force and the signs associated with each condition." This module, rather than setting out techniques, sets out risks associated with the use of restraint. The gist of the instruction contained within the Manual is that when a violent prisoner is being restrained officers involved and the person supervising must look out for warning signs associated with any of four specified medical conditions. The training involves the learners being able to describe, in open forum, the four medical conditions (positional asphyxia, excited delirium, psychosis and sickle cell disease) that may be triggered by or exacerbated by the use of force and the signs associated with each condition. All of the prison officers involved in the restraint of Mr Marshall were up to date with this training and had been certified as competent by instructors. Written training records were presented to the Inquiry for each prison officer to verify training was current. The records showed a series of boxes having been ticked by the trainer and verified by the learner. The Inquiry was concerned with three of the four specified medical conditions, namely: positional asphyxia, excited delirium and psychosis. The specific information in Volume 2[7] is set out here for ease of reference:

> **<u>"POSITONAL ASPHYXIA</u>**
> **Definition**
> This occurs when the position of the human body interferes with normal respiration, resulting in asphyxiation. When an individual is placed in a position that impedes their breathing and they cannot **escape** that position, then death can occur very rapidly

[7] Production 23, pages 252 to 255

Warning Signs

- Gurgling, gasping sounds
- Prisoner complains of being unable to breathe
- A violent and loud prisoner suddenly becoming passive, quiet and tranquil
- Blue coloration in facial skin
- Hot to touch

EXCITED DELIRIUM

Excited delirium is both a mental state and psychological arousal.
Excited delirium can be caused by drug intoxication (including alcohol) or psychiatric illness or a combination of both. Cocaine is a well known cause of drug induced excited delirium.

Warning signs:

- Have unexpected strength and endurance, apparently without fatigue
- Show an abnormal tolerance of pain
- Feel hot to touch
- Be agitated
- Sweat profusely
- Be hostile
- Exhibit bizarre behaviour and speech.

PSYCHOSIS

Psychosis is a general term used to describe mental conditions in which there is loss of contact with reality.

Warning signs:

- Mental conditions in which there is loss of contact with reality
- May be extremely suspicious
- Believe their personal safety is under threat
- Then become extremely frightened and agitated
- May become physically aggressive and violent."

The instruction to the trainer is as follows:

"Validation

Group Discussion

Whilst in open forum the instructor will ask the learners to describe the signs and symptoms of the four medical conditions associated with the use of force.
Learners should respond with the following;

- Positional asphyxia
- Excited Delirium
- Psychosis
- Sickle Cell Disease"

There is a note to the trainer as follows:

> **"IF PRACTICABLE:**
> **If it is considered that a prisoner's abnormal behaviour may be due to mental illness or drug abuse, advice should be sought urgently from health care staff before C&R techniques are employed, if possible.**
> **IF A MEDICAL EMERGENCY OCCURS DE ESCALATION OF TECHNIQUES MUST HAPPEN AT ONCE AND MEDICAL ADVICE MUST BE SOUGHT IMMEDIATELY."**

[30] The note to the trainer, and the information within it, is not found in Volume 1[8] of the Manual. It is a training direction to the trainer.

[31] There is another module within Volume 2[9] of the Manual that is called "C&R Cuffing Techniques"[10] and deals with the application of plastic handcuffs. In summary, the module provides that only C&R instructors or Number 1 in a restraint team may apply them. It specifies that they should only be applied to a compliant prisoner.

In the Note to trainer it is provided that**:**

> **"**Plastic handcuffs may be employed in conjunction with the use of Control & Restraint holds if their deployment will be helpful in maintaining the holds (eg whilst in narrow doorways or stairs are negotiated) or to enable the prisoner to walk normally and in a natural upright position, thus ensuring the prisoner's safe and secure relocation…..
>
> After securing in wristlocks, prisoner is brought to kneeling position."

[32] Some of the training modules within Volume 3[11] of the C&R Manual contain more extensive medical/safety instructions than in Volume 2. However, the contents of Volume 3 were not known to the prison officers who restrained Mr Marshall at the time of the restraint. The existence of Volume 3 was not disclosed to the Inquiry during the

[8] Production 23
[9] Production 23
[10] Production 23 at pages 363 to 377
[11] Supplementary Production 6/1

first tranche of evidence in July 2018. There is a discussion of the enhanced contents of Volume 3 within the evidence given by Mr Baskind and Mr Henry. The pertinent differences were mentioned in a supplementary report by Mr Baskind dated 18 November 2018[12] .

[33] Governors & Management ADVICE (GMA 048A/16)[13] is dated 22 August 2016. The readership is specified as: "All Staff, Governors-in-Charge, NHS Prison Healthcare Teams, Head of Prison Services & Contracts."

The subject is: **Managing Individuals displaying Excited Delirium Syndrome.**

The Contact named is: **Gillian Walker**, National Resilience Manager, Operations Directorate.

The document continues:

> **"PURPOSE**
> The purpose of this notice is to provide guidance to staff in relation to managing individuals displaying Excited Delirium Syndrome.
> EXCITED DELIRIUM SYNDROME
> Excited Delirium Syndrome is both a mental state and physiological arousal. It can be caused by drug intoxication (including alcohol) or psychiatric illness or a combination of both.
>
> **ANNEX A Excited Delirium Syndrome Medical Emergency Flowchart** has been designed by a Working Group that included colleagues from Establishments, Operations Directorate (OD), Health, NHS and Scottish Ambulance Service to support staff in identifying the signs of Excited Delirium Syndrome in prisoners and how to respond appropriately.
>
> All staff should familiarise themselves with this guidance to ensure appropriate response measures are in place.

[12] Supplementary Production 6/4
[13] Supplementary Production 2/1

CONTROL AND RESTRAINT TECHNIQUES
Work is ongoing with OD and SPSC to identify clear guidelines for operational staff around what recognised control and restraint techniques are safe and most effective in dealing with these types of situations. This includes the identification of the most effective method of transferring individual displaying such behaviour to hospital. Where necessary, changes to the C&R manual will be made to support this work."

[34] ANNEX A, headed **Excited Delirium Syndrome Medical Emergency**, begins with an illustration of a Cycle that may eventually lead to Cardiac Arrest and Death. The illustration sets out: "Agitation -> Increased Muscle Activity -> Increased Temperature -> Increased Agitation ->" and so on repetitively.

Box one of the flowchart contains:

"**Prisoner demonstrates sudden change in behaviour with some of these symptoms**:
Note the sudden change of behaviour combined with rapid breathing, constant or near constant activity and skin hot to touch strongly indicates danger of sudden cardiac arrest – DIAL 999 ->
Staff/ Manager Response – If response not successful after a few minutes follow the 'No' procedures box below:

- Seek medical advice
- Report to immediate Manager
- De-escalate
- Calm the situation
- Talk calmly and provide reassurance
- Leave in cell or contain in immediate location if possible
- Avoid the use of C&R if at all possible – If C&R used avoid placing person face down* →

Was the above response successful? – No →
<u>This is now potentially a life threatening medical emergency</u>

- **Avoid the use of C&R restraint techniques unless immediate threat to self and/or others***
- Call 999
- Call Health Care immediately or Doctor out of hours
- Observe constantly

- Notify Duty Manager
- Prepare for safe transfer to ambulance
- Provide Scottish Ambulance Service with briefing of situation on arrival →

Risks and Conditions to consider:

- Safety of staff, prisoners and others
- The situation/environment
- Level of violence demonstrated – armed or not
- Staff briefing
- Escort Staff and Equipment
- The regime – i.e. night shift, patrol – consider calling staff to assist with C&R/ transfer to ambulance
- Prisoner history if available
- Prisoner location
- Staff availability, Experience, competence
- Route to ambulance
- Inform Police

***Our aim is to avoid making the situation worse by avoiding using C&R techniques until the last possible minute – I.e. when transferring to ambulance or to avoid injury to self or others. If C&R is used placing the person face down should be avoided – Use minimum force for the shortest duration possible.**"

Relationship between restraint and death

[35] Doctor Robert Ainsworth, Consultant Forensic Pathologist, was one of two authors of a joint forensic report[14]. He gave oral evidence to the Inquiry. He and his colleague performed a post mortem examination on the body of Allan Marshall on 29 March 2015. They came to the conclusion that the medical cause of death was "hypoxic-ischaemic brain injury due to out-of-hospital cardiac arrest occurring during physical restraint in a man with coronary artery atheroma". Dr Ainsworth discussed the report and provided supplementary evidence. The report catalogues a large number of injuries sustained by Mr Marshall that were considered to be associated with the restraint. It was

[14] Production 1

not concluded that any of the injuries particularly caused or directly contributed to the death. The authors provided a commentary within the report as follows:

> "On the basis of the post mortem findings, and in view of the circumstances surrounding Mr Marshall's death, it would ultimately appear that his death was due to him suffering irreversible hypoxic-ischaemic brain injury following an out-of-hospital cardiac arrest, the latter occurring during a period of physical restraint and associated with the presence of established severe coronary artery atheroma.
>
> At autopsy, he was found to be relatively tall but of slim build, with a BMI of ~20. There were also numerous blunt-force injuries externally – bruises, abrasions and occasional lacerations, with the majority to his trunk and limbs, some of the injuries showing signs of healing. There were also stigmata of his medical treatment.
>
> Internally, there were areas of soft tissue haemorrhage within the trunk and limbs, with small areas of bruising on the scalp and at the base of the neck anteriorly. The brain was also generally swollen. There were however no signs of significant trauma.
>
> As regards the presence of any significant natural disease, he was found to have established severe atheroma within one of the main coronary arteries in his heart. All of his other major organs appeared healthy.
>
> Subsequent neuropathology confirmed the presence of global ischaemic brain injury, with histology confirming the presence of severe atheromatous disease within the left anterior descending coronary artery. There was also patchy acute inflammation within the lungs (bronchopneumonia).
>
> Finally, toxicology identified therapeutic amounts of lignocaine and diazepam (plus metabolite) in a hospital serum sample taken on the day after his admission, with quantities of lignocaine and chlorpromazine also detected in a urine sample taken on the actual day of his admission. In turn, analyses of post mortem blood revealed a potentially therapeutic amount of morphine and a trace amount of diazepam, as per his recorded medical treatment.
>
> Taking all of these findings into account, and mindful of the circumstances surrounding Mr Marshall's death, it is clear that his death was ultimately due to him suffering irreversible hypoxic-ischaemic brain injury – permanent damage to the brain due to lack of oxygen supply to it.
>
> The latter was the result of him suffering a significant period of cardiac arrest, whereby his heart was not beating and the oxygen and/or blood supply to his

brain was compromised. A period of only a few minutes of cardiac arrest may be associated with the development of such irreversible brain pathology, and in this instance it would appear that he was in cardiac arrest for a comparatively long period of time (some 20 minutes or so, but perhaps longer, according to the medical notes) before a cardiac output returned.

As to why he suffered a cardiac arrest, there are at least two factors which are considered of significance in this regard:

1. Firstly, he had underlying severe coronary artery disease, the nature of which could conceivably have caused him to suffer a significant cardiac arrhythmia at any time.

2. Secondly, immediately prior to the cardiac arrest, he was involved in a prolonged altercation with staff at the prison, during which he required significant physical restraint, The restraint appears to have involved staff containing Mr Marshall in a 'face down' (prone) position on the ground, with his arms and legs held behind him (extended backwards), and with other methods of restraint having been applied, including placing further bodily pressure on his shoulders and buttocks whilst face down, and eventually the application of plastic hand cuffs to his wrists thereby securing his arms behind him (this occurring immediately prior to arrest).

As to how the restraint may have contributed to Mr Marshall's cardiac arrest, there are a number of possibilities:

- His breathing may have been physically compromised by the restraint process, with his bodily position – face down (prone) with his arms and legs being restrained behind him, impairing his ability to breathe. Of note, there were no specific 'asphyxial signs' at autopsy to support a proposition of positional (restraint) asphyxia, albeit it is noted that his death only occurred some four and a half days after his cardiac arrest, by which time such potential features may have resolved

- It is certainly also possible that the psychological 'stress' associated with the altercation and restraint increased his risk of suffering a cardiac arrest, in the presence of potentially significant underlying heart disease, as detailed

- Given these considerations, it is also not possible to exclude pathologically that he developed some degree of associated respiratory compromise related to his asthma, the latter a condition that can reversibly cause acute airway obstruction.

Again however, there were no specific signs to support this at autopsy

In relation to his physical restraint however, whilst there were a large number of injuries noted to his body externally (many of which would be in keeping with the reported restraint process), there were no signs at autopsy to indicate that significant direct trauma had played a part in his death, with for example no signs of significant head injury and no specific injuries to indicate that his neck/throat structures had been compressed at any stage.

One other condition that must be given consideration here, in view of the circumstances surrounding the death, is 'excited delirium' or 'excited delirium syndrome', a clinical/psychiatric diagnosis that encompasses sudden deaths occurring in individuals demonstrating acuter psychiatric symptoms, potentially due to the adverse effects of drugs (typically stimulants such as cocaine), the deaths often occurring in a restraint situation. Such fatalities are also typically associated with the development of hyperthermia – a raised body temperature. In this instance, it is acknowledged that he was reportedly exhibiting unusual behaviour prior to his restraint, but it is not possible to comment firmly upon the possibility of him having been intoxicated with drugs at the time of the cardiac arrest, due to the availability of only limited hospital toxicology samples for analysis (albeit the tests undertaken on the hospital urine sample analysed did not reveal amphetamine or other 'routine' stimulant drugs). He was also documented as being 'afebrile' at the time of his hospital admission, and presumably therefore was not hyperthermic at this time, with him also documented clinically to have developed complications of such a condition e.g. rhabdomyolysis.

Finally, in relation to his heart disease, it is noted that the degree of coronary artery disease found is unusual for someone of Mr Marshall's age, and whilst this perhaps would most likely reflect his reported misuse of drugs (with accelerated atheroma formation for example well recognised in abusers of stimulant drugs, such as amphetamine and cocaine), it is not possible to definitively exclude that he may have been suffering from an underlying genetic predisposition to arterial disease e.g. familial hypercholesterolaemia. As such, it is advisable that his first-degree relatives consider clinical genetic screening in this regard, which can be facilitated through their own GP(s).

