

**Prisons &
Probation**

Ombudsman
Independent Investigations

Investigation into the death of Mr Alan Maudsley a prisoner at HMP Exeter on 20 July 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

This is the investigation report into the death of Mr Alan Maudsley from bronchopneumonia, a final development of bladder cancer, on 20 July 2015, at HMP Exeter. He was 51 years old. I offer my condolences to Mr Maudsley's family and friends.

While I am satisfied that, overall, Mr Maudsley's care was equivalent to that he could have expected in the community, the clinical reviewer considers that doctors at HMP Erlestoke should have made an earlier referral for suspected cancer. After his diagnosis, Mr Maudsley received good quality care at Erlestoke followed by a high standard of end of life care at Exeter in the terminal stage of his illness.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2016

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Summary

Events

1. On 13 December 2005, Mr Alan Maudsley received an indeterminate sentence for public protection with a minimum term to serve of two years and eight months. He had been at HMP Erlestoke since 15 December 2011.
2. In January 2013, a prison doctor diagnosed Mr Maudsley with a urinary infection when he reported blood in his urine. He prescribed antibiotics but did not retest at the end of the course. Mr Maudsley reported no further problems until December 2014, when he said he had blood in his urine again. A prison GP found no sign of infection and referred him for a routine appointment with an urologist. In January 2015, another prison GP noted the blood in his urine was severe and referred him urgently under the NHS pathway for suspected cancer.
3. In January 2015, hospital doctors diagnosed Mr Maudsley with bladder cancer. In April, surgeons removed his bladder and discovered the cancer was widespread. Active treatment was not possible.
4. Healthcare staff at Erlestoke reviewed Mr Maudsley regularly and his condition deteriorated over time. On 3 June, a doctor sent him to hospital with severe constipation. On 16 June, when he was discharged from hospital, Mr Maudsley moved to HMP Exeter for palliative care. Mr Maudsley died at Exeter on 20 July. Members of his family were with him at the time.

Findings

5. The clinical reviewer concluded that, overall, Mr Maudsley's care was equivalent to that he could have expected to receive in the community. However, he noted that a urine infection diagnosed and treated in January 2013, was not retested to ensure it had cleared. Mr Maudsley did not report further blood in his urine for nearly two years but it is not possible to know whether the blood in 2013 was an early sign of bladder cancer. Although it would not have changed the outcome for Mr Maudsley, as he was referred shortly afterwards, the doctor who saw Mr Maudsley twice in December 2014, did not consider his symptoms in line with national guidelines and refer him to a specialist at the earliest opportunity.
6. When Mr Maudsley went to hospital from Erlestoke, restraints were used without any meaningful input from healthcare staff into risk assessments. Although managers appear to have made generally appropriate decisions, there is a need for informed contributions from healthcare staff for prisoners who are seriously or terminally ill. We make two recommendations to HMP Erlestoke.

Recommendations

- The Head of Healthcare at HMP Erlestoke should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.
- The Governor and Head of Healthcare at Erlestoke should ensure that healthcare staff understand their role in contributing to risk assessments for prisoners taken to hospital, that all relevant staff understand the legal position and that assessments fully take into account the health of a prisoner and the actual risk the prisoner presents at the time.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Exeter and HMP Erlestoke, informing them of the investigation and asking anyone with relevant information to contact him. No one responded
8. The investigator obtained copies of relevant extracts from Mr Maudsley's prison and medical records. He interviewed seven members of staff at HMP Erlestoke by telephone in September 2015.
9. NHS England commissioned a clinical reviewer to review Mr Maudsley's clinical care at the prison.
10. We informed HM Coroner for Exeter and Greater Devon of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report
11. One of the Ombudsman's family liaison officers contacted Mr Maudsley's family to explain the investigation. They did not have any specific issues for the investigation to consider.
12. The initial report was shared with the Prison Service. They did not identify any factual inaccuracies.
13. Mr Maudsley's family received a copy of the draft report. They pointed out a number of omissions and this report has been amended accordingly. Mr Maudsley's family also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
14. The investigation has assessed the main issues involved in Mr Maudsley's care, including his diagnosis and treatment, whether appropriate palliative care was provided, Mr Maudsley's diabetes, management of his hearing aid and medical hold, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

Background Information

HMP Exeter

15. HMP Exeter is a local prison holding about 500 men. Dorset NHS University Foundation Trust provides health services. There are 12 cells on F Wing for prisoners who need social care and one cell for end of life palliative care. The wing has facilities for visiting relatives.

