Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Martin a prisoner at HMP Grendon on 19 October 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Martin died of blood cancer on 19 October 2018 while a prisoner at HMP Grendon. He was 42 years old. I offer my condolences to his family and friends.

I am satisfied that the healthcare that Mr Martin received at Grendon was good and equivalent to that which he could have expected to receive in the community.

I am concerned that his application for compassionate release was lost in the prison and was therefore never completed.

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

Sue McAllister CB
Prisons and Probation Ombudsman **May 2019**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Findings 5

Summary

Events

1. Mr Alan Martin was serving a life sentence for murder and had been at HMP Grendon since 1 March 2018.

2. Mr Martin had Bell's palsy (an acute paralysis of the facial nerves), and on 5 March, a prison GP reviewed him and re-prescribed prednisolone for it. The GP noted that he had a high pulse rate (120 beats per minute) and a red, swollen throat so prescribed amoxicillin, an antibiotic.

3. On 7 March, a prison GP saw Mr Martin and noted that his Bell's palsy symptoms remained the same but his right eye looked downwards and outwards and his pupil was enlarged. The GP organised an urgent MRI scan (a technique used to produce a detailed image of internal body structures).

4. On 19 March, Mr Martin went to hospital for his scan but it did not take place because he was breathless. When he went back to Grendon, a nurse noted that he had difficulty breathing, he was wheezing, he had a cough and a fever. His blood pressure and pulse rate were high and his blood oxygen saturation was low. A prison GP saw Mr Martin and sent him back to hospital.

5. Hospital staff diagnosed him with pneumonia and Non-Hodgkin lymphoma, a form of blood cancer. When he was sent back to Grendon on 11 April, he was prescribed antibiotics and underwent chemotherapy.

6. On 17 April, a nurse created a cancer care plan. On 2 May, Mr Martin went to hospital because the results of his blood tests were abnormal and his condition got worse. He returned to Grendon on 10 August 2018. Healthcare staff frequently reviewed Mr Martin's cancer care. When he was too weak to go to the healthcare unit, a prison GP saw him in his cell.

7. Mr Martin's health deteriorated further and on 21 September, staff sent him to hospital, where he stayed as an inpatient. On 3 October, a haematology registrar gave Mr Martin a prognosis of three months, and told him that he needed palliative care.

8. On 7 October, Mr Martin was sent to a hospice. That day, Mr Martin signed an order to say that he did not want to be resuscitated if his heart or breathing stopped.

9. On 19 October, Mr Martin died in the hospice, with his parents at his side. A hospital doctor established that he died of blood cancer.

Findings

10. The healthcare that Mr Martin received at Grendon was good and equivalent to that which he could have expected to receive in the community.

11. On 19 March, a prison GP appropriately sent Mr Martin back to hospital after hospital staff had discharged him to Grendon. This led to him receiving a diagnosis of blood cancer. Healthcare staff appropriately reviewed Mr Martin's

cancer care. When he went to hospital and then to a hospice, healthcare staff frequently obtained updates about his care.

12. Prison staff appropriately reviewed the level of restraints used when Mr Martin was taken to hospital. When he spent a prolonged period in hospital for treatment, staff removed the restraints and when Mr Martin later went to the hospice, he was unrestrained and the escorting officers were not in uniform.

13. While we cannot say whether or not Mr Martin would have been released early on compassionate grounds, his application was lost at Grendon, and was therefore never completed despite his poor prognosis.

Recommendations

- The Governor and Head of Healthcare should ensure that there is a robust process in place to ensure that applications for early compassionate release are completed promptly, including that they are transferred safely between the healthcare department and the prison and that staff check on the progress of applications.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Grendon to inform them of the investigation and to ask anyone with relevant information to contact him. No one responded.

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

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

17. We informed HM Coroner for Buckinghamshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The investigator wrote to Mr Martin's father to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

19. We considered the main issues involved in Mr Martin's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

20. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Grendon

1. HMP Grendon holds around 230 men, serving indeterminate or long, determinate sentences, with at least 18 months left to serve. It is a unique prison, run by prisoners and staff on democratic, therapeutic principles. It has six wings, five of which operate as autonomous therapeutic communities. The sixth is an induction and assessment wing.

2. Care UK provides healthcare services at Grendon. There is no inpatient unit.

HM Inspectorate of Prisons

3. The last inspection at HMP Grendon was in May 2017. Inspectors reported that Grendon was a safe prison, with very little violence. They noted that the relationship between staff and prisoners was excellent. They found that healthcare services were well-led and the range was appropriate. Inspectors noted that prisoners had good access to GPs and clinics were available three times a week. They noted that the in-possession medication policy was inadequate because it did not offer sufficient advice to prescribers. However, they found that arrangements to support prisoners with social care needs were established with the local authority.

Independent Monitoring Board

4. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2017, the IMB reported that the relationship between prisoners and staff was commendable and that prisoners were treated humanely and with care. They found that an effective healthcare service was provided, even though it had been difficult to maintain staffing levels.

