Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adam Malyn, a prisoner at HMP Parc, on 4 October 2019

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 | 020 7633 4100
F | 020 7633 4141

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.

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 Adam Malyn died from the misuse of synthetic cannabinoids (psychoactive substances (PS)) on 4 October 2019 at HMP Parc. He was 32 years old. I offer my condolences to his family and friends.

There is no evidence that Mr Malyn intended to take his life at the time of his death. He was fully aware of the risks of using PS and was given support to stop but continued to use them. His death appears to have been the accidental result.

Although Parc has a comprehensive local drugs strategy, Mr Malyn was able to obtain PS on at least four occasions. Parc will need to ensure that it addresses any areas of need in its local strategy to reduce the availability of drugs.

I am concerned that the officer who found Mr Malyn unresponsive in his cell was unable to radio for assistance because the battery attached to his radio was not charged. This issue needs to be addressed.

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

Sue McAllister CB
Prisons and Probation Ombudsman **December 2020**

Contents

Summary 1

The Investigation Process 3

Background Information 3

Key Events 6

Findings 9

Summary

Events

1. In August 2018, Mr Adam Malyn was convicted of burglary, theft and driving offences and was sent to HMP Cardiff. He was sentenced to two years in prison and in November he was transferred to HMP Parc.

2. Between 22 February and 1 March 2019, officers found Mr Malyn under the influence of drugs on three occasions. Healthcare staff attended and provided clinical care. They also monitored him and recorded the incidents. A nurse reviewed Mr Malyn before they stopped monitoring him.

3. On 8 August, Mr Malyn was released on licence but was recalled into custody a week later. On 23 September, he was transferred to Parc.

4. At 5.00pm on 4 October, an officer carried out a roll check on the wing where Mr Malyn lived and saw that he was sitting on his bed in his cell watching television.

5. At 7.58pm, an officer carried out another roll check. The officer looked through the cell door observation panel and saw Mr Malyn, lying on the floor of his cell, with "his head facing under the bed and his arm propping him up". He was not moving. The officer went into the cell and tried to turn him over into the recovery position. The officer thought that Mr Malyn was dead. He tried to radio for assistance but his radio battery was flat so he went to the wing office and told the officers there.

6. At 8.01pm, an officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). Two officers went into the cell and started cardiopulmonary resuscitation (CPR). Healthcare staff went to Mr Malyn's cell, took over resuscitation attempts and continued until ambulance paramedics arrived.

7. At 8.24pm, an ambulance paramedic confirmed that Mr Malyn had died.

8. The police found drug paraphernalia which tested positive for PS in Mr Malyn's cell, and Mr Malyn had traces of PS in his bloodstream after his death. A post-mortem examination found that in the absence of a natural cause, synthetic cannabinoid misuse provided an explanation for his death.

Findings

Substance misuse

9. We are satisfied that Mr Malyn was aware of the potentially fatal risks of substance misuse and that he was given support to stop.

Drug strategy at HMP Parc

10. Parc has a comprehensive substance misuse strategy which reflects the Welsh and national strategies, and we commend the Substance Misuse Observational Record (a local measure that prison and healthcare staff use to monitor prisoners after substance misuse incidents) and the rapid response service as examples of

good practice. Nevertheless, Mr Malyn was able to access PS on at least four occasions at Parc.

Clinical care

11. The clinical reviewer concluded that the clinical care that Mr Malyn received at Parc was as good and equivalent to that which he could have expected to receive in the community.

Emergency response

12. The officer who found Mr Malyn unresponsive in his cell was unable to radio for assistance because the battery attached to his radio was flat.

Recommendations

- The Director should ensure that prison and healthcare staff check that radios work when they start their shift and that spare batteries are available.

The Investigation Process

13. 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.

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

15. The investigator interviewed six members of staff at Parc on 6 November 2019.

16. Healthcare Inspectorate Wales (HIW) commissioned a clinical reviewer to review Mr Malyn's clinical care at the prison.

