

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Lawrence, a prisoner at HMP Risley, on 12 October 2018

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Thomas Lawrence died on 12 October 2018, from the toxic effects of psychoactive substances (PS), at HMP Risley. He was 27 years old. I offer my condolences to Mr Lawrence's family and friends.

In July 2018, Mr Lawrence told his offender supervisor that he had built up a drug debt in the prison due to buying PS. There is no evidence in the prison records that Mr Lawrence was ever seen under the influence of drugs at Risley, though prisoners told police after his death that he used drugs in prison.

Mr Lawrence's death was the fifth at Risley in the past two years where the prisoner was found to have used PS before their deaths. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern at the availability of PS at Risley. Since Mr Lawrence's death, the prison has updated its drugs strategy with the aim of reducing supply and demand. The prison needs to ensure this is implemented fully, to reduce the serious harm caused by drug use, and ensure that staff are vigilant for signs of drug use.

The investigation found that there was a delay in the emergency response when Mr Lawrence was found unresponsive in his cell and that there were failings in the way the resuscitation attempts were carried out. I cannot say whether the delay affected the outcome for Mr Lawrence, but we know that in an emergency situation, a delay of a few minutes may be critical.

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

January 2022

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Summary

Events

1. Mr Thomas Lawrence was serving a sentence of five years and 11 months for supplying drugs. He was moved to HMP Risley on 10 May 2018.
2. In July 2018, Mr Lawrence told his offender supervisor that he had built up a debt when he had first arrived at Risley, in part from buying psychoactive substances (PS). He said that he was worried his debt would “follow him around the prison” and he felt unable to leave the wing to go to work. He asked for a transfer to a different prison and his offender supervisor contacted several prisons to try to arrange one.
3. At 11.48am on 12 October, while unlocking prisoners for lunch, an officer found Mr Lawrence unresponsive in his cell. He called to two other officers to come to the cell. They found Mr Lawrence lying across his bed, slumped against the wall. An officer asked for healthcare assistance on her radio and said it was a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff arrived and began cardiopulmonary resuscitation (CPR) until paramedics arrived at 12.08pm. The paramedics took over emergency treatment, but at 12.30pm, pronounced that Mr Lawrence had died.
4. A post-mortem examination and toxicology tests showed that Mr Lawrence died from the toxic effects of PS.

Findings

5. Mr Lawrence was the fifth PS-related death at Risley in less than two years. HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern at the prevalence of PS at the prison. We are aware that Risley introduced a new drugs strategy in November 2019, to tackle supply and demand. This will need to be implemented fully to reduce the harm caused by PS.
6. There was no evidence in the prison records that staff had ever seen Mr Lawrence under the influence of drugs, even though prisoners reported to police that he used drugs and was under the influence on the morning of his death. Staff need to be vigilant for signs of drug use and take appropriate action.
7. The officer who unlocked Mr Lawrence’s cell on the morning of 12 October, did not check on his welfare as he should have done. This made no difference in this case, as Mr Lawrence was seen an hour later chatting to another prisoner, but it is important that officers satisfy themselves that prisoners are alive and well when they unlock them in the morning.
8. There was a short delay in the emergency response as the officer who found Mr Lawrence called out to colleagues for assistance rather than calling a medical emergency code over his radio.
9. None of the officers who first attended Mr Lawrence’s cell started CPR. When staff did start CPR, they kept Mr Lawrence on his bed, rather than moving him to the landing floor.

10. A hot debrief was not held following Mr Lawrence's death and staff were not asked to complete incident reports forms as they should have been.

Recommendations

- The Governor should ensure that staff are vigilant for signs of drug use and take appropriate action when a prisoner appears to be under the influence of drugs.
- The Governor should ensure that when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, and in particular that:
 - all officers administer basic life support if appropriate and without delay;
 - the prisoner is moved from his cell to the landing so that resuscitation efforts are made on a hard surface and with sufficient room; and
 - other prisoners are immediately moved away from the landing and locked back into their cells.
- The Governor should ensure, in line with policy, that staff directly involved in a death in custody complete Incident Report Forms as soon as possible following the death.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Risley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Lawrence's prison and medical records. She interviewed seven members of staff at Risley on 16 January 2019.
13. NHS England commissioned an independent clinical reviewer to review Mr Lawrence's clinical care at the prison. The investigator and clinical reviewer jointly interviewed staff.
14. We informed HM Coroner for Cheshire of the investigation. The Coroner sent us the results of the post-mortem examinations. We have given the Coroner a copy of this report.
15. The investigator contacted Mr Lawrence's mother to explain the investigation and to ask her if she had any matters that she wanted the investigation to consider. Mr Lawrence's mother asked for a copy of our report, but she did not raise any issues.

