Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martyn Bruce, a prisoner at HMP Parc, on 27 July 2021

A report by the Prisons and Probation Ombudsman

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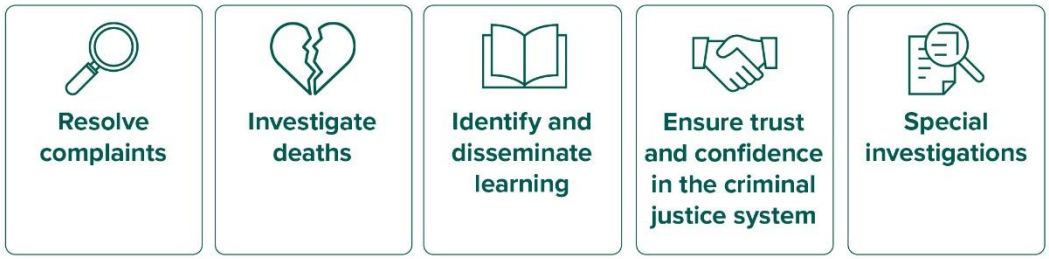
OUR VISION

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

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Martyn Bruce died in hospital of hypoxic/ischaemic encephalopathy (an acute loss of blood and oxygen flow to the brain) and pneumonia on 27 July 2021, while a prisoner at HMP Parc. This was caused by a sudden cardiac arrest as a result of the use of psychoactive substances (PS). He was 54 years old. I offer my condolences to Mr Bruce's family and friends.

The clinical reviewer found that the clinical care that Mr Bruce received at Parc was equivalent to that which he could have expected to receive in the community.

We are satisfied that when Mr Bruce was identified as having taken PS, staff took swift and appropriate action to manage the risks and provide support. However, we are concerned about the ready availability of PS at Parc, which Mr Bruce was able to access on a number of occasions. We note the work that has been undertaken to address these issues as part of Parc's local drugs strategy. As implementation continues and practice develops, we hope that the supply of and demand for drugs are reduced.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2023**

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Summary

Events

1. Mr Bruce was serving a life sentence for murder. It was not his first time in prison. He had a long history of substance misuse and his use of PS had resulted in seizures.

2. Staff found Mr Bruce under the influence of PS on several occasions at Parc. After each incident, the substance misuse rapid response team reviewed him and provided support and harm reduction advice.

3. At 4.37pm on 20 July 2022, a prisoner found Mr Bruce unresponsive and called for help from officers. When officers arrived at his cell, they found him face down on the floor and called for assistance. More officers arrived and a medical emergency code blue was called, requesting an ambulance. Officers began performing cardiopulmonary resuscitation (CPR).

4. At around 4.43pm, two nurses arrived at the cell. They attached a defibrillator and took control of the CPR.

5. At 5.01pm, paramedics arrived at the cell and managed to find a pulse. Mr Bruce was transferred to hospital and placed in an induced coma.

6. On 27 July, hospital staff and Mr Bruce's family decided to turn his life support machine off. He died at 11.24am, with his family at his bedside.

7. The Coroner concluded that Mr Bruce's cause of death was hypoxic/ischaemic encephalopathy (an acute loss of blood and oxygen flow to the brain) and pneumonia, which was caused by sudden cardiac arrest resulting from PS use.

Findings

Clinical care

7. The clinical reviewer concluded that overall, the clinical care that Mr Bruce received at Parc was equivalent to that which he could have expected to receive in the community.

Substance misuse

8. The clinical reviewer found that prison staff at Parc managed Mr Bruce's substance misuse well. He was assessed on every occasion that he was identified as under the influence of drugs and provided with appropriate advice and monitoring to ensure that his risks were reduced.

9. We were pleased to find that Parc had taken action to address learning from previous PS-related deaths. They had developed and implemented a comprehensive local strategy for tackling the availability of substances and the management of associated risks.

10. Overall, we are satisfied that Mr Bruce received the appropriate support in line with his needs and the new local drug strategy.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Bruce's prison and medical records.

14. The investigator interviewed five members of staff at Parc. The interviews were completed by telephone due to COVID-19 restrictions.

15. NHS England and Improvement commissioned a clinical reviewer to review Mr Bruce's clinical care at the prison. The investigator and clinical reviewer jointly conducted the majority of the interviews.