HM Inspectorate of Prisons

16. The most recent inspection of Exeter was in August 2013. The Inspectorate found that care for prisoners on F Wing with complex needs and disabilities was impressive. There were 24-hour health services and a wide range of clinics, including for chronic diseases. Two nurses led the care of older prisoners. Palliative care was supported through an excellent new suite which had been created for the care of terminally ill prisoners

Independent Monitoring Board

17. 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 most recently published annual report for the year to December 2013, the IMB said there had been little continuity of GPs, but health services were generally good and F Wing provided good care for terminally ill prisoners.

Previous deaths at HMP Exeter

18. Mr Maudsley was the eighth prisoner to die of natural causes at Exeter since 2012. We have found that Exeter has consistently provided good end of life care.

HMP Erlestoke

19. HMP Erlestoke is a medium security prison near Devizes in Wiltshire, which holds around 500 men. Great Western Hospitals NHS Foundation Trust provides health services at the prison. Nurses are on duty from 8.00am to 5.00pm Monday to Friday. There is an out-of-hours service at night and weekends. GPs from a local practice run a clinic each weekday morning.

HM Inspectorate of Prisons

20. The most recent inspection of Erlestoke was in October 2013. The inspectorate found that the level and quality of health services were good, but too many hospital appointments were cancelled because of a lack of escorts.

Independent Monitoring Board

21. The Erlestoke IMB annual report for the year to March 2015, said that it had been a difficult year for healthcare staff because of staff shortages. Despite this staff had worked well to achieve a 'green light' status in the prison quality and performance indicators. However, the Board was concerned there were too many missed hospital appointments because of a lack of escorts, and too many missed healthcare appointments.

Findings

The diagnosis of Mr Maudsley's terminal illness and informing him of his condition

22. On 13 December 2005, Mr Maudsley received an indeterminate sentence for public protection for arson, with a minimum term to serve of two years and eight months. He had been at Erlestoke since December 2011. The Parole Board had never considered him suitable for release. Mr Maudsley suffered from diabetes and deafness. He smoked cigarettes and had a history of substance misuse.
23. On 9 January 2013, a prison GP recorded that Mr Maudsley had blood in his urine (haematuria). Tests showed it was a urinary infection and the doctor prescribed antibiotics. There is no record of any further test to check that the infection was fully clear.
24. Mr Maudsley did not report any further blood in his urine until 9 December 2014, when a prison GP examined him. She thought he might have renal colic (a type of pain caused by kidney stones) and asked for a urine test. A nurse did not do a dipstick test until 16 December. On 23 December, the GP saw Mr Maudsley again with ongoing haematuria (blood in urine) and recorded no signs of infection. She did not test his urine again, but referred Mr Maudsley to an urologist for a routine appointment.
25. On 8 January 2015, a prison GP reviewed Mr Maudsley. He noted he had normal renal function but had suffered persistent severe haematuria for the last month. The GP referred Mr Maudsley urgently to an urologist under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. On 20 January, a urology specialist examined Mr Maudsley. Investigations found a cancerous tumour in his bladder wall. Hospital consultants informed Mr Maudsley of his condition. The next day, Mr Maudsley told a nurse that doctors had found a growth. The nurse offered support to Mr Maudsley.
26. The National Institute for Health and Care Excellence (NICE) Guidelines say that healthcare staff should 'refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for bladder cancer if they are aged 45 and over and have: unexplained visible haematuria without urinary tract infection or visible haematuria that persists or recurs after successful treatment of urinary tract infection'. The clinical reviewer noted that Mr Maudsley had visible blood in his urine in January 2013 but this was found to be from a urinary tract infection. There was no record that, Mr Maudsley's urine was re-tested after the treatment, to ensure the infection had cleared, which the clinical reviewer considered should have happened. It is therefore not possible to know if the blood was an early sign of bladder cancer. However, Mr Maudsley did not complain of further blood in his urine until nearly two years later.
27. The clinical reviewer considered that, when the doctor saw Mr Maudsley on 9 December 2014, standard practice would have been to diagnose or exclude a urine infection immediately, by testing the urine with a dipstick and/or by sending

a sample to a laboratory for microscopy and culture. It was not until 16 December that a nurse carried out a dipstick test and recorded blood and protein in the urine. The clinical reviewer noted that, as there were no results recorded for leucocytes and nitrites, this suggested that the bleeding had not been caused by an infection. In the absence of an infection, the doctor should have referred Mr Maudsley urgently to a specialist for suspected cancer.

