Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Lavin, a prisoner at HMP Altcourse, on 12 November 2020

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.

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 Michael Lavin was found collapsed in the segregation unit at HMP Altcourse on 28 October 2020. He was taken to hospital where he died on 12 November. The post-mortem examination found that he died from hypoglycaemic encephalopathy (brain damage due to low blood glucose) with terminal bronchopneumonia. He was 52 years old. I offer my condolences to Mr Lavin's family and friends.

Mr Lavin had type 2 diabetes and had had a hypoglycaemic episode due to low blood sugar on 24 October. Staff saw Mr Lavin lying on his cell floor in the early hours of 28 October and assumed he was asleep. I am concerned that staff took too long to recognise that Mr Lavin was unresponsive and when they did, they called for nursing assistance rather than using a medical emergency code, which led to a delay in an ambulance being called. I cannot say whether the delays affected the outcome for Mr Lavin, but we know that in an emergency situation, a delay of a few minutes can be critical.

The clinical reviewer concluded that the care Mr Lavin received at Altcourse was not equivalent to the care he could have expected to receive in the community. In particular, there was no care plan in place for his type 2 diabetes and no one considered whether his challenging behaviour might be due to poorly controlled diabetes.

I am also concerned that the prison delayed telling Mr Lavin's family that he was seriously ill in hospital.

Sue McAllister CB
Prisons and Probation Ombudsman **January 2022**

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Summary

Events

1. Mr Michael Lavin was remanded in prison custody on 1 September 2020, charged with assault, and sent to HMP Altcourse.

2. Mr Lavin had mental health problems, a history of alcohol and heroin abuse, and type 2 diabetes. He had a history of minor acts of self-harm and had been supported at times through prison suicide and self-harm prevention procedures (known as ACCT). His behaviour was challenging and in October he was frequently restrained by staff.

3. On 24 October, staff saw Mr Lavin fitting on his cell floor. When nurses examined him, they found he had a low blood sugar level and was having a hypoglycaemic episode. Mr Lavin responded quickly to treatment and then became aggressive and spat at the nurses and was restrained. His aggressive behaviour continued through the day: he smashed his cell door observation panel and started spitting at staff through the broken panel. In the evening, he was taken to the segregation unit, known at Altcourse as the Care and Separation Unit (CSU), under restraint.

4. Mr Lavin had been supported by ACCT up to 23 October and staff restarted the procedures for additional support when Mr Lavin moved to the CSU. From 25 October, he was on two checks an hour. He was restrained again on 26 October.

5. When the night officer checked Mr Lavin at 3.00am on 28 October, Mr Lavin was standing up in his cell and making a noise. When the officer asked him to go back to bed, he said that if he was awake then everyone would be awake. At 3.30am, Mr Lavin was sitting on his cell floor. Half an hour later, he was still sitting on the floor and was rambling to himself. When the officer asked him to go back to bed, he replied with expletives. At 4.30am, Mr Lavin was lying on the floor with his trousers down, masturbating. From 5.00am, officers noted that he appeared to be asleep on his cell floor, with his trousers still down.

6. Officers went into Mr Lavin's cell at 7.40am to give him breakfast and to ask if he wanted a shower. Mr Lavin was breathing, but he did not respond to their instructions so they told him they would return in a few minutes. When they returned at 7.45am, Mr Lavin remained unresponsive and he did not react when they used pain response techniques, including pinching his ear. The officers called for nursing assistance and when nurses examined him at 7.56am, they found he had a very low blood sugar level and was unconscious. An emergency ambulance took Mr Lavin to hospital where he remained in intensive care until he died on 12 November.

7. The post-mortem examination found that Mr Lavin died from hypoglycaemic encephalopathy (brain damage caused by low blood sugar) with terminal bronchopneumonia (lung infection).

Findings

8. The clinical reviewer concluded that Mr Lavin's healthcare at Altcourse was of a suboptimal standard and was not equivalent to that which would have been received in the wider community.

9. She found that Mr Lavin was not referred to a Long-Term Conditions clinic for his diabetes and had no care plan in place.

10. She also noted that it was unclear whether Mr Lavin's challenging behaviour was due to his mental health or due to a medical problem, such as poorly controlled diabetes. She considered there was a missed opportunity to assess the root cause, including assessing his mental capacity.

