Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martyn Thomas a prisoner at HMP Parc on 21 January 2016

A report by the Prisons and Probation Ombudsman
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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*

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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 Thomas died on 21 January 2016 while a prisoner at HMP Parc. The post-mortem was inconclusive. The coroner has not been able to determine the definitive cause of his death. Mr Thomas was 32 years old. I offer my condolences to Mr Thomas' family and friends.

Mr Thomas had a heart attack some months before his death and there was some suspicion that on that occasion he had taken New Psychoactive Substances (NPS). Mr Thomas' care after his heart attack was not well organised or coordinated, as medication was not immediately available, care plans were not tailored to his needs, and the prison did not pursue an anticipated follow up appointment. I agree with Health Inspectorate Wales that, although Mr Thomas' death was not preventable or foreseeable, his care was not equivalent to that he could expect to receive in the community.

I am concerned that the officer who performed the morning unlock did not check on Mr Thomas' wellbeing as he should have done.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2017**

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Summary

1. On 26 January 2015, Mr Martyn Thomas' licence was revoked and he was recalled to the custody of HMP Cardiff. He was transferred to HMP Parc on 13 February. On 11 May, Mr Thomas was sentenced to two years and four months imprisonment for violent offences.

2. Both his initial health screens at Cardiff in January, and at Parc in February, concluded that he was fit and well.

3. On 25 August, Mr Thomas had a heart attack and doctors put him in an induced coma for several days. When he came round, he implied to the family liaison officer that he had taken an illicit substance. While he was in hospital, a cardiologist diagnosed him with a fast but irregular heartbeat which could be treated with medication. They did not rule out the possibility that his heart attack had occurred because he had used a New Psychoactive Substance (NPS).

4. The hospital discharged Mr Thomas on 25 September and specialists advised him that he should only use the gym gently for the first two weeks and have a follow up hospital appointment in three months. Healthcare staff did not tell gym officers this or chase the appointment when it did not come through. There was also a short delay in the prison providing his medication on discharge from hospital.

5. On 27 October, nurses urgently attended to Mr Thomas when he became short of breath and had an irregular pulse. They assessed him and a doctor halved his medication. On 27 November, medication was stopped completely when Mr Thomas complained about the side effects and said he did not want to take it anymore. Healthcare staff monitored him after this period but still no one chased the delay in arranging the hospital appointment.

6. On 20 January, Mr Thomas used the gym with his friend and seemed well. An officer saw Mr Thomas at approximately 8.15pm, and noted he seemed well. The next morning, at approximately 7.30am, the same officer unlocked Mr Thomas' cell door and pushed it ajar without seeing or interacting with Mr Thomas. Another prisoner went into the cell shortly after and found Mr Thomas unresponsive. Prison staff called a code blue at 7.37am and requested an ambulance immediately. Healthcare staff and paramedics attempted to revive Mr Thomas but were unable to do so. Mr Thomas was pronounced dead at 8.20am.

Findings

7. The post-mortem examination concluded that the cause of Mr Thomas' death was unascertained. He had a history of drug use in the community and suspected usage in prison, and of heart problems. We cannot be certain Mr Thomas had not used any illicit drugs, including NPS, but we are content that the risk of doing so was discussed with him and that the prison has appropriate policies to warn prisoners of their dangers.

8. Although Health Inspectorate Wales does not feel Mr Thomas' death was foreseeable or preventable, we agree with them that Mr Thomas did not receive care at the prison equivalent to that he could have expected to receive in the community. Healthcare staff failed to promptly provide Mr Thomas' medication when the hospital discharged him, to liaise with secondary care services about his condition, to create individualised care plans to meet his needs or to chase up anticipated hospital appointments.

9. We are also concerned that at unlock the officer did not gain sight of Mr Thomas and satisfy himself that he was well. Our investigation found that this practice was not isolated to one officer.

Recommendations

- The Head of Healthcare should ensure that the pharmacy does not delay prescribing drugs which secondary cares services have recommended.
- The Head of Healthcare should ensure that where there are changes to an individual's condition or proposed therapy, staff liaise with interested secondary care services.
- The Head of Healthcare should ensure that care plan templates are accompanied by individual assessments and tailored interventions.
- The Head of Healthcare should ensure that there is a robust system to monitor and chase up appointments as necessary.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners wrote to her.

11. The investigator visited HMP Parc on 4 February 2015. She obtained copies of relevant extracts from Mr Thomas' prison and medical records, and interviewed two prisoners.

12. Health Inspectorate Wales (HIW) reviewed Mr Thomas' clinical care at the prison.

13. We informed HM Coroner for Bridgend and Glamorgan Valleys District of the investigation. Our investigation was suspended for nearly six months until we received the post-mortem report from the coroner. We regret the consequent delay in issuing this report. We have given the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Thomas' sister, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not raise any concerns.