28. A prison GP said that she referred Mr Maudsley for a non-urgent urologist appointment on 23 December, as the haematuria were the only symptoms present when she saw him. She was satisfied that Mr Maudsley was clinically reassessed and referred by a colleague when his symptoms developed further.
29. The clinical reviewer concluded that, it is unlikely that the four-week delay in making an urgent referral would have made a difference to the management and outcome of Mr Maudsley's condition. However, in other cases, early and appropriate diagnosis could preserve or prolong life. We make the following recommendation:

The Head of Healthcare at HMP Erlestoke should ensure that GPs follow relevant National Institute for Health and Clinical Excellence (NICE) guidelines for suspected cancer and refer patients appropriately.

Mr Maudsley's Clinical Care

HMP Erlestoke

30. On 6 February 2015, surgeons at the hospital removed a large tumour from Mr Maudsley's bladder. On 10 February, he was discharged back to the prison. A nurse recorded that the urologist had said that treatment choices included radical surgery to remove his bladder.
31. On 27 March, an oncologist assessed Mr Maudsley as not suitable for chemotherapy and Mr Maudsley agreed to have surgery. On 14 April, surgeons at the hospital removed Mr Maudsley's bladder and created an ileal conduit, where urine drains into a urostomy bag. Tests showed that Mr Maudsley had widespread cancer, which could not be actively treated. Hospital staff informed Mr Maudsley and he returned to the prison on 5 May.
32. Over the next few weeks healthcare staff saw Mr Maudsley every day to monitor his condition, give him medication and change his urostomy bags. Mr Maudsley's condition deteriorated over time.
33. On 2 June, a prison GP noted Mr Maudsley had abdominal pain and constipation, for which she prescribed a laxative. The next day, another GP reviewed Mr Maudsley and noted he had not improved. He sent him to hospital, where he remained until 16 June. His condition deteriorated significantly and, when he was discharged, Mr Maudsley was taken to HMP Exeter for palliative end of life care.
34. The clinical reviewer found that healthcare staff at Erlestoke reviewed Mr Maudsley frequently and issued prescribed medication appropriately. He had some concerns about the management of Mr Maudsley's anticoagulant medication, which was prescribed in hospital, and has made a recommendation

about this, which the Head of Healthcare will need to address. Overall, we are satisfied that Mr Maudsley received good quality care at Erlestoke after his diagnosis. There was good communication with the hospital and Mr Maudsley's pain was managed satisfactorily.

Management of Mr Maudsley's diabetes and hearing aid

35. After we issued the initial report, Mr Maudsley's family raised concerns about the management of Mr Maudsley's diabetes and hearing aid. We have investigated this matter further.
36. The medical records show that healthcare staff frequently reviewed Mr Maudsley's diabetic control and regularly monitored his sugar levels. Healthcare staff frequently issued Mr Maudsley with glucose measurement sticks to measure his sugar levels. A prisoner, who was Mr Maudsley's carer while at Erlestoke, told the investigator that he did not have any concerns about Mr Maudsley's diabetes management at the prison and the clinical reviewer, who provided an addendum report, concluded that Mr Maudsley's diabetes management was equivalent to that in the community.
37. We also found that Mr Maudsley frequently received replacement batteries for his hearing aid and healthcare staff appropriately referred him to the hospital's Audiology Department. The prisoner told the investigator that Mr Maudsley was profoundly deaf and that he could not hear without his hearing aids however he always used his hearing aids and there were always batteries available to him. He said that he never had cause to raise any issues on Mr Maudsley's behalf regarding his hearing impairment and his hearing aid. The clinical reviewer also concluded that the management of Mr Maudsley's hearing aid and impairment was adequate.

HMP Exeter

38. On 17 June, the day after he arrived at Exeter, a nurse noted that Mr Maudsley said he was comfortable and not in pain. On 18 June, a prison GP discussed his condition with him. She recorded that Mr Maudsley was aware he was terminally ill and knew there was no further active treatment available. Mr Maudsley decided that he did not want anyone to try to resuscitate him if his heart or breathing stopped.
39. On 10 July, a prison GP and a palliative care nurse reviewed Mr Maudsley. He complained of increased pain and the nurse advised using a syringe driver to provide constant pain relief medication. (A syringe driver is a small battery-powered pump that delivers medication into a syringe with a needle placed just under the skin.) Mr Maudsley agreed, and nurses set up the syringe driver. The GP and Mr Maudsley discussed his condition and that he was approaching the end of his life.
40. On 20 July, a nurse saw Mr Maudsley in the morning and checked his syringe driver. She noted that Mr Maudsley and his family, who had arrived the night before, were settled. Mr Maudsley was sleeping and appeared comfortable. Just after 11.20am, a nurse noted Mr Maudsley's breathing rate had changed and was laboured. At 12.05pm, Mr Maudsley stopped breathing. Another nurse

checked for a pulse but did not attempt resuscitation, in line with his wishes. A prison GP certified Mr Maudsley's death.