Background Information

HMP Risley

16. HMP Risley is a medium security training prison which holds over 1,000 convicted men. Bridgewater Community Healthcare NHS Trust provides healthcare services in the prison. There is 24-hour healthcare cover and substance misuse services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Risley was in June 2016. Inspectors found that levels of violence were comparable with other category C prisons with around 20% of prisoners reporting that they felt unsafe and others reporting that they had been victimised. Inspectors noted that there was evidence to suggest that the availability of psychoactive substances (PS) was undermining prisoner wellbeing and around 60% of prisoners told inspectors that it was easy to obtain drugs at Risley. Inspectors noted that while PS was a major threat, the prison had responded with a coherent strategic approach including an action plan overseen by relevant committees. Weekly PS action meetings were held to identify and disrupt the flow of PS.
18. Inspectors found that the clinical and psychosocial drug service team was skilled and delivered a comprehensive range of appropriately focussed interventions. However, inspectors also noted that the number of times healthcare staff were responding to PS incidents was having a major impact on routine healthcare services.

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 last annual report for the year to 31 March 2018, the IMB highlighted the impact PS was having on levels of violence experienced by both officers and prisoners along with the need for the attendance of emergency services to deal with these incidents.

Previous deaths at HMP Risley

20. Mr Lawrence was the sixth prisoner to die at Risley since October 2016. Of the previous deaths, one was from natural causes and four were linked to PS use. Of these, two died as a direct result of using PS; one died in a fire in his cell while trying to smoke PS; and one was found to have PS in his system after he hanged himself.
21. In a previous investigation, we found that wing staff appeared to have been unaware that the prisoner was a frequent user of PS in the prison.
22. In three previous investigations, we found that staff failed to call a medical emergency code and in one case, we found that the prison did not hold a hot debrief.

Psychoactive Substances (PS)

23. Psychoactive substances (formally known as ‘new psychoactive substances’ or ‘legal highs’) are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
24. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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.
25. HM Prisons and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

26. On 9 February 2018, Mr Thomas Lawrence was remanded in prison custody, charged with supplying controlled drugs, and sent to HMP Manchester. On 12 March, he was convicted and sentenced to five years and 11 months in prison.
27. On 5 May, staff noted that Mr Lawrence appeared to be under the influence of an illicit substance when he collected his evening meal. His eyes were glazed, and he was unsteady on his feet.
28. On 10 May, Mr Lawrence was moved to HMP Risley. A nurse carried out his reception health screen. She noted that Mr Lawrence told her that he did not have a problem with personal use of either drugs or alcohol. She asked Mr Lawrence if he wanted to be referred to the substance misuse service, but he said he did not. She noted that Mr Lawrence had a history of depression, but he said that his problem was a tendency to 'over-think' situations, that he was 'okay' presently and that he had no history or present thoughts of self-harm. She noted that Mr Lawrence was settled in mood and manner. (At the time, Mr Lawrence was receiving 15mg of mirtazapine (an antidepressant) a day, which he was allowed to keep in his own possession. The usual starting dose of mirtazapine is 15mg to 30mg a day and it can be increased to up to 45mg a day.)
29. Following his induction, Mr Lawrence was moved to a cell on A Wing.
30. On 11 June, a nurse saw Mr Lawrence for possible support in areas of daily living, including substance misuse. Mr Lawrence said he had no problem with substance misuse. He agreed to refer himself to the service in the future if he needed support.
31. During a medicines compliance check on 13 June, Mr Lawrence was found to have no mirtazapine tablets when he should have had 13 tablets left. Mr Lawrence said that he had been taking double his daily dosage. Mr Lawrence was re-prescribed 15mg of mirtazapine a day but told he would have to collect one tablet each day instead of holding the medication in his possession.
32. On 18 June, Mr Lawrence was moved to B Wing, and then on 19 June he was moved to C Wing.
33. Mr Lawrence's offender supervisor met him on 10 July for a sentence plan meeting. She told the investigator that Mr Lawrence said he had built up a debt while he was on A Wing because he broke another prisoner's Nintendo Game Station and he had been buying PS. Mr Lawrence told her that he was concerned that the debt would "follow him around the prison", and that he did not feel able to leave the wing to go to work. Mr Lawrence asked for a transfer and she told him that she would contact other prisons.
34. The offender supervisor sent an email to HMP Berwyn later that morning to ask if they could take Mr Lawrence. After the exchange of several emails over the following weeks, Berwyn said that they would only be able to take Mr Lawrence if a one-to-one swap could be made with one of their prisoners, but they had no one at that time who wanted to go to a prison in the north of England. She also sent transfer requests to several other prisons. She said that she would update Mr

Lawrence on her efforts to arrange a transfer and about the responses she was receiving.

