Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Lancaster-Madeley, a prisoner at HMP Isle of Wight, on 29 July 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

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 His Majesty's 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. On 14 March 2018, Mr Andrew Lancaster-Madeley was sentenced to 14 years in prison for sexual offences.

4. Mr Lancaster-Madeley died in hospital from multiple organ failure on 29 July 2023, while a prisoner at HMP Isle of Wight. This was caused by carcinomatosis (a condition where the cancer cells from the original tumour spread to form tumours throughout the body) which was in turn caused by small cell cancer which had probably spread from the lungs. He also had severe chronic obstructive pulmonary disease and hypertension (high blood pressure). He was 60 years old. We offer our condolences to Mr Lancaster-Madeley's family and friends.

5. The PPO family liaison officer wrote to Mr Lancaster-Madeley's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

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

7. The clinical reviewer concluded that the clinical care Mr Lancaster-Madeley received at HMP Isle of Wight was of a good standard and was at least equivalent to that which he could have expected to receive in the community. She found that a member of the nursing team had visited Mr Lancaster-Madeley in hospital and highlighted this as an area of good practice.

8. The clinical reviewer made one recommendation not related to Mr Lancaster-Madeley's death which the Head of Healthcare will want to address.

9. The PPO investigator investigated the non-clinical issues relating to Mr Lancaster-Madeley's care.

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

11. We did not find any non-clinical issues of concern and we make no recommendations.

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

12. At an inquest held on 18 November 2025, the Coroner concluded that Mr Lancaster-Madeley died of natural causes.

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