16. We informed HM Coroner for South Wales Central of the investigation. He provided us with a copy of the post-mortem report, and we have sent him a copy of this report.

17. The Ombudsman's family liaison officer wrote to Mr Bruce's next of kin, his sister and brother-in-law, to explain the investigation. They asked for a copy of this report. They said that a prison officer on bedwatch duty at the hospital told them that gangs were smuggling drugs into the prison and using prisoners as guinea pigs. They asked us if this was correct. We have addressed this issue in our report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified no factual inaccuracies.

19. Mr Bruce's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Parc

20. HMP Parc is a medium security private prison run by G4S. It holds around 1,600 male prisoners and young adults who are either on remand or convicted.

21. G4S Medical Services provide primary physical and mental health care services. There is 24-hour general healthcare service and a local GP practice which provides GP services, including a daily clinic and out-of-hours cover. Three healthcare staff are located in the prison at night.

HM Inspectorate of Prisons (HMIP)

22. The most recent inspection of Parc was in June and July 2022. It found that although the availability of drugs remained a significant threat at Parc, prison leaders were doing some impressive work to reduce the flow such as working with the police to target staff corruption which had resulted in the dismissal of several staff and subsequent criminal investigations. The report also noted that a range of measures put in place to reduce the availability of drugs, including body and post scanners, were having positive results.

23. Inspectors reported that Dyfodol, the substance misuse service, was well integrated in the prison and the team manager worked closely with senior prison leaders to make sure that substance misuse was a consistent strategic priority through regular, well-attended meetings. Despite high demand for the service, inspectors noted that the substance misuse needs of patients were met by a well-led and adequately resourced service.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to February 2019, the IMB noted that tackling drug supply into the prison was an ongoing high priority for management.

Previous deaths at HMP Parc

25. In the two years before Mr Bruce's death, there were ten deaths from natural causes, two drug-related deaths and one self-inflicted death at Parc. There were no notable similarities between our findings in these investigations.

26. Six prisoners have died at Parc since Mr Bruce's death, four of which were from natural causes, and one was self-inflicted. The cause of one of these deaths, which occurred in April 2022, is currently unknown but may be PS-related.

Psychoactive substances (PS)

27. PS (formerly known as ‘legal highs’) continue to be a serious problem across the prison estate. They can be difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

Background

28. Mr Martyn Bruce had a long history of offending and had served several custodial sentences. He also had substance misuse issues.

29. Mr Bruce reported to staff that he had post-traumatic stress disorder (PTSD) and anxiety, and that he had had seizures as a result of his PS use. He also reported that he had been diagnosed with frontal lobe damage. He had no known history of attempted suicide or self-harm and had not been monitored under suicide and self-harm prevention procedures, known as ACCT.

30. On 19 March 2005, Mr Bruce was remanded to HMP Cardiff, charged with murder. He was convicted in February 2006 and sentenced to life imprisonment, with a 16-year minimum tariff to serve.

HMP Parc

31. On 26 September 2018, Mr Bruce was transferred to Parc. Staff completed a mental health review and concluded that he did not need any additional support. They noted on his electronic medical record that he had used PS since 2005. Mr Bruce told staff that he had not used PS recently because he did not want to let his family down.

32. On 23 October, staff called a medical emergency code blue after they found Mr Bruce under the influence of an unknown substance. He had a seizure and was taken to hospital in an ambulance.

33. Mr Bruce returned to Parc the next day and staff opened a substance misuse observation record (SMOR) for him. When a prisoner appears to be under the influence of an unknown substance, staff should open a SMOR and complete regular observations to manage the risks. Healthcare staff will undertake an initial check within the first four hours, and then repeat checks every four hours until they are content that the prisoner is no longer under the influence.

34. Staff closed the SMOR the following day when they were satisfied that Mr Bruce had recovered.

2019

35. On 29 November 2019, a paramedic assessed Mr Bruce after he was found under the influence of PS in prison. Staff opened another SMOR, which was closed later that day when he had recovered.

2020

36. On 5 April 2020, healthcare staff advised Mr Bruce that he had been identified as clinically vulnerable in the event that he contracted COVID-19. He was transferred to an assisted living unit for older prisoners and those who are clinically vulnerable.

