Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Lawrence, a prisoner at HMP Doncaster, on 20 January 2021

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 I 020 7633 4100
F I 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*

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 Ryan Lawrence was found hanged in his cell at HMP Doncaster on 20 January 2021. He was 25 years old. I offer my condolences to Mr Lawrence's family and friends.

Mr Lawrence arrived at Doncaster on 10 December 2020, after he was remanded in custody charged with offences against his partner and her property. Over the next six weeks, there were no indications that Mr Lawrence was at risk of suicide or self-harm and I am satisfied that staff could not have foreseen his actions.

My investigation identified delays in the emergency response when Mr Lawrence was found hanging. The delays made no difference to the outcome for Mr Lawrence as he had been dead for some time when he was found, but staff at Doncaster need to follow the correct procedures for medical emergencies and act without delay.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman November 2021

Contents

Summary

Events

1. Mr Ryan Lawrence was remanded in prison custody on 8 December 2020, charged with assaulting his partner and causing damage to her home, and sent to HMP Doncaster. Mr Lawrence told a reception nurse that he had no thoughts of suicide or self-harm.

2. Mr Lawrence added his partner's telephone number to his list of approved contacts by saying it was his sister's. He telephoned his partner multiple times on 19 and 20 January. She did not answer most of his calls and Mr Lawrence left voicemail messages saying that he believed she had started a relationship with another man. In one message he said that he would wait for her in the afterlife.

3. At 5.17am on 20 January 2021, while carrying out a roll check, an operational support officer (OSO) saw Mr Lawrence hanging from his bed frame. The OSO called out to an officer who radioed a medical emergency code and then left the landing to collect a telephone. The officer returned several minutes later and then she and the OSO went into the cell. The officer cut Mr Lawrence down as the OSO was not carrying an anti-ligature knife. The Night Orderly Officer then arrived and cut the remnant of the ligature that was around Mr Lawrence's neck. He was about to attempt resuscitation when nurses arrived and told him that resuscitation was inappropriate as Mr Lawrence had rigor mortis (stiffening of the body that occurs after death).

4. Mr Lawrence left a note stating that he was going to a better place. Mr Lawrence's partner also apparently took her own life three days later.

Findings

5. We are satisfied that Mr Lawrence gave staff no reason to believe he was at risk of suicide in the six weeks before his death.

6. Mr Lawrence's partner was the victim of his offence and he should not have been able to add her telephone number to his list of approved numbers.

7. There was a delay in entering Mr Lawrence's cell when staff found him hanging. There was also a delay in removing the ligature as the officer who cut Mr Lawrence down did not cut the remnant of the ligature from Mr Lawrence's neck. Neither of these issues affected the outcome for Mr Lawrence as he was dead when found, but it is important that staff respond to medical emergencies correctly and without delay.

8. Mr Lawrence was clearly dead when found as he had rigor mortis. Staff need to be reminded that they should not attempt resuscitation where it would be futile as this is distressing for staff and undignified for the deceased.

Recommendations

- The Director should ensure that prisoners' personal contact numbers are checked in line with the requirements of PSI 04/2016.

- The Director should ensure that all patrol staff are issued with anti-ligature knives as part of their standard equipment.
- The Director should ensure that all staff understand their responsibilities during medical emergencies, and in particular that staff know that they should:
    - enter cells as quickly as possible in life-threatening situations, where it is safe to do so, in line with PSI 24/2011; and
    - cut the ligature from the ligature point and remove the remnant of the ligature from the prisoner's neck.
- The Director should share a copy of this report with the PCO and OSO who found Mr Lawrence and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Director should give clear guidance to staff about the circumstances where resuscitation is and is not appropriate in accordance with European Resuscitation Council Guidelines.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Lawrence's prison and medical records. He interviewed seven members of staff and one prisoner at Doncaster during March and April 2021. All the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic.

11. NHS England commissioned a clinical reviewer to review Mr Lawrence's clinical care at the prison. He interviewed one nurse by telephone.

12. We informed HM Coroner for Yorkshire South East of the investigation. The Coroner gave us Mr Lawrence's cause of death. We have given the Coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Lawrence's mother to explain the investigation process and to ask if she had any matters she wanted the investigation to consider. Mr Lawrence's mother did not respond.