There were no other significant findings. On the basis of these comments, the final cause of Mr Marshall's death is given narratively as follow:

1a Hypoxic-ischaemic brain injury due to out-of-hospital cardiac arrest occurring during physical restraint in a man with coronary artery atheroma"

[36] In his oral evidence, Dr Ainsworth expanded on the report. He referred to the death as multifactorial. He said that he occasionally came across cases where restraint led to death in the absence of identifiable disease and indeed cases where exertion such as marathon running or other physically demanding activity did so. Restraint such as the restraint of Mr Marshall caused physiological strain in the same way as any exercise did. The long struggle could be dangerous and could cause the cardiac function to be compromised. The face down posture involved with Mr Marshall could contribute to difficulty expanding his chest, which would increase the strain. The chest needs to expand while breathing. He found no signs that positional asphyxia was definitely the cause of the cardiac arrest and explained that signs may have been present and have resolved during the period between the restraint and Mr Marshall's death. Absence of the signs post-mortem did not negate the possibility that Mr Marshall's posture during the restraint contributed to the strain on his heart.

[37] Doctor Miles Behan, consultant cardiologist, said he was unaware of any cases where cardiac arrest had been caused by physical restraint. He also said that it was possible Mr Marshall could have had a heart attack at any point and that a man of his age with an otherwise sound heart, and no other risk factors, should have been able to withstand the level of prolonged physical exertion involved in resisting the restraint. He said that it was the combined effects of physical struggle and the oxygen mismatch, coupled with the disease, which caused the cardiac arrest. He did not think Mr Marshall would have suffered a cardiac arrest had he not had the underlying disease. He also said

that had there been no struggle it was very unlikely that a cardiac arrest would have occurred. There was discussion of the 'Valsalva manoeuvre', a mechanism associated with forced expiration. He thought it unlikely that a Valsalva manoeuvre caused Mr Marshall's cardiac arrest, explaining that the manoeuvre usually resulted in passing out which would result in an end to forced expiration and consciousness being regained. The defibrillator print-outs were equivocal. He viewed the video recording of the restraint in court. Viewing the video recording of the latter part of the restraint, he thought it most likely that Mr Marshall's cardiac arrest had already occurred prior to the application of the plastic handcuffs by prison officers.

[38] Doctor Neil Nichol, consultant in emergency medicine, provided a report[15]. In his oral evidence he described there being present a constellation of factors that could have triggered the cardiac arrest during a violent struggle over a prolonged period of time. He said it was less likely those factors would have done so had there not been an existing heart condition. He also said that the same set of circumstances of restraint could have the same outcome for someone with no heart defect. It was described in literature that sudden cardiac arrest can occur in restraint situations. Had there not been the extent and nature of the restraint of Mr Marshall, there was no indication that he would nevertheless have suffered a cardiac arrest at the time and place that he did. He explained that extended exertion required more oxygen and therefore hyperventilation resulted. He said that breathing was harder for a person lying face down and harder for a person handcuffed behind their back. Dr Nichol explained and discussed the Valsalva

[15] Production 2

manoeuvre, which involved restriction against breathing out. He was unaware of the Valsalva manoeuvre being linked to restraint deaths but postulated that it was a tenable theory. He considered the question of psychosis. He said that he could not be definitive but his opinion was that the fluctuations in Mr Marshall's presentation were more eloquent of a psychotic episode than a drug induced delirium. He said that in his opinion although he could not be certain, it would be fair to say that Mr Marshall was suffering from EDS during the restraint.

Mr Marshall's state of mind

[39] There was no medical examination of Mr Marshall to determine his state of mind. The Inquiry heard from a number of witnesses that Mr Marshall behaved in a manner that was unusual for a period of time leading up to the restraint. That is discussed in more detail later in this determination. Those witnesses had already given details of Mr Marshall's behaviour in their police statements and those statements were able to be considered by medical witnesses in preparing their respective reports. Furthermore, by the time these witnesses came to give their evidence, there was a body of factual evidence about Mr Marshall's presentation that was considered and commented on by the medical witnesses.

[40] Dr Jacqueline Elizabeth Scott, consultant psychiatrist, provided a report[16]. She was cautious in her evidence. She said that she had not been able to examine Mr Marshall in life nor had any other psychiatrist. She said that his presentation could

[16] Production 29

have been the result of a psychiatric condition or equally caused by chemicals. Mr Marshall's presentation was consistent with a psychiatric condition but would equally be consistent with psychoactive chemical ingestion.

[41] Dr Hazel Torrance, forensic toxicologist, referred to a report she had prepared. She explained that she had received a limited quantity of serum and was only able to run a basic drug screen. She was unable to confirm or deny that Mr Marshall had ingested any known psychoactive substances prior to the restraint. In the limited analysis she carried out she found no evidence of Mr Marshall having taken any such substance.

[42] Nurse, KQ, told the Inquiry that she administered two doses of naloxone, an anti- psychotic drug, to no effect. That, on her evidence, contra-indicated psychoactive drug intoxication.

Control and Restraint skilled witnesses

[43] Eric Baskind (instructed by the procurator fiscal depute) and Trevel Henry (instructed on behalf of Mr Marshall's family) were two expert witnesses concerned with control and restraint, both of whom were consultants in the use of force. They each provided a report[17]. I ultimately found both to be credible and reliable witnesses. In terms of Rule 4.19 of the Act of Sederunt (Fatal Accident Inquiry Rules) 2017, I ordered those two witnesses to present information concurrently. Both of them had been furnished with background papers including Volume 1 of SPS Control and Restraint

[17] Productions 3 and 28

Manual[18], witness statements taken by the police and the video evidence from the SRU. They had each had the opportunity to view Volume 2 of the Control and Restraint Manual[19]. Neither had seen Volume 3[20] of the Manual at the time of giving their evidence, the existence of which was only disclosed to the Inquiry months after they had completed their evidence. Mr Baskind did, however, very quickly provide a supplementary report[21] relating to volume 3 when asked to and Mr Marshall's family, who had instructed Mr Henry, were satisfied with the supplementary report. I was grateful to Mr Baskind for his diligence and further assistance. The supplementary report highlighted the existence of relevant information and guidance within Volume 3 that was not contained in Volumes 1 or 2 and which, in the opinion of Mr Baskind, ought to be in those volumes as well. Volume 1 of the Manual is published and electronically available to prison staff. Volume 2 is confidential and used by trainers at one-day annual training sessions. Volume 3, it transpired, was confidential and used nationally in the training of new recruits. Mr Baskind and Mr Behan pointed out that the medical/safety instructions contained in Volume 3 were more extensive than those contained in Volume 2. There were slides relating to Positional Asphyxia.

On slide 112, circumstances in which the condition could occur were listed as when:-

- A prisoner is laid face down on their stomach and pressure is applied to their back or is placed in any position that inhibits respiration
- Confined spaces

[18] Production 23
[19] Production 23
[20] Supplementary Production 6/1
[21] Supplementary Production 6/4

- A prisoner is handcuffed and left lying on their stomach.

The evidence before the Inquiry was that Mr Marshall was subject to all of these during his restraint.

On slide 113 it was specified that there was an increased risk if, *inter alia*

- The prisoner is intoxicated with alcohol or drugs
- History of mental disorders
- The prisoner has previously, through violent activity, expended much physical energy and is suffering respiratory fatigue.

On slide 115, to reduce the risk, it is provided:

- Avoid putting direct pressure on the back or spinal area of the prisoner
- Achieve a kneeling or standing position as soon as is practicable
- Monitor the prisoner's vital signs
- Get medical assistance IMMEDIATELY if you have concerns about the condition of the prisoner.

[44] In relation to Excited Delirium there was information on slide 118 as follows:

> "It may only become apparent that a prisoner is suffering from excited delirium when they suddenly collapse: beware of sudden tranquillity after frenzied activity which may be caused by severe exhaustion, asphyxia or drug related cardiopulmonary problems (problems with the heart and lungs)."

[45] Each witness had provided a report and each report was taken as read at the outset of their concurrent presentation of information. They had consulted with each other before giving oral evidence and I had been informed that there were no areas upon which they disagreed, although some minor differences did emerge. They produced a

note of a joint discussion that had taken place between them on 10 July 2018 in which they raised some issues that they considered were of particular interest. These were: foot on shoulder and buttocks area of Mr Marshall; the length of time Mr Marshall was held on the floor; and Acute Behavioural Disturbance (otherwise known as Excited Delirium Syndrome which is the term used in this determination). I invited the procurator fiscal depute to explore, in particular, the areas highlighted. In accordance with the said Rule, I also questioned the witnesses myself and I allowed some questioning by participants. What follows is a brief summary of the matters agreed on and the evidence led. The witnesses concurred that the authority for prison officers to use force against prisoners was contained in Rule 91 of the Prisons and Young Offenders Institutions (Scotland) Rules 2011.

[46] What comprises a basic operational restraint team was discussed. They agreed that it comprised a minimum of three officers who operate under the direction of a supervising officer. The supervising officer will normally be of manager grade – First Line Manager (FLM) or higher unless high risk factors require a control and restraint instructor to carry out that role. A fourth officer can be introduced to assist in restraining a prisoner or to act as an anchor during movement on the stairs. The officers in a restraint team can be identified with the numbers 1-4.

Number 1 has a number of roles and responsibilities. Where appropriate the Number 1 will:

(a) manoeuvre the team safely towards the prisoner

(b) control the movement of the prisoner's head during the initial struggle

(c) communicate with the prisoner and team members

(d) take charge of the removal and relocation

(e) continually risk assess the situation.

The other members of a standard three-officer team are known as Numbers 2 and 3. Their roles and responsibilities are to:

(a) comply with all instructions given by the Number 1

(b) isolate and apply wristlocks to the prisoner's left and right wrist

(c) communicate with the Number 1.

Sometimes the incident necessitates a further member of the team, known as the Number 4. Where appropriate, this officer's role and responsibilities are to:

(a) comply with the instructions given by the Number 1

(b) isolate and control the prisoner's legs during a roll or turnover

(c) isolate and control the prisoner's legs using leg locks

(d) act as an anchor person during removal on stairs.

[47] The witnesses agreed that there was a continuing requirement to de-escalate a restraint. One purpose of de-escalation was to gain as much cooperation as possible from the prisoner so as to bring the restraint to an end at the earliest possible opportunity. They referred, with approval, to what was contained in Volume 1 of SPS, Control & Restraint Manual relating to use of force and de-escalation (supra), where there is found, at page 1:

> "Staff will whenever possible and practicable use communication skills and other non-physical techniques to enlist the willing co-operation of prisoners in an attempt to de-escalate the situation.

> The use of force will only be considered when all other means have been exhausted or are deemed unlikely to succeed.
>
> De-escalation must be considered at the earliest opportunity after force has been used…"

It was pointed out by the witnesses that provision for and the importance of de-escalation was to be found also in Volume 2 of the Manual. A number of exercises were included in the Manual which reflected the importance of de-escalation and related skills. It was good practice. The principle of using violence as a last resort was important.

[48] They commented on the presentation and behaviour of Mr Marshall as described by prison officers in the officers' police statements and as viewed in the available video recording within the SRU. They agreed that although medical evidence and medical matters were for medical experts, the issues raised played an important part in devising and training in restraint skills, which they could properly comment on. They agreed that the existence of excited delirium syndrome (EDS) or Acute Behavioural Disturbance (the term they said was more current) as a phenomenon went back to 1998. Over the last ten years knowledge of it was rapidly evolving. However, it was controversial, with some medical opinion doubting its existence at all. They both had working knowledge of control and restraint training within industry and public services, such as the police and NHS. Deaths had resulted during restraint and they expected to find procedures within any current training manuals concerned with control and restraint. More than that, they expected to find those involved in control and restraint to be familiar with the well

documented symptoms. They expected prison officers to be familiar with the symptoms associated with EDS. They expected the training received by prison officers to be such that prison officers would be familiar with the associated signs.

[49] The witnesses commented on the training given by SPS to prison officers. On the topic of control and restraint, prison officers were required to attend a one-day refresher course each year. Part of that training included encountering prisoners presenting with symptoms associated with positional asphyxia, EDS and psychosis. Reference was made to Volume 2 of the Control & Restraint Manual[22] on the topic of medical conditions that may be triggered by or be exacerbated by the use of force and the signs associated with each condition (supra). In the Note of their joint discussion, they agreed that even had there been sufficient training provided to staff on EDS the risks can be very difficult to detect or distinguish from behaviour and signs seen during many incidents of extreme violence. However, according to these witnesses, it was not enough that the C&R Manual contained information on this topic. It was necessary that the training provided successfully imparted the information. If prison officers did not know of the signs or could not remember them, then there was a deficiency somewhere in their training. Both witnesses agreed that the use of a foot as a control and restraint technique was nowhere to be found with the Scottish Prison Service C&R Manuals they had viewed. They did not expect it to be. They knew of no control and restraint training elsewhere that included the use of a foot as a control and restraint technique. Such use was not a recognised control and restraint technique. It should not be included in a manual as a

[22] Production 23

technique and should not be routinely taught. However, both said that they knew of feet having been mentioned within control and restraint training materials not as a specific technique but mentioned as supplementary to holds in some circumstances. They differed to an extent on whether there should be any mention of feet at all in control & restraint manuals. Mr Trevel expressed the view that the use of feet should be referenced whereas Mr Henry thought there should be no mention. They did not agree on the frequency with which mention may be found in other such manuals. No examples of any specific mention within a manual was presented or referred to. They both had knowledge that the use of a foot had been used elsewhere during control and restraint. Although there was no technique in existence or taught, they both thought that it could be justified in some circumstances. If used, it would then be for the person using a foot to justify the use. That could not be done by reference to control and restraint training. In the Note of their joint discussion they set out:

> "Foot on shoulder and buttocks area
>
> 1. Placing feet on shoulder/buttocks is not routinely taught during training.
>
> 2. Whether or not either could be justified is a question of whether it was necessary to do so.
>
> 3. In general terms, it might be justified if an officer believes that his colleagues are struggling to control the subject on the ground.
>
> 4. Given that there were a number of officers already attempting to control Mr Marshall on the floor, there would not be much space left for this additional officer to join them on the floor, thus making the placing of the foot a realistic tactical option."

[50] In the oral discussion of the two experts' joint submission there was exploration by me and the Crown of the actual use of feet by prison officers. Both experts accepted

that there were particular risks associated with the use of feet, especially depending on where a foot was placed. They agreed that, in circumstances where respiration might be compromised it was dangerous and might require exceptional justification. It was agreed that in circumstances where respiration was being compromised there would be a further violent reaction by the prisoner to try to be free to breathe. That could be responded to as greater violence requiring further restraint efforts and result in a dangerous spiral. In order for the prisoner to generate more strength to resist positional asphyxia more intake of oxygen is required and so more breathing is needed and the more restraint that is placed the more there will be an effort to get breath and the more risk there will be from being restricted. They are "fighting to survive".

