Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Liam Lawson, a prisoner at HMP Hull, on 28 October 2019

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 Liam Lawson died on 28 October 2019 at HMP Hull after being found unresponsive in his cell. The cause of his death is unknown. He was 28 years old. I offer my condolences to Mr Lawson's family and friends.

The clinical reviewer concluded that, overall, Mr Lawson's care at Hull was of a good standard and equivalent to that which he could have expected to receive in the community.

Mr Lawson had a history of drug misuse in the community and he had regular contact with the prison's substance misuse team and mental health team. The investigation found that Mr Lawson had taken prescription medications before his death that were not prescribed to him. I am concerned that despite a substance misuse strategy being in place, Mr Lawson was able to obtain illicit prescription medication at Hull.

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 **March 2021**

Contents

Summary

Events

1. On 5 February 2019, Mr Liam Lawson was remanded to HMP Hull on charges of arson. On 10 May, Mr Lawson was sentenced to five years in prison for arson. It was his first time in prison.

2. Mr Lawson had a history of substance misuse (alcohol and drugs) and had taken an overdose of prescription medication in 2009.

3. Mr Lawson was described by prison staff as having a positive attitude and he volunteered for the role of a prisoner befriender. He engaged with the prison's substance misuse team and was prescribed anti-depressant medication to help with his anxiety and depression.

4. At approximately 1.30pm on 29 October, prisoners found Mr Lawson unresponsive in his cell. Prison officers entered his cell and found him slumped over his desk. An officer called a medical emergency code and the control room called an ambulance promptly. Staff tried unsuccessfully to resuscitate Mr Lawson. Paramedics arrived at 2.02pm and assessed him but at 2.22pm they confirmed that Mr Lawson had died.

5. A post-mortem was unable to determine the cause of Mr Lawson's death.

Findings

Management of Mr Lawson's substance misuse and mental health.

6. The clinical reviewer concluded that the care Mr Lawson received for his substance misuse and mental health was of a good standard and equivalent to that which he could have expected to receive in the community. He had regular support from the prison's substance misuse team and mental health team and was offered appropriate recovery work.

7. We are concerned that despite a substance misuse strategy being in place, Mr Lawson was able to obtain illicit prescription medication at Hull.

Clinical care

8. The clinical reviewer concluded that, overall, the care Mr Lawson received at Hull was good and equivalent to that which he could have expected to receive in the community.

Recommendation

- The Governor should ensure that the prison's local drugs strategy includes effective actions to address the illicit trading of prescription drugs.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. Three prisoners responded.

10. The investigator visited Hull on 4 November 2019. She obtained copies of relevant extracts from Mr Lawson's prison and medical records and spoke to three prisoners.

11. NHS England commissioned a clinical reviewer to review Mr Lawson's clinical care at the prison. The investigator and clinical reviewer jointly interviewed five members of staff on 22 and 23 January 2020.

12. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. Our investigation was delayed while we waited for the cause of death.

14. We wrote to Mr Lawson's mother, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Lawson's mother said that investigations had shown that Mr Lawson did not have a heart condition. She asked about Mr Lawson's role as a prison befriender and if he was seen by his keyworker. Mr Lawson's mother also asked questions about his prescribed medication. We have answered these questions in the report. We have addressed other issues that Mr Lawson's mother raised in separate correspondence.

15. Mr Lawson's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Hull

17. HMP Hull is a local prison that holds up to 1,056 men in ten wings. City Healthcare Partnership provides health services at the prison. GP surgeries are held four days a week, with an out of hours service at other times.

HM Inspectorate of Prisons (HMIP)

18. The most recent full inspection of HMP Hull was in April 2018. HMIP had concerns about many areas. Inspectors reported that risks to the prison included the availability of drugs and mobile phones and associated violence. The introduction of a dedicated search team, who supplemented routine searches carried out by wing staff, enabled swift action to be taken in response to intelligence. Electronic drug testing equipment had also been introduced, which meant incoming mail, property and mail order deliveries could be 'swab tested' for drugs.

Independent Monitoring Board

19. 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 July 2020, the IMB reported that the environment at the prison was fair and supportive. There were 373 incidents where prisoners were found to be under the influence of illicit substances. This was a 27% reduction from the previous year.

Previous deaths at HMP Hull

20. Mr Lawson was the 14th prisoner to die at Hull since November 2017. Of the previous deaths, nine were from natural causes, one was drug-related, and three were self-inflicted. There have been six deaths since Mr Lawson's death, three from natural causes and three self-inflicted deaths.

21. There were no similarities between Mr Lawson's death and previous deaths at the prison.

Key Events

22. On 5 February 2019, Mr Liam Lawson was remanded to HMP Hull, charged with arson. He had a history of alcohol and substance abuse and suffered from anxiety and depression. Mr Lawson's person escort record (PER) noted that he had a history of self-harm and had taken an overdose of medication in 2009.