15. Mr Thomas' sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

16. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Parc

17. HMP Parc is a medium security private prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. It also has a unit for around 60 young people under 18.

18. G4S Medical Services provide primary physical and mental health care services. There is 24-hour general healthcare, palliative care facilities and a local GP practice provides GP services including daily clinic and out of hours cover. Three healthcare staff are located throughout the prison at night. Appropriate emergency equipment is located across the prison, all operational staff are first aid trained and most know how to use defibrillators.

HM Inspectorate of Prisons

19. The most recent inspection of Parc was in January 2016. In their survey of prisoners, more prisoners than in comparator prisons said it was easy or very easy to get drugs in the prison. Inspectors noted that Parc was working with the local police to disrupt the supply of drugs to the prison but their efforts to tackle the availability of drugs were not sufficiently effective. They noted the substance misuse policy was up to date and the prison was also developing a specific new psychoactive substances (NPS) strategy. Actions to overcome the problem included raising awareness among staff and prisoners, monitoring and responding to incidents and sharing information across departments. A peer support scheme focussing on NPS was also planned.

20. Although inspectors deemed healthcare services to be reasonably good, prisoners were overwhelmingly negative about it and prescribing practices were one of the areas to draw most criticism. Inspectors thought the pharmacy services themselves were reasonable although they considered the systems in place on some wings was unsatisfactory.

Independent Monitoring Board

21. 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 2016, the IMB noted that the overwhelming dissatisfaction with healthcare services as highlighted by the HM Inspectorate of Prisons report was mostly about the access to service rather than the quality of services themselves. The Board was concerned about the level of substance use at Parc, and particularly the use of NPS.

Previous deaths at HMP Parc

22. Mr Thomas' was the ninth death from natural causes at Parc since the beginning of 2014.

New Psychoactive Substances (NPS)

23. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are 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 NPS 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, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

24. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

25. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

26. On 26 January 2015, Mr Martyn Thomas' licence was revoked (having only been released from prison ten days earlier) and he was recalled to the custody of HMP Cardiff. He was transferred to HMP Parc on 13 February. On 11 May, Mr Thomas was sentenced to two years and four months imprisonment for offences of violence.

27. Mr Thomas' medical record relating to his previous period in custody mentions that he had used steroids and was a social cocaine user. He appeared to be physically fit and healthy but with occasional issues resulting from scuffles on the wing or his intense exercise regime.

28. During an initial health screen at Cardiff, a nursing assistant recorded that Mr Thomas seemed fit and well, did not report any chest pains or have any other health concerns. Mr Thomas said that he had not used drugs in the last month and did not take any drugs intravenously. He was transferred to Parc on 13 February and an officer (who also had a healthcare assistant role) recorded that he was fit and well.

29. On 16 February, a gym officer showed Mr Thomas the facilities and how to use them. He also asked Mr Thomas to complete a PAR-Q (Physical Activeness Readiness Questionnaire), a health screening tool used in most gyms. Mr Thomas confirmed that he did not have a heart or blood pressure condition and he did not experience chest pain when exercising. On 25 February, a nurse also recorded that Mr Thomas was fit to attend the gym.

30. On 12 March, Mr Thomas discussed quitting smoking during an appointment with a dental surgery assistant. She told him to make an appointment with his GP but there is no record that he did this.

31. On 25 August, Mr Thomas had a heart attack while in the cell he shared with another prisoner. The prisoner told us that he had rung his cell bell in the middle of the night when he heard Mr Thomas make unusual noises. Healthcare staff responded and he was taken to hospital. Hospital doctors put him in an induced coma for a few days and when he came round, he implied to a prison family liaison officer that he had 'taken something' but would never do so again.

32. On 8 September, a consultant cardiologist at the hospital wrote to the prison and said that the indications were that Mr Thomas had sustained ventricular tachycardia (a fast but irregular heart rhythm, which can lead to fibrillation, a condition which stops the heart pumping blood). The results of an echocardiogram (a scan which looks at the structure of the heart) and a diagnostic coronary angiogram (a scan which can examine the flow of blood through the arteries) were normal. The cardiologist confirmed that he could be treated with bisoprolol (a treatment for high blood pressure), as an operation was not necessary, and that he should be followed up in three months.

33. The hospital discharged Mr Thomas on 25 September with a diagnosis of minor ventricular fibrillation with the possibility that his arrest was secondary to the use of NPS. A cardiology specialist advised that Mr Thomas could resume gentle exercise in the gym for the first two weeks before a gradual return to normal

activity. There is no record that anyone in the healthcare department shared this information with gym staff. The specialist also said that a follow up with a consultant cardiologist would be arranged in due course.