11. Mr Lavin was restrained by staff on eight occasions between 6 and 26 October. Although the pathologist concluded that this did not contribute to his death, we are concerned that he was not always examined by healthcare staff after each use of force.

12. Mr Lavin was known to be diabetic and had experienced a hypoglycaemic episode on 24 October. Prison staff should have been more aware that he might have fallen unconscious on the morning of 28 October and should have attempted to wake him sooner.

13. We are also concerned about the emergency response. When officers found him unresponsive to pain stimuli at 7.45am they should have radioed a medical emergency. Calling for nursing assistance resulted in a 10 minute delay before nurses attended and called an emergency ambulance.

14. We are concerned that Altcourse waited until the morning of 29 October to tell Mr Lavin's family that he was seriously ill in hospital, despite knowing that he had been taken to intensive care the previous afternoon.

Recommendation

- The Head of Healthcare should ensure that staff refer prisoners with long-term medical conditions to the relevant Long-Term Conditions clinic for initial assessment and ongoing reviews.

- The Head of Healthcare should ensure that there are systems and processes in place to support ongoing clinical management of prisoners with challenging behaviour, which should include assessing mental capacity.

- The Director and Head of Healthcare should ensure that every attempt is made for healthcare staff to examine a prisoner in person following a use of force, in line with PSO 1600, and that this may involve returning a few hours later when the prisoner is calmer.

- The Director should ensure that staff carrying out ACCT checks are aware of any significant issues, including relevant physical health issues, that could place the prisoner at risk.

- The Director should ensure that all staff understand their responsibilities in a medical emergency, including that they radio the appropriate medical emergency code without delay.

- The Director should ensure that staff inform the next of kin immediately when a prisoner becomes seriously ill, in line with Prison Rule 22 and PSI 64/2011.

The Investigation Process

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

16. The investigator obtained copies of relevant extracts from Mr Lavin's prison and medical records. The investigator interviewed eight members of staff from Altcourse in December 2020 and January 2021. All the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic.

17. NHS England commissioned a clinical reviewer to review Mr Lavin's clinical care at the prison.

18. We informed HM Coroner for Liverpool and Wirral of the investigation. The Coroner gave us Mr Lavin's cause of death. We have given the Coroner a copy of this report.

19. We contacted Mr Lavin's sister to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She raised no issues but asked for a copy of our report.

Background Information

HMP Altcourse

20. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young men. G4S manages the prison and provides primary healthcare services. There is an inpatient unit with 12 beds and 24-hour healthcare cover. Castle Rock Group provides secondary mental health services.

HM Inspectorate of Prisons

21. The most recent inspection of Altcourse took place in November 2021, but the report has not yet been published.

22. The most recent published inspection of HMP Altcourse was in November 2017. Inspectors reported that Altcourse had an excellent staff culture and that all interactions between staff and prisoners that they saw were positive, including those in the segregation unit. Inspectors also noted that poor behaviour was consistently challenged with minor disruptions dealt with swiftly. However, inspectors also noted deficiencies in the use of force where they saw video evidence showing that de-escalation was not always used effectively, they were not always assured that force was used as a last resort. Inspectors found the delivering of consistent health care input was problematic, which affected continuity of care. Inspectors also found that many patient care plans for those with long-term conditions had not been adequately reviewed.

Independent Monitoring Board

23. 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 June 2021, the IMB reported that healthcare provision had been 'stretched' over the past 12 months as a direct result of the pandemic, although staffing had remained at a safe level with the use of bank and agency staff. The IMB noted that three of the Ombudsman's reports for the year had concluded that the care afforded to the prisoners had not been equivalent to that which they would have received in the community, and the IMB had discussed the issues with the Head of Healthcare.

Previous deaths at HMP Altcourse

24. Mr Lavin's death was the 14th at Altcourse since November 2018. Of the previous deaths, 11 were from natural causes, one was self-inflicted and in one case the cause of death was unascertained. In a previous case, the clinical reviewer identified concerns around the prisoner's diabetes management.

25. There have been 10 deaths since Mr Lavin's: of these six were from natural causes and four were self-inflicted. In the one self-inflicted death we have investigated to date, we found that ACCT procedures were poorly managed.

