Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Maggs, a prisoner at HMP Parc, on 7 May 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In March 2022, Mr David Maggs was sentenced to life imprisonment for murder, with a minimum tariff of 20 years. He died of myocardial infarction (heart attack) and pulmonary thromboembolism (blocked blood vessel in lungs) on 7 May 2024, at HMP Parc. Empyema of gallbladder (inflammation of the gallbladder) and acute cholangitis (infection of the bile ducts) were listed as contributory factors. He was 73 years old. We offer our condolences to Mr Maggs' family and friends.

4. The Ombudsman's office wrote to Mr Maggs' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Maggs' clinical care at HMP Parc.

6. The clinical reviewer concluded that the clinical care Mr Maggs received at Parc was equivalent to that which he could have expected to receive in the community. He found that there were examples of good quality care, including an appropriate social services referral, adjustments to Mr Maggs' cell and excellent care from the physiotherapy service. The clinical reviewer made recommendations that did not impact on his assessment of equivalence that the Head of Healthcare will wish to address. He also stressed that these recommendations would not have affected the outcome for Mr Maggs.

7. The PPO investigator investigated the non-clinical issues relating to Mr Maggs' care. She found no non-clinical issues of concern directly impacting Mr Maggs' death and requiring a recommendation.

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

9. Mr Maggs' family received a copy of the draft report. They did not make any comments.

Governor and Head of Healthcare to note

10. It took staff six minutes to locate the defibrillator when Mr Maggs was unresponsive, despite it being on the same wing. The Governor and Head of Healthcare will want to ensure that all staff are aware of the location of emergency equipment.

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

Inquest

At the inquest held on 1 September 2025, the Coroner concluded that Mr Maggs died of natural causes.

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