[51] On the question of EDS, both said it was important to identify the symptoms before engaging in restraint. Once recognised, it becomes a medical emergency. After restraint has commenced and violence ensued, it becomes difficult to differentiate between EDS symptoms and violence unconnected with the syndrome. Rapid breathing and sweating might be expected in any restraint. The amount of time a person being restrained might resist is variable depending on a variety of circumstances such as fitness and ambient temperature. It was unclear whether prolonged restraint could trigger EDS but prolonged restraint and resistance along with other things can result in a 'toxic mix' that becomes a medical emergency. Accordingly, a person might enter into the state after restraint has begun. In normal restraint scenarios there will be variable response to pain. Thresholds were different in different individuals. It was agreed that if a medical emergency was suspected a re-evaluation was required and that once a

medical emergency arises restraint must cease. The medical emergency must take priority. Both agreed that it was important to identify the pre-restraint indicators such as psychosis or paranoia, agitation or violence, bizarre behaviour or incoherence and hallucinations so that medical intervention could take place before restraint.

[52] The video recording[23] was shown to the witnesses. As Mr Marshall was dragged from the shower area a prison officer was seen to place a foot on his thigh. Neither of the witnesses noticed any struggle from Mr Marshall at this point. Downwards pressure from a prison officer kneeling on Mr Marshall was viewed and comment invited. The witnesses differentiated between possible physical prevention of Mr Marshall rising up and downward pressure that might obstruct breathing, which must be avoided. Mr Baskind said that if a foot is placed with pressure on a person's body it would compromise their ability to breathe and the risks would be considerable. Asked about the 20 minutes struggle spoken to by prison officers before Mr Marshall was dragged from the shower area, both said that evidence from prison officers that the holds were not working was not conclusive of there being an EDS situation constituting a medical emergency. It might have been that the holds were not being properly applied by the prison officers. That in turn raised training efficacy questions that the witnesses could not answer. The witnesses commented further on viewing a foot being placed on Mr Marshall at various junctures. In some instances they agreed they could not see struggling going on that would, to their minds, justify the use of a foot to assist a restraining prison officer. On one occasion shortly after Mr Marshall was dragged along

[23] Production 22

the corridor towards the target cell, they did see upwards movement of Mr Marshall's body and thought he was struggling or that he could have been lifted and dropped. The holds did not appear to be strong. In answer to my question on whether dragging or lifting was preferable they said ideally the prisoner should be raised to his feet. On a different camera, shortly after Mr Marshall emerged from the shower area, they commented that it appeared there was very little resistance from him and very little proper restraint going on. They thought that Mr Marshall was just being held down on the floor and slid to a different position. At the point where Mr Marshall was adjacent to the door to the cell he was to be put into, the witnesses could see some but not a substantial amount of resistance from Mr Marshall and thought that the prison officers were more holding him than applying any specific type of recognised restraint. Further comment was made in relation to observing the use of a foot on the back of the shoulders area of Mr Marshall while he was being held by a number of officers. They commented that the surrounding officers present appeared unconcerned and not agitated or stressed as would have been expected if there was a struggle going on. Observing the video timed at about 08:24 hours, both said they saw no struggling and observed what might have been the plastic handcuffs (plasticuffs) being applied.
Mr Baskind said something was going on because there were ten prison officers all looking down at something whereas shortly before, those not directly involved but in the vicinity showed limited interest in what was happening. Both agreed there was a risk of positional asphyxiation when plasticuffs were applied to the rear of a prone individual. Further criticism was made in relation to there being no apparent need for

the prison officer applying a straight arm lock before the plasticuffs were positioned and of the use of a foot on Mr Marshall's upper back shoulder area in connection with this arm lock.

[53] The witnesses were asked about the opportunity, after violence had commenced, for there to have been a de-escalation and withdrawal of prison officers from the shower area. They said it would have been possible but a different set of risks would come into play, included Mr Marshall becoming a risk to himself. They suggested that it would have been possible for some of the officers to have kitted themselves up with protective equipment to protect from spitting and biting. The equipment would have offered protection from biting and excrement exposure and might have facilitated a quick and conventional removal from the shower area with Mr Marshall in an upright position.

NHS Healthcare Staff

[54] KQ, Registered General Nurse, was employed by SPS and on duty at the time of the restraint. She responded to the code blue alert and ran to the SRU. The scene she met is viewable on the video evidence. Her description was graphic. She said there were about 20 prison officers present, shoulder to shoulder like a "penalty shoot-out". She was critical of them. They did not move when they saw her coming. Mr Marshall was on his back with his arms outstretched still being restrained by prison officers. Prison officer Charles Kivlin was holding one arm and prison officer Kevin O'Hara the other arm. No one was doing CPR when she arrived. The officers seemed to be in suspended animation. She had to ask them to get out of the way. She asked what had happened and

nobody answered – there was just silence. She described the prison officers as looking through her. She asked if an ambulance had been called and got no response from any of the prison officers. She described Mr Marshall as having injuries from head to toe. His tongue was enormous and hanging out of his mouth. He was pale and his ears were blue. She wondered if he had hanged himself. The skin was shaved off the top of his feet. His shoulder had what looked like pressure sores. He had a big gaping cut over his eye, which had been bleeding. There was dried blood on his face and blood in his eyelids and nose. There were scrapes and marks on his skin. Her colleague, nurse JW performed CPR and she could feel expiratory breathing. She continued to ask what had happened and continued to be met with silence. She was unable to get the prison officers restraining Mr Marshall to let go. She prepared to use the defibrillator but received the instruction from the machine not to shock and to continue with CPR. When Dr Maxwell appeared he asked if Mr Marshall had taken something. At this point FLM Fraser said he thought that he had. Nurse KQ, having heard that for the first time, administered two doses of naloxone, an antipsychotic drug. It had no effect. The lack of effect mitigated against the proposition that Mr Marshall was suffering from the effects of drugs. Prison officer, Charles Kivlin, suddenly intervened with CPR and initially took no heed of requests to let the nurses do their job. He then returned to restraint of Mr Marshall. Subsequently, prison officer Kevin O'Hara took over CPR. Viewing the video recording, Nurse KQ estimated the timing of the code blue at about 08:27 hours. By 08:46 CPR had stopped.

[55] JW, Registered General Nurse, responded to the Code Blue and went to the SRU. She arrived at the same time as Nurse KQ. She said that she found Mr Marshall on his back and could detect no palpable pulse. She commenced CPR. She could not recall whether Mr Marshall's hands were being held. Reminded that was what she told police at the time she accepted that she had said his hands were being held. She presented as a reluctant witness. She said that she could not remember when circulation resumed and could not remember when chest compressions stopped. She did not want to view the video recording and did not think that viewing it would assist her. The procurator fiscal depute did not persist. Her recollection was that CPR was successful before the paramedics arrived. On arrival she had asked what had happened and got no response from the prison officers present.

[56] Louise Sonstebo, Scottish Police Authority, Forensic Services, provided a report[24] and gave evidence. There had been evidence from some prison officers of Mr Marshall straining to the extent that the plasticuffs applied to him had turned white., That was not obvious from the plasticuffs lodged by the Crown. I requested that these plasticuffs[25] be forensically examined along with a control unused set of cuffs. Ms Sonstebo examined both sets of plasticuffs. She said that there was no evidence of strain on the plasticuffs removed from Mr Marshall and found no whitening through strain. Had there been straining such as to cause the plastic to turn white it could not then revert to

[24] Supplementary Production 6/3
[25] Production 24

being black. Tests were carried out by her on the control set of cuffs which verified her findings.

[57] I asked for Dr Ainsworth to comment on whether he found wrist injuries on Mr Marshall that would be consistent with such straining. He reviewed his notes and told me there was a minor injury on one wrist that could have been caused by the application of plasticuffs but no injury on the other wrist. This scientific evidence sharply contrasted with the vivid evidence that Mr Marshall was straining against the plasticuffs before his cardiac arrest.

Prison Officers and prisoners (direct witnesses)

[58] It was apparent that there were credibility and reliability issues with many of the prison officer witnesses. One such issue relates to the plasticuffs. That is discussed later. I had more confidence relying on the evidence that could be verified on video or in documents rather than simply on what I was being told. I considered myself to be entitled to accept a witness' interpretation of what was shown on video recordings as well as being entitled to form my own view of what I saw.

<u>The early presentation</u>

[59] RR was a remand prisoner. He gave a statement to police and gave evidence in court. He features in a joint minute of agreement amongst the participants. It is agreed that he and Mr Marshall were placed in a cell together on 11 March 2015 and that they were both transferred to cell 13 some days later. It is agreed that on Sunday 22 March

RR approached prison officer Neil Farquhar and asked to be transferred to another cell away from Mr Marshall. He reported that Mr Marshall had woken him up several times through the preceding night and had been staring out of the window. RR described Mr Marshall's behaviour as weird and said he felt uncomfortable sharing a cell with him. He gave statements to police on 25 and 26 March, the contents of which are agreed to be true records. The statements contained details of Mr Marshall's behavior. RR's evidence is discussed in the Summary of Events (supra).

[60] Prison officer Steven Banks told the Inquiry that he was approached by prisoner RR. According to prison officer Banks, RR asked to be moved to a different cell because he was not getting on with Mr Marshall. RR did not go into specifics but just said that Mr Marshall made him feel uncomfortable. He said that there was no formal procedure for logging information of that nature and officers just try to accommodate prisoners. Prison officer Banks did not accept that RR had given him details of Mr Marshall's behaviour. However, RR's statements to the police where he mentioned passing on information have been agreed in a joint minute as an accurate account of what he said. It was also agreed that RR told prison officer Neil Farquhar that Mr Marshall had woken him up on several occasions in the preceding night and had been staring out of the window. It was agreed that RR described Mr Marshall's behavior as weird and reported that he felt uncomfortable sharing a cell with him. Where they differ, I prefer the account of RR. I am satisfied that RR did give prison officer Banks the specific information mentioned.

Glenesk Hall night shift 24 March 2015

[61] Prison officer Stuart Wilson was on duty in Glenesk Hall in the early hours on 24 March 2015. He was the patrol officer. He said that Mr Marshall pressed the emergency buzzer about 02:30 hours. He attended. Mr Marshall walked towards the hatch and asked "What's happening? Are you letting me out?" Mr Marshall was told that was not happening but kept repeating the question over and over again. Prison officer Wilson formed the view it was a little strange but said that he was not concerned. After about 20 minutes the buzzer sounded again and he attended. Through the hatch he could see Mr Marshall with his hands in his pocket leaning against his bed. Mr Marshall again repeatedly asked if he was going to be let out. He said that he shouldn't be in prison. He said "You get the keys, let me out". Mr Marshall was asked if he wanted to see the manager. He initially said yes and then said no. Prison officer Wilson remained of the view that Mr Marshall was acting a little strangely and decided that if he pressed the buzzer again he would contact the manger. He said that he was unsure how to react but conversely also said that he was fully aware of procedures to follow in the circumstances. After a further 20 minutes a prisoner located below Mr Marshall's cell complained to prison officer Wilson of loud banging from above. Prison officer Wilson said that he attended the area and heard nothing. He did not attend Mr Marshall's cell. He listened for 10 to 15 minutes and heard nothing. As he was leaving, he heard a lot of banging from Mr Marshall's cell and was prompted to call the manager, FLM Gordon Mellis. FLM Mellis asked to be kept informed and told prison officer Wilson to keep regular checks on Mr Marshall. Prison officer Wilson said that he was not specifically

told to put Mr Marshall on special observations (every 15 minutes). At around 04:15 prison officer Wilson heard loud continuous banging from Mr Marshall's cell. He went and looked through the hatch. He could see belongings scattered on the floor and milk spilled on the ground. He asked what was wrong and was curtly told to "fuck off". It sounded as though Mr Marshall was smashing up his cell and he contacted FLM Mellis, who sent members of "outside staff" prison officers Boyle and Scott. Prison officer Boyle opened the door hatch and prison officer Wilson could see there was excrement on the hatch window. The toilet window was smashed and there was milk and glass coming out from under the door. They went to the office and returned soon after with FLM Mellis, who engaged with Mr Marshall. Mr Marshall kept on mentioning an agreement FLM Mellis had broken. It sounded like rambling. FLM Mellis asked Mr Marshall if he was ok and he replied "fine". The officers left the cell area and had a discussion. FLM Mellis decided that as Mr Marshall had not harmed himself, was in no immediate danger and had harmed no-one else, he would be left until the day shift came on duty when there were greater resources. Prison officer Wilson said that everybody agreed on that course of action. Regular checks were requested by FLM Mellis but special observations were not put in place. Mr Marshall activated the emergency buzzer again at about 06:15. Prison officer Wilson went to the cell and looked through the hatch. Mr Marshall had been naked on the last occasion but was now wearing underwear. He was calm and apologetic and asked if he should start cleaning up the cell. He was told it would be a good start but he would still need to be put on Report for smashing up the

cell. FLM Matthew Sim arrived at about 06:55 to start day shift. Prison officer Wilson said he completed his paperwork and then went home, ending his involvement.

[62] FLM Gordon Mellis agreed that he was in charge on the night shift which led into the morning of 24 March. He was in charge of eleven staff. At about 04.45 prison officer Stuart Wilson radioed to inform him that Mr Marshall had smashed up his cell. He contacted prison officers Boyle and Scott to attend and he also attended himself. He could hear no disturbance. He looked through the door hatch and could see excrement smeared on the glass. There was debris behind the door and cell furniture piled up. Mr Marshall did not appear to have any injuries and he said that he therefore took the view that no medical treatment was required. He asked Mr Marshall what had happened and Mr Marshall said an agreement had been broken. When asked about the agreement, Mr Marshall said "ask your boss, they will know what I am talking about". He asked Mr Marshall if he had finished and calmed down and Mr Marshall replied "aye, I've calmed down". FLM Mellis said that he carried out a dynamic risk assessment (obligatory in terms of C&R procedure before any removal involving C&R restraint). He considered that a minimum of four staff would need to be kitted out with special safety equipment for a cell extraction. Mr Marshall was calm at that point and he decided to leave him to be dealt with by the day staff. He had no concerns for the safety of Mr Marshall. Contrary to what prison officer Wilson said, his evidence was that he instructed prison officer Wilson to put Mr Marshall on 15 minute observations. He said that he told prison officer Wilson to give a "proper handover" to the day shift. There was no elaboration on what that meant. He said that back in his office, he drafted an

email report to Anette Dryburgh (head of operations), Kenneth Paterson (FLM Glenesk), Kathleen Gallagher (FLM Glenesk) and Brian Martin (unit manager, Glenesk). When the day shift started he thought that he spoke to Derek Mackenzie ((operations FLM). He said that all handovers were verbal except where a prisoner has been forcibly removed from a cell, when a form is filled out and sent to various members of the management team. No such form was filled in on this occasion.