Assessment, Care in Custody and Teamwork (ACCT)

26. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

27. On 30 August 2020, Mr Michael Lavin was arrested and taken into police custody charged with assault of emergency workers (a nurse and a police officer). On 1 September, Mr Lavin was taken to HMP Altcourse. He had been released from Altcourse only two weeks earlier.

28. During reception health screens, nurses recorded that Mr Lavin had both physical and mental health problems, including type 2 diabetes, bipolar affective disorder, schizophrenia and a history of substance misuse (heroin and alcohol). Mr Lavin's urine drug test was positive for methadone (heroin substitute), opiates and benzodiazepines (sedatives). He was prescribed methadone and diabetes medication. Mr Lavin was not deemed suitable to hold medication in possession so nurses gave him his medication each day.

29. While in reception, Mr Lavin was noted to be agitated and he said that he would harm himself as he believed he had been wrongly arrested. Staff started suicide and self-harm prevention procedures (known as ACCT). Mr Lavin had been supported through ACCT on previous occasions while in custody.

30. A Prison Custody Officer (PCO) tried to hold an ACCT assessment interview with Mr Lavin on the morning of 2 September, but Mr Lavin refused to engage. The PCO noted that Mr Lavin was shouting from his cell and was demanding medication.

31. Throughout 3 September, Mr Lavin made superficial cuts to various parts of his body. Nurses were called each time, but Mr Lavin refused treatment and threatened to throw hot tea over one of the nurses. Mr Lavin made superficial cuts on several occasions in the following days, which he said was a coping mechanism. Mr Lavin was also noted to have a habit of picking at old wounds.

32. Staff stopped ACCT procedures on 29 September, when Mr Lavin said that he would not harm himself again as he was virtually free of pain. Mr Lavin was noted to be in good humour.

33. Staff told us that Mr Lavin's behaviour was erratic and unpredictable: at times he was pleasant and rational and other times he was aggressive and would swear and spit at them.

34. On 6 October, officers used force on Mr Lavin. He had been told to return to his cell at the end of an association period and as he walked towards his cell he tried to grab a floor mop. Officers took Mr Lavin to the floor and he tried to spit at them. The officers then brought Mr Lavin back to his feet and walked with him back to his cell using arm locks. A nurse noted that Mr Lavin sustained no injuries. Mr Lavin threatened to hang himself because he had not received his medications. His medical record notes that he had thrown his medications at the nurse but does not say which medications were involved.

35. Officers used force on Mr Lavin on seven other occasions from 12 to 26 October. The investigator reviewed the paperwork and viewed CCTV footage for each occasion and considered that officers acted appropriately each time.

36. On the evening of 22 October, Mr Lavin showed an officer several superficial cuts to his arm that he said he had done as he was having a bad day. The officer restarted ACCT procedures.

37. A First Line Manager (FLM) chaired an ACCT case review the following morning. Mr Lavin said that he harmed himself as he was feeling angry, but he now regretted doing so, and he wrote on the ACCT document that he did not want to die. Staff stopped the ACCT procedures.

24 October

38. On the morning of 24 October, staff saw Mr Lavin fitting on his cell floor. Officers noted that he was known to be diabetic and he appeared to be having a hypoglycaemic episode (a fit caused by a low blood sugar level). Nurses checked Mr Lavin's blood which confirmed he had a low blood sugar level. Nurses gave Mr Lavin glucose and medication. He recovered quickly and then became aggressive and spat at the nurses. Mr Lavin was restrained to enable staff to leave the cell safely. There is no evidence that his blood sugar levels were checked again that day.

39. On the afternoon of 24 October, Mr Lavin smashed a kettle, smashed his cell door observation panel and started spitting at staff through the broken panel, hitting one officer in the face. In the evening, Mr Lavin was taken to the segregation unit, known as the Care and Separation Unit (CSU). Mr Lavin resisted when staff tried to take him to the CSU so staff took hold of his arms and walked him to the CSU. One officer recorded that Mr Lavin had bled from a laceration above his right eye, but the nurse who was present during the move said that the cut was present before officers went into Mr Lavin's cell.

40. Staff restarted ACCT procedures. They initially observed Mr Lavin five times an hour, but on 25 October, reduced his observations to two an hour.

41. The last time force was used on Mr Lavin was on the morning of 26 October. Staff took him to the medication hatch and he became agitated: he threw a cup of water over the nurse, then started shouting and waving his arms. Officers took control of Mr Lavin's arms and head and walked him back to his cell. A nurse noted that he was unable to assess Mr Lavin for any injuries after the use of force due to his behaviour.

