Mid Kent and Medway Coroners' Service
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Telephone: [redacted]
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Date: 25 November 2024
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: HM Prison and Probation Service

1. CORONER

I am Catherine Wood, Area Coroner for Mid Kent and Medway

2. CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 27 October 2023 I commenced an investigation into the death of Jonathon Paul LAWLOR. The investigation concluded at the end of the inquest . The conclusion of the inquest was

The deceased died as a result of an accident.

1a Acute Multi-Organ Failure With Pulmonary Congestion and Oedema

1b Cocaine Toxicity

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

The deceased was held on remand at HMP ELMLEY where he had been since 24/06/2023.

He was resident in a single cell in house block 4 having spent some time in the inpatient department. There was evidence heard that he had previously used drugs but not in the prison environment itself and he was never observed by staff to be under the influence of substances. On the morning of 19th October 2023, he was seen a number of times but did not leave his cell as he complained of a headache, he did not wish to attend healthcare. At 11:29 hours a prison officer attended his cell to begin lunch procedures when he discovered the deceased laying face down on the floor of his cell unresponsive. The deceased had a small superficial injury to his head on the right side, and his head and shoulders were beneath his metal framed bed, with his body laying diagonal across the room coming out from the bed. The officer immediately declared an emergency and commenced CPR. Other officers attended to assist, and at 11:40 prison Doctor arrived and commenced treatment, this included use of a Defibrillator which found no shockable rhythm. At 11:47 hours the Doctor declared life extinct, and a post mortem revealed he had died as a consequence of Cocaine toxicity.

5. CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. -

[BRIEF SUMMARY OF MATTERS OF CONCERN]

(1) Mr. Lawlor only had two keywork sessions during the 4 months he was on remand at HMP Elmley. The reasons given were that staff shortages meant that key working sessions were not able to be offered. Offender Management in Custody(OMiC) guidance suggests that good practice entails an officer having a caseload of five or six prisoners who they will meet once a week for a key working meeting. The Prison and Probation Ombudsman who also investigated the death were aware that due to staff shortages the priority at the time of Mr. Lawlor's death were to have monthly sessions and that the prison was to increase provision as their staffing picture improved. On that basis they made no recommendations.

Whilst the number of keywork sessions Mr. Lawlor had did not play a part in his death it may be the case that key-working sessions for prisoners can assist with reducing risks for others in custody. Evidence heard at the inquest revealed that the target had been unachievable due to staffing pressures and as a large number of prisoners (approximately 70%) are on remand and stay between zero and six months the turnover is high and the prison is busy. There was also some scepticism as to whether it was the right model.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you HM Prison and Probation Service have the power to take such action.

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 17 January 2025. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8. COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons his family, HMP Elmley and Oxleas NHS Foundation Trust .

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

25 November 2024

Signature 

Catherine Wood Area Coroner for Mid Kent and Medway