Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sonny Lawrence a prisoner at HMP Bristol on 4 October 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*

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 Sonny Lawrence died on 4 October 2016 of coronary artery atherosclerosis (hardening of the arteries) at HMP Bristol. He was 26 years old. I offer my condolences to Mr Lawrence's family and friends.

The investigation found that Mr Lawrence's clinical care was equivalent to that he could have expected to have received in the community. He had an unusual condition for a man of his age, with no history of heart problems, and I am satisfied that healthcare staff at Bristol could not have predicted or prevented his death.

However, I am concerned that Mr Lawrence appears to have taken illicit drugs in prison, which a pathologist considers may have accelerated Mr Lawrence's coronary artery atherosclerosis, and Bristol evidently needs to do more to address the issue.

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 **August 2017**

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Summary

Events

1. On 31 May 2016, Mr Sonny Lawrence was remanded to HMP Hewell for attempted robbery and burglary. During an initial health screen, a nurse recorded that he did not report any health problems and that he had a history of substance misuse. In June, officers observed Mr Lawrence under the influence of a new psychoactive substance (NPS) and healthcare staff saw him in his cell for a review.

2. Mr Lawrence was moved to HMP Bristol on 1 July and did not report any health problems during an initial health screen. Three days later, a substance misuse worker saw him for an assessment and created a care plan. On 8 August, a nurse saw Mr Lawrence for a secondary health screen and offered smoking cessation advice but he declined. There is no record that Mr Lawrence had further intervention from the substance misuse team at any prison.

3. Two days later, Mr Lawrence was returned to Hewell. Due to his disruptive behaviour, he was put in the prison's segregation until he was returned to Bristol on 16 September.

4. Again, Mr Lawrence did not report any concerns during his initial health screen and a nurse recorded his blood pressure as 120/88 (in the pre-high blood pressure range).

5. On 3 October, an officer saw Mr Lawrence and thought that he was under the influence of illicit substances. Prison staff started the process to lower Mr Lawrence's incentive and earned privilege level and submitted an intelligence report. Later that evening, Mr Lawrence and his cell mate took a NPS.

6. At around 7.30am on 4 October, Mr Lawrence's cell mate checked on Mr Lawrence, after the cell had been unlocked. The cell mate realised that Mr Lawrence had stopped breathing and immediately told an officer. The officer entered the cell and made an emergency radio call at 7.49am. Another officer and a nurse arrived, and they moved Mr Lawrence onto the floor to start cardiopulmonary resuscitation. At 7.56am, paramedics arrived and took over advanced life support until they confirmed that Mr Lawrence had died at 8.24am.

Findings

7. Mr Lawrence died from severe coronary artery atherosclerosis and the clinical reviewer considered that this was an uncommon condition for a young man with no documented history of heart problems. We are satisfied healthcare staff could not have predicted or prevented his sudden death and that he received a standard of care equivalent to that which he could have expected in the community.

8. The post-mortem report identified the presence of non-prescribed substances in Mr Lawrence's blood and confirmed that the use of stimulant-type drugs can accelerate coronary artery atherosclerosis. Although we cannot be sure these non-prescribed substances contributed towards his death, we note the possibility

and consider that the prison needs to do more to reduce the availability of drugs. We are also concerned that there was no record that prison staff intended to refer Mr Lawrence to substance misuse services after being suspected of using illicit substances on 3 October.

9. We are also concerned that another prisoner, who had access to an illicit mobile phone, notified Mr Lawrence's family of his death before prison staff had the opportunity to do so.

Recommendations

- The Governor should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs and diverted medication.
- The Governor should ensure prisoners who use or are suspected of using new psychoactive substances are referred to drug treatment services.
- The Governor should review the local security strategy and ensure that everything possible is being done to prevent mobile phones entering the prison.

The Investigation Process

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

11. The investigator visited Bristol on 10 October 2016. He obtained copies of relevant extracts from Mr Lawrence's prison and medical records.

12. The investigator interviewed five members of staff and two prisoners at Bristol on 16 February 2017. He interviewed another member of staff by telephone on 22 February.

13. NHS England commissioned a clinical reviewer to review Mr Lawrence's clinical care at the prison. He attended joint interviews on 16 February.

