

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robin Marshall, a prisoner at HMP Ashfield, on 11 November 2019

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Robin Marshall died in hospital from heart failure on 11 November 2019, while a prisoner at HMP Ashfield. He was 63 years old. I offer my condolences to his family and friends.

The clinical reviewer found that Mr Marshall received exemplary care at Ashfield, which was at least equivalent to that he could have expected to receive in the community.

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

July 2020

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Summary

Events

1. On 27 September 2012, Mr Robin Marshall was sentenced to 12 years in prison. He was moved to HMP Ashfield on 15 March 2018.
2. On 18 September 2019, Mr Marshall complained of breathlessness and chest pain. A nurse assessed him and had no immediate concerns, but she referred him to a GP. The GP saw Mr Marshall that day and carried out some blood tests. The results indicated heart failure and the GP made an urgent referral to a cardiac unit.
3. On 23 September, Mr Marshall was admitted to hospital with chest pain. He spent over a month in hospital and was on a ventilator following a cardiac arrest.
4. On 26 October, Mr Marshall was returned to Ashfield. He was thoroughly assessed and monitored by prison nurses and doctors.
5. On 30 October, the hospital asked for Mr Marshall's urgent readmission. The results of liver function tests, taken during his first admission, had come back and were a cause for concern. Mr Marshall was taken to hospital straightaway. Blood was found in his faeces, caused by an ulcer, and although this was treated, Mr Marshall's condition deteriorated to the extent doctors put him in an induced coma.
6. Mr Marshall did not recover and at 4.53am on 11 November 2019, he died in hospital.
7. The post-mortem examination found that Mr Marshall died from cardiac failure and cardiomyopathy (diseased heart muscle).

Findings

8. The clinical reviewer found that Mr Marshall received exemplary care at Ashfield, which was at least equivalent to that he could have expected to receive in the community.
9. We make no recommendations.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Ashfield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Marshall's prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Marshall's clinical care at the prison.
13. We informed HM Coroner for Avon district of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Marshall's family to explain our investigation and asked if they wished to raise any issues. They did not respond.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Ashfield

16. HMP Ashfield is a specialist medium security adult male prison for prisoners convicted of sexual offences. It accommodates approximately 400 men and is managed by Serco.
17. Health services are provided by Bristol Community Health Community Interest Company. An integrated team from Avon and Wiltshire Mental Health Partnership Mental Health Trust provide mental health and substance misuse services.

HM Inspectorate of Prisons

18. The most recent inspection of Ashfield was in March and April 2019. In HMIP's survey, 84% of respondents said they felt healthcare was quite or very good. Primary care was delivered to a good standard both in the healthcare unit and on the wings if required. Access to appointments was good and prisoners with long term conditions were managed by either a GP or a nurse and had good care and support. Referrals for external hospital appointments were made promptly, and staff contributed to risk assessments to help ensure security measures were proportionate.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2018, the IMB reported that Ashfield was still a very well-run prison which continued to improve. Changes to the healthcare service had been implemented well and there were few complaints. A Health Improvement Group had been established and six prisoners were part of it. Cancelled hospital appointments averaged four a month but these were generally due to cancellations by the hospital and only occasionally were due to the prison being unable to provide escorts.

Previous deaths at HMP Ashfield

20. Mr Marshall was the third prisoner at Ashfield to die since November 2017. Of the previous deaths, one was from natural causes and one awaits classification. We have previously found a good standard of healthcare at Ashfield.