27 and 28 October

42. PCO A told the investigator that he was on duty in the CSU during the night of 27/28 October. He said that he had previously met Mr Lavin and was aware that he could behave in a bizarre way.

43. PCO A first checked Mr Lavin at 8.00pm on 27 October, and then twice an hour during the night. Nothing unusual happened during the early part of the night, but at 3.00am on 28 October, PCO A found that Mr Lavin was standing up and was making a noise that was something between a groan and a shout. PCO A said he thought that Mr Lavin wanted to disturb other prisoners as, when he told him to go back to bed, Mr Lavin replied that if he was awake, everyone would be awake.

44. At the next check at 3.30am, PCO A noted that Mr Lavin was sitting on his cell floor. At the 4.00am check, PCO A noted that Mr Lavin was still on the floor and was "rambling to himself". He said he asked Mr Lavin to get back into bed, but Mr Lavin replied with expletives.

45. When PCO A checked Mr Lavin at 4.30am, he said he saw him lying on the cell floor, masturbating in full sight. He challenged Mr Lavin, but Mr Lavin responded with abuse. PCO A said that it was unusual, but not unique, to find prisoners masturbating in such an open way.

46. From 5.00am onwards, PCO A said that Mr Lavin remained on the floor, but appeared asleep and was snoring at times. PCO A made his last check on Mr Lavin at 7.00am. His trousers remained pulled down.

47. PCO B arrived on duty at 7.00am and PCO A briefed her about the night, including Mr Lavin's behaviour. She checked Mr Lavin at 7.10am and noted that he was "asleep on floor". PCO C and PCO D arrived on duty and PCO B briefed them about the events.

48. At around 7.30am, PCO B and her colleagues visited each cell in the unit to give prisoners a breakfast pack and to ask if they wanted a shower and to clean out their cells. They were accompanied by one of the prison chaplains. They reached Mr Lavin's cell at 7.40am. The chaplain noted in the ACCT that Mr Lavin was making a groaning sound. The chaplain said that the groan did not sound like a groan of pain. (At interview PCO C described Mr Lavin groaning in a similar way.) PCO C and PCO D called Mr Lavin's name several times but he did not respond. They decided to give him a few minutes to "sort himself out" and told him to get up and get dressed and that they would return to his cell in a few minutes.

49. The officers then went to deal with prisoners on the upper landing and they returned to Mr Lavin's cell at about 7.45am.

50. When the officers returned, Mr Lavin was in the same position as earlier. The officers went into the cell and called his name. He was breathing, but he did not respond to their calls. The officers used first aid trained pain response techniques to obtain a response, including pinching his ear lobes. Mr Lavin remained unresponsive so PCO B radioed for medical assistance at 7.46am.

51. The emergency response nurse (Nurse A) was dispensing methadone when he heard the call for medical assistance. As it was not an emergency call, he continued treating the prisoner he was dealing with at that time with the intention of going to the CSU once he had finished.

52. Another nurse (Nurse B) had gone to the CSU to give prisoners their medication. She heard the call for medical assistance, but she knew that Nurse A would be responding so she continued with her duties. Shortly after, PCO C saw Nurse B on the unit and called her to come to see Mr Lavin.

53. Nurse B went to Mr Lavin's cell and saw him semi naked on his cell floor. She knew he was diabetic and she immediately suspected that he had suffered a hypoglycaemic collapse. As a medical emergency code had not been called, she had not taken any equipment with her, so she went to the CSU treatment room to

collect a blood sugar test kit and returned to Mr Lavin. He was making sounds and his eyelids were fluttering. She tried to take a blood sample to check his blood sugar level but this was difficult as his fingers were very cold. Nurse A arrived at the cell at about the point that Nurse B was able to obtain a drop of blood. She tested the sample and found that Mr Lavin's blood sugar level was 0.9 (the normal range in the morning before breakfast is between 4 and 7).

54. At 7.56am, the nurses radioed a code blue emergency. (An ambulance had already been called at 7.55am when the control room officer learned more about Mr Lavin's condition in a telephone conversation with one of the PCOs.)