34. The hospital's discharge summary prescribed bisoprolol but there was a delay at the prison providing the medication immediately. The following day, a nurse contacted the out of hours GP, who advised that Mr Thomas could wait until Monday 28 September for his medication. Staff were in fact able to give him a dose on 27 and 28 September and a nurse completed a medication in possession assessment so that he had his own from 29 September.

35. On 27 October, a nurse reviewed Mr Thomas, as he was short of breath, had an irregular pulse and felt his medication was making him ill. She performed an electrocardiogram test (which measures heart rhythms) and discussed his presentation with a prison GP, who agreed a diagnosis of sinus bradycardia (low heart rate) and ventricular ectopic (irregular rhythm). The GP reduced Mr Thomas' bisoprolol prescription by half. However, the next day, Mr Thomas told the pharmacist that he was uncomfortable taking it but she advised him to continue. He denied using any amphetamines, cocaine or NPS but said that some years ago he had used steroids.

36. On 16 November, a prison GP saw Mr Thomas at his request to discuss his medication. The GP did an angiogram, echocardiogram and electrocardiogram and recorded that all results were normal. He noted that Mr Thomas had a cardiology review coming up and advised him to avoid going to the gym.

37. On 27 November, Mr Thomas saw a prison GP and told her his bisoprolol made him feel ill. His heart rate was low and she advised him that the medication could help prevent any further cardiac events but he felt the side effects were too great, so the medication was discontinued. He denied taking NPS and she felt that healthcare assistants could monitor his blood pressure and pulse in the meantime until his cardiology review.

38. On 1 December, a nurse created a care plan to monitor Mr Thomas' cardiac function. Healthcare assistants monitored his blood pressure and pulse approximately fortnightly. His readings were normal bar, on 2 December, when his blood pressure was high at 151/93 (anything over 140/90 is high).

39. On 18 December, Mr Thomas received confirmation that his cardiology review was planned for 11 February 2016 at hospital. On 5 January 2016, Mr Thomas told a nurse that he was concerned he had not had a cardiology check-up beforehand. A letter sent from the hospital on 8 September had said he would have one within three months and she recorded that she would ask the administration team to check this and made a 'tasks' entry on the computer system which would instruct them to do this.

40. In the evening of 20 January, Mr Thomas went to the gym with his friend. They used the equipment for approximately 45 minutes and Mr Thomas mostly used the treadmill. His friend said that Mr Thomas did not seem unwell or express any difficulty at any point that evening. He also said that Mr Thomas had seemed quite well in the days leading up to his death.

41. An officer locked Mr Thomas in his cell on the first floor on 20 January at approximately 8.15pm. Mr Thomas was watching television and put his thumb up to the officer.

42. At 7.00am on 21 January, the officer was back on duty and began the wing's roll count. He started on the third floor and worked his way down, with a colleague, to the ground floor where Mr Thomas' cell was. Mr Thomas' cell was the last cell he checked and when he looked in, Mr Thomas appeared to be asleep. He attended to some paperwork in the office close to Mr Thomas' cell. At 7.30am, he started to unlock the cells, starting on the third floor. When he got to Mr Thomas' cell, he opened the door and just left it ajar to give Mr Thomas some privacy in case he was dressing or using the bathroom. He did not speak to Mr Thomas and went straight back to his office.

43. After being unlocked, Mr Thomas' friend went to his cell so they could go to breakfast. He entered the cell, found Mr Thomas in bed, told him to 'get up' and touched his stomach. It was dark in the cell but he saw Mr Thomas' fingers were black. He stepped back and pulled the door more open and saw that his veins were raised. He left the cell and banged on the wing office window summoning the officer. The officer went into Mr Thomas' cell, accompanied by two prisoners. The officer saw that Mr Thomas was in exactly the same position as he had been at roll count at 7.00am so called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) over his radio at 7.37am.

44. Two more officers attended and started cardiopulmonary resuscitation (CPR). Three nurses arrived at 7.40am with oxygen and a defibrillator. They moved Mr Thomas onto the floor to continue CPR and give him oxygen. Staff in the control room had immediately called an ambulance and paramedics arrived at 7.57am. They treated him with adrenaline, glucose, saline and CPR but when he did not respond they pronounced him dead at 8.20am.

Contact with Mr Thomas' family

45. At 7.50am on 21 January, a chaplain was told that Mr Thomas was being resuscitated. She knew his family as she had met them when Mr Thomas had had a heart attack. At 8.20am, following Mr Thomas' death, she and a senior prison manager went to see Mr Thomas' sister who lived with her aunt. She was not home initially but was traced and given the news in person. The chaplain also offered her condolences and support.