[63] From the evidence, it is apparent that no consideration was given to contacting NHS Prison Healthcare staff in relation to anything other than Mr Marshall's physical condition.

Glenesk Hall day shift 25 March 2015

[64] FLM Matthew Sim was in charge of the day shift in Glenesk Hall on 24 March 2015. He told the Inquiry that he was the one who arranged for Mr Marshall to be transferred to the SRU. He agreed that his police statement could form the basis of his evidence and confirmed that he had been telling the police the truth. It was taken as read. He said in his oral evidence that the night shift prison officer, at handover, told him there had been a problem during the night on the third floor but it was all quiet at changeover. He said that the prison officer did not elaborate on what had happened. That did not correspond with what was contained in his police statement given on 24 March 2015. In that statement he told the police that the nightshift prison officer had told him that Mr Marshall had been displaying strange behavior since around 05:00 hours

and had covered his cell observation point in excrement. I prefer and believed the contemporaneous account contained in the police interview.

[65] There were three members of staff on duty with FLM Sim. He instructed them to take extra care when checking on prisoners. Prison officer Neil Farquhar reported that Mr Marshall had destroyed all items within his cell, had barricaded the door and had excrement on him. FLM Sim said he went and spoke through the door to Mr Marshall. Prison officers Kara Scobie and Steven Banks were there. He asked Mr Marshall if he was all right and what the problem was. He said that Mr Marshall's response was reassuring to him. He tried to open the door to enter the cell but could not because of debris behind it. Mr Marshall was reluctant to engage. He said some things that did not make much sense, like quoting the Bible, saying prayers and saying "you're going to come in and get me". He seemed to be praying to members of his family. Some things he said made FLM Sim think that Mr Marshall was fearing for his own safety, such as: "What's going to happen when I come out?" Prison officer Scobie said that Mr Marshall had been "chanting and stuff in another language". She found it all very strange. FLM Sim persuaded Mr Marshall to move some debris so that the door could be opened. When it was opened, he was standing at the far corner diagonally opposite the door. He kept retreating to that corner. There was broken glass on the floor and he had no footwear on. He did not appear to have excrement on him. FLM Sim continually reassured Mr Marshall, who said "I'll trust you if you take your shoes and socks off and come over here". He thought he must have made a facial gesture because Mr Marshall then said "look at your face, you're going to do something". FLM Sim then said

something like "either you come now, or I come back and get you". He said that he thought that registered because Mr Marshall started to come out.

[66] FLM Sim had already decided to have Mr Marshall transferred to the SRU and had made arrangements with FLM David McAdam from the SRU. He told Mr Marshall that prison officers would take a hold of each arm loosely and take him to the SRU. Mr Marshall was compliant. Prison officers Scobie and Banks each took a loose hold of an arm. Prison officer Dean Golding came up from the SRU to assist with the extraction. He walked in front of the three officer team. They had to descend three staircases. Prison officer Scobie said that part of the way down, Mr Marshall saw his own reflection. He stopped and was bolt upright. The other prison officers seemed not to take any notice. At the SRU they met FLM McAdam and were directed to cell 6. Mr Marshall was briefly put into cell 6 and SRU staff comprising of FLM McAdam, and prison officers Brian Doyle, Justin White and John Nicol took over. FLM Sim initially said in court that he could not recall telling them anything about Mr Marshall making biblical references or acting bizarrely. He subsequently changed his evidence and said he did tell SRU staff about Mr Marshall smashing his cell and about his bizarre behavior but he did not elaborate on what the bizarre behavior was. FLM Sim completed a C&R removal form and sent it to operations manager Annette Dryburgh. He then returned to his office to fill out an incident report to be sent to Brian Martin, unit manager. That ended FLM Sim's involvement with this stage of proceedings.

[67] Prison officers Scobie and Banks each gave evidence but added nothing of consequence to this stage of the proceedings. FLM Sim gave no consideration to

contacting medical staff in relation to Mr Marshall and his presentation. He said he had no concerns for his mental health. But he later confirmed Mr Marshall was displaying bizarre behavior and said he expected him to be referred to mental health. He said that Mr Marshall would have been referred to medical health staff after arriving at the SRU. Normally they get a nurse to come pretty quickly but at that time of the morning the nurses are pretty busy. He said he would have done that if he was at the SRU. He said that had he thought the SRU staff would not contact medical health staff he would have done so. I could not reconcile those parts of his evidence. FLM Sim did not seek Healthcare advice. However, he said that he thought Healthcare staff should have been involved and he would have involved them later but he did not do so when it was his responsibility.

SRU admission

[68] There is some inconsistency around the information that was passed to SRU staff on Mr Marshall being transferred there. FLM Sim's eventual position was that he did make some reference to bizarre behavior. FLM McAdam was on long term sick leave during the first days of the Inquiry and provided an affidavit. After an adjournment in the middle of the Inquiry he did give oral evidence. In relation to the handover, he agreed with FLM Sim that the request was made to transfer Mr Marshall and that Mr Marshall was brought under 'come along' holds. Mr Marshall was placed briefly in cell 6. The holds and the brief placing of Mr Marshall in cell 6 can be seen on the video

evidence presented to the Inquiry[26]. FLM Sim passed information about Mr Marshall smashing up his cell. In the affidavit, FLM McAdam makes no mention of any bizarre behavior being mentioned. He offered Mr Marshall the opportunity to have a shower and then breakfast. His impression was that Mr Marshall was compliant. He thought he looked a bit vacant and his eyes were glazed. He thought he was possibly under the influence of something. Although required to seek medical advice if drug abuse was suspected, he did not take any action in respect of medical intervention at that time. Mr Marshall was walked to the shower and given soap and a towel. Mr Marshall then made what FLM McAdam considered to be an odd remark. He asked the prison officers if they knew the Lord's prayer. They did not engage with the remark but encouraged Mr Marshall to go into the shower area. Then Mr Marshall made another remark that FLM McAdam considered to be odd. He asked whether they wanted to stab him in the heart. It did not sound aggressive and appeared to be a sincere question. The prison officers did not engage with that. According to the evidence, no staff member at this point considered that there was a need for NHS Prison Healthcare intervention. After about 10 minutes Mr Marshall could be heard singing. It sounded as though he was chanting Islamic prayers but the words were muffled. At about 07.40 prison officer Nicol came to the office to report to FLM McAdam that Mr Marshall was hiding behind the door and that he thought Mr Marshall had not had a shower. They all four went to investigate and could still hear singing as described. FLM McAdam opened the door to speak to Mr Marshall. Mr Marshall came away from behind the door and retreated to

[26] Production 22

the corner next to a Belfast sink. Opening the door seemed to make Mr Marshall become aggressive or defensive. He raised his arms above his head and lifted a leg. It was described as looking like a karate kick stance. Mr Marshall again asked if they had come to stab him through the heart and said that he would be ok because God would protect him. At the same time Mr Marshall challenged and said "come on then". FLM McAdam said they tried to reassure Mr Marshall. He told the Inquiry that he could not remember what was said. He and prison officer Brian Doyle laid hands on Mr Marshall to escort him to his cell using come along holds. There is a difference between FLM McAdam and prison officer Doyle's evidence as to who first laid hands on Mr Marshall and how it was done. Prison officer Doyle told the Inquiry he was first to touch Mr Marshall by placing a hand on his shoulder to usher him out of the shower area, which set him off. FLM McAdam said that as soon as he touched Mr Marshall's wrist he became violent. They were unable to get a secure hold. Mr Marshall was violently pulling his arms and kicking. He seemed to be incredibly strong and no holds they tried had any effect. FLM McAdam said that he had never experienced anything like that level of strength and violence in an inmate. He activated the alarm to call for assistance. Mr Marshall continued to struggle and bit him on the left elbow, breaking the skin. Other prison officers arrived to assist. FLM McAdam was injured and exhausted by the struggle. He asked FLM Brian Fraser to take over supervision whilst he returned to the office. He saw prison officers Dean Golding and Jamie Hardie enter the shower area. His team, prison officers Justin Whyte, Brian Doyle and John Nicol all came to the office shortly after him. They had all been hurt. Prison officers Doyle and Whyte had been bitten on their arms.

Prison officer Doyle had sustained a broken wrist. FLM Grant arrived and FLM McAdam asked him to create a log of staff who became involved. He called senior manager Brian Martin to report the incident. Prison officers were arriving. He heard someone say that Mr Marshall had been brought out to the main hall area but he did not see that. Gerald Michie, deputy governor, came to the office. Around the same time he heard FLM Charles Kivlin shouting a code blue alert on his radio. He then looked out from his office and could see Charles Kivlin doing chest compressions and then medical staff arriving. This passage of evidence does not accord with the evidence of Nurse KQ who said there was no CPR going on when she arrived. Her evidence accords with the video recording which shows no CPR before the nurses arrive. FLM McAdam said he was up to date with training, having completed a refresher course in December 2014. He had also acted as a C&R instructor in the past, about 10 years before the incident.

The Restraint

[69] The restraint of Mr Marshall was the subject of lengthy and repeated testimony. There were, in all, 17 prison officers of some level involved at one point or another. It is not proposed to review all of that testimony in close detail. I regret to say that, as the evidence emerged, it was apparent to me that there were credibility and reliability issues around the prison officers' police statements, supplementary police statements and oral testimony. Some elements of the evidence from prison officers which could not be compared, contrasted and verified with the video evidence, I have treated with caution.

[70] A particular area of evidence that involved credibility issues concerned the use of feet during the restraint. FLM Fraser viewed the CCTV recordings[27]. He accepted that at 08:19:59 he can be seen to stamp on Mr Marshall. In cross examination for the family he described his own conduct as totally out of order. FLM Fraser identified other officers on the video recording using their feet. The C&R skilled witnesses were quite clear that from what they could see in the video recording, the use of feet was not justified where they saw it occurring and presented a danger in relation to positional asphyxia if breathing was compromised as a result. None of the prison officer staff who gave statements to the police mentioned feet being used in the restraint. In the oral evidence, all of them, with exception of FLM Fraser, began by saying they were unaware of any officer using feet during the restraint. None had previously seen the video evidence. Most changed their position when confronted with the video evidence. Then the almost universal position changed from no feet being used to not having seen feet used. I found it incredible that none noticed feet being used by colleagues on the more than ten occasions that can clearly be seen on the video evidence. The single exception to a blanket denial that feet were used was from FLM Brian Fraser, the last to give evidence. In contrast to his colleagues who maintained they had seen nothing, he admitted that he repeatedly used his feet on Mr Marshall and even admitted stamping on him albeit that in his police statement he had been silent on his use of feet. FLM Fraser went on to say that his use of feet was not justified and, as he put it, "out of order". When asked about this positional change, Mr Fraser explained that he knew before coming into Court to

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give evidence that he would be questioned on the use of feet because his "Q.C. told him". He was not represented by counsel and it might be that he was referring to one or other of the solicitors instructed by the Prison Officers' Association. In any event, I took the view that I could not treat his evidence as spontaneous and unrehearsed.

[71] The Inquiry heard evidence from numerous other prison officers involved in the restraint of Mr Marshall. It was consistently said by them all that Mr Marshall was very aggressive. In the initial struggle he injured a number of staff members. One sustained a broken wrist. Others were bitten. Mr Marshall spat. He was difficult to control with most prison officers asserting he was never under control. The Inquiry was told that restraint usually succeeded after only a few minutes. None of the prison officers had encountered such resistance to restraint before. The prison officers agreed that Mr Marshall displayed unexpected strength which some described as super-human. One said Mr Marshall had the strength of ten men. He maintained resistance to restraint for an unusually long period of time. Most said that in the long service they had as prison officers they had never experienced such a display of strength and endurance. They had never seen such tolerance of pain. They said that Mr Marshall was able to resist C&R holds that relied on pain for effectiveness. They agreed he was wet to touch and hot to touch. He continued struggling throughout. His behaviour had been bizarre. They did not understand it. They did not know what to do. Some described themselves as out of ideas. For the most part, they did not know who was in charge. There were a number of FLMs present. The scene described was one of disarray or chaos. The prison officers who gave evidence of Mr Marshall's presentation repeatedly described

observing all of the warning signs and symptoms which are known to be associated with EDS. None of them said that they made the connection at the time.

[72] In each case, the section in Volume 2 of the C&R Manual[28] dealing with positional asphyxiation, psychosis and EDS was put to the witnesses. They most often claimed a level of ignorance up to complete ignorance. There was a Local Operational Debrief conducted on 31 March 2015. FLMs, prison officers, management and nursing staff attended. The flipchart notes from the debrief session were typed up into a document.[29] It had not been provided by SPS at the beginning of the Inquiry and therefore was not then known to the Inquiry. It follows that the first prison officers to give evidence were not asked about it. The document was put to prison officers giving evidence subsequent to it being lodged. Those prison officers agreed with what is contained within it as being the contemporary views and comments expressed and discussed at the time. The comments within included: "did not feel pain, unable to gain control, the C&R Manual ran out of ideas, confusion over possible cause, unnatural strength, difficult to know who was in charge.

[73] All of the prison officers, including FLMs, said that they were up to date with refresher training and had been at the time of the restraint. One prison officer said he had successfully completed his refresher training only five weeks before he gave evidence. Yet, few could remember much about the warning signs associated with these conditions being taught in training. Some said they remembered nothing of the topic in

[28] Production 23

[29] Supplementary Production 4/3

training. One categorically said it was not included in the refresher training at all. Even after the death having occurred and a number of training opportunities having come and gone, prison officers were unable, when asked before being directed to Volume 2 of the C&R Manual[30], to recall any or some of the warning signs associated with positional asphyxia, psychosis and EDS.

[74] Those officers involved or present when the plasticuffs were applied to Mr Marshall said he that he was still struggling at the time and struggling against them being applied. That is not what appeared from the video evidence[31]. Nor is it consistent with the forensic evidence. There is no struggle obvious. The apparent absence of a struggle at that stage was seen and commented on by Mr Henry and Mr Baskind, the control and restraint skilled witnesses. Some prison officers went beyond merely saying there was a struggle when the plasticuffs were being applied.

