Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Lawlor, a prisoner at HMP Elmley, on 19 October 2023

A report by the Prisons and Probation Ombudsman

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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

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Jonathan Lawlor died on 19 October 2023 of multi-organ failure caused by cocaine toxicity while a prisoner at HMP Elmley. He was 42 years old. I offer my condolences to Mr Lawlor's family and friends.

Mr Lawlor had taken cocaine, a class A banned substance, which he had obtained illicitly in prison. There was no evidence that prison staff had seen him under the influence of an illicit substance during the four months he spent at Elmley and little evidence that he was using illicit substances.

Although Mr Lawlor reported a headache to prison staff in the hours before his death, he did not disclose any symptoms that would have indicated a need for urgent intervention.

Mr Lawlor only had two keywork sessions at Elmley due to significant staff shortages. The prison has worked to address this issue and planned to re-start weekly keywork sessions.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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Summary

Events

1. On 11 June 2018, Mr Jonathan Lawlor was sentenced to six years in prison for wounding with intent to cause grievous bodily harm and sent to HMP Elmley. He progressed through his sentence and was released on licence from HMP Ford on 30 September 2022.

2. On 22 June 2023, Mr Lawlor was remanded to HMP Elmley, charged with murder. Shortly after he arrived, staff started suicide and self-harm prevention procedures, known as ACCT, as Mr Lawlor said he had refused to eat while in police custody.

3. Over the following three months, prison staff monitored Mr Lawlor frequently. They oversaw the completion of ACCT procedures and arranged one-to-one sessions with a psychologist. Other than intelligence on one occasion that a greetings card for Mr Lawlor had tested positive for psychoactive substances (PS), there was no evidence to suggest he was using illicit drugs.

4. At 8.10am on 19 October, an officer unlocked Mr Lawlor's cell. Mr Lawlor told him that he did not want to go to work as he had a headache. Over the next three hours, staff went to Mr Lawlor's cell four times, and he continued to report having a headache.

5. At around 11.30am, an officer unlocked Mr Lawlor's cell door and saw him lying on the floor, with his upper body under his bed. He called out to an officer nearby, entered the cell and radioed a medical emergency code. Additional staff arrived as an officer moved Mr Lawlor from under the bed and started cardiopulmonary resuscitation (CPR).

6. At 11.36am, a nurse arrived and took the lead. At around 11.40am, a GP arrived and issued two different medications. However, at 11.49am, the GP advised staff to stop CPR as it was clear that Mr Lawlor was dead. At 11.51am, ambulance paramedics arrived at the cell and formally pronounced that he had died. The post-mortem concluded that Mr Lawlor died from cocaine toxicity.

Findings

7. Mr Lawlor obtained cocaine illicitly in prison. There was no evidence that staff had seen him under the influence of illicit substances at Elmley and there was little intelligence that he was using illicit substances.

8. Mr Lawlor reported a headache to staff four times on 19 October. Staff appropriately asked Mr Lawlor if he would like to see a nurse. We are satisfied that he did not disclose any symptoms that would have indicated a need for urgent intervention.

9. Mr Lawlor only had two keywork sessions during the four months he was at Elmley due to significant staff shortages. The prison told us that they planned to review resources monthly throughout 2024, with the aim of increasing keywork provision to weekly for all prisoners.

The Investigation Process

10. HMPPS notified us of Mr Lawlor's death on 19 October 2023.

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

12. The investigator visited Elmley on 25 October. He obtained copies of relevant extracts from Mr Lawlor's prison record and interviewed three prisoners.

13. The investigator interviewed six members of staff from Elmley between 25 and 30 January 2024.

14. NHS England commissioned a clinical reviewer to review Mr Lawlor's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

15. We informed HM Coroner for Mid Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Lawlor's family to explain the investigation and to ask if they had any matters they wanted us to consider. They wanted to know:

    - how long staff took to respond when they found Mr Lawlor unresponsive;
    - what happened to his head; and
    - why they found out that he had died from other prisoners.

    We have addressed these concerns in this report.

17. Mr Lawlor'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.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Elmley

19. HMP Elmley holds remanded and sentenced men in six houseblocks with a mixture of single and double cells. Oxleas NHS Foundation Trust provides mental health services and provides 24-hour primary healthcare services, with input from Minster Medical Group.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Elmley was in February and March 2022. Inspectors reported that security and good order were maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. They found that prisoners were safe from exposure to substance misuse and effective drug supply reduction measures were in place.

