Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Martin, a prisoner at HMP Winchester, on 8 June 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Lee Martin died in hospital on 8 June 2024 of metastatic pancreatic cancer (cancer of the pancreas which had spread to other parts of the body) while a prisoner at HMP Winchester. He was 40 years old. We offer our condolences to Mr Martin's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Martin received at Winchester was of a good standard, and equivalent to that which he could have expected to receive in the community. However, the clinical reviewer concluded that the clinical care Mr Martin received at his previous prison, HMP Erlestoke, was not equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations which the Head of Healthcare at Erlestoke will want to address, including one about the effective assessment and management of chronic pain.

5. Mr Martin had poor health, limited mobility and had been assessed as posing a low risk. Despite medical objections to the use of restraints, prison staff did not take into account the full picture of his health and condition and restrained him. We saw no evidence that Winchester's decisions to restrain him while in a hospice and receiving end-of-life care were justified and in line with the Graham judgment and national policy. Winchester could not explain why his escort risk assessments were not completed. This meant that we could not establish the extent to which he was restrained during hospital escorts.

Recommendations

The Head of Healthcare at HMP Erlestoke should ensure that the National Institute of Clinical Excellence (NICE) guidelines are reviewed within three months and that a patient-centred approach and plan is implemented to assess and manage chronic pain effectively.

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital or on a bed watch understand the legal position on the use of restraints and that, in all cases:

- **managers responsible for authorising restraints consider the healthcare input into the escort risk assessment and base their decision on the actual risk the prisoner poses at the time; and**

- **ensure that healthcare staff completing the medical section of the risk assessment, and managers responsible for authorising restraints complete the paperwork, and document their justification clearly.**

The Investigation Process

6. HMPPS notified us of Mr Martin's death on 8 June 2024.

7. NHS England commissioned an independent clinical reviewer, to review Mr Martin's clinical care at HMP Winchester.

8. The PPO investigator investigated the non-clinical issues relating to Mr Martin's care.

9. The Ombudsman's office wrote to Mr Martin's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He raised concerns about the care Mr Martin received at his previous prison, HMP Erlestoke. This has been addressed in the clinical review.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and Practice Plus Group pointed out some factual inaccuracies in the clinical review and this report has been amended accordingly. The action plan has been annexed to this report.

11. Mr Martin's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Previous deaths at HMP Winchester

12. Mr Martin was the sixth prisoner to die at HMP Winchester since June 2022. Of the previous deaths, two were from natural causes, two were self-inflicted and one is awaiting classification. We previously made recommendations to Winchester in 2020 and 2021 about the inappropriate use of restraints which the prison agreed to implement. We again identified issues with restraints decision-making in this case.

Key Events

13. On 19 December 2022, Mr Lee Martin was sentenced to four years in prison for harassment. He transferred to HMP Erlestoke on 9 August 2023.

14. On 10 February 2024, Mr Martin had intense abdominal pains. Mr Martin saw the prison healthcare team who started him on omeprazole (a medication used to treat stomach problems).

15. Mr Martin's abdominal pains continued and on 21 February, it was noted that they had spread to his lower back. On 23 February, healthcare staff referred him to Salisbury District Hospital after his blood test results were abnormal. He was seen in the emergency department and was discharged with painkillers and antibiotics with a plan for further tests.

16. On 24 February, Mr Martin was taken to hospital for a planned abdominal ultrasound scan, the results of which were normal. He was sent back to Erlestoke and had further tests on 6 March.

17. On 10 March, prison staff took Mr Martin to the healthcare unit as he was unwell. He was taken to hospital by ambulance and returned on 11 March.

18. On 13 March, Mr Martin returned to hospital for a biopsy which identified cancer (likely originating in the pancreas) that had spread to other parts of his body.

19. On 5 April, Mr Martin was given a prognosis of one year. On 8 April, he started palliative treatment (to relieve and manage the symptoms).

20. On 7 May, Mr Martin was discharged to HMP Winchester for 24-hour healthcare. He lived in the healthcare unit due to his frailty and poor mobility.

21. On 4 June, Mr Martin asked to go to hospital as he had not been feeling well and was not eating. He was taken to hospital at 3.11pm. The escort risk assessment stated that Mr Martin left the prison in a single cuff (where the prisoner is cuffed to the wrist of an officer) but this was changed to an escort cable (a long length of heavy metal cable with a handcuff at each end, one worn by the prisoner and the other by an officer) on the authorisation the then Head of Drug Strategy, as he needed a wheelchair in hospital. A nurse, who worked at Winchester noted that Mr Martin was still mobile and therefore posed an escape risk. The Head of Drug Strategy told the investigator that as Mr Martin was a category C prisoner, he would always recommend a single cuff for a planned or emergency escort but he changed Mr Martin's restraint to an escort cable for decency purposes due to his mobility issues.

22. At 8,05am on 5 June, more pain relief was arranged for Mr Martin. At 9.50am, the palliative care team told the escort officers that Mr Martin was going to a hospice. One of the escort officers with Mr Martin contacted the duty governor for permission to remove the restraints but was told that they must be kept on until a management check was completed.

23. At 6.30pm, the Head of Operations, completed a management check and documented that Mr Martin was not happy restrained with an escort cable but it was

to remain applied as the 'Graham judgment at this time is not applicable as he is able to sit in his chair and stand'. The Head of Operations told the investigator that Mr Martin was 'aggressive' and he therefore felt it appropriate to restrain him.

24. At 7.00pm, an escort officer contacted the duty governor to ask for the restraints to be removed but this was denied. Mr Martin was in significant pain during this time.

