Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Marshall, a prisoner at HMP Hull, on 16 September 2023

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 I 020 7633 4100

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

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 David Marshall was sentenced to 5 years and 15 days for attempted murder and false imprisonment. He died from bronchopneumonia on 16 September 2023 while a prisoner at HMP Hull. He also had advanced lung cancer which had spread to other parts of his body. This contributed to but did not cause his death. He was 51 years old. We offer our condolences to Mr Marshall's family and friends.

4. The PPO family liaison officer wrote to Mr Marshall's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about the use of restraints and the application for early compassionate release. The next of kin also asked for a copy of our report.

5. The PPO investigator investigated the non-clinical issues relating to Mr Marshall's care including the use of restraints and consideration of early compassionate release. We did not find any non-clinical issues of concern.

6. NHS England commissioned an independent clinical reviewer to review Mr Marshall's clinical care at HMP Hull. She concluded that the clinical care Mr Marshall received at HMP Hull was of a good standard and was equivalent to that which he could have expected to receive in the community.

7. The clinical reviewer made three recommendations, which were not related to Mr Marshall's death but which the Head of Healthcare will want to address.

8. We make no recommendations.

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

Adrian Usher **June 2024**
Prisons and Probation Ombudsman

10. The inquest into Mr Marshall's death was held on 15 October 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Marshall's death was due to bronchopneumonia. He also had advanced metastatic lung cancer.

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