Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Martin, a prisoner at HMP Moorland, on 14 April 2023

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 HM 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 Edward Martin died of acute myocardial ischaemia (a reduction in the heart muscle's ability to pump blood around the body) caused by ischaemic heart disease and severe coronary artery atheroma (a build-up of fatty material inside the coronary arteries) in hospital on 14 April 2023, while a prisoner at HMP Moorland. He was 70 years old. He also had a urinary tract infection which contributed to but did not cause his death. I offer my condolences to those who knew him.

4. The clinical reviewer concluded that the clinical care Mr Martin received at Moorland was of a good standard and was equivalent to that which he could have expected to receive in the community.

5. After spending several months in hospital following a stroke, Mr Martin lived on a specialist unit at Moorland where he was supported with comprehensive health and social care. He was discussed at multi-disciplinary team meetings and reviewed by GPs at Moorland.

6. The clinical reviewer has made a recommendation not directly related to Mr Martin's death which the Head of Healthcare will need to address.

The Investigation Process

7. On 14 April, the PPO was notified that Mr Martin had died.

8. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

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

11. We informed HM Coroner for South Yorkshire East of the investigation. She gave us the results of the post mortem examination. We have sent the Coroner a copy of this report.

12. Mr Martin had no next of kin.

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

Previous deaths at HMP Moorland

14. There have been twelve deaths from natural causes at Moorland in the three years before Mr Martin's' death. There was also a drug related death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

15. On 24 January 2020, Mr Edward Martin was remanded to HMP Liverpool. On 19 August, he was sentenced to 14 years and three months in prison for sex offences. On 26 October, Mr Martin was transferred to HMP Garth.

16. Mr Martin had high blood pressure and coronary heart disease (a type of heart disease that is characterised by the narrowing or blockage of the coronary arteries). He had a catheter (a flexible tube which is used to empty the bladder and collect urine) fitted in September 2022, due to an enlarged prostate gland. He also had anxiety and depression.

17. On 20 November 2022, healthcare staff sent Mr Martin to hospital because they thought that he may have had a stroke. Hospital staff reached the same conclusion, and Mr Martin remained in hospital until 20 December.

18. On 21 December, a nurse saw Mr Martin because he said that he had chest pain going into his left arm and back. She carried out an electrocardiogram (ECG- a test to look at the heart's electrical activity and rhythm) which was inconclusive, so she sent him back to hospital. Mr Martin returned to Garth the same day.

19. On 25 December, a nurse saw Mr Martin because he said that he had taken an overdose of all his medication. She sent him to hospital, where he was admitted. On 29 December, Mr Martin had a significant stroke, which meant he was left with limited mobility. He remained in hospital receiving treatment for over two months. The clinical reviewer found that there is no connection between a medication overdose and a stroke.

20. On 13 March 2023, Mr Martin was transferred from hospital to the Intermediate Care Rehabilitation Service (ICRS – a rehabilitation unit for the Yorkshire and Humber region which provides 24-hour healthcare cover) at HMP Moorland.

21. An occupational therapist saw Mr Martin and saw that he was able to eat and drink but was unable to mobilise and unable to independently get off the bed. He found that Mr Martin required full assistance with washing, dressing and continence care. He arranged for Mr Martin to be provided with a hoist and sling to transfer to a chair and commode, a pressure relieving mattress, a slide for turning and repositioning and an automated lateral turning system which enabled Mr Martin to be turned at prescribed intervals, even during sleep.

22. On 14 March, a nurse created care plans for Mr Martin's complex needs.

23. On 13 April, a nurse saw Mr Martin because he was unwell and had vomited. She noted that his National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was 15, which indicated a high clinical risk. She sent Mr Martin to hospital by ambulance.

24. On 14 April, after Mr Martin's health very rapidly deteriorated, he died in hospital.

Post-mortem report

24. A post-mortem examination established that Mr Martin died of acute myocardial ischaemia (a reduction in the heart muscle's ability to pump blood around the body), caused by ischaemic heart disease (the blood vessels supplying the heart are narrowed or blocked) and severe coronary artery atheroma (a build-up of fatty deposits on the walls of the arteries around the heart). He also had a urinary tract infection (an infection of the bladder, kidneys and the tubes connected to them) which contributed to but did not cause his death.

Inquest

25. At an inquest held on 15 February 2024, the Coroner concluded that Mr Martin died from natural causes.

Findings

Clinical care

26. The clinical reviewer concluded that the clinical care Mr Martin received at Moorland was of a good standard and was equivalent to that which he could have expected to receive in the community.

27. At Moorland, Mr Martin lived in the ICRS unit, where he was supported with comprehensive health care and social care. He was discussed at multi-disciplinary team meetings and reviewed by GPs at Moorland.

28. The clinical reviewer has made a recommendation not directly related to Mr Martin's death which the Head of Healthcare will need to address.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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