

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Murray Monk, a prisoner at HMP Littlehey, on 9 January 2021

**A report by the Prisons and Probation Ombudsman**





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## 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 Murray Monk, who was 73 years old, died of heart disease on 9 January 2021, at HMP Littlehey. We offer our condolences to those who knew him.
4. The clinical reviewer concluded that Mr Monk received a good standard of care at Littlehey, equivalent to that he could have expected to receive in the community. However, she made four recommendations, two of which we have included in our report.
5. We are concerned that staff tried to resuscitate Mr Monk despite him having a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place.
6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

## Recommendations

- The Head of Healthcare should ensure that prisoners who refuse to take their prescribed medication are discussed regularly at the multidisciplinary team meeting and their mental capacity is assessed regularly and documented in their medical record.
- The Governor and Head of Healthcare should ensure that staff:
  - are aware of prisoners with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place;
  - understand the DNACPR policy; and
  - do not start CPR against prisoners' wishes.

## The Investigation Process

7. NHS England commissioned an independent clinical reviewer, to review Mr Monk's clinical care at HMP Littlehey. The clinical review is attached to this report as Annex 1.
8. The clinical reviewer conducted joint interviews with the investigator. Due to coronavirus restrictions, the interviews were conducted by telephone. The interview transcripts are attached to this report.
9. The PPO investigator has investigated the non-clinical issues in Mr Monk's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies

## Previous deaths at HMP Littlehey

11. Mr Monk was the 20th prisoner to die at Littlehey since January 2019. Of the previous deaths, 18 were from natural causes and one was self-inflicted. We have previously made a recommendation about ensuring staff are aware of prisoners' resuscitation wishes.

## Key Events

12. In June 2011, Mr Murray Monk was sentenced to ten years in prison for sexual offences. On 15 November 2019, he was moved to HMP Littlehey.
13. Mr Monk had heart disease, angina and high blood pressure. He refused to take any of his prescribed medication because he said it was not good for him. Healthcare staff assessed that he had full mental capacity to make this decision.
14. On 23 March 2020, healthcare staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order with Mr Monk, who agreed that if he stopped breathing he did not want to be resuscitated.
15. On 23 April, Mr Monk declined to wear the DNACPR wrist band to indicate to staff that he did not want to be resuscitated.
16. On 8 September, a prison GP saw Mr Monk and they had a discussion about Mr Monk's medication. Mr Monk was adamant that he did not want any heart medication.
17. Mr Monk refused to go to hospital for his pacemaker to be checked and on 3 December, he signed a disclaimer form refusing to be seen by the cardiology team at the hospital.
18. On 9 January 2021, at 9.30am an officer was unlocking prisoners for exercise. When he unlocked Mr Monk's door, he saw that he was lying on his bed face up and was unresponsive. He shouted to an officer (who was unlocking with him) to call a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). The officer went into the cell and started cardiopulmonary resuscitation (CPR). An officer collected a defibrillator and attached it to Mr Monk.
19. A few moments later, a nurse responded to the code blue. She asked the custodial manager at the scene if a DNACPR order was in place. The custodial manager checked and was told by the communications operator that there was a DNACPR order in place, so he told staff to stop CPR immediately.
20. At 10.03am, paramedics arrived and confirmed that Mr Monk had died.
21. The post-mortem report concluded that Mr Monk died from ischaemic and hypertensive heart disease.

## Non-Clinical Findings

### Attempted resuscitation of Mr Monk

22. The two officers started CPR on Mr Monk, despite him having a DNACPR order in place. When the investigator spoke with the officers, they said that they were unaware of the DNACPR order. One officer said that it should have been on the daily morning briefing sheet, but he did not have time to look at it. The other officer said that prisoners with DNACPR orders were listed on the roll board but as he was not usually on Mr Monk's wing, he was unaware.
23. Furthermore, both officers told the investigator that even if they had been aware that a DNACPR order was in place they still would have started CPR, until they were told to stop by healthcare staff. This is a misunderstanding as Littlehey's DNACPR policy is clear that staff should not resuscitate where a DNACPR is in place unless it is a self-harm incident or an incident such as choking or a fall.
24. We are concerned that staff started CPR on Mr Monk against his wishes. Therefore, we make the following recommendation:

#### **The Governor and Head of Healthcare should ensure that staff:**

- **are aware of prisoners with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place;**
- **understand the DNACPR policy; and**
- **do not start CPR against prisoners' wishes.**

**Louise Richards**  
**Assistant Ombudsman**

**June 2021**

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