Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Nicola Lawrence a prisoner at HMP New Hall on 24 September 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.

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

Ms Nicola Lawrence died on 24 September 2016 of methadone toxicity at HMP New Hall. She was 38 years old. I offer my condolences to Ms Lawrence's family and friends.

Ms Lawrence had a history of mental health and substance misuse problems. She told staff that she had suicidal thoughts and staff took action to support her, although we identify some weaknesses in this support. However, Ms Lawrence died of methadone toxicity and the investigation has been unable to determine how she obtained additional methadone or whether she realised the risk she was taking. However, I am concerned that staff did not recognise that Ms Lawrence may have been exhibiting signs of methadone toxicity or consult healthcare colleagues. I am also concerned that there were weaknesses in the emergency response.

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 9 September 2016, she was recalled to HMP New Hall for 28 days for theft.

2. During her initial health screen Ms Lawrence told healthcare staff that she had a history of multiple sclerosis, a broken wrist, and was dependent on heroin, for which she was prescribed methadone. Although Ms Lawrence told the nurse that she had tried to take her own life at the beginning of 2016, there is no evidence that the nurse tried to identify her mental health history and did not use a structured approach to assess her risk.

3. The nurse referred Ms Lawrence to a prison doctor, who prescribed her medication, including methadone, to manage her various health needs. A doctor saw Ms Lawrence the next day to review her medication and introduced a plan to safely increase her methadone dose to 30mg per day, which was still a low dose.

4. On 13 September, Ms Lawrence told her case manager that she had suicidal thoughts. He started suicide and self-harm prevention procedures, known as ACCT, that day. He did not tell the healthcare team until the next day, which meant no one from the team attended the first case review, as required. A nurse booked an appointment for Ms Lawrence to see the mental health team.

5. On 14 September, Ms Lawrence's case manager reviewed her risk of suicide and self-harm, and assessed her as at low risk.

6. A member of the healthcare team saw Ms Lawrence twice in September for a mental health assessment. There was no evidence that they used standard risk assessment tools to assess and manage her risk but they referred her for a primary care mental health appointment. This never took place.

7. At a case review on 19 September, Ms Lawrence said she was hearing voices telling her to harm herself but staff reduced her observations to once an hour. On 21 September, staff stopped ACCT monitoring as Ms Lawrence said that she no longer had suicidal thoughts. A prisoner told the investigator that Ms Lawrence had told her on 22 September that she felt suicidal. The prisoner said that she told two prison officers about this, but both officers denied being told.

8. On the evening of 23 September, an officer noted that Ms Lawrence was asleep on the floor, snoring loudly. She said that she told her to get on her bed, but that Ms Lawrence raised her arm and remained on the floor. Both officers on duty that night agreed to observe Ms Lawrence every half an hour when completing other ACCT observations. There was no evidence that they had considered Ms Lawrence was at risk of suicide or self-harm. At 11.30pm, an officer became concerned as Ms Lawrence was no longer snoring and, when an officer called out to her, she did not respond.

9. While an officer called a medical emergency code blue promptly, there was a five minute delay in entering the cell as the operational support grade had difficulty accessing his key from the sealed pouch. When they went into Ms Lawrence's cell, both officers immediately started cardiopulmonary resuscitation before

healthcare staff took over. At 11.55pm, paramedics arrived on the wing, and at 12.29am, paramedics pronounced that Ms Lawrence had died.

Findings

10. Overall, we are satisfied that Ms Lawrence's clinical care was equivalent to that she could have expected to receive in the community. Despite this, the clinical reviewer noted that when Ms Lawrence arrived at New Hall, the healthcare team did not use standard assessment tools to assess her anxiety and depression. This meant that her first night in custody plan was not fully informed by a comprehensive risk assessment.

11. We are concerned that Ms Lawrence's case manager had not received any formal ACCT case management training at the time of Ms Lawrence's death.

12. We are not satisfied that enough was done to address Ms Lawrence's potential risk of suicide and self-harm. Staff did not fully consider Ms Lawrence's risk factors, and relied solely on her comments that she was positive and had plans for the future as an indicator that she was no longer at risk to herself. There were deficiencies in ACCT procedures, including ineffective caremap actions.