23. A nurse completed Mr Lawson's initial health screen and noted his history of anxiety and depression. Mr Lawson refused a referral to the substance misuse team and denied any thoughts of suicide or self-harm. A second health screen took place on 6 February with a nurse who made a referral to the prison's mental health team.

24. On 9 February, Mr Lawson told staff that it was his first time in prison and that he felt vulnerable. He said that he felt under threat because of his brother's alleged offences and was struggling to cope on a normal wing. On 11 February, a prison manager approved his application for vulnerable prisoner status, and he was moved to the vulnerable prisoner wing.

25. On 13 February, Mr Lawson referred himself to the Drug and Alcohol Recovery Team (DART) and an appointment took place on 14 February with a recovery worker. Mr Lawson said that he drank alcohol regularly and had also used cocaine, cannabis and benzodiazepines in the four weeks before he was sent to prison. She told him about the risks of using illicit substances and drinking alcohol excessively. As a remand prisoner, Mr Lawson was able to seek support from the DART team and would be allocated a caseworker if he was sentenced. Mr Lawson said that he suffered with a number of mental health issues and was happy to receive support from the prison's mental health team. He told the recovery worker that he preferred one-to-one sessions to group work because he felt anxious around other people.

26. The same day, an officer was given the role as Mr Lawson's keyworker. He noted that Mr Lawson was working as a prisoner befriender (a volunteer role to provide other prisoners with support) and wanted to set a good example to other prisoners. He saw Mr Lawson regularly and noted his positive attitude and commitment towards his befriender role.

27. On 26 February, a mental health nurse assessed Mr Lawson and noted he was having difficulty sleeping after the death of his grandmother. Mr Lawson said that a lack of sleep was causing him to hallucinate and feel disorientated. She assessed his risk of depression and anxiety as mild to moderate and said he was suitable for low intensity treatment. The next day, a prison GP prescribed mirtazapine (an antidepressant) and decided that Mr Lawson should not keep his medication in his possession because it was his first time in prison, and he had a history of self-harm. On 5 March, a nurse assessed Mr Lawson as a low risk for in-possession medication and he was allowed to keep a week's dosage of mirtazapine in his cell.

28. On 8 March, staff submitted a security intelligence report which said that Mr Lawson's mail had tested positive for psychoactive substances (PS). An analyst recommended that staff should continue to monitor Mr Lawson's incoming mail.

29. The mental health nurse saw Mr Lawson again on 11 March. Mr Lawson said that he was sleeping better and felt a lot more positive and energetic. He felt less anxious and was happy to be discharged from the mental health service. Mr Lawson agreed to participate in group work for depression and anxiety.

30. On 1 April, Mr Lawson complained of feeling unwell, his heart was racing, he felt clammy and said that his head felt strange. A nurse recorded his physical observations as normal and the results of an electrocardiogram and blood tests were also normal.

31. On 10 May, Mr Lawson was sentenced to five years in prison for arson. He was allocated a DART recovery worker. The DART worker told us that she saw Mr Lawson daily because she worked on his landing. She described Mr Lawson as engaging, pleasant and polite. On 29 May, she referred him to the SMART programme, a mutual aid group. Mr Lawson decided, however, that he did not want to attend and was placed on a waiting list for the Inside Out Programme (a 24-session course that focuses on addictive behaviour, self-management and recovery). She said Mr Lawson was unsure what help he needed but he was seen monthly to provide information and support. On 22 October, Mr Lawson expressed an interest in becoming a recovery champion, to provide additional support and advice to prisoners.

32. On 7 June, Mr Lawson attended the positive mental health promotion group. He participated well and said he did not have any thoughts of suicide or self-harm.

33. On 7 August, a pharmacist saw Mr Lawson in his cell to check his prescribed medication. Mr Lawson did not have as much as he should have done, and he said that he had taken more than the prescribed dose because his medication was not helping. The pharmacist assessed Mr Lawson as being unsuitable for in-possession medication and noted that he may have traded his mirtazapine medication with other prisoners. An appointment was made with a prison GP to review his medication needs, but Mr Lawson did not attend.

34. On 7 and 16 September, staff submitted a security intelligence report which said that Mr Lawson was receiving mail sprayed with PS, which was passed to another prisoner to sell. Security staff followed up on this and completed several targeted searches on a number of prisoners' cells, but nothing was found.

35. On 23 October, Mr Lawson complained of abdominal pains. A nurse examined him and diagnosed muscle strain from playing badminton. The nurse did not record Mr Lawson's physical observations in his medical record but told us that these were taken and were normal.

Events of 28 October 2019

36. At approximately 12.15pm on 28 October, Mr Lawson was locked in his cell by an officer. He told us that he had spoken to Mr Lawson that morning and he was positive and upbeat. Mr Lawson did not report any issues or concerns. CCTV footage showed no one leaving or entering Mr Lawson's cell until he was unlocked.

37. The officer unlocked Mr Lawson's cell at approximately 1.30pm. He told us that he saw Mr Lawson sitting in the chair at his desk with his back to the cell door.