[75] Prison officer Charles Kivlin told police that at no point when he was there was anyone on Mr Marshall's back. On viewing the video recording in Court, he had to accept that he himself repeatedly used a foot on Mr Marshall's back, but maintained he saw no other officer using feet. In his initial police statement he made no mention of plasticuffs. In his second police statement, He had said "as soon as the cuffs were applied, I could see the plastic at the joint turning from black to white under the force being exerted by the prisoner, however within seconds, the fight went out of him…" To begin with, under oath, he maintained that he had told the police the truth at the time he

[30] Production 23
[31] Production 22

made the statement. The results of the forensic examination of the plasticuffs by Louise Sonstebo were put to him. In evidence in chief, he was asked whether he maintained the position that the plastic turned white due to strain being applied by Mr Marshall. He initially maintained his position. He then modified his position to say that he was convinced at the time they turned white but looking at the cuffs in court he accepted he must have been wrong. I did not find that evidence credible.

[76] Prison officer Matthew Sim said nothing about plastic handcuffs in his original police statement. In his subsequent police statement, given on 7 April 2015, he told police "I got very concerned when Charlie [Kivlin] told me he thought they [the cuffs] were going to break. Charlie said the black plastic was turning white with the strain".

[77] In his original police statement given on 25 March 2015, prison officer Steven Banks said that he applied the plasticuffs. According to him, prison officers Kivlin and O'Hara each had an arm. It seemed to help the staff as they gained more control. As they were about to lift Mr Marshall, he went limp and the staff responded quickly by not moving him. C&R techniques were maintained and the cuffs were removed. In his subsequent police statement he said that prison officers Kivlin and O'Hara had Mr Marshall's arms behind his back and straight up in the air. Someone suggested they may need two sets of cuffs because Mr Marshall may be able to break them due to his strength. He applied the cuffs and was trying to tighten them while Mr Marshall continued to struggle. The cuffs were on for about 30 seconds when there were concerns about Mr Marshall, observed not to be responding and not moving. The cuffs were removed by prison officer Banks. He said that he saw prison officer Kivlin perform chest

compressions. A code blue alert was sent. Then, about 2 minutes after the code blue alert, medical staff arrived and took over the chest compressions. In neither statement did he mention any discoloration of the cuffs due to strain. During his oral evidence he was prompted as to why he had made no mention of discolouration but others involved had said that it had happened. His response was "I believe there was a degree of discolouration from black to a lighter colour as he strained. I saw that. The cuffs have a certain amount of flexibility. I didn't mention that in my police statements but I do remember it now." It is disturbing that prison officer Banks chose to give false evidence about the plasticuffs changing colour through straining.

[78] Prison officer O'Hara, in his original police statement given at 14:51 on 24 March 2015 said that Mr Marshall was still struggling when the plastic cuffs were placed on him. In his supplementary statement, on 7 April 2015, he said "Prior to the male going limp, he had plasticuffs on him and I could see the plastic turning white with the level of force he was putting on them." In his oral evidence he also changed his position. He was shown the cuffs and accepted that he could see no stretch marks. His position became that, at the time, someone at the back had said the cuffs were stretched and turning white and they were cut off soon after that. People were saying they were stretching and his explanation in court was that he must have heard that. He thought someone said they were stretching. Questioned on behalf of Mr Marshall's family he said, "It must have stuck in my mind that someone said the cuffs turned white. I gave help to put his hands through the plasticuffs then I took my eyes off them. I was looking elsewhere". He further offered the explanation that someone else said that the cuffs turned white

because of strain and that is what "planted the thought in his head". That was what led him to tell the police that he saw the cuffs turn white. He thought, at the time, that he was telling the police the truth. He said that he was trained in the use of plasticuffs. He said that the loops in the cuffs are applied one at a time and tightened one at a time. However, it was clear from other evidence, examination of the cuffs and illustrations within Volume 2 of the C&R Manual[32] (formerly redacted) that the loops have to be tightened simultaneously and cannot be tightened independently. He was asked whether there was discussion among officers in relation to the plasticuffs and them turning white under strain. He told the Inquiry that after the incident he went to the office and then went to the Physical Education (PE) area of the SRU. He sat in a group with other PE prison officers including prison officer Kivlin and they did discuss what had happened. His justification was that they worked in the same area together. There is thus, at least, the possibility if not likelihood that cross contamination of evidence took place. It did not inspire confidence that when presented with the cuffs to examine and introduced to the contents of Louise Sonstebo's report, the evidence of some prison officers was modified and explanations given about how they could or must have been mistaken. It was as disturbing as it was illuminating that, even under oath, I appeared not be getting the whole truth.

[79] In the context of prison officers apprehending Mr Marshall kicking out or biting and injuring them, FLM Fraser conceded it would have been possible for Mr Marshall to have been restrained on his back or upright. He conceded that deploying protective gear

[32] Production 23, pages 377 to 380

to a restraint team in order to reinforce prison officers might have facilitated that. He accepted that he was in charge for most of the restraint. As the person in charge with the duty to observe, he ought to be the witness best placed to describe what took place. His evidence of responsibility corresponded with that of FLM McAdam, both of whom said that FLM Fraser agreed to take over supervision from FLM McAdam when Mr Marshall was still in the shower area. Apart from FLM Fraser and FLM McAdam, virtually all of the other prison officers and FLMs who were involved and gave evidence said that they did not know who was in charge.

[80] FLM Fraser described going to the shower area in response to a call for assistance. He said that for a period of about 25 minutes prison officers struggled to restrain Mr Marshall who constantly struggled every time they tried to put a hold on him. When they tried to use a C&R technique he would move out of it. He was surprised by Mr Marshall's strength and the length of time he maintained the struggle. He could hear Mr Marshall spitting. He heard Mr Marshall shouting. He said that throughout, Mr Marshall was shouting about God and the devil although he could not remember exactly what was said. Mr Marshall did not make any sense. He threatened to defecate on staff. Unlike other prison officers who maintained there was never control, he said that when other staff took over the restraint, they managed to get more control of Mr Marshall. He told the police that maybe four staff members lifted Mr Marshall up and removed him from the room into the corridor. However, he accepted that the video evidence shows Mr Marshall being dragged out of the room across the floor and not lifted. The joint C&R skilled witness evidence was to the effect that little or nothing in

the way of a struggle could be seen on video, including the time when plasticuffs were applied to Mr Marshall. Although it is not apparent from the video evidence, FLM Fraser maintained that Mr Marshall continued to struggle throughout. According to him, Mr Marshall was still struggling on the floor outside the cell it was intended to put him in and that was why it was decided to put plasticuffs on him. He was not sure who applied the cuffs but they managed to put them on Mr Marshall behind his back. Someone then said "I've not felt him struggling". He said that he instructed Mr Marshall to be put in the recovery position and for the cuffs to be cut off. Mr Marshall looked unconscious. He was turned onto his back. FLM Fraser told police that prison officer O'Hara then started CPR chest compressions. However, he accepted, on viewing the video recording, those chest compressions did not happen. It was not until the nurses arrived that chest compressions began and it was the nurses who did them.

[81] A number of prison officers and staff agreed with the solicitor for POA's proposition suggested to them that there was an extended 'out of control moment'. I understood that to mean the period before control was achieved. However, the majority, if not all, of the prison officers involved in the restraint then agreed with the further proposition suggested to them that control was never achieved. That is not immediately apparent from the video evidence once Mr Marshall is out of the shower area. It was the evidence of Messrs Baskind and Henry that Mr Marshall was in fact under control for significant periods during his movement from the door of the shower area to the spot where he suffered cardiac arrest. Mr Baskind observed at one stage that there was not much, if any, struggling going on and very little in terms of serious restraint techniques

being used. Rather, Mr Marshall was being held face down. It was accepted in evidence and was also clear from the CCTV recording that none of the officers involved in the restraint had any clothing ripped. Nor did they appear to be in any way unduly dishevelled.

[82] There are some other particular parts of direct evidence that I consider helpful in informing a view of the overall picture.

[83] FLM Fraser said that he heard utterances from Mr Marshall. He was shouting about God and the devil. Other prison officers who were asked about Mr Marshall saying things or shouting said they heard nothing during the restraint. Some positively maintained that Mr Marshall actually said nothing.

[84] The Inquiry heard from a number of prisoners who were being housed in the SRU at the time of these events. As was the case with prison officers, some of what was said in evidence did not stand up to scrutiny when compared with other evidence. In particular, some of the recollections of physical movements were at best confused when compared to the video evidence. On the other hand, some of the oral evidence did correspond with the video recordings, making acceptance of that evidence more straightforward. Prisoner NW said that Mr Marshall had shouted to prison officers to get off him and that he could not breathe. He heard him screaming. He said that the screaming was "not human". It was an angry scream. He found it very uncanny and worrying. NW could see only a very small amount of what occurred that morning but another prisoner, RM, was providing an ongoing narrative. NW spoke to being aware of a sense of panic among the prison staff at the conclusion of this event. He said he

heard nurses shouting for a doctor. He heard the defibrillator machine instructions not to shock. That is consistent with other evidence. In his statement to the police at the time he had said he had heard Mr Marshall shouting that he couldn't breathe. Challenged in cross examination by then counsel for SPS he maintained that he did indeed hear that being shouted.

[85] RM said that he saw some of what occurred in the corridor outside his cell, being cell 3 as per the schematic layout of the SRU[33]. He spoke to seeing it through the partly open observation hatch in his cell. He was challenged on behalf of SPS with the suggestion that he was lying about being able to see anything out of the hatch. He told the Inquiry that a prisoner could bang the cell door to get the hatch to open a bit and provide a partial view of the corridor. Prison officer Brian Doyle subsequently acknowledged that some prisoners would bang the cell door and thereby succeed in partially opening the hatch cover thus affording a view. Prison officer Doyle said that sometimes the magnet might spring off. Furthermore, it is evident from the video recording[34] that prison officer Paul Hay in fact closes the hatch of RM's cell as he passes it towards the end of the restraint and possibly after cardiac arrest. It is axiomatic that for something to be capable of being closed, it must first be open. The other evidence of RM is unsettling. He said that he heard prison officer Justin White saying "That cunt's mad". He heard slapping, like someone being hit. Dr Ainsworth, in his evidence, confirmed that some of the marks seen on Mr Marshall's body at post mortem were

[33] Production 25
[34] Production 22

consistent with him having been hit. Nurse KQ spoke to seeing numerous marks on Mr Marshall's body and spoke to seeing bruising appearing as she looked on. RM said he saw the boy [Mr Marshall] coming out of the shower room. There was no evidence that he could have known Mr Marshall was in the shower room by any other means than having seen it. He said that he saw Mr Marshall being "dragged" along the section, which corresponds with what can be seen in the video recording. He describes and correctly named a number of the officers that he saw, including FLM MacAdam, prison officer Justin White and prison officer Brian Doyle. He spoke to seeing a stout guy "twisting the boy's arm". He told of another officer with black hair and a PTI polo shirt "hitting the boy in the ribs and the boy [Mr Marshall] making a high-pitched scream". Later he said that Mr Marshall had screamed "like a woman". He described the ending of the struggle, saying that Mr Marshall became a dead weight on the floor. He saw two nurses coming in with a defibrillator machine and he asked twice, through his cell door, if the boy was dead. He shouted; "You fucking murderous bastards. I'll tell the world". He told the Inquiry that he shouted: "You torturing sado-masochistic bastards. You've killed him". "If he is dead them I'm going to tell the world". "If he is dead, you'll need to come in and kill me". He said that he had never before seen restraint with such violence and lack of care for the prisoner. He felt a rage in his eyes because he could not help Mr Marshall. RM said that some weeks after these events he himself was assaulted in prison by prison officers. He felt that prison staff members were trying to discredit him. He felt that they were trying to interfere with his mental health. I asked SPS to verify whether RM had been attacked. After close of the Inquiry, I received confirmation

that RM made a complaint of having twice been attacked by prison officers in June 2015. The complaints were referred to the police and no further action was taken.

[86] There were positive aspects of prison officer Kivlin's evidence that merit being mentioned. Although he was never in charge, it was prison officer Kivlin who suggested moving Mr Marshall out of the shower area to where there was more space. Although it turned out to be an irregular use of plasticuffs that he was aware of at the time, it was his idea that it might be useful to deploy them. No one suggested an alternative plan. Though they may not have had it immediately in mind, the other prison officers involved in the application of the plasticuffs, namely FLM Fraser (ostensibly in charge), prison officer Grant and prison officer McAdam were all aware that plasticuffs, in accordance with the C&R Manual, should only be applied to upright and compliant prisoners.

[87] Prison officer Kivlin went on to describe a restraint situation he was involved in some time after Mr Marshall's restraint, when another prisoner had presented with symptoms of EDS. On that occasion prison officer Kivlin identified the symptoms and it resulted in the officers withdrawing but keeping control. They got the nurses involved. He said that the prisoner concerned came round and was quite unaware of what had taken place. Prison officer Kivlin said that, looking back, he believed that Mr Marshall had EDS. The training he had received from SPS had not succeeded in alerting him to the signs of EDS at the time he had been involved with Mr Marshall. Asked about the allocated 10 minutes for refresher training on the 4 topics (page 252-3 of Volume 2 of the

Manual)[35], prison officer Kivlin said that it might actually only be 2 minutes and that the day of training did not last 8 hours. Asked what he thought he would do were he an instructor he said: "If I were training I'd take as long as is necessary to make staff aware of the consequences of this subject".

SPS Management Evidence

[88] Gillian Walker was SPS National Resilience Manager, Operations Directorate. She was the SPS witness responsible for policy relating to Control and Restraint and was the contact person in relation to EDS. She said that since the incident involving Mr Marshall there had been 10 to 12 EDS incidents, none of which resulted in a fatality. She was the policy owner of C&R. She said that staff members were not health care experts and that reliance was placed on medical expertise. It was her view that the staff should have been making the NHS Prison Healthcare Team aware of Mr Marshall's presentation. She confirmed that, in terms of Prison Rule 91, C&R techniques were to be used only as a last resort. She confirmed that where a prisoner does offer physical violence, prison officers must seek to de-escalate the situation wherever possible. If hands were placed on Mr Marshall at all, including come along holds, that constituted the use of C&R and generated the need for a NHS healthcare assessment and for completion of a Use of Force Form. Mr Marshall ought to have been seen by healthcare staff at the SRU in terms of it being a Rule 91 referral. She said that now, following staff reporting that C&R techniques were not working in situations where unusual strength

[35] Production 23

and pain resistance were shown, a review of the C&R holds in the C&R manual had been carried out. The review was not presented to the Inquiry and I was not told the result or whether it had been implemented as at the time she gave evidence. Questioned on behalf of SPS, she said that the circumstances of Mr Marshall's restraint and death were a very significant incident. There had never previously been a restraint death to her knowledge. She received monthly incident reports and intelligence. CREW, she explained, is a harm reduction and outreach charity based in Scotland that provides guidance on psychoactive drugs. The organization publishes documents and guidance for the use of other organizations. CREW information was circulated within the prison estate. She was responsible for introducing leaflets. GMA 048A/16[36] was such a leaflet. It names her as the contact but it was not prepared by her. It was introduced following Mr Marshall's fatality. She accepted that it was more detailed than what was currently in the C&R Manual.