13. Ms Lawrence died of methadone toxicity and we do not know whether or not she intended to take her life. It is likely that Ms Lawrence was taking illicit methadone. Despite conflicting anecdotal evidence from prisoners after Ms Lawrence's death about whether she was saving her methadone, there was no intelligence that she had diverted her methadone, that she or anyone else had brought it into the prison for her, or that staff knew anything about it.

14. When staff found Ms Lawrence lying on the floor of her cell, snoring loudly, they were sufficiently concerned about Ms Lawrence to agree to check on her at regular intervals. However, they failed to recognise the signs of potential methadone toxicity and missed four opportunities to seek medical intervention.

15. The process of opening a sealed pouch should not delay staff going into a cell and starting resuscitation efforts promptly. We cannot say whether the outcome might have been different for Ms Lawrence if staff had gone into her cell promptly.

Recommendations

- The Head of Healthcare should ensure that the care plans for prisoners' first night in custody are informed by a comprehensive risk assessment and that standard assessment tools are used when assessing a patient with mental health needs.

- The Governor should ensure that all staff are adequately trained to assess and manage ACCT procedures.

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including ensuring that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm.

- The Governor and Head of Healthcare should ensure that all staff are trained to recognise the common symptoms of drug-induced unconsciousness and methadone toxicity and know how to respond.
- The Governor should ensure that all staff are able to open their sealed key pouches in a timely manner to avoid delay in entering a cell.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP New Hall informing them of the investigation and asking anyone with relevant information to contact her.

17. The investigator obtained copies of relevant extracts from Ms Lawrence's prison and medical records.

18. NHS England commissioned a clinical reviewer to review Ms Lawrence's clinical care at the prison.

19. The investigator and clinical reviewer jointly interviewed six members of staff and two prisoners at HMP New Hall on 8 November. The investigator conducted a telephone interview on 23 November with one officer and a videolink with another officer on 26 January 2017. A third officer responded to her written questions.

20. We informed HM Coroner for West Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS. They raised one factual inaccuracy. We do not consider the omission of the fact that staff were not trained to recognise the signs of methadone toxicity as a factual inaccuracy, and therefore have not changed the paragraph.

22. Mr Lawrence's family received a copy of the initial report. They raised a number of concerns that we have addressed in separate correspondence. In addition to this, we have changed the wording to reflect Ms Lawrence's family's feedback.

Background Information

HMP New Hall

23. HMP New Hall is a local prison, holding around 400 women and young offenders, on remand or sentenced. Spectrum Community Health CIC provided primary health care services until August 2016 and Nottinghamshire Healthcare NHS Foundation Trust provided mental health services. Spectrum Healthcare and Turning Point provided substance misuse services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP New Hall was in June 2015. Inspectors reported that health services were strong, particularly mental health provision. They found that the support for women with substance misuse issues had improved since their previous inspection, but required further work.

25. The inspectors found that support on arrival and during the early days at the prison was very good. They found that security arrangements were generally proportionate, but delays in responding to some intelligence was a concern, particularly given the obvious challenges in managing problems with the use of illicit and diverted prescribed drugs.

Independent Monitoring Board

23. 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 reported that prison security remained a problem, particularly in relation to drugs. They were concerned about the increased number of incidents of women coming into prison with drugs secreted on their person. They said that the prison and the IMB had tried unsuccessfully to obtain a body scanner.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is responsible. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Previous deaths at HMP New Hall

28. There have been four previous deaths at HMP New Hall since 2014. We made previous recommendations about the management of ACCT procedures.

Key Events

24. Ms Lawrence was released on licence on 6 July 2016. On 9 September 2016, she was recalled to prison for 28 days for theft, and was taken to HMP New Hall.

25. During her initial health screen that day, a nurse identified that Ms Lawrence had a history of multiple sclerosis (MS) and heroin dependency. She had a broken wrist, and walked using a stick. Ms Lawrence told her that she had tried to take her life in the community at the beginning of the year. Ms Lawrence had a history of depression and anxiety but the nurse did not identify this. There is no evidence that Ms Lawrence discussed her past suicide attempts or that the nurse used a structured approach to assess Ms Lawrence's risk.