His head was on the desk turned to one side and his hands were outstretched as though he was trying to reach for something on the floor. The officer asked Mr Lawson what he was doing but did not get a response. He said he continued with unlocking other prisoners because he had no reason to suspect anything was wrong.

38. Very shortly afterwards, two prisoners went to Mr Lawson's cell and found him unresponsive. They called for help and two officers immediately went to the cell. One officer checked Mr Lawson for any signs of life but found none. He started cardiopulmonary resuscitation and the other officer radioed an emergency code blue to indicate Mr Lawson was unresponsive, and the control room called an ambulance. A nurse and a prison paramedic arrived to assist.

39. Hospital paramedics arrived at 2.02pm and took control of Mr Lawson's care. At 2.22pm, they confirmed that Mr Lawson had died.

Information received after Mr Lawson's death

40. Mr Lawson had written a note to his parents which staff found in his cell after his death. Mr Lawson said he was having strange pains and twinges in his heart. The note did not express any intention of suicide or self-harm.

41. Security intelligence submitted after Mr Lawson's death suggested that he had taken prescription medication that had not been prescribed to him on the morning of his death. Other intelligence suggested that he had been buying other prisoners' prescription medication for a long time.

42. Security intelligence also suggested that Mr Lawson had told another prisoner that he was experiencing heart palpitations on the morning of this death. The prisoner said he told Mr Lawson to seek medical advice and he did not see Mr Lawson again before they were locked in their cells. There is no evidence that Mr Lawson told staff that he was feeling unwell.

Contact with Mr Lawson's family

43. The prison appointed a family liaison officer (FLO) and identified Mr Lawson's mother as his next of kin. At 3.50pm, the FLO and the Deputy Governor travelled to Mr Lawson's mother's address to inform her of her son's death. They continued to offer support.

44. The prison contributed to the cost of Mr Lawson's funeral in line with national guidance.

Support for prisoners and staff

45. After Mr Lawson's death, Deputy Governor 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.

46. The prison posted notices informing other prisoners of Mr Lawson'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 Lawson's death.

Post-mortem report

47. The post-mortem was unable to establish the cause of Mr Lawson's death.

48. Toxicology results showed the presence of Mr Lawson's prescribed medication in his system at therapeutic levels which would not have contributed to his death. The results also showed the presence of prescription medication that had not been prescribed to him. The pathologist said that it was highly unlikely that these drugs, either in isolation or combination, would have been a significant factor in Mr Lawson's death.

49. The pathologist considered the possibility that Mr Lawson had an underlying heart condition. While the post-mortem findings showed nothing to suggest that Mr Lawson's death was anything other than natural, the pathologist concluded that the exact cause was best regarded as unascertained.

Findings

Management of Mr Lawson's substance misuse and mental health

50. The post-mortem report showed that Mr Lawson had codeine, carbamazepine and gabapentin in his blood. Mr Lawson had never been prescribed these medications in prison, so he had clearly obtained them illicitly.

51. Mr Lawson had engaged with the prison's substance misuse team and mental health team and we are satisfied that he was offered opportunities to address his history of substance misuse and history of mental health conditions. He initially engaged in substance misuse work and was encouraged to attend group support sessions. When he decided not to attend, substance misuse staff continued to support him. DART and healthcare staff had no suspicion that he was using illicit substances or taking non-prescribed medication and he was encouraged to become a recovery champion.

52. The clinical reviewer did not have any concerns about the care Mr Lawson received for his substance misuse and mental health and concluded that the care he received was equivalent to that which he could have expected to receive in the community.

Clinical care

53. The clinical reviewer concluded Mr Lawson's clinical care at Hull was of a good standard and equivalent to that which he could have expected to receive in the community.

54. When healthcare staff found that Mr Lawson was taking too much of his prescribed medication, they appropriately assessed that he was unsuitable to have his medication in his possession.

55. There was no evidence which suggested that Mr Lawson had a heart condition. When Mr Lawson complained that his heart was racing, healthcare staff completed appropriate investigations and investigated his symptoms with normal results.

Drug strategy at HMP Hull

56. The prison has a substance misuse strategy which sets out a number of actions to reduce the demand for and supply of illicit drugs. Despite this, Mr Lawson was able to obtain prescription medication illicitly. We are concerned that the presence of non-prescribed drugs in Mr Lawson's blood after his death demonstrated a failure with the prison's drug supply and demand reduction strategy.

57. Drug taking and trading is a serious problem across much of the prison estate and Hull is not alone in facing this problem. In April 2019, HMPPS published a National Drug Strategy setting out their plans to reduce substance misuse by sharing best practice and providing direction and detailed guidance for prisons. In relation to reducing the supply of drugs, the new Prison Service strategy says:

"Every prison is different and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

58. The key issue in this case was the illicit trading of prescription drugs. We make the following recommendation:

The Governor should ensure that the prison's local drugs strategy includes effective actions to address the illicit trading of prescription drugs.

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