14. We informed HM Coroner for Avon of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. Our investigation was suspended for over three months so as not to prejudice the police's investigation into the circumstances of Mr Lawrence's death.

16. One of the Ombudsman's family liaison officers contacted Mr Lawrence's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know why another prisoner had been able to contact her by mobile phone while her brother was undergoing cardiopulmonary resuscitation and again shortly after he had died. She also indentified some additional concerns that have been addressed through separate correspondence.

17. Mr Lawrence's family were informed the initial report was available, but did not wish to receive a copy or make any comment.

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

Background Information

HMP Bristol

19. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men. Bristol Community Health provides primary healthcare services and Medco Secure Health Services provide GP services. Avon and Wiltshire Mental Health Partnership NHS Trust provides mental health services and substance misuse services. All wings have a treatment room staffed by a nurse and healthcare assistants during the day. There is a nurse and a healthcare assistant on duty at night.

HM Inspectorate of Prisons

20. The most recent inspection of Bristol was in March 2017, though the most recently published inspection was in October 2014. In 2014, inspectors found healthcare provision had improved and reception screening was streamlined and swift. Access to the nurse and GP were good and clinical treatment was sound. There was a wide range of clinics, including one for chronic diseases. Prisoners with drug or alcohol problems received prompt treatment and a good level of care. Emergency resuscitation equipment on all wings and in the health centre was well maintained. Mental health provision was high quality.

Independent Monitoring Board

21. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its latest annual report for Bristol, for the year to November 2016, the IMB reported that priority and routine healthcare services are offered on the wings daily, and include the delivery of medication. They noted that nurses reported occasional diverting of prescribed medication when officers were not present to oversee the process.

Previous deaths at HMP Bristol

22. Mr Lawrence was the third prisoner to die from natural causes at Bristol and the second to show evidence of using illicit substances since January 2015. There were no similarities with the natural cause deaths. For the other death involving illicit substances, we criticised the deceased's access to diverted medication.

HMP Hewell

23. HMP Hewell can hold up to 1074 prisoners and contains two sections: A category B local section (house blocks 1-6) and a category D open section (Hewell Grange). Since April 2016, Care UK has provided healthcare services and South Staffordshire NHS Trust, the mental health services. There is 20 bed inpatient unit used for prisoners with physical and mental health needs.

HM Inspectorate of Prisons

24. The most recent inspection of Hewell was in August 2016. Inspectors reported that waiting times for no urgent GP appointments were too long and that staff shortages significantly affected service delivery. All prisoners received an in-

depth secondary health screen within 72 hours, although there was a backlog that was being addressed. Areas in healthcare, including the inpatient unit, were dirty and poorly ventilated.

Independent Monitoring Board

25. In the IMB's latest annual report for Hewell, for the year to September 2016, the IMB reported a considerable disruption to healthcare services following the change of provider. They noted that the high numbers of agency staff resulted in a lack of continuity in patient care.

New psychoactive substances (NPS)

26. 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.

27. 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.

Key Events

28. On 31 May 2016, Mr Sonny Lawrence was remanded to HMP Hewell for attempted robbery and burglary.

29. During an initial health screen, a nurse recorded that Mr Lawrence did not report any health problems and that he had a history of cannabis and cocaine misuse. Healthcare staff offered Mr Lawrence a secondary health screen on 14 and 21 June, but he failed to attend.

30. On 22 June, a nurse saw Mr Lawrence after officers reported that he had taken a new psychoactive substance (NPS). She recorded that his oxygen saturation level was 92-93% on oxygen and that his resting pulse rate was 104 bpm (normal being 60 to 100 bpm). He would not allow her to take any further observations and she advised officers to keep him under observation. Later the same day, a mental health nurse saw Mr Lawrence for a review and he told her that he could not remember anything. He did not report any ongoing issues or thoughts of self-harm.

31. Five days later, Mr Lawrence confirmed that he did not want to attend the prison's Integrated Substance Misuse Service.

32. On 1 July, Mr Lawrence was transferred to HMP Bristol and a nurse saw him for an initial health screen. He did not report any health concerns or disclose that he had taken illicit substances at Hewell. She noted that he appeared alert and orientated and recorded that his blood pressure was 116/76 (within the normal range).