55. Ambulance paramedics arrived at 8.11am and treated Mr Lavin at his cell until 8.54am when they took him to hospital. Mr Lavin was initially treated in the accident and emergency department where a CT scan revealed a fracture to the jaw and brain swelling. At 2.10pm he was moved to the intensive care unit and placed in a medically induced coma. Mr Lavin remained in intensive care until he died at 8.35am on 12 November.

Contact with Mr Lavin's family

56. Altcourse contacted Mr Lavin's brother at 8.45am on 29 October to tell him that Mr Lavin was in hospital. Family members visited Mr Lavin in hospital and his sister was with him when he died.

57. Altcourse contributed to the cost of Mr Lavin's funeral in line with national instructions.

Support for prisoners and staff

58. The Duty Director debriefed the staff who responded to Mr Lavin. The staff care team also offered support.

59. The prison posted notices informing other prisoners of Mr Lavin'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 Lavin's death.

Post-mortem report

60. The pathologist was aware that Mr Lavin had been restrained by prison staff on 26 October. He said that the fracture of Mr Lavin's jaw was an old injury and unrelated to the timeframe leading up to Mr Lavin's death, and that in his view there was no evidence of significant head trauma which would have contributed to Mr Lavin's death. He did not consider the minor areas of abrasion and bruising on Mr Lavin's body to be significant.

61. Post-mortem examination found alterations to Mr Lavin's brain indicative of a hypoglycaemic injury sustained around two weeks before his death. The pathologist gave Mr Lavin's cause of death as hypoglycaemic encephalopathy (brain damage due to low blood glucose) with terminal bronchopneumonia.

62. The pathologist noted that there was evidence that Mr Lavin had been discharged from hospital at the end of August 2020 following an insulin overdose. This appears to have occurred before Mr Lavin entered prison on 30 August as there is no reference to it in his prison medical records.

Findings

Clinical care

63. The clinical reviewer found that Mr Lavin's healthcare was sub-optimal and not equivalent to that he could have expected to receive in the community. She acknowledged that his presenting behaviour was challenging but noted that it was unclear whether his behaviour was the result of a mental health condition or the result of a medical problem, such as poorly controlled diabetes. She considered that there was a missed opportunity to assess and review Mr Lavin through a multidisciplinary team panel in order to establish any root causes. She also found no evidence that his mental capacity was assessed.

64. The clinical reviewer also found that Mr Lavin was never referred to the Long- Term Conditions clinic for his type 2 diabetes and there was no evidence that a care plan was in place. We recommend:

The Head of Healthcare should ensure that staff refer prisoners with long-term medical conditions to the relevant Long-Term Conditions clinic for initial assessment and ongoing reviews.

The Head of Healthcare should ensure that there are systems and processes in place to support ongoing clinical management of prisoners with challenging behaviour, which should include assessing mental capacity.

65. The clinical reviewer noted other deficiencies in Mr Lavin's care and has made several other recommendations which the Head of Healthcare will need to address.

Examination by healthcare staff after a use of force

66. Prison Service Order (PSO) 1600 requires that:

> "An appropriately qualified healthcare professional (doctor or registered nurse) must be informed whenever force has been used to restrain a prisoner. He or she must examine the prisoner as soon as possible and must complete an F213 in all cases even if the prisoner appears not to have sustained any injuries. The prisoner must see an appropriately qualified healthcare professional within 24 hours of the incident occurring."

67. Prison staff used force on Mr Lavin on eight occasions between 6 and 26 October. The pathologist does not consider that there is evidence that head trauma contributed to Mr Lavin's death. Nevertheless we are concerned that there were a number of occasions when healthcare staff did not examine Mr Lavin after he had been restrained by prison staff, either because of his behaviour (for example, on 26 October) or because Mr Lavin swore at nurses and refused to be examined immediately after the incident.

68. In a Learning Lessons Bulletin on the use of force (published in May 2016) we noted that healthcare staff are usually asked to see prisoners immediately after a use of force incident. We found that it is common for nurses to take the view (perhaps on advice from prison staff) that it would not be safe to enter the cell to

examine a prisoner because he is too angry immediately after a use of force. In these circumstances, the prisoner will simply be spoken to through the observation panel in the cell door. We also noted that prisoners may be too worked up to engage with healthcare immediately after the incident and may refuse to be examined, or may say that they have no injuries because adrenaline is masking the pain.