[89] C&R manual volumes 1 and 2[37] were first introduced in 2000. They were revised in 2012 and the revised versions introduced in 2013. Using Volume 2 of the C&R manual, training was provided to prison officers by C&R instructors in annual refresher courses. The course included a module relating to four medical conditions that may be triggered or exacerbated by the use of force and the signs associated with each condition. The conditions are: Positional Asphyxia, Excited Delirium, Psychosis and Sickle Cell disease. There was evaluation at the end of the course. C&R instructors had

[36] Production 2/1
[37] Production 23

themselves been trained in the delivery of training and assessed. Since the death of Mr Marshall no changes had been made for C&R instructors in relation to C&R training.

[90] Asked about Volume 3 of the C&R Manual[38], used by SPS training college for new recruits, which had come to light during the Inquiry and which has the same introductory date as Volumes 1 and 2, she denied prior knowledge of it. She said "we" were not aware that the college had a Volume 3. That is particularly unfortunate given that there is greater specification relating to the medical conditions and the associated risks in Volume 3 than there is in Volumes 1 and 2. There was no explanation why the extent of the information included in Volume 3 should be absent from Volume 2. It thus became obvious that SPS had within its organization fuller information to impart within training than what was included in refresher courses attended by those prison officers involved in the restraint. (See Mr Baskind's supplementary report)[39].

[91] This witness confirmed that there was no provision within the C&R manuals for the use of feet by a prison officer and, according to her, there was no need to develop a technique. She went on to say that there was no bar on feet being used.

[92] In relation to Governors & Management ACTION (GMA)s, she said that they could be accessed electronically by all members of staff, who were expected to keep up to date. There was no general audit to determine whether the particular GMA had been accessed by any member of staff. There was no way of telling whether prison officers had accessed the documents or read them.

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[38] Supplementary Production 6/1

[39] Supplementary Production 6/4

[93] Following completion of Gillian Walker's evidence information came to the attention of the Inquiry that there had been mention of the existence of Volume 3[40] in a preliminary email exchange between SPS and the Crown, which was not pursued, thus allowing Volume 3 to drop from the preliminary discussion relating to productions. There was also later produced to the Inquiry completed attendance records and successful refresher course completion documents in respect of all of the prison officers who had been involved in the restraint. The documentation took the form of a series of tick boxes verifying completion of modules. In each case the prison officer concerned had certified that he or she had received training, including training on the four medical conditions associated with C&R. In each case the prison officer had been certified competent. Each prison officer had countersigned the document.

[94] Paul Hay, C&R Staff Training Manager, was the refresher trainer for all staff. He said that the day course takes 6 to 8 hours and covered all the material in the C&R manual. Training had not changed since 2012/14. It is devised by the Operational Risk Management (ORM) team. They were responsible for allocation of 10 minutes to training on the four medical conditions associated with C&R. Trainers go by the Manual. Referring to the module within Volume 2 of the C&R Manual relating to the 4 medical conditions associated with restraint[41], he confirmed he was in charge of delivering training and said that he was satisfied that the 10 minutes allocated to training on the

[40] Supplementary Production 6/1
[41] Production 23, pages 252 to 255

conditions was sufficient. He said that trainers were audited by the SPS College and assessed annually. He feeds information into the college.

[95] He agreed that GMA048A/16[42] contained greater information on symptoms associated with EDS and the risks involved than was provided in Volume 2 of the C&R Manual[43]. It gave specific guidance. That was not currently included in Volumes 1 and 2 of the C&R Manual. He had taken it upon himself to make up a PowerPoint presentation[44] with slides that replicated GMA048A/16[45] for use in refresher training. He said that he shows the slides during training on EDS from the Manual. He did that following the death of Mr Marshall because he thought it was important. As well as showing the PowerPoint slides he hands round a laminated copy of the GMA to learners. That inclusion of information from the GMA is the only deviation from the manual. He did not know if other establishments had replicated the use of the GMA in this way. He had thought that Operational Risk Management would want to know the GMA was out there for everyone. He contacted ORM for permission to use his PowerPoint presentation and was told that he could do so but that they were not changing the national product. It had been used by him in his training each year since 2016. He said that the GMA was published for everyone to read. There was no means of acknowledging it has been read simply through publication of it and no way of checking readership. There was no audit. He was aware that some prison officers felt there was

[42] Supplementary Production 2/1
[43] Production 23
[44] Supplementary Production 6/2
[45] Supplementary Production 2/1

not enough training on EDS and he confirmed that no changes had been made to the C&R manuals.

[96] He was directed to Volume 3 of the C&R Manual[46] and said that he had not previously seen it. He thought, from the college course descriptor, that it was for new recruits. He confirmed that it contained more information on the four medical conditions, and he could not explain why. He was unable to speak further about Volume 3 and suggested that the Operational Risk Management Team and college could give more information.

[97] Asked about the constitution of removal teams, he said that prison officers should know what to do and there should be an FLM in charge. The FLM in charge was an independent witness who directs actions and should not get involved in the removal. If a prisoner displays symptoms when in his cell he should be left there. It is the safest place for the prisoner.

[98] He said that the Marshall incident sent shock waves through the prison. Surprisingly, he said he was satisfied that all prison officers were fully aware of EDS and what to do when it arises. He said that he would be surprised to learn that some prison officers did not know of EDS. When asked, he could not explain why the prison officers who had given evidence had deficient knowledge of EDS. It was put to him that one prison officer who said in evidence that he did not know about EDS had completed his annual training only five weeks before giving evidence. He could offer no explanation for that.

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[46] Supplementary Production 6/1

[99] His position was that if a prisoner was in a cell and was displaying symptoms associated with the medical conditions, the prisoner should be left in the cell and NHS assistance summoned. If symptoms are observed it was possible to call the GMA up on a computer.

[100] If there was a need to move a prisoner from A to B, that amounted to a planned removal. If violence breaks out there is a need to get control in order to de-escalate. FLMs should have back up plans.

[101] He said that prison officers were not medically qualified. If symptoms were apparent the prison officer should refer to the medical team. He tells prison officers what to look for in identifying symptoms associated with psychosis and EDS.

[102] Lesley McDowall, Health Strategy and Suicidal Prevention Manager, was questioned on whether prison officers were qualified to made clinical assessments of prisoners. She said it was not for staff to seek to effect a clinical assessment or to seek to identify the level of risk to which a prisoner might be exposed. Those were clinical functions that required to be carried out by medical staff. She referred to GMA 079A/14[47], which makes provision for the "Management of an Offender at Risk due to any Substance". She said that seeking medical advice, including advice from a doctor out of hours or from medical staff in the prison, was mandatory in all cases where an individual is suspected to be under the influence of drugs. On being pressed, she said that any level of suspicion of intoxication, however seemingly trivial, should trigger the process. She went on to say that over 2,000 such "processes" happen each

[47] Supplementary Production 4/8A

year across the Scottish Prison Estate. She was referred to a CREW document dated August 2014[48] and confirmed it was in force at the time of Mr Marshall's restraint. The document relates to "New Psychoactive Substances". At page 14 there is a section dealing with Drug Induced Psychosis. She confirmed that the advice given included: "If you are required to deal with a psychotic situation…. Do not attempt to restrain the person. This can increase strain on the heart."

[103] Rev Sheena Orr was the chaplaincy advisor at the prison. She acted independently. She explained that her function included religious aspects and she also had a pastoral role. Prisoners could be referred by a member of staff. It was up to the staff to involve her. She might see people in a life crisis. Family emergencies could happen at any time. It could be appropriate to involve her when there is a mood change in a prisoner or the prisoner becomes particularly upset. It was possible to call her on an emergency basis but that had never happened. She had only once been asked to see someone who had been quoting scripture. It would be open to a chaplain having visited a prisoner to suggest healthcare intervention. She thought there could be a greater role to be played by the chaplaincy service in relation to pastoral case.

Discussion

[104] Prior to his unusual behavior reported by Mr Marshall's cell mate, RR, Mr Marshall had been quiet, normal and kept himself to himself. It follows that his new behavior was abnormal for him. There were opportunities for prison staff to take some

[48] Supplementary Production 4/2

action. As a first step, given the religious or spiritual connotations, assistance could have been sought from the chaplaincy adviser, Rev. Sheena Orr. She may have been able to provide some assistance. She was aware that people who are unwell sometimes make biblical references. It would be open to her, having visited a prisoner such as Mr Marshall, to suggest healthcare intervention. Although Mr Marshall made religious/spiritual references then and throughout, there is no evidence at all that any members of SPS staff considered obtaining chaplaincy assistance. That might be an issue that requires consideration by SPS. It would not be appropriate for there to be a culture that necessarily considers religious practices or beliefs to be psychotic.

[105] According to the evidence led from SPS Management, all the prison officers involved with Mr Marshall had been annually trained in recognising and dealing with four medical conditions that may be triggered by or exacerbated by the use of force. They were all up to date with that training and had been certified as competent. The conditions and instructions in regards to them are included in Volume 2 of the SPS C&R Manual[49]. Psychosis is one of the four conditions. Psychosis is described in the materials as a general term to describe mental conditions in which there is loss of contact with reality. The warning signs are listed as: "mental condition in which there is loss of contact with reality; may be extremely suspicious; believe their personal safety is under threat; then become extremely frightened and agitated; may become physically aggressive and violent." The instruction to the trainer in Volume 2, which the Inquiry was told was passed on verbally to prison officers during training, is: "IF

[49] Production 23

PRACTICABLE: if it is considered that a prisoner's abnormal behaviour may be due to mental illness or drug abuse, advice should be sought urgently from health care staff before C&R techniques are employed, if possible…"

[106] It was repeatedly said in evidence that prison officers (including FLMs) are not medically qualified to make a diagnosis of psychosis. That is undoubtedly true. However, that is not what is required of them. They are required to observe signs and symptoms that correspond with those described in Volume 2 of the Manual[50]. If they come across those signs or symptoms, then that is the gateway to considering that the abnormal behaviour may be due to mental illness or drug abuse. I consider later whether "abnormal" might need clarification within the C&R Manual.

[107] Insofar as the exercise is not a medical one but matching behaviour with specified criteria, there is no reason why the Inquiry cannot look to the evidence led of behaviour and consider whether, on the facts proved, involvement of SPS Prison Healthcare staff advice might have made a difference. In my opinion the behaviour described by RR and passed on to prison officers, in the absence of some other explanation, clearly corresponded with some of the specified signs. There was no evidence that it was impractical for urgent advice to be sought from NHS Prison Healthcare staff. On the evidence led, that could and should have been done. That failure to identify and act upon the warning signs displayed by Mr Marshall was one of a series of lost opportunities that might have interrupted the sequence of tragic events that led to Mr Marshall's cardiac arrest and subsequent death.

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[50] Production 23

[108] The next pertinent event relates to Mr Marshall's behaviour during the night shift in Glenesk Hall on 24 March 2015. Set out earlier in this Determination, there is clear evidence of Mr Marshall behaving in ways that correspond with even more of the warning signs associated with psychosis in terms of Volume 2 of the A&R Manual[51]. Prison officers made direct observations of Mr Marshall's abnormal behaviour. Apart from it being night shift with limited staff, there was no evidence that it was impractical for there to be urgent advice sought from NHS Prison Healthcare staff. There was an on-call doctor available. There is evidence that a decision was made by prison officers to leave dealing with Mr Marshall until the day staff came on duty. Another lost opportunity.

[109] The day shift members of staff who took over on 24 March 2015 were in a similar position to the nightshift staff in terms of Mr Marshall's presentation. Mr Marshall's behaviour corresponded with warning signs for psychosis. One difference on this occasion was that the intention had been formed to move Mr Marshall to the SRU using C&R holds. Apart from convenience, there was no urgency that rendered it impractical to have Mr Marshall assessed by NHS Prison Healthcare staff before he was moved to the SRU. This chapter draws circumstances closer to the physical restraint that led to Mr Marshall's cardiac arrest. The proposition that had NHS Prison Healthcare staff been summoned then the sequence leading to Mr Marshall's cardiac arrest may have been broken is repeated. Another opportunity was lost.

[51] Production 23, page 253 to 254

[110] When Mr Marshall was handed over to the SRU staff information was passed about him having been violent in the smashing up his cell and had then calmed down. There is evidence, which I accept, that information about his bizarre behaviour was passed to the SRU staff. As above, SRU prison staff, on becoming aware of Mr Marshall's abnormal behaviour in respect of displaying signs associated with psychosis, ought to have requested NHS Prison Healthcare staff assistance. FLM McAdam said that he suspected Mr Marshall may have taken drugs. That raised a separate requirement in terms of GMA 079A/14[52], dated 30 December 2014 and in force at the time (Management of an Offender at Risk due to any Substance – Policy & Guidance). The GMA defines "Substance" thus: "A substance could be an illicit drug, new psychoactive substance, prescribed medication, alcohol or chemical". It provides that during normal working hours, upon identifying an offender who is suspected of being at risk due to a substance (due to intelligence or presentation) the member of staff should complete the Observations referral and notify Healthcare staff, provide the offender's details and describe how the offender is presenting. The staff member should request that Healthcare staff attend the scene immediately to assess the offender or escort the offender to the Health Centre. The GMA author was Lesley McDowall. Accordingly, FLM McAdam having made the observation that he had made was under a requirement to request the immediate attendance of Healthcare staff. Had he done so, Mr Marshall would not have entered the shower area when he did and the sequence of events might have been interrupted.

[52] Supplementary Production 4/8A

[111] Mr Marshall's behaviour in the shower area before hands were placed upon him raised suspicions relating to his mental state among prison officer staff members. There was a considerable amount of evidence relating to prayers, chanting, singing and bizarre behaviour. There were comments made by Mr Marshall that were not sensible. On the basis of the warning signs associated with psychosis, there appears to have been an abundance of evidence to trigger the involvement of NHS Prison Healthcare staff in terms of C&R training. That did not happen. There was no evidence of it occurring to any member of the prison officer staff (including FLMs), that they ought to immediately summon Healthcare assistance. A further opportunity was lost.

