Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Monaghan, a prisoner at HMP Berwyn, on 30 August 2022

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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 Gary Monaghan died in hospital on 30 August 2022 of idiopathic pulmonary fibrosis (scarring of the lungs) at HMP Berwyn. He was 74 years old. We offer our condolences to Mr Monaghan's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Monaghan received at Berwyn was equivalent to that which he could have expected to receive in the community. However, he found that there had been a delay in completing a DNACPR (Do Not Attempt CPR) order for Mr Monaghan.

5. We also found there was a delay in starting the application for Mr Monaghan's early release on compassionate grounds after he received his terminal prognosis.

Recommendations

- The Head of Healthcare should ensure that DNACPR paperwork is completed promptly.

- The Governor should ensure that applications for early release on compassionate grounds are started and submitted as promptly as possible.

The Investigation Process

6. Health Inspectorate Wales commissioned an independent clinical reviewer to review Mr Monaghan's clinical care at Berwyn.

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

8. The investigator wrote to Mr Monaghan's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

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

Previous deaths at HMP Berwyn

10. Mr Monaghan was the seventh prisoner to die at Berwyn since August 2020. Of the previous deaths, five were from natural causes and one was self-inflicted. We have made a recommendation in a previous case about the need for compassionate release applications to be progressed and submitted promptly.

Key Events

11. On 27 March 2013, Mr Gary Monaghan was sentenced to life imprisonment for murder, with a minimum term of 15 years and five months. In July 2017, he was moved to HMP Berwyn.

12. On 2 December 2021, Mr Monaghan was taken to hospital with breathing difficulties. He tested positive for COVID-19 in hospital and remained there until 6 December.

13. In February 2022, Mr Monaghan was taken to hospital twice due to breathing difficulties. Hospital doctors advised this was caused by scarring to his lungs and long COVID.

14. On 11 March, Mr Monaghan attended an outpatient appointment with a thoracic consultant. The consultant diagnosed Mr Monaghan with idiopathic pulmonary fibrosis (a condition in which the lungs become scarred and breathing becomes increasingly difficult). He gave him advice about inhaler use and organised a six-month review.

15. On 31 March, the prison GP asked nurses to do weekly nursing observations and weight checks to monitor for any deterioration.

16. During April, Mr Monaghan continued to struggle with his calorie intake and was still breathless. The prison GP wrote to the hospital doctor for advice, who replied that the best approach would be to control the symptoms and palliative care (care for conditions that cannot be cured).

17. On 13 May, a prison GP prescribed antibiotics to Mr Monaghan to treat a lung infection.

18. On 19 May, a palliative care consultant reviewed Mr Monaghan and noted that Mr Monaghan did not want any further hospital treatment and that a DNACPR (Do Not Attempt CPR) order should be completed (a form to say that a person does not want to be resuscitated if their heart or breathing stops).

19. On 20 May, a prison GP prescribed further antibiotics but Mr Monaghan refused to take them as he said they were not making him feel any better and were giving him diarrhoea.

20. On 22 May, a nurse reviewed Mr Monaghan and advised that he needed to go to hospital. Mr Monaghan was taken to hospital that day and admitted. As prison staff had not completed the DNACPR paperwork, hospital staff completed it.

21. On 6 June, a hospital consultant told prison staff that Mr Monaghan was in the last weeks of his life.

22. On 9 June, a palliative care nurse at the hospital met with staff from Berwyn about where Mr Monaghan should be treated towards the end of his life, as Berwyn was not able to provide the specialist care he required.

23. On 28 June, the prison contacted the hospital consultant to ask for a prognosis on how long Mr Monaghan was expected to live so they could submit an application for his early release on compassionate grounds.

24. On 15 July, the prison released Mr Monaghan on a temporary licence, but he remained in hospital. A prison officer stayed with Mr Monaghan during the daytime.

25. On 22 July, prison staff submitted an application for Mr Monaghan's early release on compassionate grounds to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS). This was not processed before Mr Monaghan died.

26. On 15 August, Mr Monaghan was moved to a hospice. Mr Monaghan died there on 30 August.

Post-mortem report

27. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Monaghan's cause of death as idiopathic pulmonary fibrosis.

Non-Clinical Findings

Compassionate release

28. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can permanently be released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for indeterminate sentenced prisoners are set out in Chapter 12 of Prison Service Order (PSO) 4700. The criteria include that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

29. On 6 June 2022, a hospital consultant told prison staff that Mr Monaghan was in the last weeks of his life. This should have prompted the prison to start the compassionate release application. However, prison staff did not contact the hospital for a formal prognosis until 28 June and the application was not submitted until 22 July.

30. We are concerned that the prison did not start an application for compassionate release as soon as they were made aware of the consultant's prognosis on 6 June. We recommend:

    The Governor should ensure that applications for early release on compassionate grounds are started and submitted as promptly as possible.

Louise Richards **March 2023**
Assistant Ombudsman

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