Background Information

HMP Doncaster

14. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 remanded or convicted male prisoners. Care UK provides clinical services. The prison directly employs qualified paramedics as part of the healthcare team, and they respond to emergency calls in the prison.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons carried out an unannounced inspection of Doncaster in September 2019. Inspectors were very concerned by the levels of self-harm and that there had been five self-inflicted deaths in the year leading up to the inspection. Inspectors noted that there had been another self-inflicted death shortly after the inspection. Inspectors found that not all recommendations from the Prisons and Probation Ombudsman in response to these deaths were being regularly reviewed, and that action was not being taken to ensure that they were embedded in operational practice.

Independent Monitoring Board

16. 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 report for the year to 30 September 2019, the Board noted it was concerned about the high rate of self-harm and the self-inflicted deaths that had occurred in the reporting year. Early learning from these incidents showed that not all Assessment Care in Custody Teamwork (ACCT) processes were being followed as expected. There was an ACCT improvement plan in place and the Board had seen positive work and progress, but it remained an area to watch over.

Previous deaths at HMP Doncaster

17. Mr Lawrence was the 23rd prisoner to die at Doncaster since January 2019. Of the previous deaths, nine were self-inflicted, 11 were from natural causes and two were drug-related. There were no similarities between Mr Lawrence's death and the previous deaths.

Key Events

18. On 8 December 2020, Mr Ryan Lawrence was arrested on charges of assaulting his partner and causing damage to her home. Mr Lawrence spent two days in police custody before being remanded in prison custody and sent to HMP Doncaster on 10 December. This was not his first time in prison.

19. At his reception health assessment, Mr Lawrence told a nurse that he had no history of self-harm or mental health issues. He said he had no thoughts of suicide or self-harm.

20. During his reception and induction interviews with officers, Mr Lawrence named his partner as his next of kin. In his list of approved contact numbers, he listed his partner's telephone number as the number belonging to his sister. Mr Lawrence told staff in the First Night Centre that he had no history of self-harm and that he had no current thoughts of suicide or self-harm. He said that he felt 'okay' about being in custody and felt supported by staff.

21. Mr Lawrence arrived at Doncaster without a court warrant, but Doncaster received an electronic copy of the warrant early the next morning detailing his alleged offence of assault.

22. On 17 December, a Prison Custody Officer (PCO) noted that she had held a key worker session with Mr Lawrence. He said that he felt safe and happy on the wing.

23. On 29 December, Mr Lawrence had a remote video-link remand hearing with Humber Magistrates' Court. The court directed that Mr Lawrence should remain in custody and set his next remand hearing for 26 January 2021. Following the hearing, Mr Lawrence told a PCO that he had no concerns, that he felt safe and that he did not need support from either healthcare staff or a buddy. He moved later that day to a cell on Houseblock 2D.

24. Mr Lawrence telephoned his partner several times that evening. The investigator listened to the calls. Mr Lawrence told his partner that the reason he had been remanded back in custody was because there were outstanding prosecution witness statements, but he was hopeful that he would be released from custody at his next hearing. The investigator considered that Mr Lawrence seemed optimistic and not especially concerned that he would remain in custody for the next month.

25. On 30 December, Mr Lawrence had a video-link conference with his solicitor. After the conference he again told staff that he was fine and that he did not need additional support.

26. On 11 January 2021, Mr Lawrence began sharing a cell with prisoner. His cellmate told the investigator that Mr Lawrence would telephone his partner every evening. Sometimes she would not answer but when she did answer, most of their conversations were argumentative. He said that he could only recall them having one pleasant conversation. However, Mr Lawrence never said anything to him to suggest he might be at risk of harming himself.

27. On the morning of 18 January, Mr Lawrence and his cellmate were seen fighting in their cell. Staff intervened and separated them. Mr Lawrence spent the night in the

segregation unit and, following an adjudication hearing on 19 January, moved in the afternoon to a new cell: a double cell on Houseblock 2A of which he was the sole occupant.