21. In February 2023, an independent review of progress took place. The report said that Elmley faced substantial staff shortages which meant that keyworker sessions had stopped, but leaders were focused on how to make improvements with the resources they had and were delivering more than many prisons with a similar or better staffing position.

Independent Monitoring Board

22. 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 31 October 2022, the IMB reported that there had been a steady increase in keywork that had been driven by management monitoring. They also noted that regular perimeter patrols inside the prison walls found an increase of items that had been thrown over the prison wall.

Previous deaths at HMP Elmley

23. Mr Lawlor was the seventeenth prisoner to die at HMP Elmley since October 2020. Of the previous deaths, twelve were from natural causes, three were self-inflicted and one was drug related. Since Mr Lawlor's death and up to the end of 2023, there have been three further deaths at Elmley, one from natural causes, one self-inflicted and one for which we are awaiting the cause of death.

Key Events

24. On 11 June 2018, Mr Jonathan Lawlor was sentenced to six years in prison for wounding with intent to cause grievous bodily harm. He was sent to HMP Elmley.

25. Mr Lawlor progressed well through his sentence and was released on licence from HMP Ford on 30 September 2022.

2023

26. On 22 June 2023, Mr Lawlor was remanded to HMP Elmley, charged with murder.

27. Shortly after he arrived, staff started suicide and self-harm prevention procedures, known as ACCT, as Mr Lawlor had refused to eat in police custody. They admitted him to the inpatient department and monitored him under constant supervision.

28. On 28 July, an officer saw Mr Lawlor for a keywork session and noted that he had started eating again and said he wanted to make himself physically and mentally stronger. He added that Mr Lawlor had a supportive family with whom he had regular contact.

29. On 8 August**,** a Supervising Officer (SO) chaired an ACCT case review and noted that Mr Lawlor continued to have regular contact with his family. She added that Mr Lawlor said he was happy to keep working with the psychology team and that they would continue ACCT monitoring, with hourly observations in place. Later that day, prison staff submitted an intelligence report, stating that a greetings card addressed to Mr Lawlor had tested positive for psychoactive substances (PS).

30. On 11 August, an officer saw Mr Lawlor for a keywork session. He recorded that Mr Lawlor was annoyed about the time staff were taking to process a letter he had sent. The officer explained that the process could take a while and that he would contact the relevant team for an update.

31. On 18 August, an SO chaired an ACCT case review which a nurse attended. She noted that Mr Lawlor said that he felt like every time he opened up, he got set back and that going to a standard houseblock while on an ACCT would make him vulnerable. He asked attendees to stop ACCT procedures, but they instead reduced his ACCT monitoring to one conversation during the day and five observations at night. He moved to Houseblock 4 (a standard wing) later that day.

32. On 23 August, a psychological therapist noted that she checked on Mr Lawlor briefly as she was not able to offer him a full session. She recorded that he seemed well and presented as positive.

33. On 29 August, an SO chaired an ACCT case review and noted that Mr Lawlor seemed positive and engaged well. He said that he had settled on Houseblock 4 and was hoping to get a job in the prison gym when a space became available. The SO added that attendees agreed to stop ACCT monitoring.

34. On 21 September, the psychological therapist saw Mr Lawlor for a psychology session. He told her that he had recently had some intrusive thoughts and had had

a panic attack. He said that he had felt better and more settled since moving to a different spur on the houseblock.

35. On 5 October, the psychological therapist visited Mr Lawlor for a psychology session, but he told her that he did not want to go ahead with it as he felt unwell. There is no evidence that he presented as under the influence of illicit substances.

36. On 10 October, prison staff submitted an intelligence report stating that they had detected what was likely a mobile phone signal coming from Mr Lawlor's cell. Security staff reviewed the intelligence and noted that it was possible that Mr Lawlor was engaging in substance misuse. However, they decided that a further assessment was not needed. There is no evidence to explain the reason for this decision.

37. On 12 October, a Shannon Trust Facilitator recorded that Mr Lawlor had completed his Shannon Trust mentor training and presented as enthusiastic throughout. (The Shannon Trust trains prisoners to help other prisoners who have difficulty reading.)