Key Events

21. On 27 September 2012, Mr Robin Marshall was sentenced to 12 years in prison for sexual offences. He was moved to HMP Ashfield on 15 March 2018.
22. A nurse completed the reception screen and at that time Mr Marshall did not have any significant diagnoses and was not on any medication.
23. On 16 September 2019, Mr Marshall told a nurse he had been increasingly breathless over the past two weeks and had experienced occasional stabbing pains in the middle of his chest. She examined him and had no immediate concerns, but she made a GP appointment for him for 18 September. She advised Mr Marshall to report any worsening of symptoms.
24. On 18 September, a prison GP examined Mr Marshall and arranged blood tests. The blood test results, received on 19 September, showed a significant presence of 'brain natriuretic peptides' (which can indicate heart failure). He made a fast-track referral to a heart failure clinic and booked another GP appointment.
25. On 23 September, a nurse saw Mr Marshall who was complaining of crushing chest pain on his left side. He was pale, and his oxygen saturation levels were only 91% (a normal level is 95-100%), even though the nurse was giving him oxygen. The nurse gave him aspirin and called an emergency ambulance as his oxygen saturation levels continued to decrease (they were 89% when the ambulance arrived).
26. Mr Marshall was admitted to hospital for over a month. During that time, he was diagnosed with fluid on his lungs, a left ventricular thrombus and cardiac arrest. He had to be ventilated during the first part of his admission.
27. On 26 October, Mr Marshall was discharged from hospital and returned to Ashfield. A nurse assessed him on his return. She noted concerns about his health and the prison's ability to care for him safely. She reviewed his new medication (warfarin) and checked the prison had adequate stocks to supply it over the weekend. She also recorded that his body's blood clotting abilities would need assessing given his warfarin prescription. A prison GP also saw Mr Marshall that day and told the team that there should be a low threshold for returning Mr Marshall to hospital.
28. On 27 October, a nurse saw Mr Marshall again and recorded that he was anxious about his health. She referred him to the mental health team.
29. On 28 October, a healthcare assistant visited Mr Marshall in his cell to discuss his personal care needs. He needed help to dress, wash and shave and she noted that healthcare would provide assistance; he also had a buddy (another prisoner who would provide assistance).
30. On 28 October, Mr Marshall was reviewed by a prison GP. He was also seen that day by a nurse, who discussed his medication and monitoring arrangements with him. She took clinical observations and recorded that he would be seen by a GP again in one week. If his oxygen saturations levels fell below 88%, he was to be readmitted to hospital.

31. On 30 October, a prison GP recorded that a hospital had been in touch requesting Mr Marshall's urgent admission. Liver function tests that had been taken during his previous admission had come back with abnormal and concerning results.
32. Mr Marshall was urgently admitted to hospital. He was not restrained on account of his poor mobility. A scan revealed fluid on his liver, and he was expected to stay in hospital for a few more days.
33. Mr Marshall's condition deteriorated, and blood was detected in his faeces. An emergency endoscopy procedure (a small camera is passed down the patient's throat to aid investigations) took place on 2 November, and Mr Marshall was admitted to the Intensive Care Unit. The internal bleeding (which was presumed to have caused the blood in his faeces) was found to be from an ulcer and this was treated. However, Mr Marshall was extremely unwell by this time, and on 6 November, clinicians put him in an induced coma.
34. On 10 November, hospital staff removed Mr Marshall's breathing tube but, ultimately, he was unable to recover.
35. On 19 November, Mr Marshall died. The hospital advised the prison the time of death was 4.53am.

Contact with Mr Marshall's family

36. On 23 September, the prison appointed an officer as the family liaison officer. He provided the family with advice and support, and they were with Mr Marshall when he died on 19 November.
37. Mr Marshall's funeral was on 20 December. A prison manager and a prison chaplain, attended. In line with national policy, the prison paid for the funeral costs.

Support for prisoners and staff

38. After Mr Marshall's death, a prison manager debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
39. The prison posted notices informing other prisoners of Mr Marshall's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Marshall's death.

Post-mortem report

40. The post-mortem report concluded that Mr Marshall died from cardiac failure and dilated cardiomyopathy (diseased heart muscle).

Findings

Clinical care

41. The clinical reviewer found that the care Mr Marshall received at HMP Ashfield was exemplary and at least equivalent to that he could have expected to receive in the community. Healthcare staff promptly assessed Mr Marshall and arranged further investigations when necessary. The reviewer highlighted that the timely assessments and thorough recording of management plans was an area of good practice.
42. We make no recommendations.

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