35. During a check of his cell on 27 July, Mr Lawrence was found to be in possession of 'hooch' (illicitly brewed alcohol). At a disciplinary hearing, he was found guilty of breaking prison rules. He received a suspended punishment of stoppage of earnings and the loss of certain privileges.
36. On 15 August, Mr Lawrence saw a prison GP for a review of his mirtazapine prescription. The GP noted that Mr Lawrence was anxious but had no suicidal thoughts. He discussed options with Mr Lawrence and agreed to double his dose of mirtazapine to 30mg a day.
37. On 4 September, the offender supervisor met Mr Lawrence for a formal offender assessment. She noted that Mr Lawrence had started using cannabis when he was 13 or 14 years old and had started using cocaine when he was around 17 or 18. He said that he had used 'Spice' (a form of PS) when he first arrived at Risley, but he had remained drug free since then and he was feeling better as a result. She noted that Mr Lawrence recognised that some of his previous offending behaviour had been impulsive, but he was keen to engage with programmes to address his problem-solving skills. She noted that he displayed good interpersonal skills throughout the interview.
38. The offender supervisor told the investigator that the last time she met Mr Lawrence was on 27 September, when he again asked about a transfer away from Risley. She told him she was awaiting responses from three prisons on a possible transfer.
39. On 4 October, HMP Haverigg emailed the offender supervisor to say that they would accept Mr Lawrence on transfer. She told the investigator that it was just a provisional acceptance at that point and that if Haverigg did finally accept him, his transfer could take a few weeks due to the distance to Haverigg and the availability of transport.

12 October

40. Officer A told the investigator that he unlocked Mr Lawrence's cell at about 8.00am on 12 October, so Mr Lawrence could take a shower and make telephone calls. He said that Mr Lawrence was lying under his duvet and did not respond when he greeted him. He said that if prisoners appeared to be asleep when he unlocked them, he did not disturb them.
41. Officer A said that when he returned to Mr Lawrence's cell at 9.00am to re-lock the door, Mr Lawrence was sitting on his bed chatting with another prisoner. He asked the other prisoner to return to his cell and he locked the door.
42. At about 9.30am, Officer A went to unlock the wing cleaners and he noticed that Mr Lawrence's cell bell light was on. He asked Mr Lawrence what he wanted, and Mr Lawrence asked for a pillowcase. He told him that he would check if there were any spare ones available. The officer said that he had then been caught up in an incident with another prisoner and he forgot about the pillowcase.

43. Shortly after 11.30am, officers began unlocking prisoners for lunch. A log of events completed at the scene shows that Officer B unlocked Mr Lawrence's cell at about 11.48am. After he had unlocked the cell, he called to Officer A and Officer C, asking them to come and look at Mr Lawrence.
44. Officer A said that Mr Lawrence was on his bed and he appeared unconscious. He said he could not find a pulse and Mr Lawrence appeared to not be breathing.
45. Officer C said that when she went to the cell, both officers were inside and she saw Mr Lawrence lying across his bed, slumped against the cell wall. She radioed for assistance. She told the investigator that she thought she said, "Can healthcare attend Charlie wing south side, we've got a code blue." (A code blue is a medical emergency code used when a prisoner is unconscious or having breathing difficulties, which alerts healthcare staff and tells the control room to call an ambulance immediately.) The control room log shows that the code blue was called at 11.51am and an ambulance was called immediately. (The log of events at the scene states that the code blue was called at 11.50am.)
46. Officer D said that he was in the wing office when a custodial manager (CM) asked him to collect an oxygen cylinder and take it to Mr Lawrence's cell. The log of events shows that the officer reached the cell at 11.51am. He said that when he arrived, Mr Lawrence was on his bed and lying on his side and in the recovery position. No one was trying to resuscitate him. He said that he could not find a pulse or signs of breathing. He then rolled Mr Lawrence onto his back on his bed and started to give chest compressions.
47. A nurse told the investigator that she was Risley's Primary Care Manager, and she heard a call asking for healthcare staff to attend C Wing. One of her colleagues radioed the control room for further information and they were then told that it was an emergency code blue call. She said that two nurses went to C Wing, and she followed after collecting a prison GP.
48. The log of events show that the CM and the first two nurses arrived three minutes after the emergency call, and the prison GP and the Primary Care Manager arrived one minute after that.
49. The nurses and officers continued to try to treat Mr Lawrence with chest compressions, with oxygen and with emergency drugs. He was also checked periodically with a defibrillator. All the treatment went on while Mr Lawrence remained on his bed. The Primary Care Manager said that the reason for this was that there were other prisoners standing on the landing watching. She also said that it seemed to her that Mr Lawrence was already dead when she first arrived and she would not have started efforts to resuscitate him if efforts had not already been started by officers.
50. Ambulance paramedics arrived at 12.08pm. They assisted with the efforts to try to resuscitate Mr Lawrence, but again without success and at 12.30pm, they declared that Mr Lawrence was dead.

