Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Owen Maughan, a prisoner at HMP Lancaster Farms, on 16 December 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

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 Owen Maughan died of a blocked bowel caused by a blood clot on 15 December 2021 while a prisoner at HMP Lancaster Farms. He was 36 years old. I offer my condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Maughan received at HMP Lancaster Farms was equivalent to that which he could have expected to receive in the community. She made several recommendations about secondary health screenings, management of long-term conditions, use of the NEWS2 tool and following up missed secondary health appointments. We repeat some of her recommendations below.

5. The prison failed to provide us with an up to date record of the Family Liaison Log, despite three requests.

Recommendations

- The Head of Healthcare should ensure that staff complete secondary health screenings in line with NICE guidance, NG57 physical health of people in prison.
- The Head of Healthcare should ensure all clinical healthcare staff are competent in the use of the NEWS2 assessment when responding to medical emergencies.
- The Governor should ensure that a family liaison log is started as soon as the family liaison officer is deployed and all communications with the family are recorded.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Maughan's clinical care at HMP Lancaster Farms.

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

8. We wrote to Mr Maughan's next of kin, his mother, to explain the investigation. She raised concerns about the timing of being told of Mr Maughan's death, compassionate release and the fact that she was unable to be with her son when he died. Her concerns have been addressed in this report and in separate correspondence.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies. The action plan has been annexed to this report.

Previous deaths at HMP Lancaster Farms

10. Mr Maughan was the second prisoner to die at Lancaster Farms since December 2019. The previous death was from natural causes. There are no similarities between our findings in the investigation into Mr Maughan's death and our investigation findings for the previous death.

Key Events

11. On 29 May 2020, Mr Maughan was sentenced to two years in prison for a violent offence. He was released on licence on 17 February 2021. A few days later, he was recalled to prison for breaching his licence conditions. On 10 March, he transferred to HMP Lancaster Farms.

12. Mr Maughan had several pre-existing health conditions, including liver cirrhosis (liver disease), oesophageal varices (abnormal and enlarged veins in the throat), hypertension (high blood pressure), primary adrenal insufficiency (when the adrenal glands do not produce sufficient hormones), portal vein thrombosis (blood clots in the veins of the liver) and chronic pancreatitis (inflamed pancreas).

13. On his arrival at Lancaster Farms, a nurse completed his initial health screen. She noted his pre-existing medical conditions and took his observations which were all within the normal range. Healthcare staff did not complete a secondary health screen as they should have done. Mr Maughan raised no health-related concerns over the months that followed.

14. On 9 October, Mr Maughan vomited fresh blood. He was taken to hospital and was admitted as an inpatient. He was diagnosed with bleeding in his stomach, high blood pressure and alcoholic liver disease. He was referred to Leeds Teaching Hospital for specialist treatment and consideration of a liver transplant.

15. On 29 October, Mr Maughan was discharged from hospital. He was taken to Preston prison because it provided 24-hour healthcare and was able to meet his healthcare needs. Lancaster Farms retained overall responsibility for Mr Maughan.

16. On his arrival at Preston, a nurse saw Mr Maughan. His blood pressure and oxygen levels were low and he had a NEWS2 score of six, which meant that medical staff needed to review him urgently. (NEWS2 is a tool used to monitor clinical deterioration.) Healthcare staff called an ambulance and he was taken back to hospital. Mr Maughan received appropriate treatment and his condition stabilised.

17. On 30 October, Mr Maughan was discharged from hospital. He returned to Preston and was placed under four hourly observations. Healthcare staff created a care plan to support the management of his alcohol liver disease.

18. On 1 November, Mr Maughan became unwell again and had a NEWS2 score of six. He was taken to hospital by ambulance. A CT scan showed that his bowel was inflamed. He stayed in hospital to have his blood monitored but his health continued to deteriorate.

19. On 16 November, Lancaster Farms started an application for Early Release on Compassionate Grounds on Mr Maughan's behalf. The prison could not complete the application because the hospital did not provide them with medical evidence of Mr Maughan's condition. The prison chased the hospital for this information on several occasions.

20. Mr Maughan's health continued to deteriorate in hospital.

21. At around 9.30pm on 15 December, the prison bedwatch officers told hospital staff that they thought Mr Maughan had died. In the early hours of 16 December, a

hospital doctor confirmed Mr Maughan's death. Once Mr Maughan's death was certified, the prison's Family Liaison Officer (FLO) notified Mr Maughan's next of kin, his mother, of his death.

Cause of death

22. The Coroner gave Mr Maughan's cause of death as bowel ischemia (when the blood flow to the bowel is blocked) caused by superior mesenteric vein thrombus (a blood clot in the vein of the bowel). He also had decompensated alcoholic liver disease which did not cause but contributed to his death.

Non-Clinical Findings

Family liaison

23. The prison provided us with an incomplete FLO log as the last entry was dated 7 January 2022. The prison told us that they did have a FLO log in place but not all communications with Mr Maughan's family were recorded. We make the following recommendation:

The Governor should ensure that a family liaison log is started as soon as the family liaison officer is deployed and all communications with the family are recorded.

Lisa Burrell
Assistant Prisons and Probation Ombudsman **February 2023**

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