17. We informed HM Coroner for South Wales Central of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer wrote to Mr Malyn's mother to explain our investigation. Mr Malyn's mother asked if Mr Malyn had used his cell bell or raised the alarm in any other way. We have addressed her question in this report.

19. Mr Malyn's mother received a copy of the initial report. She did not respond.

20. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background information

HMP Parc

21. HMP Parc is a medium security private prison run by G4S. It holds around 1,600 prisoners and young adults who are either on remand or convicted. It also has a unit for around 60 young people under 18 years old.

22. G4S Medical Services provide primary physical and mental health care services. There is 24-hour general healthcare and palliative care facilities. A local GP practice 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

23. The most recent inspection of Parc was in November 2019. Inspectors found that most health services remained reasonably good, although secondary mental health provision was poor. Many prisoners described access to health services and treatments as being problematic, but Inspectors found an appropriate range of appropriate primary care services, with short waiting times for most, including the GP. Support for patients with long-term conditions had improved as a result of enhanced staffing. Social care arrangements were well established and good individual support packages were delivered.

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 were concerned with the number of incidents of violence, substance misuse and self-harm. They were pleased that the key worker programme was being rapidly rolled out across the prison. The IMB were pleased that the healthcare department had reduced non-attendance of prisoners at clinical appointments. They were very concerned about the lack of secondary psychiatric care, particularly for elderly prisoners.

Previous deaths at HMP Parc

25. There were eight deaths from natural causes, four drug-related deaths and two self-inflicted deaths at HMP Parc in the two years before Mr Malyn's death. Four prisoners have died at Parc since Mr Malyn's death, three of the deaths were from natural causes and the other was self-inflicted. There are no significant similarities between our findings in this investigation and those of the other deaths.

Psychoactive Substances (PS)

26. Psychoactive substances are a serious 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 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 risks precipitating or exacerbating the deterioration of mental health. It has also been linked to suicide and self-harm.

27. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time, 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 PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

28. HM Prison and Probation Service (HMPPS) has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

29. On 28 August 2018, Mr Adam Malyn was convicted of burglary, theft and driving offences and sent to HMP Cardiff. On 29 October, he was sentenced to two years in prison and was moved to HMP Parc on 2 November.

30. At his initial health screen, healthcare staff noted that Mr Malyn had asthma, anxiety and depression. Mr Malyn said that he had previously been dependent on alcohol but had not drunk alcohol for two months and did not need any support. He said that he had no thoughts of self-harm or suicide. A prison GP locum re-prescribed his medication which included fluoxetine, an antidepressant, and inhalers for asthma.

31. On 5 November, an offender supervisor carried out an offender interventions initial assessment (an assessment of offending related needs and risk of serious harm). She noted that Mr Malyn had received his substance misuse induction, that alcohol was his main drug of choice although he had smoked cannabis daily before he went to prison, and that he said he had never taken drugs in prison or had a drug overdose. She assessed that Mr Malyn could be managed by an offender supervisor as a low risk.

32. On three occasions (22 February, 26 February and 1 March 2019), officers found Mr Malyn apparently under the influence of drugs. On each occasion, a medical emergency code blue was radioed by the officer who found Mr Malyn and healthcare staff responded promptly. Staff opened a Substance Misuse Observational Record (SMOR) which remained open until healthcare staff were certain that Mr Malyn was no longer under the influence of drugs.

33. On 26 February, a substance misuse offender supervisor saw Mr Malyn and carried out a 'PS rapid response intervention'. Mr Malyn told him that he did not normally use PS. He said he remembered using another prisoner's vape in the exercise yard before the code blue response and thought he had been 'spiked'. He advised Mr Malyn about harm reduction techniques and noted that Mr Malyn was waiting to complete a substance misuse course.

34. On 7 March, Mr Malyn tested positive for PS. He was moved to the Credwch Unit (a re-engagement unit, used to encourage and motivate people who struggle to comply with prison rules) and placed on a basic Incentives and Earned Privileges (IEP) regime. Officers subsequently searched Mr Malyn's cell, which he shared with another prisoner, and found no drugs or evidence of substance use. In May 2019, Mr Malyn completed a substance misuse course.