38. Between 13 and 17 October, Mr Lawlor made 42 phone calls from the prison phone system. (Calls from the prison phone system are recorded but staff do not normally listen to them unless there is intelligence to suggest that is necessary.) The majority of calls were to his partner. The investigator listened to a number of the calls. Mr Lawlor did not mention using illicit substances.

Events of 19 October

39. At 8.10am on 19 October, an officer unlocked Mr Lawlor's cell. At interview, he said that Mr Lawlor was out of bed but told him that he did not want to go to work as he had a headache.

40. At around 9.00am, the officer unlocked Mr Lawlor's cell again so that he could attend work, but Mr Lawlor continued to report a headache and asked to stay in his cell. The officer told us that Mr Lawlor was lying on his bed. A short while later, the psychological therapist arrived on the wing to see him for a psychology session, but he chose not to engage.

41. At around 10.20am, a prisoner asked to see Mr Lawlor to give him his Shannon Trust certificate and T-shirt. CCTV footage shows that an officer unlocked Mr Lawlor's cell and stood in the doorway until the prisoner had done so.

42. At around 10.43am, an officer arrived on the houseblock to collect Mr Lawlor for a court-ordered psychiatric assessment by video-link. An officer went to Mr Lawlor's cell to get him, but he declined and said that he did not feel well. The officer, who told us that she knew Mr Lawlor from a previous sentence, went to his cell to explain the importance of the psychiatric assessment but he asked her to re-arrange the appointment as he had a headache. At interview, the officer told us that she asked Mr Lawlor if he wanted to see the healthcare team, but he said, "No, I just want to sleep it off." She added that he looked pale, but spoke clearly and did not present any differently to her previous contacts with him.

43. At around 11.30am, an officer unlocked Mr Lawlor's cell door so that he could collect his lunch. He saw him lying on the floor, with his upper body under his bed.

He shouted out to him but failed to get a response, so he called out to another officer who was unlocking the cells on the other side of the landing.

44. The officer went into Mr Lawlor's cell and at 11.33am, he radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties). He and the other officer moved Mr Lawlor from under the bed, and noticed at that point that he was not breathing and had a cut on his head. One of the officers asked two prisoners who were standing by the cell door to press the general alarm due to the amount of noise on the radio network. (The control room log shows that staff called an ambulance at 11.34am, so there was no delay despite the radio network noise.)

45. At 11.35am, an SO arrived at the cell with several other officers. As they went into the cell, an officer had just moved Mr Lawlor onto his back. The SO asked him to start cardiopulmonary resuscitation (CPR) and cleared the cell of furniture. She took over CPR. In the meantime, a physical education instructor arrived and asked staff to collect a defibrillator.

46. At 11.36am, a nurse arrived and staff moved Mr Lawlor out of the cell for easy access. She established an airway and applied a defibrillator, but it did not detect a shockable rhythm. At 11.40am, a GP arrived. Over the next eight minutes, she gave Mr Lawlor three doses of adrenaline and two doses of naloxone (used to reverse the effects of opioids). At 11.49am, the GP advised staff to stop CPR as it was clear that Mr Lawlor was dead. At 11.51am, ambulance paramedics arrived and formally pronounced that Mr Lawlor had died.

Contact with Mr Lawlor's family

47. At 12.00pm, the prison appointed an SO as the family liaison officer. She checked Mr Lawlor's prison record and established that he had named his partner and his sister as his next of kin. Because of the nature of the offence Mr Lawlor was charged with, the family liaison officer requested a police risk assessment before visiting his partner's address, but in the meantime, the prison received several calls from Mr Lawlor's family to say they had heard that he had died (we do not know whether they were alerted by another prisoner or by someone outside the prison). The family liaison officer consulted with two prison managers, who decided that she should notify Mr Lawlor's partner by phone.

48. At 2.55pm, the family liaison officer tried to phone Mr Lawlor's partner twice but was unable to get through. At 2.58pm, she phoned Mr Lawlor's sister and broke the news of Mr Lawlor's death. (His partner was with his sister and found out at the same time.) At 3.53pm, after giving Mr Lawlor's sister some time to process the information, the family liaison officer called her back to offer support and explain the next steps.

49. The family liaison officer provided ongoing support to Mr Lawlor's partner and mother. His funeral took place on 1 December and the prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

50. After Mr Lawlor's death, a prison manager 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.

51. The prison posted notices informing other prisoners of Mr Lawlor'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 Lawlor's death.