28. A PCO told the investigator that Mr Lawrence rang his cell bell three times during the early evening of 19 January. The first time was to ask if he could have his property back as it had been taken to stores when he went to the segregation unit. He told Mr Lawrence that the stores unit had closed for the evening so he would not be able to get his property until the following day. Mr Lawrence's two other calls were to ask for a television aerial. The PCO said he tried to find a spare television aerial, but he was not able to find one. He told the investigator that Mr Lawrence gave no indications that he might be at risk of harming himself.

Telephone calls 19 and 20 January

29. Mr Lawrence telephoned his partner 52 times between 1.59pm on 19 January and just after midnight on 20 January. Mr Lawrence's partner did not answer most of the calls. Mr Lawrence left voicemail messages saying that he thought she had started a relationship with another man. In one message he said that he would wait for her in the afterlife and in another message, he said that he had written her a letter.

20 January

30. At just after midnight, an Operational Support Officer (OSO) and a PCO came to the landing to make a standard check on prisoners. They reached Mr Lawrence's cell at 12.02am. The OSO told the investigator that she looked into Mr Lawrence's cell, but she could not recall what he was doing.

31. Mr Lawrence telephoned his partner for a final time at 12.28am. She did not answer his call and he left a voicemail message to say that she "could have stopped all this by answering the phone".

32. They both carried out the early morning roll check on 20 January and reached Mr Lawrence's cell at 5.17am. When the OSO looked into the cell, she saw Mr Lawrence on his knees with a ligature running from his neck to the upper rail of the bunk bed. She called out to the PCO, who was checking another cell further along the landing. The PCO came to the cell and looked through the observation panel. The PCO radioed a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties). She than left the landing to collect a cordless telephone from the wing office. She told the investigator that in her experience of dealing with code blue calls in the daytime, it was standard practice to collect a telephone to provide the control room with more information about the incident.

33. The PCO then returned to the wing and the OSO opened Mr Lawrence's cell door at 5.20am. She did not have an anti-ligature knife, but the PCO used her knife to cut the ligature and she laid Mr Lawrence on the floor. As she did so, she noted that he had rigor mortis (stiffening of the body that occurs two to six hours after death). The Custodial Operations Manager (COM), the Night Orderly Officer, arrived and cut the remnant of the ligature from around Mr Lawrence's neck. He told the investigator that he checked Mr Lawrence for signs of life and was about to

attempt resuscitation when nurses arrived and said that Mr Lawrence was dead, and that resuscitation was inappropriate. Ambulance paramedics arrived at 5.24am and after examining Mr Lawrence they confirmed that he was dead at 5.33am.

34. Mr Lawrence had left a brief note on a table in which he apologised to his partner, expressed his love for her, and said that he was going to a better place with no more pain.

Contact with Mr Lawrence's family

35. In line with Government advice on COVID-19 working practices, one of Doncaster's family liaison officers made several telephone calls to Mr Lawrence's partner, starting from just after 8.30am, but she did not answer the calls. The family liaison officer then began to telephone Mr Lawrence's mother, but again without success. Doncaster then asked Humberside police for help and they visited Mr Lawrence's mother's home at around 12.45pm and told her the news.

36. Doncaster contributed to the cost of Mr Lawrence's funeral in line with national instructions.

Support for prisoners and staff

37. The COM debriefed the staff who responded when Mr Lawrence was discovered. The staff care team also offered support.

38. 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

39. The pathologist gave Mr Lawrence's cause of death as suspension by ligature (hanging). Toxicological tests found a therapeutic level of un-prescribed promethazine in Mr Lawrence's blood and urine. Promethazine is an antihistamine that is also used for insomnia. ('Night Nurse' is one of the brand names for promethazine.)

Events since Mr Lawrence's death

40. On 23 January, Mr Lawrence's partner was found dead. She was 28 years old.

Findings

Assessment of Mr Lawrence's risk of suicide or self-harm

41. Mr Lawrence was remanded to prison charged with a violent offence against a close family member (his partner). This is a known risk factor for suicide, and we would have expected to see some consideration of whether he should have been placed on suicide and self-harm monitoring procedures (known as ACCT) when he first arrived at Doncaster.

42. However, we consider that Mr Lawrence did not give staff any reason to consider that he was at risk of killing himself over the six weeks following his arrival and we do not consider that his death was foreseeable or preventable.