On 16 August, Mr Bruce asked to stop shielding and signed a disclaimer to that effect. He returned to his previous location on B Wing.

37. On 26 September, staff found Mr Bruce under the influence of PS and opened a SMOR. A nurse assessed him later that day and agreed to close the SMOR when he no longer appeared to be under the influence.

38. On 5 November, Mr Bruce appeared under the influence of PS and staff called an emergency code blue. Mr Bruce recovered quickly, and no further medical treatment was needed.

2021

39. On 5 January 2021, healthcare staff told Mr Bruce that he had been added to the COVID-19 shielding list again, in line with national guidelines. He told staff that he did not want to shield and signed another disclaimer so that he could remain on B Wing.

40. Mr Bruce requested a prescription of mirtazapine (which he had been prescribed before) for low mood. On 18 February, a GP assessed him in response to the request. Mr Bruce told the GP that he was stressed about several issues, including his mother who was in a home and had dementia, his pending parole hearing, prisoners on the wing banging on the walls in the early hours of the morning and the death of his brother the year before. He said he had not used PS recently and had no intention of using it again. The GP prescribed the mirtazapine, pending a urine drug screen.

41. On 24 February, Mr Bruce spoke to his community offender manager (COM) for the first time. They discussed preparations for his tariff expiry date in March. After the meeting, the COM, Mr Bruce's prison offender manager (POM), and a psychologist completed a report recommending that Mr Bruce should be progressed to open conditions. At interview, both the COM and the POM told us that Mr Bruce was apprehensive about the prospect of his eventual release, given the amount of time he had spent in custody, but that he was supportive of the proposed transition to open conditions to help him prepare.

42. On 30 June, a nurse assessed Mr Bruce after he was found under the influence of PS again. A SMOR was opened, and the mental health team were informed. There is no record of when the SMOR was closed.

43. The next day, a nurse started a dual diagnosis assessment for Mr Bruce's substance misuse and mental health issues. He reported that he had disturbing and intrusive thoughts, nightmares and anxiety. He told her that he had experienced difficult things as a child and had spent time in care. He also said he had been traumatised significantly while serving in the armed forces. Mr Bruce said that when he used PS, it helped him to feel better in the short term as he would forget things and not get disturbed by intrusive thoughts.

44. On 3 July, an officer held a key work session with Mr Bruce. He told the officer that he had taken PS the previous week to self-medicate a back injury. Mr Bruce told the officer that he was speaking to Dyfodol and was waiting for a response.

45. On 8 July, Mr Bruce was seen under the influence of PS again and staff called a code blue emergency. Staff opened a SMOR, which was closed later in the day, when he had recovered. The next day, as a follow-up to the dual diagnosis assessment with the nurse, Mr Bruce was assessed by the mental health team and referred to the dual diagnosis nurse to look jointly at his mental health and drug issues.

46. On 12 July, traces of synthetic cannabinoids were found in Mr Bruce's urine following a routine drug screen. A review with Dyfodol was organised. Mr Bruce died before the Dyfodol review could take place and the dual diagnosis work could be progressed.

20 July

47. On the morning of 20 July, the POM met Mr Bruce, who appeared "really positive" and in a "really good mood". She told Mr Bruce that his COM would visit him the following week for a face-to-face meeting to discuss his impending transfer to open conditions.

48. At around 7.00am, an officer completed a roll check. He checked on Mr Bruce and raised no concerns.

49. At around 12.35pm, a further roll check took place, and no concerns were noted for Mr Bruce.

50. At around 4.37pm, a prisoner on B Wing told an officer that Mr Bruce appeared to be unresponsive and needed help. She went to his cell and found Mr Bruce lying face down on the floor. She immediately shouted for assistance. Two more officers arrived at the cell within seconds, and one officer radioed a code blue emergency. Other officers arrived at the cell, including a Custodial Manager (CM), who radioed for all available nurses to attend immediately. An officer began conducting cardiopulmonary resuscitation (CPR) on Mr Bruce, assisted by the CM.

