Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Marti, a prisoner at HMP Isle of Wight, on 12 May 2021

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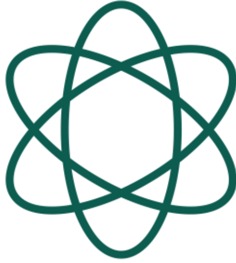
Our vision

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

OGL

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

3. Mr Robert Marti died in prison on 12 May 2021 of a blood clot in the lung caused by pancreatic cancer while a prisoner at HMP Isle of Wight. Mr Marti was 66 years old. We offer our condolences to Mr Marti's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Marti received at the prison was equivalent to that he could have expected to receive in the community. She made no recommendations.

5. We found that the decision to use an escort chain when escorting Mr Marti to hospital on 30 January 2021 was not justified given his advanced illness and poor mobility.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

- The Governor should ensure that staff maintain an accurate family liaison log so that there is an effective record of events, issues, concerns and action taken.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Marti's clinical care at HMP Isle of Wight.

7. The PPO investigator has investigated non-clinical issues, including Mr Marti's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Marti's next of kin, his niece, to explain the investigation. They did not respond.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Isle of Wight

10. Mr Marti was the 15th prisoner to die at the prison since May 2019. Of these deaths, nine were from natural causes and five were self-inflicted. Since Mr Marti's death, there have been five further deaths. Of these deaths, four were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Marti's death and our investigation findings for the previous deaths.

Key Events

11. On 15 June 2009, Mr Robert Marti was remanded to HMP Dorchester. On 28 May 2010, he was sentenced to an indeterminate period of imprisonment for public protection for sex offences. Mr Marti was transferred to HMP Isle of Wight on 26 November 2015.

12. On 20 December 2018, Mr Marti went to the prison GP. He had diarrhoea and looked jaundiced. The GP took blood samples and referred him to the hospital gastroenterology department (the department which treats diseases of the digestion organs).

13. On 8 February 2019, prison officers found Mr Marti on the floor of his cell and called a code blue (an emergency response for a prisoner having breathing difficulties). The prison's family liaison officer informed Mr Marti's next of kin. He was taken to hospital and on 11 February, hospital staff informed Mr Marti that he had pancreatic cancer. He returned to prison on 16 February.

14. On 18 February 2019, a prison GP told Mr Marti that his cancer could not be removed. They discussed putting a Do Not Attempt Resuscitation (DNAR) order in place and discussed the Emergency Release on Compassionate Grounds (ERCG) process. Mr Marti said that he did not want to apply for ERCG.

15. Mr Marti had chemotherapy and radiotherapy between March 2019 and April 2020. On 17 April, hospital consultants told Mr Marti that his cancer was still inoperable.

16. On 30 January 2021, Mr Marti told prison staff that he had severe pain in his arm and was very weak. They called a code blue and paramedics found that his shoulder was misaligned. Mr Marti stayed in hospital overnight. The risk assessment for this escort stated that there were medical objections to the use of restraints. The authorising manager stated that an escort chain was to be used and removed only for treatment. The restraints were removed when Mr Marti complained of chest pain and the risk assessment was updated.

17. On 2 February, a prison GP told Mr Marti that he was getting closer to the end of his life.

18. On 23 March, Mr Marti changed his mind about ERCG, and the prison began the application on 6 April. The application was not submitted before he died because the prison was still trying to find a hospice bed for him.

19. On 20 April, officers called a code blue after finding Mr Marti on the floor with breathing difficulties. He was given an end of life cell on the healthcare wing.

20. Mr Marti died on 12 May 2021. The prison's family liaison officer did not document conversations between themselves and Mr Marti's next of kin between 12 May and 3 June, but the prison has confirmed that conversations took place within this period.

21. The prison organised Mr Marti's funeral in line with national policy.

Post-mortem report

22. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Marti’s cause of death as Pulmonary Thromboembolism (blood clot in the lung), caused by pancreatic cancer, which had spread throughout the body.

Non-Clinical Findings

Restraints, security and escorts

23. 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. A judgment in the High Court in 2007 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 suffering from a serious medical condition. The judgment indicated 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.

24. On 30 January 2021, Mr Marti was escorted to hospital after a code blue was called. The risk assessment for this escort stated that there were medical objections to the use of restraints, that Mr Marti had a restricted ability to escape and mobility issues. Despite the medical objections and mobility issues, the authorising manager stated that an escort chain was to be used and removed only for treatment. The authorising manager updated the risk assessment due to Mr Marti having chest pains and stated that no restraints should be used until Mr Marti had recovered. According to the bedwatch log, restraints were removed at 6.00pm.

25. We have taken into account the clinical record entries for the code blue on 30 January 2021, as well as the previous escort risk assessment (where restraints were not used) and we find that the use of restraints was not justified when escorting Mr Marti to hospital on 30 January 2021. We acknowledge that the authorising manager corrected their decision after Mr Marti was admitted to hospital, but restraints should not have been used in the first place. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Record of contact with the next of kin

26. The family liaison log is a standard document used to record communication between the prison and the next of kin. Mr Marti's log did not include entries between 12 May and 3 June 2021. The prison has confirmed that the family liaison officer contacted Mr Marti's niece on 17 May, 27 May and 3 June 2021. The liaison officer has provided a summary of the three conversations, but this summary lacks information surrounding how quickly the next of kin was informed of Mr Marti's death. Because of this, we cannot be sure that there was no delay in informing the next of kin of Mr Marti's death. We also cannot be sure that all other actions were

carried out within the requirements of the family liaison officer role. We make the following recommendation:

The Governor should ensure that staff maintain an accurate family liaison log so that there is an effective record of events, issues, concerns and action taken.

Sarah Stolworthy **March 2022**
Acting Assistant Ombudsman

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