

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil Brennan, a prisoner at HMP Cardiff, on 2 August 2021

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Brennan died of lung cancer on 2 August 2021, while a prisoner at HMP Cardiff. He was 62 years old. We offer our condolences to Mr Brennan's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Brennan received at Cardiff after his cancer diagnosis was of a good standard and equivalent to that which he could have expected to receive in the community.
5. We did not identify any non-clinical issues of concern and make no recommendations.

The Investigation Process

6. Healthcare Inspectorate for Wales commissioned a clinical reviewer to review Mr Brennan's clinical care at HMP Cardiff.
7. The PPO investigator investigated the non-clinical issues in Mr Brennan's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Brennan's family to explain our investigation.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Cardiff

10. There were four deaths from natural causes (one of which was related to COVID-19) and three self-inflicted deaths at Cardiff in the two years before Mr Brennan's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

11. In May 2021, Mr Brennan was remanded to HMP Cardiff for possessing an offensive weapon and failing to answer court bail. Later that month, he was convicted and sentenced to seven months in prison. He stayed at Cardiff and was due to be released on 27 August 2021.
12. On 14 June, Mr Brennan was seen by a prison nurse following a fall. She arranged for him to go to University Hospital Wales because his right arm was swollen, and he could not bend it.
13. Mr Brennan was admitted to hospital and had an X-ray and MRI scan. On 15 June, a hospital consultant diagnosed Mr Brennan with lung cancer and suspected brain tumours. A prison nurse manager called Mr Brennan's family to tell them that he was in hospital. She also told them that the consultant would call them to discuss his diagnosis and treatment, which he did on 16 June.
14. On 22 June, Mr Brennan went back to HMP Cardiff and was admitted to the healthcare unit. The prison nurse manager updated Mr Brennan's family and put in place regular monitoring for Mr Brennan's health needs, including a falls assessment.
15. Mr Brennan was escorted to a follow up hospital appointment on 4 July and told that his cancer was terminal. The prison nurse manager informed his family that his prognosis was weeks or months. The prison arranged for Mr Brennan's family to visit him and referred him to a local hospice. Mr Brennan and his family contributed to his care plans and he said that he would prefer to die in prison than a hospice.
16. Early release on compassionate grounds was considered on 9 July, in line with national guidance. It was decided by Mr Brennan, his family and a prison doctor that he would be better supported in the prison's healthcare unit until he required hospice care.
17. Mr Brennan's health continued to get worse, and he developed a chest infection on 13 July. The Governor authorised for his door to be left unlocked 24 hours a day so healthcare staff could get to him more easily.
18. On 22 July, Mr Brennan was taken to hospital for an X-ray and diagnosed with a hip fracture. He was admitted to University Hospital Wales for routine surgery. The operation went well but he remained in hospital as he developed blood clots.
19. Family visits were facilitated during Mr Brennan's hospital stay. He remained in hospital, where he died on 2 August at 8.00am of lung cancer which had spread to his bones and brain. His family members were with him when he died.

Post-mortem report

20. A post-mortem examination was not conducted. A hospital doctor confirmed Mr Brennan's death and the coroner accepted the cause of death as non-small cell carcinoma of lung (lung cancer) with extensive bone and brain metastases (tumours in the bones and brain). He also had a pathological left neck of femur

fracture (a break in a bone caused by an underlying disease) which did not cause but contributed to his death.

Clinical Findings

21. The independent clinical reviewer concluded that the care that Mr Brennan received was equivalent to that he could have expected to receive in the community. The clinical reviewer said that when Mr Brennan was diagnosed with cancer his care was of a good standard and referrals were timely. He also noted that the palliative care plan and reviews involved Mr Brennan and his family. He was satisfied that Mr Brennan was located in the best place to meet his health needs.

Karen Johnson
Assistant Ombudsman

January 2022

**Prisons &
Probation**

Ombudsman
Independent Investigations