51. At around 4.43pm, two nurses arrived at Mr Bruce's cell. One nurse attached a defibrillator and took over CPR.

52. Paramedics arrived at the cell at 5.01pm and took control of the situation. A second paramedic team arrived at 5.04pm. They detected a pulse, but Mr Bruce had a cardiac arrest on three occasions. At 5.44pm, having stabilised Mr Bruce, paramedics transferred him into an ambulance. On the way to hospital, Mr Bruce had a further cardiac arrest before being stabilised. When he arrived at hospital, he was put into an induced coma in the intensive care unit.

53. On 27 July, the decision was taken to turn Mr Bruce's life support machine off after a CT scan showed no signs of brain activity. Mr Bruce died at 11.24am with his family at his bedside.

Contact with Mr Bruce's family

54. The prison's family liaison officer (FLO) called Mr Bruce's brother-in-law at around 9.30am on 20 July to tell him that Mr Bruce had had a cardiac arrest and been transferred to hospital.

55. The FLO maintained contact with Mr Bruce's family until his death, and in line with national instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

56. The duty governor held a debrief with prison staff involved in the emergency response. All staff were offered the support of the prison's care team.

57. The Governor posted notices informing other prisoners of Mr Bruce's death and offering support in case they had been adversely affected.

Post-mortem report

58. Toxicology tests showed that traces of a synthetic cannabinoid (most likely in the form of 'PS' or 'Spice') were present in Mr Bruce's system when he died.

59. The post-mortem concluded that Mr Bruce's cause of death was hypoxic/ischaemic encephalopathy (acute loss of blood and oxygen flow to the brain) and pneumonia, which was caused by sudden cardiac arrest as a result of PS use.

Findings

Clinical care

60. The clinical reviewer found that the healthcare that Mr Bruce received at Parc was equivalent to that which he could have expected to receive in the community. He found that his general clinical needs were appropriately managed, with regular GP reviews and provision of medication and counselling.

61. The clinical reviewer made two recommendations about learning in relation to administrative processes which did not impact directly on Mr Bruce's death, but which the Head of Healthcare at Parc will need to address.

Substance misuse

62. Mr Bruce's substance misuse history was appropriately documented in his medical record and staff were aware of his needs. They made appropriate referrals and offered ongoing support to help Mr Bruce address his substance misuse issues while in prison.

63. The clinical reviewer found that Mr Bruce's use of PS was well managed by healthcare staff at Parc, who assessed him on every occasion that he was identified as under the influence of drugs and quickly opened a Substance Misuse Observation Record or "SMOR". He was also seen by the rapid response team from Dyfodol after each occasion, who assessed, monitored, and advised on the risks of continued PS use. These support services were put in place as part of a new local drug policy, which incorporated the learning from previous PS related deaths at Parc.

64. We found that prison staff received intelligence following Mr Bruce's death to suggest that other prisoners might have used him as a "tester" for drugs on the wing. The prison shared all appropriate information with South Wales Police Crime in Prison Team for the purposes of further investigation. Any further action taken by police would be considered as criminal proceedings, outside of the remit of the PPO.

65. We are concerned about the availability of drugs at Parc which Mr Bruce had accessed on a number of occasions. However, we found no evidence that staff had missed opportunities to intercept this or identify that Mr Bruce was in possession of PS before he used it, which he appears to have been careful to hide. We recognise that managing the supply of drugs is a challenge across the prison estate, particularly for prisons with dynamic populations such as at Parc. We were pleased to learn that new policy arrangements had been implemented to tackle the issues such as the investment in drone and mobile phone detection technology and the introduction of a rapiscan machine (to detect PS sprayed on to incoming mail). These measures took into consideration the learning from previous PS deaths. Both our investigation and the recent HMIP inspection found that the prison was still actively developing its practice in this area as part of its strategy implementation to try to reduce the demand and supply of drugs in the prison. We hope that as this work continues, the wider the availability of drugs will be reduced.

66. When Mr Bruce was identified as having taken PS, we found that new risk management and support systems, set out in the local strategy, had been used appropriately. He was given swift support to manage the live risks and advice to try to prevent him taking them again, on each occasion. He was also given opportunities through his dual diagnosis assessment and keywork sessions to explore and address his issues with PS in the longer term. We therefore make no recommendations.

Inquest

67. The inquest into Mr Bruce's death concluded on 29 June 2023, and concluded that his death was drug related.

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