69. We said that we do not consider that a brief look through a cell observation panel meets the requirement for a prisoner to be examined by a healthcare practitioner. Where it is not possible to conduct a proper examination immediately after an incident, we consider that the prisoner should be seen again by healthcare a few hours later. This gives time for the prisoner to calm down and also for any physiological effects, such as bruising or pain, to develop. We also take the view that, wherever possible, the prisoner should be able to speak to healthcare staff out of the hearing of officers.

70. We recommend:

The Director and Head of Healthcare should ensure that every attempt is made for healthcare staff to examine a prisoner in person following a use of force, in line with PSO 1600, and that this may involve returning a few hours later when the prisoner is calmer.

ACCT checks

71. When Mr Lavin was moved to the CSU on 24 October, staff restarted ACCT procedures. On the day he was found unresponsive, 28 October, he was subject to two ACCT checks an hour. From 5.00am, officers thought he was asleep on the floor of his cell. They did not realise he was unresponsive until around 7.45am.

72. While we accept that ACCT is about managing prisoners at risk of suicide and self-harm, and that staff carrying out ACCT observations are usually checking that the prisoner has not self-harmed or is in distress, we consider that the overall purpose of the ACCT checks is to keep the prisoner safe. We consider that there was key information that would have helped to keep Mr Lavin safe that was not made clear to the staff responsible for carrying out his ACCT checks. Not only was Mr Lavin diabetic, but he had experienced a hypoglycaemic episode on 24 October, the day he was taken to the CSU. Staff should have been made aware of this. Had they been, it is possible that they would have reacted differently when they saw Mr Lavin lying motionless on the floor of his cell and checked on his welfare much earlier. We make the following recommendation:

The Director should ensure that staff carrying out ACCT checks are aware of any significant issues, including relevant physical health issues, that could place the prisoner at risk.

Emergency response

73. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes and Altcourse's Local Notice 07/2018 Medical Code Responses sets out the actions staff should take in a medical emergency. When staff discover a medical

emergency, they should call the relevant medical emergency code immediately, so that prison healthcare staff are aware of the nature of the emergency and respond promptly with the correct equipment, and that an ambulance is called immediately. Altcourse's Notice to Staff 07/2018 on medical code responses states that a code blue should be called where a prisoner is unconscious.

74. We consider that staff should have checked Mr Lavin's wellbeing when he did not respond to them at 7.40am, particularly as he was making a groaning sound, he had been lying on the floor of his cell for three hours at that point, and, according to PCO C, they knew he was diabetic.

75. We are very concerned that they did not radio a code blue emergency when Mr Lavin failed to respond to use of pain stimuli when they returned at 7.45am. At interview the officers said that they did not consider it was a code blue emergency because Mr Lavin was breathing, and one said that they knew there would be a nurse nearby at that time of the morning.

76. Mr Lavin was unconscious and not responding to pain stimuli. PSI 3/2013 makes it clear that a medical emergency code should be called when there are serious concerns about the health of a prisoner. The point of doing so is not just to alert healthcare staff to attend with the appropriate equipment, but also to trigger the control room to call an ambulance immediately. PSI 3/2013 says that, if staff are in any doubt about the nature of the situation, they must call an emergency code and that "it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required".

77. The failure to call a code blue meant there was a 10 minute delay before an ambulance was called. We cannot say if this affected the outcome for Mr Lavin, but we know that it could make the difference between life and death in other medical emergencies. We make the following recommendations:

The Director should ensure that all staff understand their responsibilities in a medical emergency, including that they radio the appropriate medical emergency code without delay.

Family liaison

78. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner becomes seriously ill.

79. Mr Lavin was taken to hospital at 8.54am on 28 October. At 2.10pm, he was moved to the intensive care unit and placed in a medically induced coma. Mr Lavin's brother was not informed that Mr Lavin had been taken to hospital until 8.45am on 29 October. We consider that Altcourse failed to comply with Prison Rule 22 as it was clear on the afternoon of 28 October that Mr Lavin was seriously ill. We make the following recommendation:

The Director should ensure that staff inform the next of kin immediately when a prisoner becomes seriously ill, in line with Prison Rule 22 and PSI 64/2011.

Inquest

80. An inquest into Mr Lavin's death concluded on 6 May 2025 and that his cause of death was hypoglycaemic encephalopathy with terminal bronchopneumonia.

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