Previous deaths at HMP Grendon

5. Mr Martin was the fourth prisoner to die at Grendon since October 2015. Two of the previous deaths were from natural causes and one was self-inflicted. There are no significant similarities with the circumstances of the previous deaths.

Findings

The diagnosis of Mr Martin's terminal illness and informing him of his condition

6. Mr Alan Martin was serving a life sentence for murder, and having served time in a number of prisons, was transferred to HMP Grendon on 1 March 2018. He had a history of self-harm, substance misuse and mental health issues. Before he went to Grendon, Mr Martin developed Bell's palsy.

7. On 2 March, a nurse completed Mr Martin's initial health screen, and noted that he had Bell's palsy.

8. On 5 March, a prison GP reviewed Mr Martin and re-prescribed prednisolone for his Bell's palsy. Mr Martin had a high pulse rate (120 beats per minute) and a red, swollen throat for which he prescribed amoxicillin, an antibiotic. A nurse noted that Mr Martin also had high blood pressure (135/98).

9. On 6 March, a nurse saw Mr Martin and noted that his pulse rate (127 beats per minute) and blood pressure (147/103) remained high. She planned to review Mr Martin the next day.

10. On 7 March, a prison GP saw Mr Martin and noted that his Bell's palsy symptoms were the same but that his right eye looked downwards and outwards and his pupil was enlarged. He spoke to a neurologist at a hospital who organised an urgent MRI scan.

11. On 19 March, Mr Martin went to hospital for his scan but it could not be done because he was breathless. When he went back to Grendon, a nurse noted that he had difficulty breathing, was wheezing, had a cough and a fever. His blood pressure was pre-high (128/76), his pulse rate was high (140 beats per minute) and his blood oxygen saturation level was low (91%). A prison GP saw Mr Martin and decided to send him back to hospital.

12. Hospital staff said that he had pneumonia and Non-Hodgkin lymphoma, a form of blood cancer. Mr Martin remained in hospital until 11 April. When he went back to Grendon, he was prescribed antibiotics and hospital staff planned a course of chemotherapy which he completed

13. The clinical reviewer said that a high pulse rate (which Mr Martin had had from 5 March) was a very rare symptom with Non-Hodgkin lymphoma and would not have raised a suspicion of cancer. When Mr Martin was sent back to Grendon from hospital on 19 March, he was clearly unwell. The prison GP made the appropriate decision to send him back to hospital. This led to hospital staff diagnosing him with pneumonia and blood cancer.

Mr Martin's clinical care

14. On 11 April, a nurse saw Mr Martin. He noted that hospital staff had created a cancer treatment plan. The nurse gave the on-duty prison manager, the prison wing staff and the control room staff a leaflet with information about Mr Martin's illness and treatment. He told Mr Martin to tell wing staff if he became unwell. He booked a routine GP review and re-prescribed Mr Martin's medication.

Healthcare staff followed Mr Martin's cancer treatment plan and arranged his outpatient chemotherapy appointments with the hospital.

15. On 12 April, a prison GP saw Mr Martin and prescribed medication for blood pressure, stomach acid and heart problems, and an antibiotic and a vitamin D diet supplement.

16. On 17 April, a nurse created a cancer care plan which included a weekly nutritional risk assessment. On 24 April, Mr Martin went to hospital because he was dehydrated.

17. On 2 May, Mr Martin went back to hospital for a lengthy period as an inpatient because he had abnormal blood test results and his condition had got worse. He returned to Grendon on 10 August 2018.

18. During August and September, healthcare staff frequently reviewed Mr Martin's cancer care. When he was too weak to go to the healthcare unit, a prison GP saw him in his cell. Healthcare staff discussed Mr Martin's care at a multidisciplinary team meeting.

19. On 7 September, Mr Martin told a nurse that he was felt dizzy. The nurse noted that his physical observations were normal, that he was steady on his feet and coherent. A prison GP, reviewed Mr Martin and noted that he gave him iron tablets for possible anaemia. On 12 September, when Mr Martin went to hospital for an outpatient appointment, hospital staff noted that he had extreme anaemia.

20. On 13 September, the Head of Healthcare saw Mr Martin. He told her that he was still dizzy and that the hospital said that he may have balance problems because of the length of time that he was lying down. She noted that Mr Martin was able to shower himself but that his cell was untidy. She arranged for Mr Martin's peers to tidy his cell.

21. On 17 September, Mr Martin saw a nurse at the medication hatch and told him that he was dizzy and had balance problems. He referred him to a prison GP. Later that day, the nurse manager saw Mr Martin after he had fallen in the shower and banged his head. She completed a falls risk assessment and noted that there were no signs of injury but that Mr Martin had been dizzy, felt nauseous and had vomited for a number of days.

22. On 19 September, the nurse manager spoke to healthcare staff at the hospital because Mr Martin remained unwell, and was frequently vomiting. She was concerned that the vomiting was preventing the absorption of his medication. Mr Martin was lethargic and was not taking fluid or food. A prison GP noted that he should go to hospital for an assessment. Mr Martin said that he did not want to go because he was fed up with constant investigations and his condition was not improving. On 21 September, healthcare staff persuaded Mr Martin to go to hospital because of his deteriorating health and continuing vomiting.