Post-mortem report

52. The post-mortem report found that Mr Lawlor died of acute multi-organ failure caused by cocaine toxicity. He also had pulmonary congestion and oedema (a build-up of fluid in the body which causes swelling) which did not cause but contributed to his death. Mr Lawlor had an injury on the right side of his head with some bleeding. This did not cause his death. The post-mortem report states that the most probable cause of his injury was a fall in which he hit his head on one of the bolts that connected the metal bed frame to the cell floor.

Findings

Illicit substances

53. The post-mortem examination confirmed that Mr Lawlor died of multi-organ failure caused by cocaine toxicity. Cocaine is a Class A banned substance which Mr Lawlor obtained illicitly in prison.

54. Although staff found a greetings card addressed to Mr Lawlor that tested positive for PS two months before he died and mobile phone scanning detected a signal coming from his cell just over a week before his death, there was no significant intelligence or evidence to suggest that he was using illicit substances at Elmley. There was nothing in the wing observation book in the seven days before Mr Lawlor's death to suggest he was using drugs. All the wing staff we interviewed said that they had never seen him under the influence during his time at Elmley. In addition to this, the three prisoners interviewed said that Mr Lawlor presented as his usual self in the days leading to his death.

55. HMPPS's Drug Strategy, published in April 2019, highlights the importance of building a picture of the security risks to enable prisons to better to target their resources to tackle them. At the time of Mr Lawlor's death, Elmley had a drug strategy dated 2022-2023. The strategy acknowledged that illicit drugs presented a threat to the security and safety of staff and prisoners. It set out measures to target illicit drug trafficking, including the use of intelligence, scanning prisoners' mail, the use of drug detection dogs and a body scanner.

56. At interview, the Head of Drug Strategy told us that when staff see a prisoner under the influence (UTI), they complete a UTI form and healthcare visit the prisoner for a review. He said that while the prison occasionally found cocaine coming in, it was not particularly commonplace. He said that the security team had conducted a review since Mr Lawlor's death which had not identified any significant intelligence linked to the ingress of cocaine. He also said that the drug strategy was currently being reviewed and updated and was due to be published in May 2024. We are satisfied that these actions are appropriate.

57. While we are concerned that Mr Lawlor was able to obtain cocaine, an illicit Class A drug, at Elmley, the prison has a comprehensive drug strategy in place that they were in the process of reviewing and updating. Before Mr Lawlor's death, there had not been a drug-related death at Elmley in over two years. The death was related to morphine, which was prescribed, and there was no evidence of illicit substance use. Considering this and the fact that the drug strategy is being updated, we are satisfied that Elmley is making credible progress to reduce the supply and demand for illicit substances. We therefore do not make a recommendation.

Events of 19 October

58. Mr Lawlor reported a headache to prison staff four times between 8.00am and 11.00am on 19 October but they did not request a healthcare review. At interview, an officer told the investigator that staff do not routinely contact the healthcare team if a prisoner reports a headache and Mr Lawlor did not at any point ask him to do so. Another officer told us that although Mr Lawlor looked pale, she did not think it

was unusual for him. There is no evidence that prison staff suspected that he was under the influence of drugs.

59. It is appropriate that staff asked Mr Lawlor if he wanted to see the healthcare team and we are satisfied that he did not disclose any symptoms to warrant urgent healthcare intervention such as a seizure or difficulty speaking.

Keywork

60. Mr Lawlor only had two keywork sessions during the four months he was at Elmley. The Head of Residence and Services told the investigator that at the time of Mr Lawlor's death, staff shortages significantly affected keywork delivery and the prison's priority was to deliver one monthly session to each prisoner during regime hours. However, he said that this was not always possible given how busy and understaffed the prison was at the time.

61. The Head of Residence and Services told us that the prison was currently reviewing the keywork strategy for 2023-24, which states that the prison plans to monitor keywork monthly in 2024 and increase provision as the staffing picture improves. He said that the prison's aim was to revert to the original Offender Management in Custody (OMiC) model which requires all officers to hold a caseload of up to six prisoners and to see them for weekly keywork sessions. We are satisfied that this action was appropriate. We do not make a recommendation.

Inquest

62. At the inquest, which took place on 18 November 2024, the Coroner concluded that Mr Lawlor died as a result of an accident.

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