26. The nurse referred Ms Lawrence to a prison doctor. Later that day, Ms Lawrence saw a doctor, who noted that Ms Lawrence had started smoking heroin in the community, and prescribed her methadone.

27. On 10 September, a prison doctor reviewed Ms Lawrence's medication and continued her methadone prescription. This consisted of 10mgs of methadone twice a day for the first day (10 September), increasing to 30mgs (a low dose), once a day by the third day. She remained on this dose until her death. Healthcare staff prescribed medication to manage Ms Lawrence's multiple sclerosis, and she was taken to hospital, where her arm was placed in a cast.

28. The Head of Healthcare told the clinical reviewer that the general administration of methadone was witnessed by two members of staff, and recorded in the controlled drug book. A dispensing nurse told the investigator that when issuing methadone she was required to have a conversation with the patient to make general observations and check that they were not under the influence of illicit drugs. The patient was then required to provide her identification card before receiving methadone, and had to take it with water in front of staff. She said that an officer watched 90% of the time.

29. A nurse told the investigator that there was no intelligence about Ms Lawrence potentially diverting her methadone. She explained that, had there been, she would have referred her to the Integrated Drug Treatment System clinic to assess her risk. She said that as well as drugs being brought into prison, she was aware that some women vomited their methadone to sell it.

30. On 13 September, Ms Lawrence told a Supervising Officer (SO), who was her case manager, that she had suicidal thoughts. He started suicide and self-harm prevention procedures, known as ACCT. He completed an ACCT assessment and recorded that staff were to observe Ms Lawrence twice an hour until her next ACCT review. He completed a caremap, with four actions for Ms Lawrence to complete. These were for her to go the chapel for grief counselling (as it was coming up to the anniversary of her partner's death), to contact Care UK, to look at the prison visitors' scheme and to work on how to ask for help. None of the actions had a specific timescale and were all marked as "ongoing".

31. On 14 September, the case manager held an ACCT case review with Ms Lawrence. No one from the healthcare team attended because he had not told them that Ms Lawrence was being monitored under ACCT procedures until that

day and by then the mental health team had no capacity to attend. He recorded that Ms Lawrence appeared tearful. He assessed her as at low risk of harm to herself and of further risk behaviours. Ms Lawrence's healthcare records said that an appointment was booked for her to see the mental health team the next day.

32. On 15 September, a mental health nurse assessed Ms Lawrence's mental health. Another mental health nurse saw her again on 16 September. The clinical reviewer noted that standardised risk assessment tools were not used to assess the level of Ms Lawrence's levels of anxiety and depression, and there was no structured approach to Ms Lawrence's risk assessment and management. She was however added to the list for discussion at the next multidisciplinary team meeting.

33. Staff continued to observe Ms Lawrence twice an hour until a further ACCT case review on 19 September. The case manager, Ms Lawrence and a member of the mental health team attended. At this review, Ms Lawrence told staff that she was hearing voices, telling her to stay on her own and to harm herself. Despite this, the case manager noted that Ms Lawrence believed that she had a purpose, wanted to finish a computer course and that she had an appointment with the mental health in-reach team and Turning Point (mental health services). He reduced Ms Lawrence's observations to once an hour as he assessed that her risk had reduced in the absence of evidence of self-harm and because Ms Lawrence was making plans for the future.

34. On 21 September, Ms Lawrence's case was discussed at a multidisciplinary team meeting. A senior mental health practitioner decided in conjunction with three mental health nurses that Ms Lawrence should have a primary care mental health assessment.

35. That day, the case manager held an ACCT case review with Ms Lawrence and a mental health nurse. He recorded that Ms Lawrence reported feeling better, that she talked of future goals, and that she no longer had suicidal thoughts. He and the nurse jointly decided to stop ACCT monitoring. A post-closure review was arranged for 27 September.