23. Mr Martin stayed in hospital as an inpatient. Healthcare staff obtained frequent updates about his care and condition. On 3 October, the nurse manager spoke to a haematology registrar, who told Mr Martin that he needed palliative care as his life expectancy was three months.

24. On 19 October, Mr Martin died. There was no post-mortem examination but a hospital doctor established that he had died of blood cancer.

25. The care that Mr Martin received at Grendon was equivalent to that which he could have expected to receive in the community. Mr Martin went to his outpatient chemotherapy appointments. Healthcare staff created and followed a cancer care plan and when he fell, they completed a falls risk assessment. Prison GPs prescribed appropriate medication and visited him in his cell when he was too unwell to go to a clinic.

Mr Martin's location

26. On 18 September, the Head of Healthcare noted that if Mr Martin remained unwell and at risk of falling, they would review whether he needed to go to HMP Bullingdon, where there was an inpatient unit. Mr Martin did not want to go to Bullingdon.

27. On 7 October, Mr Martin went to the hospice at a hospital. He signed an order to say that he did not want to be resuscitated if his heart or breathing stopped.

28. We are satisfied that healthcare staff monitored Mr Martin's condition and agreed to consider moving him to the inpatient unit at Bullingdon if he remained unwell. When Mr Martin became seriously ill, he went back to hospital, where it was arranged for him to move to a hospice, where he died.

Restraints, security and escorts

29. When prisoners travel outside prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.

30. From 19 March 2018, Mr Martin frequently went to hospital for tests and treatment. Prison staff completed risk assessments before he went to hospital. The medical section was always completed and there were no medical objections to the use of restraints. Mr Martin was a Category C prisoner and was assessed as a medium risk to the public and of escape because of the nature of his offence. Mr Martin had previously harmed himself and this was taken into consideration in deciding the level of restraint. Prison managers noted that Mr Martin should be restrained with a single cuff which could be replaced by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) in hospital.

31. On 3 May, Mr Martin went back to hospital and stayed there for treatment until 10 August. On 18 May, the Head of Security reviewed the level of restraint and arranged for Mr Martin's restraints to be removed.

32. On 8 October, Mr Martin went to a hospice, unrestrained. The Head of Security reviewed the risk assessment and noted that officers should not wear uniforms, that only one officer should remain in the room and that when his family visited, they could be alone with him.

33. Prison managers appropriately assessed the level of restraints used. When Mr Martin spent a prolonged period in hospital for treatment, escorting officers removed his restraints. When Mr Martin moved to the hospice, he was unrestrained and the officers were not in uniform.

Liaison with Mr Martin's family

34. On 18 May, a custodial manager appointed an officer, as the family liaison officer (FLO) and an offender manager, as the deputy family liaison officer. The family liaison log recorded at that time that Mr Martin's cancer was "curative", and a wing therapist, kept the family informed about his health.

35. On 3 October, the deputy FLO told Mr Martin's parents that he was in hospital and that he had a prognosis of between three and six months. The next day, Mr Martin's father visited him in hospital.

36. On 7 October, a custodial manager spoke to Mr Martin's father by telephone and told him that Mr Martin's condition had deteriorated and that he was at the hospice. The next day, the FLO and deputy FLO met Mr Martin's parents at the hospice. His parents visited him most days when he was at the hospice, and were with him when he died.

37. Mr Martin's funeral took place on 14 November, and Grendon contributed to the cost in line with national instructions.

Compassionate release

38. Prisoners can be released from custody before their sentence has expired on compassionate grounds. This is usually if they have a terminal illness, with a short prognosis, often of three months or less.

39. On 3 October, the nurse manager spoke to a doctor at a hospital who said that Mr Martin's life expectancy was three months and that he should receive palliative care.

40. The Head of the Offender Management Unit, said that he started the compassionate release process by sending the application to the nurse manager. It is not clear when this happened as the paperwork is lost.

41. The nurse manager said that the medical section of the application was completed and the document returned to the Offender Management Unit. In the absence of the application and any other relevant evidence, it is unclear who sent the document. However, the Head of the Offender Management Unit said that he never received the document. There is no evidence that anyone checked on the progress of the application.

42. On 4 October, an offender manager noted in an email to the Head of the Offender Management Unit that she would not support the application unless Mr Martin was bed-bound. She noted the reasons why she would not support the application, including that he posed a high risk of serious harm, that he had psychopathic tendencies and had never been considered safe for release throughout his sentence.

43. While we cannot know whether or not Mr Martin’s application for early compassionate release would have been successful, we are concerned that it was not completed as it was lost in the prison. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a robust process in place to ensure that applications for early compassionate release are completed promptly, including that they are transferred safely between the healthcare department and the prison and that staff check on the progress of applications.

Prisons & Probation
Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141