Mr Lawrence's partner

43. Prison Service Instruction (PSI) 04/2016, *The interception of communications in prisons*, says that staff must check prisoners' personal contact numbers before adding to them to the system in certain circumstances, including where the prisoner is identified as a domestic abuse perpetrator or potential perpetrator or where this is a risk involving the intimidation of victims/witnesses. The PSI also says that where details of current victims are known, staff must take proactive steps to block telephone and written communications from the prisoner to that victim. However, the PSI says that the measures put in place are only as good as the information the prison receives and that staff will, therefore, need to work with probation colleagues to verify information.

44. Mr Lawrence's partner was the victim of his offence, but he was able to add her telephone number to his list of approved numbers by saying that the number belonged to his sister. Mr Lawrence telephoned his partner repeatedly while in Doncaster and they initially appeared to have re-established their relationship. However, during the evening and night of 19 January, Mr Lawrence's partner stopped answering his calls. He made a final call to her a little after midnight and left a voicemail message that suggested her failure to answer his calls was the reason he was going to take his life. Three days later, Mr Lawrence's partner also apparently took her own life.

45. When Mr Lawrence arrived at Doncaster on 10 December, he arrived without a court warrant. However, Doncaster received an electronic copy of the warrant early the next morning which noted that his alleged offence was the assault of his partner. As Mr Lawrence's alleged offence was a violent one against his partner, we consider that staff should have identified him as a potential domestic abuse perpetrator and should, therefore, have checked his personal contact numbers. We make the following recommendation:

    The Director should ensure that prisoners' personal contact numbers are checked in line with the requirements of PSI 04/2016.

Emergency response

46. At night, officers and OSOs have a key in a sealed pouch for use in an emergency. Prison Service Instruction (PSI) 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

47. When the OSO and PCO found Mr Lawrence hanging there was a three-minute delay before they went into the cell, as the PCO left the landing to collect a telephone. We do not criticise the OSO for not entering the cell on her own while the PCO was away. Even if she had gone into the cell in the meantime, she would not have been able to cut the ligature as she had not been issued an anti-ligature knife as part of her standard equipment. However, we are concerned that they did not enter the cell together and cut Mr Lawrence down immediately after they saw him hanging.

48. We are also concerned that the OSO said she had been told she should never enter a cell on her own under any circumstances, which is clearly contrary to PSI 24/2011.

49. The delay made no difference in this case as Mr Lawrence had been dead for some time when he was found. However, we know that prompt medical assistance and resuscitation can make a critical difference in a medical emergency, and, without checking Mr Lawrence in person, the PCO and OSO could not have been sure that resuscitation attempts would have been futile.

50. When the PCO returned, she and the OSO entered the cell and she cut the ligature away from the ligature point. However, we are concerned that the PCO did not cut the remnant of the ligature, and that it remained tight around Mr Lawrence's neck until it was cut away by the COM. Any attempt at resuscitation would have been futile while the ligature remained in place.

51. We make the following recommendations:

The Director should ensure that all patrol staff are issued with anti-ligature knives as part of their standard equipment.

The Director should ensure that all staff understand their responsibilities during medical emergencies, and in particular that staff know that they should:

- **enter cells as quickly as possible in life-threatening situations, where it is safe to do so, in line with PSI 24/2011; and**
- **cut the ligature from the ligature point and remove the remnant of the ligature from the prisoner's neck.**

The Director should share a copy of this report with the PCO and OSO who found Mr Lawrence and arrange for a senior manager to discuss the Ombudsman's findings with them.

52. We note the COM's evidence that he intended to attempt resuscitation, but before he did so nurses arrived and said that resuscitation would be inappropriate as Mr Lawrence was clearly dead.

53. The European Resuscitation Guidelines 2015 say that resuscitation is inappropriate and should not be attempted where there is clear evidence that it would be futile. Nurses recognised that Mr Lawrence had rigor mortis, a clear sign of death, and that resuscitation should not be attempted. However, the COM appeared to be unaware of this guidance. It is important that staff understand the circumstances in which resuscitation is inappropriate. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Director should give clear guidance to staff about the circumstances where resuscitation is and is not appropriate in accordance with European Resuscitation Council Guidelines.

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 I 020 7633 4100
F I 020 7633 4141