Information received after Mr Lawrence's death

51. Police investigators viewed CCTV footage taken on the morning of 12 October which showed several other prisoners going to Mr Lawrence's cell. When interviewed by police, several prisoners said that Mr Lawrence had used illicit drugs at Risley, and he appeared to be under the influence of drugs on the morning of his death.

Contact with Mr Lawrence's family

52. A prison manager was appointed as family liaison officer (FLO). Mr Lawrence had named his mother as next of kin and the FLO, with two colleagues, drove to her home in Manchester, where they arrived at just before 4.00pm. Mr Lawrence's brother answered the door and said that his mother was not at home at the time, although she was on her way back. Mr Lawrence's mother arrived around ten minutes later and the FLO informed her of her son's death.
53. The prison contributed to the cost of Mr Lawrence's funeral in line with national guidance.

Support for prisoners and staff

54. The prison told us that a prison manager debriefed the staff who were involved in the response when Mr Lawrence was found. However, there is no record of the meeting. The investigator interviewed six staff who attempted to resuscitate Mr Lawrence: three officers, two nurses and a doctor and none of them attended a debrief meeting or were aware that one had been held.
55. The staff care team offered support to officers in the days following Mr Lawrence's death and the healthcare team held a separate meeting for support within their team.
56. 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

57. Toxicology tests showed that Mr Lawrence had taken PS before he died. The post-mortem report concludes that the most likely cause of Mr Lawrence's death was due to PS toxicity.

Findings

Availability of psychoactive substances (PS) at Risley

58. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was a source of increasing concern in prisons and that PS use had a profoundly negative impact on the physical and mental health of prisoners. Mr Lawrence's death is an example of the dangers of PS and illustrates how prisons must do all they can to eradicate its use.
59. HM Inspectorate of Prisons (HMIP) reported in September 2016 that 60% of prisoners at Risley said that it was easy to get illicit drugs at the prison. Inspectors found that Risley had responded with a coherent approach to identify and disrupt the flow of PS. They also found that the clinical and psychosocial drug service team delivered a comprehensive range of appropriately focused interventions to prisoners.
60. At the time that Mr Lawrence was in Risley, the prison had a specific strategy to manage the threat and risk of PS (published in June 2015 and reviewed in July 2016). The aim of the strategy included improving staff, prisoner and prisoner family awareness of the risks of PS; tackling supply of PS through visits; and supporting prisoners in dealing with their PS use.
61. In April 2019, HM Prison and Probation Service published the National Drug Strategy. It set out their plans to reduce substance misuse in prisons by providing direction to assist all stakeholders and detailed guidance for prisons to help them identify issues and share best practice.
62. In relation to reducing the supply of drugs, the HMPPS 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.”
63. In November 2019 Risley implemented a new substance misuse strategy that was more clearly focused on reducing supply and demand for drugs and in building recovery for those who use illicit substances. The policy is reinforced through dedicated monthly meetings that make use of security intelligence reports on emerging threats. As a new drugs strategy has been introduced since Mr Lawrence's death, we make no recommendation.

Mr Lawrence's PS use

64. When Mr Lawrence arrived at Risley on 10 May, he told the reception nurse that he did not use illicit substances and he said he did not want to be referred to the

substance misuse service. When he saw another nurse on 11 June, Mr Lawrence again said he did not want to be referred. He was told he could refer himself in the future if needed.

65. On 10 July, Mr Lawrence told his offender supervisor that he had built up a debt on A Wing, in part due to PS use. There is no evidence in the prison records that staff at Risley had ever seen Mr Lawrence under the influence of drugs. However, other prisoners told police that Mr Lawrence had used drugs at Risley and appeared under the influence of drugs on the morning of his death.
66. We are satisfied that Risley offered Mr Lawrence support for potential substance misuse issues, but he declined help. However, we are concerned that despite prisoners telling police that Mr Lawrence used drugs and was under the influence on the morning of his death, staff appeared to be unaware. We make the following recommendation:

The Governor should ensure that staff are vigilant for signs of drug use and take appropriate action when a prisoner appears to be under the influence of drugs.