[112] Yet another opportunity was lost when the shower area door was opened in order to execute a planned extraction of Mr Marshall. Mr Marshall retreated to a corner of the shower area between a shower cubicle and a Belfast sink. He moved away from the door. That retreat is similar to Mr Marshall's presentation in Glenesk Hall when the cell door was opened. He appeared to prison officers to be scared. He adopted a martial arts type stance. There was evidence of his presentation appearing defensive and aggressive. He asked prison officers if they had come to stab him through the heart. On the account of some prison officers Mr Marshall challenged them to advance. The signs said to be associated with psychosis were obvious and it is worth a reminder of them here; mental condition in which there is a loss of contact with reality; may be extremely suspicious; believe their personal safety is under threat; then become extremely frightened and agitated; may become physically aggressive and violent. It appears that, on the evidence, Mr Marshall was at that point displaying a full set of the psychosis

warning signs. He was also displaying signs associated with EDS, some of which are common to both psychosis and EDS. According to Volume 2 of the C&R Manual, Excited Delirium is both a mental state and psychological arousal. Excited Delirium can be caused by drug intoxication (including alcohol) or psychiatric illness or a combination of both. According to the skilled evidence presented to this Inquiry it is a syndrome, that is to say a group of concurrent symptoms or a characteristic combination of behaviour. It was pertinently described as "a toxic mix". Knowledge and understanding of the syndrome has grown considerably over recent years. It has grown since the C&R Manual was published. SPS knowledge was greater at the time of Mr Marshall's restraint than was reflected in the C&R Manual. Understanding has developed further, leading to GMA 048A/16[53], which contains greater information on symptoms associated with EDS and the risks of death involved. It provides specific guidance. Within Volume 2 of the C&R Manual[54], in force at the time of the restraint, the listed warning signs were: have unexpected strength and endurance, apparently without fatigue; show an abnormal tolerance of pain; feel hot to touch; be agitated; sweat profusely; be hostile; exhibit bizarre behaviour and speech. The action prison staff members are directed to take is the same as that mentioned above for psychosis, namely urgently seek advice from health care staff before C&R techniques are employed, if possible. On the evidence, Mr Marshall was also displaying some of the signs associated

[53] Supplementary Production 2/1
[54] Production 23

with EDS. He was agitated. He may have been exhibiting hostility. He was exhibiting bizarre behaviour and speech.

[113] Had the prison officer staff involved realised they were seeing signs of psychosis and/or EDS they were under instruction to summon Healthcare advice before C&R techniques were employed, if possible. The evidence was that it was possible. The prison officers could have come back out of the door, closed and locked it, and summoned NHS Prison Healthcare assistance. Questions arose in the course of the evidence relating to the security of the shower area. It could be and was locked. Outwith the shower area, the corridor was secure and locked. The Inquiry heard that the lock on the shower area door was not as robust as those on cell doors. In response to the suggestion that Mr Marshall could have been kept locked in the shower area while NHS Prison Healthcare was summoned it was said he might have harmed himself. I was not persuaded by that since he was, in fact, left in the shower area unattended for a period of time with seemingly no concern. I found it somewhat disingenuous to suggest that the security of the shower area suddenly became such an issue that there would not have been time to safely request NHS Prison Healthcare assistance.

[114] The evidence is that it did not occur to any of the prison officers to make a connection with possible psychosis and/or EDS as a result of observing the warning signs and therefore summon SPS Prison Healthcare assistance. There appears no question at this point of any animosity towards Mr Marshall. At most he was inconveniencing the prison officers. Prior to the commencement of the physical altercation, a final opportunity to interrupt the sequence of events was lost.

[115] What followed next was the prolonged restraint of Mr Marshall that led to his cardiac arrest. The part of the restraint that occurred in the shower area is not captured on video. The only video evidence is of prison officers entering, leaving and lingering outside the shower area in conversation. What can be verified is that Mr Marshall compliantly entered the shower area. I accept that the evidence from a number of the prison officers that he asked whether the officers wanted to stab him through the heart as he entered the shower area and then made the utterances he is said to have made including biblical references and religious singing and incoherent chanting. These made no sense to the prison officers. After a period of time, SRU prison officers can be seen to enter the shower area. Soon afterwards, a number of other officers rush to the scene and enter the shower area. The officers were each identified during the evidence. Although the precise sequence is not agreed among prison staff witnesses, I accept that hands were laid upon Mr Marshall and that he reacted violently. In the immediate struggle that followed within the shower area one officer received a broken wrist trying to restrain Mr Marshall. Two other officers were bitten by Mr Marshall. Mr Marshall received a large number of injuries, some of which have not been adequately explained. There is no explanation for the injuries to his feet seen by Nurse KQ. He received a cut to his face above his eye. It was said that that the facial injury was self-inflicted when Mr Marshall intentionally hit his own head onto the floor in the shower area. However, no history of prior self-harming was presented to the Inquiry.

[116] Although there is evidence from prison staff of a struggle continuing within the shower area, following the response to calls for assistance prisoner officer staff can be

seen coming and going with some lingering in conversation outside the door to the shower area. The video evidence[55] does not present a picture of urgency.

[117] Once Mr Marshall is outside the shower area and in view of the video cameras there is video capture of what occurs. Prison officers spoke of a continuing struggle to control Mr Marshall. Some resistance against restraint can be seen, particularly to begin with, but the level of restraint the prison officers referred to seems exaggerated. Once out into the corridor, apart from limited sporadic movement, there is no video verification of a continuing energetic struggle that the prison officers gave evidence about. The prison officers said that they struggled to apply recognised holds on Mr Marshall but the C&R skilled witnesses, on viewing the video recordings, said that they could not see much evidence of recognised holds being attempted. They saw Mr Marshall being held down and slid across the floor. They identified one point at which Mr Marshall struggles when he raises his buttocks up from the floor and a foot is employed to push him back down. So far as timing is concerned, that broadly corresponded with the evidence of prisoner NW who heard Mr Marshall shout get off and shout that he could not breathe. Other inmates spoke of Mr Marshall screaming. I accept that evidence. The video evidence and evidence of Mr Marshall shouting out introduces to the overall mix the question of positional asphyxia. Within Volume 2 of the C&R Manual[56] positional asphyxia is defined as occurring when the position of the human body interferes with normal respiration, resulting in asphyxiation. The warning

[55] Production 22
[56] Production 23

signs include gurgling, gasping sounds; prisoner complains of being unable to breathe; a violent and loud prisoner suddenly becomes passive, quiet and tranquil. The C&R skilled witnesses, Mr Henry and Mr Baskind, explained that when a prisoner is struggling to breathe because of prone restraint there is greater energy expended to get breath which in itself creates a greater demand for oxygen supply, and so on. It is worthy of note here that the information contained within Volume 3 of the C&R Manual (not originally available to the Inquiry but in existence at the time of Mr Marshall's restraint) contains pertinent detail on the risks associated with positional asphyxia that went significantly beyond the information imparted to prison officers within the Volume 2 refresher course. As set out on slide 112 within Volume 3 of the C&R Manual[57]: Positional Asphyxia can occur when a prisoner is laid face down on their stomach and pressure is applied to their back or is placed in any position that inhibits respiration; confined spaces; a prisoner is handcuffed and left lying on their stomach. It also sets out that the risk is increased if the prisoner is intoxicated with alcohol or drugs; has a history of mental disorders; has previously, through violent activity, expended much physical energy and is suffering respiratory fatigue. It is specified that the risk may be reduced by avoiding putting direct pressure on the back or spinal area of the prisoner; achieving a kneeling or standing position as soon as practicable; monitoring vital signs. The slide goes on to specify that medical assistance should be got IMMEDIATELY if officers have any concerns about the condition of the prisoner. While there is clear evidence that Mr Marshall was restrained in the way cautioned against, as

[57] Supplementary Production 6/1

can be seen on the CCTV recording, it is not possible, in the absence of unequivocal medical evidence, to reach a conclusion that positional asphyxia directly led to his death. However, it is clear that it formed part of the 'toxic mix' suggested by the C&R skilled witnesses.

[118] The evidence was that there was little or nothing in the way of recognised C&R holds being applied and no attempts to de-escalate. Mr Marshall was being held to the floor and slid towards the target cell. Throughout the restraint period Mr Marshall was displaying warning signs associated with EDS. The prisoner officer staff showed no recognition of these signs. They all said that they had no idea why Mr Marshall was presenting with unexpected strength and endurance and showing abnormal intolerance to pain. They did not know what to do about that.

[119] It is clear that the plasticuffs should not have been applied to Mr Marshall when he was prone. That was contrary to C&R requirements for their use. The prison officers involved knew that but, out of ideas, thought it might assist in getting control. They had said in evidence that Mr Marshall had bouts of strength and then periods of passivity. On the video and other evidence there is no obvious struggle going on when the plasticuffs are actually being applied. Rather, it appears that the plasticuffs might have been applied to Mr Marshall after he had suffered the cardiac arrest. If that is correct, the prison officers involved did not appear to realise Mr Marshall had already suffered the cardiac arrest or at least did not immediately respond to it. For Mr Marshall the critical time towards successful resuscitation without permanent brain damage through oxygen starvation was running. The prison officers involved in restraining him were reluctant to

release him. They said that they were expecting a further burst of energetic resistance. It took some time for it to be realised that Mr Marshall had suffered a cardiac arrest. It is impossible to accurately measure that time period because it is not known precisely when Mr Marshall suffered the cardiac arrest. Once realisation dawned, the plasticuffs were removed. A code blue alert was made. It is not known how much time passed from the cardiac arrest and the alert. The precise timing of the alert is not known. That is because the recording of the alert was destroyed. That is something that ought not to be able to occur. In response to the alert, medical staff rushed to the scene. It is clear that the delay in the nursing staff getting to Mr Marshall was only in the order of about two minutes. It was only after they arrived that CPR was commenced. Up until that point, members of prison staff in excess of 10 in number were around Mr Marshall and he was still being held to the floor. Mr Marshall was eventually resuscitated and recommenced breathing. As already discussed, it is not precisely known, and cannot be ascertained, for how long he was not breathing and during which time no oxygen was reaching his brain. It was too long a period. On the medical evidence, it was the period of oxygen starvation to the brain that directly caused Mr Marshall's death.

Conclusions

[120] It is central to a fatal accident inquiry to establish the truth. Getting to the truth was hampered in this Inquiry. The early attitude presented on behalf of SPS was unhelpful. During the preliminary hearings SPS resisted producing complete control & restraint materials and produced training manuals with parts redacted. Faced with what

came close to a refusal, I had to insist in the provision, to me, of unredacted materials and ultimately ordered that some of the redacted material had to be produced. It was argued that the redacted material amounted to "intelligence", which it clearly was not. After examination of the unredacted material it was apparent to me that some of the redacted material was relevant to the Inquiry (for example information relating to the proper use of plasticuffs). It turned out that some of the material was not only relevant but particularly helpful in understanding what had taken place. Particularly within the modern FAI Rules, I do not think that it can be left to SPS to choose to redact. For an Inquiry to be properly case manged it important that the sheriff is made aware of all relevant material at the earliest opportunity and that any proposed redaction is discussed at the preliminary hearing. If SPS had wanted to redact any material, the information should have been available in full at the preliminary hearing stage when representations could have been made in connection with withholding any part of the information.

[121] There were some other documents and information in the hands of SPS that ought to have been available before the start of the inquiry and were only made available during the inquiry. For example, one such document related to specific instructions to obtain medical assistance if a prisoner was thought to be under the influence of drugs. The absence of that document at the start of the Inquiry resulted in some prison officers not being asked why they did not take a particular course of action. There was also a written account of an operation debrief that took place after the accident and before the police had returned to take fuller statements from prison offices

following Mr Marshall's death. It is hard to understand why it did not occur to SPS or their advisors that such a contemporaneous account would be relevant and helpful to the Inquiry in establishing the truth. Two volumes of the SPS Control & Restraint Manual were produced to the Inquiry. It came to light that there was a third, which contained greater detail and more comprehensive instruction than the other two.

[122] It was clear that prison officer staff did not tell the whole truth on a number of occasions. Sometimes they appeared to be mutually and consistently dishonest. I have made mention of my misgivings earlier in this determination. The result is that, except where there was verification, for example from the video recordings, establishing the veracity of the oral evidence was difficult. As has recently been established in Scottish criminal law, I approach the video evidence on the basis that I may accept the interpretation on it provided by witnesses and find that helpful. Equally, having viewed the video recordings, I am entitled to form my own view on what is contained. While I do not believe that any of the prison officers involved in the restraint of Mr Marshall intended his death, it is true that he sustained many injuries during the restraint. It also appeared clear from the evidence led that, at least some of, the prison officers were actively reticent in providing their evidence to the Inquiry.

[123] From early presentation when he shared a cell with RR, Mr Marshall was observed to be acting strangely and abnormally by prison officers. Volume 2 of the SPS Control & Restrain Manual[58] sets out warning signs associated with psychosis, described as a mental condition in which there is a loss of contact with reality and the prisoner

[58] Production 23

may be extremely suspicious. The advice in Volume 2 of the Manual is: "If it is practicable, if it is considered that a prisoner's abnormal behaviour may be due to mental illness or drug abuse, advice should be sought urgently from healthcare staff…" It was said repeatedly in evidence that prison officers are not medically qualified and not equipped to make a diagnosis of psychosis. I accept that must be correct. However, the prison officers are not being directed to make a diagnosis. That is for the medical staff. They are directed to spot warning signs and when they do, refer the matter to healthcare staff. In that regard, on the face of it, I am as well equipped to consider whether Mr Marshall's presentation, from time to time, corresponded with the warning signs criteria. There can be little doubt that it did and therefore might have properly triggered a referral to healthcare staff. However, the instruction makes matters more complicated. There are gateways. The prison officer has to consider whether the prisoner behaviour is abnormal. That might be easier for a prison officer who has a long standing knowledge of the prisoner's behaviour. It is less straightforward in a situation where the prison officer has had little to do with the prisoner or where the prisoner has not been in the prison long enough for a profile to be constructed; for example in the case of a remand prisoner. As I understand the evidence, there is no formal method of logging such a prisoner's presentation to perhaps pass on to the next shift. The next gateway is an assessment by the prison officer of whether the prisoner's behaviour may be due to mental illness or drug abuse. The drug abuse suspicion might be easier if drugs are actually found. In the absence of such, it appears that prison officers are being directed to make an assessment that seems more appropriate for a medical professional.