36. A prisoner who lived on the same wing as Ms Lawrence (Oak House) told the investigator that on 22 September, Ms Lawrence told her how upset she felt after a telephone conversation with family members, and that she did not want to live anymore. The investigator listened to recordings of these conversations, which confirmed they would have been upsetting for Ms Lawrence.

37. The prisoner told the investigator that she did not know Ms Lawrence and was concerned about the conversation, so reported it to two officers. One officer told the investigator that she did not have this conversation with the prisoner, and we have seen evidence that the other officer was not working on the wing that day. Another officer, who is on long terms sick absence from the prison following Ms Lawrence's death and who was only able to provide the investigator with written answers, said that the prisoner did not at any time speak to her about Ms Lawrence.

Events of 23 and 24 September

38. On 23 September, an officer was on night duty on Oak House with an operational support grade (OSG). She wrote in her statement that she started her shift at approximately 7.15pm, and went straight to Oak House for a handover from day staff. She said that no issues were raised.

39. At 9.30pm, the OSG and the officer started the full roll check. The officer noted that, when she looked in Ms Lawrence's cell, she was lying on the floor, snoring very loudly. The OSG told the investigator that while he had not known Ms Lawrence to sleep on the floor before, it was not unusual for her to snore loudly. The officer said that she called to Ms Lawrence and suggested that she move to her bed. She said that Ms Lawrence did not initially respond but after she raised her voice, Ms Lawrence acknowledged her by waving her right arm.

40. Although Ms Lawrence was no longer being monitored under ACCT procedures, the OSG and the officer passed her cell every half an hour to complete observations on other prisoners. Although they told the investigator that her behaviour was normal, they agreed to check on her until she got into bed. Neither the OSG nor the officer gave any indication that they were checking on Ms Lawrence because they thought she posed a risk to herself, they did not consider beginning suicide and self harm prevention measures and it is not clear why they decided to monitor her.

41. The officer completed checks at 10.00pm and 10.30pm. She said that on both occasions, Ms Lawrence remained lying on the floor, snoring very loudly.

42. At 11.00pm, the OSG checked on Ms Lawrence and told the investigator that she was still asleep and was snoring loudly. He checked on her again at 11.30pm, and told the investigator that she was no longer snoring. He said that he banged on her door but she did not move. As he had lost his voice, he could not shout to Ms Lawrence, so he ran to the wing office to tell the officer that Ms Lawrence was not responsive. He said that this took a matter of seconds.

43. They returned to Ms Lawrence's cell, and again tried to get a response. The OSG's statement said that they went into the cell at 11.35pm. He told the investigator that there was a five minute delay between him first seeing that Ms Lawrence was not responsive and going into her cell as he was struggling to remove the key from his pouch. He said that it was 'fiddly' and hard to break the seal, especially in an emergency situation. He said that he had had difficulty removing the keys from the pouch before.

44. When they went into the cell, the officer radioed a medical emergency code blue (a code blue indicates a person with breathing difficulties and automatically triggers the control room to call an ambulance). Records indicate that the control room called for an ambulance at 11.36pm.

45. They moved Ms Lawrence on to her back and started cardiopulmonary resuscitation. They described taking turns doing chest compressions until 11.38pm when two nurses arrived.

46. A nurse told the investigator that she had picked up the emergency bag on the way to the wing. In her statement, the other nurse described attaching the

defibrillator to Ms Lawrence, and that it advised to continue resuscitation efforts and not to shock. Both nurses continued cardiopulmonary resuscitation, as the defibrillator repeatedly advised.

47. At 11.55pm, the ambulance arrived at Oak House and paramedics took over cardiopulmonary resuscitation. A second response ambulance arrived at the prison at 12.02am, and two more paramedics assisted with resuscitation efforts. At 12.29am, paramedics pronounced that Ms Lawrence had died.

Contact with Ms Lawrence's family

48. After Ms Lawrence's death, the prison appointed an officer as family liaison officer. At 9.15am on 24 September, he visited Ms Lawrence's parents to break the news of her death and to offer his condolences and support. On 27 September, the Governor wrote to Ms Lawrence's parents to offer support. The officer continued to support Ms Lawrence's family. The prison contributed to the costs of her funeral, in line with national instructions.