41. A post-mortem examination found that the cause of death was bilateral basal pneumonia (infection of the lungs), bladder cancer and ischaemic heart disease (disease of the blood vessels supplying the heart muscles with oxygen). Pneumonia is a common final development for people who are terminally ill.
42. The clinical reviewer concluded that the palliative care provided by Exeter showed a consistently high standard of care. We are satisfied that nurses and doctors at Exeter showed a clear understanding of high quality palliative care in line with NHS guidelines and looked after Mr Maudsley very well.

Mr Maudsley's location and medical hold

43. An offender supervisor told the investigator that she started working with Mr Maudsley at around June 2013. She wanted Mr Maudsley to move to Calderstones, a specialist mental health hospital, because Mr Maudsley had been assessed as having low intellectual capacity. She told the investigator that she believed that Calderstones was the best location for him and it was closer to his family.
44. She said that Calderstones received her first referral on 27 December 2013 and assessed Mr Maudsley on 10 January 2014 and 10 February 2014. Mr Maudsley however was regarded as not suitable for admission because he did not accept his offence. She therefore continued working with Mr Maudsley on his offending behaviour.
45. The offender supervisor re-referred Mr Maudsley to Calderstones on 30 October 2014 when he made a full and frank admission for his offending. On 20 January 2015, the hospital staff told her that there was a technical issue that caused delays in Mr Maudsley's referral but confirmed that they wanted to assess Mr Maudsley in person in the next two weeks. This is also recorded in Mr Maudsley's prison records.
46. While the assessment for admission at Calderstones was arranged, a urology specialist examined Mr Maudsley and found a cancerous tumour in his bladder wall. The offender supervisor recorded on 22 January that a medical hold was placed on Mr Maudsley for his transfer as a result, and that healthcare staff started investigations on Mr Maudsley's cancer.
47. Mr Maudsley then had an urgent appointment in hospital to find out what the prognosis and the management of his bladder cancer would be. Although there was not a definite prognosis on life expectancy, it was clear that Mr Maudsley's health was deteriorating and healthcare staff started to consider moving Mr Maudsley to a palliative care unit.
48. After Mr Maudsley's diagnosis, he remained living in a single cell in a small unit at Erlestoke, where he was well established and settled. A nurse told us that healthcare staff did not have any concerns about Mr Maudsley's location after he returned from hospital after his surgery. He was independent, and received good support from his friends in the unit. However, as Mr Maudsley's health declined it was evident that he needed to move to a prison with 24-hour healthcare.

49. There are a number of entries in Mr Maudsley's medical records where healthcare staff recorded making reasonable attempts to move Mr Maudsley to a 24 hour healthcare facility close to his family and on 16 June, after a period in hospital, Mr Maudsley moved to Exeter's palliative care suite.
50. The clinical reviewer concluded that the medical hold placed on Mr Maudsley for a move to Calderstones was appropriate given Mr Maudsley's deterioration in his health and we are satisfied that the decision to move Mr Maudsley to a palliative care unit was adequate. Once Mr Maudsley was diagnosed with bladder cancer, we are satisfied that staff at Erlestoke made appropriate efforts to transfer Mr Maudsley to an establishment with 24-hour healthcare as soon as it was clear his condition was deteriorating. The palliative care suite at Exeter has suitable facilities with enough space for easy access and nursing. We consider that this was an appropriate location for Mr Maudsley's end of life care