33. The following day, an assistant psychologist saw Mr Lawrence to offer him a substance misuse risk assessment. Mr Lawrence agreed to this but she thought that he was under the influence of an illicit substance so she delayed the assessment. On 4 July, a substance misuse worker saw Mr Lawrence for an initial assessment and completed a care plan, which included completing in cell work on prevention and relapse. Bristol closed Mr Lawrence's substance misuse plan on 10 August, when he moved back to Hewell. There is no indication that Mr Lawrence received any further intervention from the substance misuse team at Bristol or Hewell.

34. In July, healthcare staff offered Mr Lawrence two secondary health screens but he failed to attend. When a nurse did see Mr Lawrence for a secondary health screen on 8 August, he did not report any problems. The nurse noted that Mr Lawrence's blood pressure was 120/50 (within the normal range) and that he smoked cigarettes. He offered him smoking cessation advice, but Mr Lawrence declined this.

35. On 10 August, Mr Lawrence moved back to Hewell after attending a hearing at Magistrates Court, and a nurse saw him for a review in the prison's segregation unit. Mr Lawrence did not raise any concerns to him.

36. Mr Lawrence remained in the segregation unit, as he alleged that he was under threat from prisoners on other wings, and healthcare staff regularly saw him. Mr

Lawrence complained of having lumps on his penis but did not raise any other concerns.

37. Mr Lawrence returned to Bristol on 16 September, after attending a hearing at Crown Court, and a nurse saw him for an initial health screen. Mr Lawrence did not report any health problems and the nurse noted that his blood pressure was 126/88 (in the pre-high blood pressure range). Mr Lawrence refused to disclose his substance misuse history and there is no record that healthcare staff arranged a secondary health screen.

38. On 21 September, a prison GP reviewed Mr Lawrence in the segregation unit, after he had damaged and flooded his cell the day before, and did not identify any concerns. Two days later another GP went to review Mr Lawrence, but he refused to see her.

39. On 3 October, an officer placed an entry in the wing observation book stating that a member of staff had seen Mr Lawrence presenting as if he was under the influence of an illicit substance. A prison manager subsequently reviewed his entry and requested that staff put a case note on Mr Lawrence's record, reduce him to the basic level on the incentive and earned privilege scheme, and submit a security intelligence report. There was no record that prison staff passed this information onto healthcare staff or made a referral to the substance misuse team.

40. Later that evening, Mr Lawrence and his cell mate smoked some NPS in a 'bong' before going to sleep. His cell mate also confirmed that Mr Lawrence had taken some 'fake Valium'. ('Valium' is the brand name for diazepam, used to treat anxiety disorders, alcohol withdrawal symptoms or muscle spasms.)

Events of 4 October 2017

41. Mr Lawrence's cell mate woke at approximately 3.30am on 4 October and noticed that Mr Lawrence had changed from wearing jogging bottoms to wearing boxer shorts. The cell mate also noticed that Mr Lawrence was snoring.

42. At around 7.30am, an officer looked through the observation hatch on Mr Lawrence's cell and opened the door. He told the investigator that he saw Mr Lawrence lying on the bottom bunk bed and that he said "good morning", before moving on to unlock the next cell. There is no indication that Mr Lawrence or his cell mate responded.

43. Shortly after the cells were unlocked, Mr Lawrence's cell mate checked on Mr Lawrence and noticed that he was cold, unresponsive and had blue lips. The cell mate immediately left the cell to tell the officer that Mr Lawrence had stopped breathing. The officer went to Mr Lawrence's cell and noticed that he did not respond to his leg being shaken. He called an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) at 7.49am and the control room immediately called for an ambulance.

44. Another officer and a nurse arrived and checked Mr Lawrence's vital signs but could not find a pulse. Meanwhile, the first officer escorted other prisoners out of the cell. They moved Mr Lawrence on to the floor and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 7.56am and moved Mr Lawrence on

to wing landing for greater accessibility. Advanced life support continued until 8.24am, when a paramedic confirmed that Mr Lawrence had died.

Contact with Mr Lawrence's family

45. At 8.50am, the prison appointed a Senior Officer (SO) as a family liaison officer. The SO started the process of identifying Mr Lawrence's next of kin.