Support for prisoners and staff

49. After Ms Lawrence's death, a duty governor and a deputy governor debriefed all the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. They were told that they could contact the prison's care team if they had any specific issues. Care UK management debriefed medical staff separately.

50. The prison posted notices informing other prisoners of Ms 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 Ms Lawrence's death.

51. A member of staff said that the prison did not adequately support her after Ms Lawrence's death, and after she was told to stop working by occupational health, she was diagnosed with post-traumatic stress disorder. The officer provided no further information.

Post-mortem report

52. The post mortem report gave the cause of Ms Lawrence's death as methadone toxicity. The report states that the level of methadone in Ms Lawrence's blood was within the range encountered in methadone associated fatalities, even in chronic and therefore tolerant users.

Findings

Clinical care

53. During her reception healthcare screening on 9 September 2016, a nurse and a prison doctor appropriately identified Ms Lawrence's physical healthcare needs and prescribed her methadone in line with the maintenance regime she received in the community. Despite this, no one identified her history of depression and anxiety.

54. A nurse should have taken a comprehensive mental health history during Ms Lawrence's mental health assessment on 15 September but did not do so. The clinical reviewer noted that standardised tools were not used to assess Ms Lawrence's level of anxiety and depression and that there was no structured approach to her risk assessment and management. This was again the case when a nurse saw Ms Lawrence on 16 September. Another nurse recorded that Ms Lawrence would be discussed at a multidisciplinary team meeting on 21 September. As a result of this meeting, Ms Lawrence was referred for a primary care mental health assessment, but this did not happen before her death. If a structured approach had been used to assess Ms Lawrence's risk when she first arrived at New Hall, a referral to the primary care mental health services could have been made at an earlier stage.

55. The clinical reviewer concluded that while opportunities were missed to identify and manage Ms Lawrence's anxiety and depression, the care she received overall was equivalent to that which she could have expected in the community.

56. The clinical reviewer makes a number of recommendations about the management of Ms Lawrence's mental health issues which the Head of Healthcare should address. We make the following recommendation:

    The Head of Healthcare should ensure that the care plans for prisoners' first night in custody are informed by a comprehensive risk assessment and that standard assessment tools are used when assessing a patient with mental health needs.

ACCT procedures

57. The case manager started ACCT procedures for Ms Lawrence on 13 September 2016 but did not tell the healthcare team until the next day, which prevented them from attending her first case review, a mandatory requirement of Prison Service Instruction (PSI) 64/2011. While a member of healthcare staff attended all subsequent case reviews, no one in the healthcare team reviewed Ms Lawrence's medical records before the reviews, and they did not provide a considered and informed medical opinion about her potential risk of suicide or self-harm.

58. At Ms Lawrence's second case review on 19 September, the case manager recorded that Ms Lawrence spoke of hearing voices which told her to harm herself in secret. Despite this, he assessed her risk to herself as low. He told the investigator that his decision was based on Ms Lawrence having positive plans for the future. He assumed that mental health issues would be addressed

separately. Ms Lawrence's comments that she was positive and making future plans should not have been the sole consideration when assessing her. We believe that Ms Lawrence had a number of significant risk factors which, taken together, indicated she was at risk of suicide and self-harm: she had recently been recalled to prison, she was a drug user, she had a history of depression and severe anxiety, previous attempts of suicide, she disclosed that she was hearing voices telling her to harm herself, and it was nearing the anniversary of her partner's death.

59. During the ACCT review on 22 September, a nurse told the investigator that Ms Lawrence's behaviour had been settled for a while and she had denied suicide or self-harm ideation. She said that she jointly decided with the case manager that Ms Lawrence no longer needed to be monitored under ACCT procedures. No-one appears to have identified or addressed Ms Lawrence's risk factors. The clinical reviewer said, and we agree, that the assessment and management of risk at New Hall were inadequate and needed improvement.