35. On 8 August, Mr Malyn was released on licence.

36. On 14 August, Mr Malyn was recalled into custody and sent to HMP Cardiff. On 23 September, he was transferred to Parc. That day, a mental health nurse carried out Mr Malyn's initial health screen and noted that Mr Malyn said he had not used drugs in the last month and had no concerns about his mental health.

Events of 4 October

37. At 5.00pm on 4 October, an officer carried out a roll check on Mr Malyn's wing. He saw Mr Malyn sitting on his bed, watching television, with his food in front of him.

38. At 7.58pm, an officer completed another roll check. He looked through Mr Malyn's cell door observation panel and saw him lying on the floor, "with his head facing under the bed and his arm propping him up". He saw a clear liquid around Mr Malyn's head and realised that he was not moving. He opened the cell door, called to him and tried to turn him over into the recovery position. He thought that Mr Malyn was dead as his eyes were closed, his mouth and airway were full of vomit, his skin was clammy and discoloured and the blood vessels were visible. He tried to turn him onto his back but could not move him because he was too heavy. He tried to use his radio but the battery was flat, so he ran to the wing office on the ground floor and told the officers there that he thought that Mr Malyn was dead.

39. At 8.01pm, an officer radioed a medical emergency code blue.

40. Two officers went into Mr Malyn's cell. One officer could not find a pulse, so they turned him onto his back and started CPR. Nursing staff went into Mr Malyn's cell. One nurse said that Mr Malyn's torso was purple. An operational manager got a defibrillator and a nurse attached it to Mr Malyn. On three occasions it advised not to shock. A nurse tried to insert an airway but found that Mr Malyn's jaw was locked. A nurse gave him oxygen. Officers continued CPR in rotation.

41. At 8.03pm, a control room officer called for an ambulance, and connected the call to the wing office so that a nurse could give more information about Mr Malyn's condition to the ambulance service operator. At 8.10pm, an ambulance arrived at Parc and at 8.17pm, paramedics were at Mr Malyn's cell. At 8.24pm, an ambulance paramedic, confirmed that Mr Malyn had died.

42. After Mr Malyn's death, the police found an asthma inhaler, with black, sooty residue foil placed over the mouth piece, in Mr Malyn's cell. The cylinder had been removed from the inhaler. The police believed that the foil had come from a food container which was found in a bin in the cell. There was a piece of burnt toilet paper in the toilet bowl which had been rolled to make a wick, with one end partially burnt. The police also found a dismantled vape device near to the inhaler.

Contact with Mr Malyn's family

43. On 4 October, the Deputy Director appointed a family liaison officer. At 10.30pm, they visited Mr Malyn's mother. They broke the news of Mr Malyn's death and offered their condolences. The family liaison officer remained in contact with Mr Malyn's mother. Mr Malyn's funeral took place on 30 October. Parc contributed to its cost in line with national instructions.

Support for prisoners and staff

44. After Mr Malyn’s death, an operational 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.

45. The prison posted notices informing other prisoners of Mr Malyn’s death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Malyn’s death.

Post-mortem report

46. Mr Malyn had traces of PS in his bloodstream after his death. The inhaler found in his cell after his death tested positive for PS. The post-mortem examination established that in the absence of any other cause of death, Mr Malyn died from synthetic cannabinoid (PS) misuse.

Findings

Substance misuse

47. Mr Malyn died from synthetic cannabinoid misuse.

48. In November 2018, he told an offender supervisor that alcohol was his main drug of choice, that he smoked cannabis daily before he went to prison and that he had never taken drugs in prison or had a drug overdose. However, between February and March 2019, he was found under the influence of PS on three occasions and had a positive drug test for PS that same month.