46. At 9.07am, the prison's multi-faith manager received a telephone call from Mr Lawrence's sister stating that a prisoner had informed her of the situation by mobile phone. Around five minutes later, the prison Governor returned her call and arranged a visit. At 11.18am, the Governor, the SO and an Officer arrived at Mr Lawrence's sister's address and confirmed that Mr Lawrence had died. They offered their condolences and support.

47. The SO remained in contact with Mr Lawrence's sister until his funeral, which took place on 7 November 2016. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

48. After Mr Lawrence's death, a prison manger 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.

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

Post-mortem report

50. The post-mortem report found that Mr Lawrence had died from severe coronary artery atherosclerosis (hardening of the arteries in the heart). The report also found low levels of diazepam and ketamine in Mr Lawrence's blood and cannabinoids in his urine. The report concluded that these non-prescribed medications would not have accounted for Mr Lawrence's sudden death, though stimulant-type drugs (such as ketamine) can accelerate coronary artery atherosclerosis.

Findings

Clinical care

51. The clinical reviewer considered that severe coronary artery atherosclerosis is uncommon in a young man without a family history of such a genetic disorder. There were also no records to indicate that Mr Lawrence had any long-term physical health conditions or had reported any issues with his heart or chest. The clinical reviewer noted that, although, he did not always engage with healthcare staff or attend secondary health screens, attempts were made to deliver optimal care at all times.

52. The clinical reviewer was satisfied that cardiopulmonary resuscitation was started appropriately when Mr Lawrence had been found unresponsive.

53. We are satisfied that healthcare staff could not have predicted or prevented Mr Lawrence's sudden death and that he received a standard of care equivalent to that he could have expected in the community.

Illicit drugs

54. The post-mortem report revealed low levels of diazepam and ketamine, non-prescribed drugs, in Mr Lawrence's blood and cannabinoids in his urine. We consider it likely that he obtained these and other drugs while in prison. Although there is no evidence to suggest that drug misuse caused Mr Lawrence to have a sudden cardiac arrest, the post-mortem report indicates that the effects of coronary artery disease can be accelerated by previous use of stimulant-type drugs.

55. In 2015, Bristol introduced a Substance Intoxication Strategy to tackle the threat that intoxicating substances, particularly NPS, had on the safety of prisoners and staff, and the good order and discipline of the prison. The Strategy focused on informing prisoners of the risk of these substances, reducing access to them, punishing those involved and supporting those prisoners using them. The Strategy does not contain any reference to the risks presented by diverted medication and methods to reduce their supply.

56. One method of supporting prisoners using intoxicating substances is to refer them for a substance misuse assessment. We are satisfied that Bristol appropriately referred Mr Lawrence to the prison's substance misuse service in July. We also consider that when he returned to Bristol in September, he did not disclose his substance misuse history or display any unusual behaviour, so a referral was not required. However, we are concerned that there was no evidence that prison staff had started a substance misuse referral when Mr Lawrence was suspected of using NPS on 3 October.

57. We are also concerned that the presence of non-prescribed drugs in Mr Lawrence's blood and urine, and the statement that he had been taking 'fake Valium', demonstrates a failure with the prison's drug supply and demand reduction strategy. While we recognise that the prison's Substance Intoxication Strategy is relatively detailed, we note that there is no reference to using person or cell searches and that other tactics had been proposed rather than

implemented. Further, we are concerned that the Strategy does not cover the risks from diverting prescribed medication and that there is not a separate policy to cover this. We consider that further work is required to reduce the availability of illicit drugs and diverted medication so we make the following recommendations:

The Governor should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs and diverted medication.

The Governor should ensure prisoners who use or are suspected of using new psychoactive substances are referred to drug treatment services.

Access to mobile telephones

58. We are concerned that a prisoner was able to notify Mr Lawrence's sister of his condition and subsequent death by mobile telephone. This is likely to have been very distressing and we consider that the prison needs to do more to prevent prisoners gaining access to mobile phones. We therefore make the following recommendation:

The Governor should review the local security strategy and ensure that everything possible is being done to prevent mobile phones entering the prison.

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