Restraints, security and escorts

51. The Prison Service has a duty to protect the public when escorting prisoners outside prison and 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 prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's condition, mobility and ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
52. From 20 January 2015, Mr Maudsley attended at least 10 hospital appointments from Erlestoke. (He had no further hospital appointments after he moved to Exeter.) For each of these appointments the prison completed an escort risk assessment, which included a section for healthcare staff to record any 'objections for the use of restraints' or any 'other medical condition likely to influence the escort'. Records show that managers decided that he should be handcuffed for most hospital visits, which officers removed for treatment.
53. On 14 April, when Mr Maudsley went to hospital for surgery, the Head of Security assessed him as low risk in all areas including to the public and escape. The risk assessment recorded that there was no medical information reported to security. The security department asked healthcare staff for further information. Healthcare staff said that there were no healthcare objections to the use of restraints, no medical condition likely to influence the escort, and that Mr Maudsley's condition was not serious or life threatening. Mr Maudsley was sent to hospital handcuffed.
54. The Governor of Erlestoke carried out a further assessment on 16 April when Mr Maudsley was in hospital after the surgery and tests had discovered he had widespread cancer. There was no healthcare input and he authorised the continued use of restraints. On 18 April, a custodial manager (the name is not clear) reviewed the use of restraints and noted that as Mr Maudsley was "frail

and immobile” there was no need for restraints. Officers removed Mr Maudsley’s restraints the same day.

55. On 3 June Mr Maudsley went to hospital, where he remained until 16 June before moving to HMP Exeter. By this time his condition had deteriorated significantly. The escort risk assessment recorded no relevant medical information reported to security and the Head of Security initially approved sending Mr Maudsley to hospital handcuffed. However, another prison manager noted Mr Maudsley could not walk and decided he should not be restrained.
56. A nurse told us that the escort risk assessments were documents relevant to security rather than healthcare staff. She and a colleague said that healthcare staff simply state whether a prisoner is fit to travel or not. The Head of Security told us that healthcare staff had a template to complete as part of the escort risk assessment and should note any medical issues relevant to risk.
57. We are pleased to note that a custodial manager approved the removal of restraints on 18 April and a manager changed the original decision to restrain Mr Maudsley on 3 June. It therefore does not appear that Mr Maudsley was unnecessarily restrained or for very long. However, healthcare input into the risk assessment on 16 April might have led to a different conclusion. While there was no real detriment to Mr Maudsley, it does not appear that healthcare staff understood their part in the risk assessment process. All those involved in making decisions about escorting prisoners to hospital appointments need to ensure that they take prisoner’s health and mobility fully into account, in line with the requirements of the 2007 High Court judgment. This requires considered and meaningful input from healthcare staff. We make the following recommendation:

The Governor and Head of Healthcare at Erlestoke should ensure that healthcare staff understand their role in contributing to risk assessments for prisoners taken to hospital, that all relevant staff understand the legal position and that assessments fully take into account the health of a prisoner and the actual risk the prisoner presents at the time.

Liaison with Mr Maudsley’s family

58. Mr Maudsley was in contact with his family while at Erlestoke. Staff let them know when he went to hospital in February, April and June, and kept them informed of his condition.
59. HMP Exeter appointed an officer as Mr Maudsley’s family liaison officer. On 17 June 2015, she contacted Mr Maudsley’s sister, who he had named as his next of kin. She arranged visits and continued contact with members of Mr Maudsley’s family. Members of his family were with him when he died on 20 July.
60. Mr Maudsley’s funeral was on 6 August and the prison contributed towards the cost, in line with national instructions. We are satisfied there was very good liaison with Mr Maudsley’s family.

Compassionate release

61. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).
62. The PPCS told us they received an email on 5 June 2015 from HMP Erlestoke stating that they were considering applying for compassionate release for Mr Maudsley. We were told that an application was started at Erlestoke and an offender supervisor completed one of the sections of the compassionate release application on 8 June. He wrote that it had previously been agreed that Mr Maudsley would be released from custody and placed in the care of mental health services at Calderstones because this facility was seen as being more appropriate for his needs (as another offender supervisor confirmed to the investigator). However, due to his ill health, he assessed that Mr Maudsley was better placed in a palliative care unit.
63. On 9 July, Exeter informed the PPCS that Mr Maudsley was terminally ill and that they were applying for compassionate release. A prison GP completed a medical report on 13 July. She noted that hospital doctors had not yet provided a definite prognosis on life expectancy, which is fundamental requisite for compassionate release eligibility. However, she said that palliative care nurses had assessed Mr Maudsley's life expectancy in weeks. HMP Exeter submitted the application and the PPCS received it on 14 July. On 17 July, PPCS also received an initial release plan from Exeter and asked for further information on Mr Maudsley's release plan. Sadly, a decision was not reached before Mr Maudsley died.
64. We are satisfied that both prisons appropriately considered compassionate release.

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