There is a final gateway. If prison officers have got the distance of considering advice should be sought urgently from healthcare staff it is to be done if "practicable".

[124] There are a number of occasions before his eventual physical restraint when Mr Marshall displayed warning signs that correspond with the psychosis criteria set out in the Manual. Had there been a referral to healthcare staff on any of them, the chain of events that finally led to Mr Marshall suffering a cardiac arrest might have been interrupted. In the absence of any medical assessment of Mr Marshall in life, it is not possible to be more specific. However, I do think that these several occasions should be considered as lost opportunities. That leads me to consider the terms of the instructions. It is a system. In my opinion it is a system that could be simplified and improved. It is recommended that SPS give consideration to reviewing the instruction in the C&R Manual (or elsewhere) relating to psychosis such that observation of any warning signs associated with psychosis is a necessary trigger to require urgent healthcare advice being sought. That would remove from prison officers the responsibility to make a value judgment they might not be equipped to make.

[125] A suspicion of drug abuse already has another set of instruction attached to it as well as the consideration of possible psychosis. Those instructions are contained in GMA 079A/14[59], which was in place at the time of Mr Marshall's accident. In terms of those instructions, if a prisoner is suspected of having taken drugs the prisoner must be immediately referred to prison healthcare staff, including the on-call doctor if it is out of hours. Two issues arise. Firstly, it can be confusing to have two competing instructions

[59] Supplementary Production 4/8A

to prison officers. It is recommended that SPS give consideration to ensuring that there is consistency within the advice or instructions contained in GMAs and the instructions in all volumes of the C&R Manual to ensure that there can be no confusion about the circumstances to trigger a requirement for seeking NHS Prison Healthcare advice.

[126] Secondly, on the evidence, SPS have no way of determining whether any prison officer has read and understood instructions contained with a GMA. There arises an obvious difficulty. If prison officers are expected to comply with instructions within a GMA then there needs to be a method of ensuring that they read and understand the contents and that needs to have some sort of audit. It is recommended that SPS give consideration to the introduction of a system of working that ensures prison officers have read and understood any advice or instruction that is contained within a GMA directed towards them. This applies to any GMA that prison officers are required to follow and, in particular, I mention GMA 048A/16[60], which was issued following the death of Mr Marshall. That GMA provides clear instruction on EDS and specifically instructs that there might arise an emergency risk to life, an important feature missing from the existing C&R instructions. It is recommended that SPS give urgent consideration to revising all versions of the C&R Manual to include the information and advice contained in GMA 048A/16. Understanding of EDS is rapidly expanding. The module in the C&R Manual in relation to the four medical conditions that can be caused or exacerbated by the use of C&R techniques, and which carry the risk of fatality, exists uncomfortably within a manual otherwise dedicated to the techniques themselves. It is

[60] Supplementary Production 2/1

recommended that SPS give consideration to separating out from the C&R Manual the training module relating to the four medical conditions that may be triggered or exacerbated by the use of force and delivering that training separately from C&R training.

[127] From the combination of medical opinion from Dr Torrance, Dr Behan and Dr Nichol it can be inferred that Mr Marshall, at the time of his restraint, was not suffering from drug induced psychosis. Considering the evidence from numerous sources regarding the classic symptoms of EDS, including those most specific to the condition – physical strength, the lack of fatigue and resistance to pain and the direct evidence from those involved in the restraint, I am satisfied on the balance of probabilities that Mr Marshall was suffering from EDS during and at the end of his restraint. No clinical examination was made of him in life and none is needed to reach that conclusion. As a syndrome, the syndrome comprises a collection of symptoms. They are listed in Volume 2 of the C&R Manual[61]. Prison officers repeatedly gave evidence that Mr Marshall was displaying many if not all of the symptoms. Some of symptoms are common with symptoms associated with psychosis. Mr Baskind and Mr Henry referred to psychosis as a pre-restraint indicator for EDS. Prison staff members are refresher trained annually. Part of that training involves recognising the warning signs or symptoms associated with psychosis, positional asphyxia and EDS. According to the training module in Volume 2 of the C&R Manual, as at the time of the restraint, prison officers were directed to consider whether a prisoner's behaviour was abnormal. Mr Marshall's

[61] Production 23

abnormality was a view reached by all the prison officers once they engaged physically with Mr Marshall and experienced his unexpected strength and endurance, apparently without fatigue and his abnormal tolerance of pain. The prison officers also all spoke of observing the other signs associated with EDS. According to the C&R instruction, if they observed the signs they should have sought urgent advice from health care staff before employing C&R techniques, if possible. Looking to the listed signs, it might only have been those signs that are generally common with psychosis that were apparent before the physical struggle. Once techniques are employed, prison officers are directed to de-escalate the techniques at once and immediately seek medical advice, if a medical emergency occurs. It is not clear within the instructions how the prison officers are to identify when a medical emergency has occurred. As was pointed out by the C&R skilled witnesses, once a restraint exercise has begun officers would be focussed on ending it by being successful and then de-escalating. They expect the C&R techniques they have learned to work and to be able to bring a prisoner under control within a few minutes. It is difficult to disengage while the restraint exercise is continuing. At the beginning of the restraint some prison officers were injured as a result of attempting C&R techniques that did not work. I have no doubt that influenced those who relieved them. When the others arrived and took over they knew Mr Marshall had the capacity to injure them but they were not prepared for the show of strength and endurance they encountered. Even if an opportunity to disengage had presented itself, none of them claimed to be actively conscious of the mortal danger to Mr Marshall and the medical emergency that had already arisen. In the violent exchange, the possibility that

Mr Marshall might be suffering from EDS did not occur to any of them. For them, the sole focus of the exercise was to continue until Mr Marshall was contained and within the target cell. It is recommended that SPS should give consideration to urgently including within the C&R Manual, or other training materials if created, the information contained in Annex A to GMA 048A/16.

[128] It is apparent from the evidence led and the video evidence that the prison officers did not expect Mr Marshall to suffer a cardiac arrest. Realisation can be seen to dawn on those present. They appeared paralysed, perhaps by the realisation that the violent struggle they had participated in seemed to have ended in a death. The paralysis might go some way to explain why CPR did not commence immediately. The initial oral evidence from each prison officer who was asked was to the effect that the plasticuffs placed on Mr Marshall were cut off as soon as it was noticed Mr Marshall had gone limp. He was then put in the recovery position and prison officers commenced CPR. The difficulty with that evidence is that it is not what appears on the video recordings. On the video recordings Mr Marshall appeared limp before the plasticuffs were applied. After they were eventually removed he was placed on his back and restraint continued. No prison officer got involved in CPR. It did not commence until the nurses arrived some two minutes after the code blue alert, whenever that was. The prison officers were apparently wrong about the timings. It is difficult to reach any conclusion other than a joint lack of candour. Taking all the evidence together, it is established that Mr Marshall was oxygen starved for too long. It is that period of oxygen starvation following his cardiac arrest that led to the permanent and irreversible brain damage he suffered.

Because it is impossible to precisely fix the time Mr Marshall stopped breathing it is impossible to sufficiently relate any particular period of delay to the ultimate outcome. It might have helped unravel these facts had the code blue recording and the timing of it not been destroyed by SPS. It is recommended that SPS give consideration to introducing a system of working whereby there is always at least one staff member within a removal team who is a first responder and that there is a designated duty for that prison officer to respond and administer CPR when an appropriate situation arises.

[129] It is recommended that SPS immediately introduce a policy provision that ensures that all code blue alerts are recoded and preserved.

[130] During the evidence from prison officers, it appeared that, at the time of the restraint, none of them had a sufficient working knowledge or familiarity with the warning signs associated with EDS to enable them to identify it. I did not think that the prison officers were lying about their lack of understanding in the heat of the moment. Even after the event and after all prison officers had attended further annual training sessions, that included identifying the warning signs associated with the four medical conditions, many presented as unable to specify the warning signs associated with EDS. I was less ready to accept from the prison officers that at the time of giving evidence they knew so little about EDS. Mr Hay, C&R Staff Training Manager was asked about the prison officers' apparent lack of knowledge. C&R training was his responsibility. He said that the death of Mr Marshall had sent shock waves through the prison community.

He knew about GMA 048/16[62]. It made it explicit that death through cardiac arrest may result from restraint of a prisoner suffering from EDS. Annex A to the GMA was a flowchart headed "Excited Delirium Syndrome Medical Emergency". It begins with an illustration of a cycle that may eventually lead to cardiac arrest. The guidance sets out expanded warning signs for EDS and provides a specific warning that sudden change and presentation with some of the symptoms of EDS indicates danger of sudden cardiac arrest and constitutes a medical emergency. There is specific advice that includes leaving the prisoner in a cell or containing the prisoner in the immediate location if possible. There is advice to avoid the use of C&R techniques if at all possible and, if techniques are used, to avoid placing the prisoner face down, using minimum force for the shortest duration possible. Compared to the teaching instruction set out in Volume 2 of the C&R Manual, the advice and flowchart in the GMA makes it explicit that cardiac arrest is the risk involved in the restraint of a prisoner suffering from EDS and that the observation that a prisoner was displaying symptoms associated with EDS constituted a medical emergency. Mr Hay confirmed that the GMA was circulated and available for prison officers to read. He also confirmed that there was no audit and no way of checking that any prison officer had read the GMA. He claimed that he was satisfied that the allocated 10 minutes allocated for annual training covering all of the four medical conditions associated with restraint was sufficient. He said that he had taken it upon himself to produce slides containing the information in the GMA and he used them during C&R refresher training. He also had laminated a copy of Annex A and it was passed around

[62] Supplementary Production 2/1

prison officers during training. He had suggested to the Operational Risk Management Team that the slides might be introduced for all prisons in the prison estate but that had not been taken up. He was permitted to use them for Edinburgh training. It is recommended that SPS give consideration to introducing a system of working whereby it can be ensured that information contained in GMAs is both received and understood by the intended recipients.

[131] It is clear that the information in the GMA[63] is superior to that contained in Volume 2 of the C&R Manual[64] and could beneficially be included in training materials used. That inclusion should not be delayed. It is not clear why Mr Hay's suggestion was rejected. According to Mr Hay, the prison officers who gave evidence were all exposed to Mr Hay's enhanced training using the slides. Mr Hay said that he was satisfied that all prison officers were fully aware of EDS and what to do when it arose. He said that he would be surprised to learn that some prison officers did not know of EDS. Yet, if they were to be believed, the prison officers who gave evidence were lacking in knowledge of the EDS symptoms (or some of them) and insufficiently aware of the risk of cardiac arrest. One such prison officer had received annual training just 5 weeks prior to giving evidence. They cannot both be right. It is not possible to square Mr Hay's satisfaction that all prison officers knew about EDS with the evidence led from many of the prison officers that they did not. I already have reservations about some of the evidence from prison officers in relation to the plasticuffs turning white and none of them hearing

[63] Supplementary Production 2/1
[64] Production 23

Mr Marshall calling out during the restraint. However, for them to present as having limited knowledge of EDS while being fully aware of it would require them to be willing to perjure themselves despite repeated admonition from me to tell the truth. The C&R skilled witnesses, Mr Baskind and Mr Henry, agreed that up to date information and instruction should be contained within the C&R Manual. They were approving of the contents of the GMA. Importantly, they pointed out that it was not enough for the C&R Manual to contain information on the topic. It was necessary that the training provided successfully imparted the information. If prison officers did not know of the signs or could not remember them, then there was a deficiency somewhere in their training. I have no difficulty accepting that evidence and accordingly recommend changes to training and impart of knowledge to prison officers. The tick box sign off of training and declaration of competency used by SPS trainers at present appears to be inadequate. With the benefit of hindsight, prison officer Kivlin neatly summed the training issue up when he said "If I were training I'd take as long as is necessary to make staff aware of the consequences of this subject". It is recommended that SPS give consideration to introducing a system of evaluation whereby it can be effectively established that the information contained in training provided to prison officer staff has been successfully imparted to the recipient.

[132] More than one prison officer used feet during the restraint of Mr Marshall. There is clear video evidence of a foot being repeatedly used to push Mr Marshall to the ground whilst he was in a prone position. The dangers in relation to possible death through positional asphyxia have been discussed. Positional asphyxia as a specific cause

of the accident or death of Mr Marshall is not established. However, the contributing factor of resisting that downward pressure in the struggle by Mr Marshall has been discussed. It was particularly referred to by Mr Baskind and Mr Henry. The use of feet is not a recognised restraint technique and can be very dangerous. I do not think that it is satisfactory that there is acceptance by SPS that feet might be used while there is no training or guidance on when and how feet may be used. That is particularly so when the specific dangers are considered. That is not an acceptable set of circumstances. It is recommended that SPS give consideration to either including specific training on the use of feet as a C&R technique within the C&R Manual or, alternatively, disallowing the use of feet within any restraint.

[133] There was a Local Operational Debrief conducted on 31 March 2015. During that debrief there was an open exchange of information among witnesses even before the police had taken fuller statements. Conducting such a debrief at that juncture seriously risked cross-contamination of evidence. It is recommended that SPS introduce a policy that, in a case involving police investigation, no operational debrief shall be conducted until the police have concluded their investigations and taken statements from witnesses.

[134] FLM Mellis, in his evidence, said that he told prisoner office Wilson to give a "proper handover" to the dayshift. It was not apparent what the distinction was between a "proper handover" and something other than that. In my opinion all handovers must be proper handovers and nothing less is appropriate. It is recommended that SPS introduce a system whereby there is a formal handover on

changes of shift and a written account of any unusual prisoner activity or presentation to be kept and presented to the FLM on the following shift at shift handovers.

[135] Finally, Allan Stewart Marshall's death was a tragedy. I am satisfied that the evidence which has been led in this Inquiry amply demonstrates that Mr Marshall's death was entirely preventable. There were numerous opportunities over the period from the early hours of 22 March 2015 and the end of the restraint on 25 March 2015 when a decision by a prison officer to seek NHS Prison Medical Care assistance could have broken the chain of events. These were instances when better training of SPS staff could have made the difference. It has, in fact, been difficult to identify anything that went significantly well.

[136] Mr Marshall's family were present throughout the hearing. They heard the evidence and viewed the restraint of Mr Marshall shown on video over and over again. It must have been a harrowing experience for them. Throughout they conducted themselves with restraint and dignity. I am grateful to them for their participation and I offer them my sincere condolences.