60. Although staff appropriately started ACCT procedures after Ms Lawrence disclosed thoughts of wanting to harm herself, ACCT monitoring was stopped after a very short time, two days before her death and with no clear justification. The case manager told the investigator that he had been trained as an ACCT assessor but had not received ACCT case management training before he became Ms Lawrence's case manager. He undertook training after Ms Lawrence's death, and said he could identify what he would have done differently, including not relying on how Ms Lawrence presented as an indicator that she was no longer at risk to herself. We make the following recommendation:

The Governor should ensure that all staff are adequately trained to assess and manage ACCT procedures.

61. We are concerned that ACCT procedures were not properly managed. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview. The caremap should set actions aimed at reducing the prisoner's risk to herself, and set a timescale to complete these actions. None of the caremap actions were meaningful, considered whether substance misuse was a particular risk factor for Ms Lawrence or had a specific timescale. All actions were recorded as ongoing. We do not know whether Ms Lawrence intended to take her life but had she continued to be monitored under ACCT procedures, it is likely that her needs would have been better supported. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including ensuring that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of suicide and self-harm.

Obtaining additional methadone

62. The post mortem gave Ms Lawrence's cause of death as methadone toxicity, and indicated that the level of methadone was above therapeutic levels.

63. The IMB reported in 2016 that prison security remained a problem, particularly in relation to drugs. They were concerned about the increased number of incidents of women coming into prison with drugs secreted on their person. HM Inspectorate of Prisons also noted New Hall's challenges in managing problems with the use of illicit and diverted prescribed drugs.

64. The clinical reviewer said that Ms Lawrence's prescription of methadone was in line with accepted practice, it was administered in a controlled environment and she had been maintained on a low dosage (30 mgs) for 13 days before her death.

65. While we think it possible that Ms Lawrence was taking illicit methadone, despite conflicting anecdotal evidence from prisoners after Ms Lawrence's death about whether she was saving her methadone, there was no intelligence that she had diverted her methadone, that she or anyone else had brought it into the prison for her, or that staff knew anything about it. We therefore make no formal recommendation.

Ms Lawrence's presentation on the evening of 23 September

66. An officer said that when she was completing the roll check on the evening of 23 September, Ms Lawrence was lying on the floor of her cell, snoring very loudly. Although Ms Lawrence was not being monitored under ACCT procedures, the OSG and officer agreed to check her at half hour intervals. The OSG told the investigator that while he had not known Ms Lawrence to sleep on the floor before, it was not unusual for her to snore loudly. They both said they believed that Ms Lawrence's behaviour was normal.

67. We are concerned that staff were not alert to the risk that Ms Lawrence could have been displaying the effects of drug intoxication. Typically, people who die from the effects of methadone become deeply unconscious, unrousable and are often heard to be snoring heavily before they stop breathing. These warning signs have been evident in a number of deaths we have investigated.

68. Ms Lawrence was lying on the floor, snoring loudly when staff checked on her between 9.30pm and 11.00pm, but no one was concerned about her wellbeing until she was found no longer snoring at 11.30pm. There were four missed opportunities to identify a medical emergency, and we would have expected staff to have recognised the symptoms of potential methadone toxicity and seek medical assistance promptly. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff are trained to recognise the common symptoms of drug-induced unconsciousness and methadone toxicity and know how to respond.

Emergency response

69. Prison staff correctly and promptly called a code blue when they found Ms Lawrence unresponsive in her cell. While resuscitation efforts were managed appropriately once staff went into Ms Lawrence's cell, we are concerned that there was a five minute delay in going into her cell. The OSG told the investigator that the reason for the delay was that he could not break the seal on his key pouch, and that he had experienced difficulty before. The officer confirmed that he had difficulty opening the pouch as the seal was tight.

70. The process of opening a sealed pouch should not delay staff going into a cell and starting resuscitation efforts promptly. We do not know if this is a general issue, or specific to this officer, and we cannot conclude whether the outcome might have been different for Ms Lawrence if staff had gone into her cell promptly, We make the following recommendation.

The Governor should ensure that all staff are able to open their sealed key pouches in a timely manner to avoid delay in entering a cell.

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