46. The chaplain stayed in touch with the family to offer support and give advice. Mr Thomas' funeral was on 11 February and the prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

47. After Mr Thomas' death, prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

48. The prison posted notices informing other prisoners of Mr Thomas' death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Thomas'

death. The prisoners who were directly involved at the scene were told in person by the chaplain and offered support.

Post-mortem report

49. The post-mortem report said no anatomical abnormality had been identified and the cause of death was unascertained. A toxicology report concluded that no drugs, drug metabolites or alcohol were detected when blood and urine was screened. No common synthetic metabolites or synthetic cannabinoids were detected either.

Findings

Clinical care

50. Although Mr Thomas' death was not foreseeable or preventable, HIW concluded that the care Mr Thomas received at the prison was not equivalent to that he could have expected in the community as there were issues with his medication, liaison with the secondary care team when he suffered with a low heart rate (with irregular rhythm) and the lack of individual care plans.

51. When Mr Thomas returned to Parc on 25 September 2015, hospital doctors prescribed bisoprolol but he did not receive it until 27 September. HIW considered that the prison should have prescribed the medication immediately on his return given that the hospital had not supplied any on discharge.

52. On 27 October, a nurse and a prison GP found Mr Thomas' heart rate was low with an irregular rhythm so the doctor halved his bisoprolol medication. However, they did not outline a plan to monitor his heart rate and blood pressure thereafter or liaise with his secondary care team about the issue. HIW feels these should have been the next steps. A similar issue occurred on 27 November when again his heart rate was low and medication was stopped completely without any liaison with the secondary care team.

53. Although the nurse opened a care plan for Mr Thomas on 1 December and identified a number of nursing priorities (including preventing complications and providing information about disease), HIW was critical of the content. They felt that where a standardised template is used, specific individualised assessments or focussed interventions should accompany that template but there was no evidence of this in Mr Thomas' case.

54. On 5 January 2016, Mr Thomas told a nurse he was concerned the hospital had not scheduled a cardiology check-up, as planned in September 2015. She said she would ask someone in the administration team to chase the matter and she made a 'task entry' on the computer system, but there was no evidence anyone chased the appointment. We make the following recommendations:

The Head of Healthcare should ensure that the pharmacy does not delay prescribing drugs, which secondary cares services have recommended.

The Head of Healthcare should ensure that where there are changes to an individual's condition or proposed therapy, staff liaise with interested secondary care services.

The Head of Healthcare should ensure that care plan templates are accompanied by individual assessments and tailored interventions.

The Head of Healthcare should ensure that there is a robust system to monitor and chase up appointments as necessary.

Drug strategy policy

55. The post-mortem report was inconclusive and the toxicology tests did not reveal any drugs or synthetic substances in Mr Thomas' urine or blood. However, we cannot completely rule out that Mr Thomas may have taken something that was not detected by the toxicology tests

56. The prison's Drug and Alcohol Strategy Policy, last amended in April 2014, focuses on disrupting supply of and demand for drugs as well as offering treatment, support and care. It aims to achieve these aims via prevention, intervention and support, suppression and enforcement.

57. In 2016, after Mr Thomas' death, the prison developed a separate NPS Strategy which focuses on information gathering given it was a newly emerging problem. Incidents are tracked so security efforts can be focussed. In every suspected case, prisoners are seen by a substance misuse offender supervisor and where a group are suspected of having taken it they have to attend restorative conferences. A testing regime was also planned.

58. We spoke to friends of Mr Thomas shortly after he had died and they said they were aware of NPS on the wing but felt it was unlikely that he would have taken any. They told us they had received leaflets in their canteen bags, which educated them around the dangers of NPS, and other prisoners were attempting to educate their peers.

59. While we cannot be sure whether Mr Thomas had used any illicit drugs, including NPS, we are content that the prison has introduced appropriate policies to warn prisoners of the dangers of them.

Unlock procedures

60. When Mr Thomas was found unresponsive in his cell at 7.37am, the officer noticed that Mr Thomas was in exactly the same position he had been at the roll check. The officer confirmed that he had not seen Mr Thomas when he unlocked his cell because he thought Mr Thomas might be getting dressed or using his bathroom facilities. Mr Francis confirmed that it was common for officers just to unlock the cell door and not make any attempt to speak to or check on the welfare of the prisoner.

61. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

62. Additionally, Prison Service Instruction 75/2011 'Residential Services' states that "there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock… Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".

63. We do not know if checking on Mr Thomas during the unlock process might have prevented his death. It meant, though, that staff missed an opportunity to check his wellbeing and resulted in another prisoner finding him unresponsive. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

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