Unlock procedures

67. Prison Service Instruction 75/2011 Residential Services states:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...

“[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock .. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process.”

68. When Officer A unlocked Mr Lawrence’s cell at about 8.00am on 12 October, he saw that Mr Lawrence was under his duvet and he did not respond when he greeted him. The officer said he did not disturb prisoners if they appeared to be asleep. Prison guidance says that staff should check on a prisoner’s welfare at unlock by getting a response from them. Officer A did not do this and did not act in line with national instructions. We acknowledge this made no difference in Mr Lawrence’s case as Officer A saw him an hour later, when he was sitting on his bed chatting to another prisoner. However, in other circumstances the failure to get a response at unlock could lead to a delay in identifying that a prisoner needs medical attention. We make the following recommendation:

The Governor should ensure that when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Incident management

Use of emergency codes

69. PSI 03/2013, Medical Emergency Response Codes, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, including the use of a medical emergency code (code blue or code red). The PSI explicitly states that all prison staff must be made aware of, and understand, this instruction and their responsibilities during medical emergencies.
70. When Officer B unlocked Mr Lawrence at 11.48am, he called to his colleagues to ask them to come and look at him, rather than calling a medical emergency code. This caused a short delay in the emergency response.
71. In three previous investigations at Risley, we have criticised the failure of staff to use a medical emergency code. In response to a recommendation made following our investigation into the last death before Mr Lawrence's, Risley said they had delivered training to staff and issued ERIC (Emergency Response in Custody) cards on the actions to be taken. Mr Lawrence's death occurred before that action plan was implemented so we do not repeat that recommendation here.

Resuscitation efforts

72. After Officer B and Officer A checked Mr Lawrence for signs of life, they moved him into the recovery position on his side but neither of them started efforts to resuscitate him. It was Officer D who started giving chest compressions after he had collected and taken an oxygen cylinder to the cell. The log of events indicate that Officer D arrived three minutes after Mr Lawrence had been discovered.
73. After he had checked Mr Lawrence, Officer D started giving chest compressions while Mr Lawrence was lying on his bed. The efforts to resuscitate him on his bed continued after the nurse and the doctor arrived and took control of the situation.
74. European Resuscitation Council Guidelines for Resuscitation 2015 state that resuscitation should be performed on a firm surface wherever possible. The efforts to try to resuscitate Mr Lawrence while he remained on his bed would have been further hindered due to the restrictions of trying to treat him in a small cell. The only apparent reason that staff treated Mr Lawrence in his cell was that there were other prisoners on the landing. It is unacceptable that prisoners were not moved away immediately, and we are surprised that none of the staff, particularly the doctor and the nurses, recognised that delivery of care would have been improved by moving Mr Lawrence to the landing floor. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, and in particular that:

- **all officers administer basic life support if appropriate and without delay;**
- **the prisoner is moved from his cell to the landing so that resuscitation efforts are made on a hard surface and with sufficient room; and**

- **other prisoners are immediately moved away from the landing and locked back into their cells.**

Support for staff

75. Prison Service Instruction (PSI) 64/2011 on actions following a death in custody states that a senior member of staff must hold a 'hot debrief' immediately after all deaths in custody and a member of the care team must attend. Risley said that a prison manager held a hot debrief but made no notes. None of the staff interviewed for this investigation attended a hot debrief and none met a member of the care team on the day of Mr Lawrence's death. It would appear therefore that a hot debrief was not held.
76. Our investigation into the death that preceded Mr Lawrence's at Risley, found that no hot debrief was held and we made a recommendation. The prison's action plan said managers had been reminded in July 2019, which was after Mr Lawrence's death. We therefore make no recommendation.

Incident report forms

77. PSI 64/2011 states that staff directly involved in a death in custody, particularly those who were first on scene, must complete Incident Report Forms as soon as possible. In Mr Lawrence's case, none of the staff completed report forms. We make the following recommendation:

The Governor should ensure, in line with policy, that staff directly involved in a death in custody complete Incident Report Forms as soon as possible following the death.

Clinical care

78. The clinical reviewer found that that Mr Lawrence received a good standard of care that was equivalent to that which he could have expected to receive in the community. However, she made several recommendations which the Heads of Healthcare at Risley and Manchester will need to address.

Inquest

79. At the inquest, held from 20 to 24 November 2023, the jury concluded that Mr Lawrence's death was drug related.

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