25. At 9.50am on 6 June, an escort officer contacted the prison to inform them that Mr Martin was going to a hospice. He was told that the restraints could not be removed until a management check was completed.

26. Mr Martin was moved to the hospice later that day, where he remained restrained by an escort cable. A matron, who completed the medical section of the risk assessment, objected to the use of restraints. The rest of the risk assessment paperwork was incomplete.

27. The Head of Security completed a management check at 2.15pm while Mr Martin was in the hospice. He noted that Mr Martin was to remain restrained until a doctor provided a prognosis and a report about his mobility. He also noted that although Mr Martin stated he could not get out of bed, nursing staff advised that he was mobile. The bed watch log for the events of 6 June stopped at 8.15pm. Winchester told us that Mr Martin had slept through the night and so the escort officer deemed it unnecessary to complete an entry.

28. On 7 June, Mr Martin's restraints were removed following a management check which the Head of Residential Services, completed. He noted that the restraints were bruising Mr Martin's wrists as he was frail, he was not able to speak, he was not eating at all and he was in a lot of pain. He also noted that Mr Martin was unable to stand, needed assistance and had been given a prognosis of one week.

29. On 8 June, Mr Martin slept all day and had not moved, leading hospital staff to suspect that he had fallen into an unconscious state from which he was unlikely to wake. They confirmed to the escort officers that Mr Martin was at the end of his life.

30. At 12:40pm and 5.18pm, the matron visited Mr Martin and stayed with the family. He became unresponsive and died at 10.45pm, with his family by his bedside.

Post-mortem report

31. A hospital doctor established that Mr Martin had died from metastatic pancreatic carcinoma (pancreatic cancer which had spread to other parts of the body). The Coroner accepted the cause of death and no post-mortem examination was carried out.

Inquest

32. At an inquest held on 1 July 2025, the Coroner concluded that Mr Martin died of natural causes.

Clinical findings

33. The clinical reviewer concluded that the clinical care Mr Martin received at Winchester was of a good standard and equivalent to that which he could have received in the community. The matron's actions were highlighted as thoughtful, compassionate and an example of good practice.

34. However, he concluded that the clinical care Mr Martin received at his previous prison, Erlestoke, was not equivalent to that which he could have expected to receive in the community. He found that Erlestoke's management of Mr Martin's pain did not meet the standards outlined in the NICE guidance. He also found a number of issues with the care Mr Martin received, including poor communication and information sharing, an absence of consideration for the cause of Mr Martin's pain, and the prescription of pain medication to Mr Martin without explanation. He made two recommendations which the Head of Healthcare at Erlestoke will want to address, including the following:

35. The Head of Healthcare at HMP Erlestoke should ensure that the National Institute of Clinical Excellence (NICE) guidelines are reviewed within three months and that a patient-centred approach and plan is implemented to assess and manage chronic pain effectively.

Non-clinical findings

Restraints, security and escorts

36. The Prison Service has a duty to protect the public when escorting prisoners outside prison such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

37. A judgment in the High Court in 2007, known as the Graham judgment, made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The Prevention of Escape: External Escorts Policy Framework states that restraints should not routinely be used where mobility is severely limited, for example, due to ill health.

38. On 4 June, Mr Martin was taken to hospital, restrained initially with a single cuff and subsequently an escort cable. Mr Martin had terminal cancer and limited mobility. Winchester assessed Mr Martin's risk as normal, even though he had had no disciplinary hearings in prison, he was on an enhanced prison incentive scheme, and there was no intelligence to suggest he posed a risk of escape or harm to staff.

39. On occasion, prison staff overruled medical objections to the use of restraints with no justification given. We found restraints arrangements were not in line with the

policy framework. Management checks were completed, and despite Mr Martin's evident deterioration in health, managers continued to restrain him, contrary to the Graham judgment. The Head of Operations told the investigator that Mr Martin was "quite aggressive and mobile". However, when the investigator reviewed the bed watch logs, it was evident that Mr Martin was in significant pain and was not eating. Escort staff contacted the prison more than once to ask for the restraints to be removed.

40. By 6 June, Mr Martin was unwell, in significant pain and in a hospice. We do not consider that it was appropriate or necessary to leave him restrained while waiting for a doctor's report on mobility. Even when the Head of Residential Services decided on 7 June that restraints could be removed, there is no evidence that a mobility report was received or needed.

41. We have previously made recommendations to Winchester about the inappropriate use of restraints. Winchester agreed to review the process to ensure staff understood the Graham judgment. However, this case demonstrates that significant issues with the inappropriate use of restraints remain.

42. The decision to restrain Mr Martin was not based on his current condition or the risk that he posed. Mr Martin was significantly unwell with terminal cancer, unable to move and was receiving palliative care in a hospice. The decision to restrain him with an escort cable until a day before he died was unjustified, particularly as there were always two escort officers with him.

43. Winchester also told us that they could not explain why the escort risk assessments were not completed. This meant that we could not establish a complete picture to explain why they continued to restrain Mr Martin. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital or on a bed watch understand the legal position on the use of restraints and that, in all cases:

- **managers responsible for authorising restraints consider the healthcare input into the escort risk assessment and base their decision on the actual risk the prisoner poses at the time; and**
- **ensure that healthcare staff completing the medical section of the risk assessment, and managers responsible for authorising restraints complete the paperwork, and document their justification clearly.**

Governor to note

44. There are no entries in the bed watch log after 8.00pm on 6 June 2024. While we recognise that Winchester explained that Mr Martin had slept through the night and staff felt there was no need to complete an entry, it is important to record observations contemporaneously.

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Prisons and Probation Ombudsman **January 2026**

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