49. We cannot say whether he continued to misuse drugs regularly after March 2019. There is no record that he was found under the influence after this date and before his release on licence in August. There is no record that he used drugs after he went back to Parc in September until his death.

50. There is evidence that Mr Malyn's offender supervisor met him frequently, discussed his PS use and arranged for him to complete a substance misuse course. The offender supervisor obtained updates from officers who were on Mr Malyn's wing about his behaviour and drug misuse. There is no evidence to suggest that Mr Malyn wanted to take his life or harm himself and it appears that his death was the accidental result of substance misuse.

51. We are satisfied that Mr Malyn was aware of the potentially fatal risks of continuing to misuse drugs and that he was given support to stop.

Response to incidents of substance misuse

52. On three occasions (22 February, 26 February and 1 March 2019), officers found Mr Malyn apparently under the influence of drugs. On each occasion, a medical emergency code blue was radioed by the officer who found Mr Malyn and healthcare staff responded promptly. Staff opened a SMOR, which remained open until healthcare staff were certain that Mr Malyn was no longer under the influence of drugs.

53. We are satisfied that staff at Parc understand their responsibilities to report and record all instances of prisoners found under the influence of illicit substances. Prison staff submitted intelligence reports that Mr Malyn and other prisoners on his wing were using drugs. On 9 March, prison staff acted on the intelligence and carried out a cell search.

Drug strategy at HMP Parc

54. The Drug Strategy Manager said that Parc's local drug strategy is aligned to the national drug strategy and was being revised at the time of Mr Malyn's death. She said that Parc had invested in a new body scanner which was used with other drug detection methods. She said that Parc uses a designated substance misuse service (Dyfodol) which provides the drug and alcohol referral process across the criminal justice sector in the seven South Wales local authorities, the three South Wales health boards and the four state-run Welsh prisons.

55. The Drug Strategy Manager said that there are 11 substance misuse offender supervisors at Parc who manage substance misuse treatment, work with individual prisoners and manage prisoners' sentences. Parc has a PS rapid response service which means that a substance misuse offender supervisor will speak to any prisoner who is the subject of a PS intelligence report or who is seen by healthcare staff under the influence of PS.

56. The Acting Head of Security said that the security department prevented illicit items entering the prison in line with the local drug strategy. He said that the security department reviewed and assessed the importance of intelligence reports and took action where necessary.

57. We consider that Parc's local drugs strategy includes sensible actions to reduce the demand for and supply of illicit drugs and we commend the rapid response service and the SMOR as examples of good practice.

Clinical care

58. The clinical reviewer concluded that the clinical care that Mr Malyn received at Parc was good and equivalent to that which he could have expected to receive in the community.

59. The clinical reviewer found that the emergency response on 4 October was appropriate and timely.

Emergency response

60. There is no evidence that Mr Malyn used his cell bell to call for help between 5.00pm and 7.58pm on 4 October.

61. We are satisfied that when the officer realised that Mr Malyn was unresponsive, he promptly opened the cell door to check if he was breathing. We are concerned, however, that he could not radio for assistance because the battery in his radio was flat and that he therefore, had to go down two flights of stairs to the wing office to ask for help. We were unable to interview him as he left Parc soon after the incident and we therefore do not know why his radio battery was flat.

62. It is unlikely that this affected the outcome for Mr Malyn as it appears that he had been dead for some time before he was found. However, it is essential that a medical emergency code is called as quickly as possible to ensure that healthcare staff attend and that control room staff call an ambulance immediately. We make the following recommendation:

    The Director should ensure that prison and healthcare staff check that radios work when they start their shift and that spare batteries are available.

63. When the officer told officers that there was a medical emergency, the correct emergency code was promptly radioed, prison staff and healthcare staff went to Mr Malyn's cell and tried to resuscitate him until ambulance paramedics arrived. A control room officer immediately telephoned the ambulance service who were escorted promptly to Mr Malyn's cell.

Prisons & Probation
Ombudsman
Independent Investigations

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

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

T | 020 7633 4100
F | 020 7633 4141