Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Lloyd a prisoner at HMP Haverigg on 10 March 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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 Steven Lloyd died of a heart attack on 10 March 2015, while a prisoner at HMP Haverigg. He was 43 years old. I offer my condolences to Mr Lloyd's family and friends.

Mr Lloyd had a history of chest pains, which clinicians appropriately investigated. On 10 March, when Mr Lloyd complained of chest pains and difficulty breathing, night staff did not immediately recognise this as an emergency and did not call an ambulance until Mr Lloyd's condition deteriorated. While it does not appear that this would have changed the outcome for Mr Lloyd, it is important that prison staff at night understand the circumstances in which they should call an ambulance.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Summary

Events

1. Mr Steven Lloyd had been in prison since 2006 and was serving an indeterminate sentence for public protection. Mr Lloyd had been at HMP Haverigg since February 2014.

2. Mr Lloyd had a medical history of asthma, irritable bowel syndrome, and chronic back pain. He had a history of substance misuse and had smoked for many years. Shortly after he was first sent to prison, Mr Lloyd began to complain of chest pain, which clinicians investigated appropriately. None of the tests identified any problems.

3. In January 2015, Mr Lloyd said he had been using illicitly obtained opiate medication and wanted to be prescribed methadone as he was suffering withdrawal symptoms. A substance misuse nurse found no evidence of opiate withdrawal. Mr Lloyd frequently sought additional medication and was sometimes abusive to healthcare staff when they reduced his medication or declined to prescribe specific medication he requested. On 23 February, Mr Lloyd was moved to the segregation unit after a rooftop protest about not getting the medication he wanted. Healthcare staff saw him daily in the segregation unit and he received his prescribed medication.

4. At 12.00am on 10 March 2015, while still in the segregation unit, Mr Lloyd told a night patrol officer that he had pains in his chest and arms and had difficulty breathing. The night patrol officer radioed for help and two prison officers arrived. Mr Lloyd collapsed and the officers requested an ambulance at 12.19am. The ambulance arrived just after 1.00am. Mr Lloyd had a cardiac arrest when paramedics took him to the ambulance. Prison officers and a paramedic administered cardiopulmonary resuscitation in the ambulance on the way to hospital and the paramedic gave him emergency medication. Mr Lloyd did not recover and doctors recorded his death, shortly after he arrived at the hospital.

Findings

5. The prison healthcare team reviewed Mr Lloyd's medical conditions frequently and he received appropriate treatment. Each time Mr Lloyd complained of chest pain, clinicians carried out appropriate investigations, which were negative.

6. We are satisfied that Mr Lloyd received an appropriate standard of care at the prison, equivalent to that he could have expected to receive in the community. However, although this is unlikely to have affected the outcome for Mr Lloyd, we consider that the prison should have called an ambulance sooner.

Recommendation

- The Governor should ensure that prison staff understand the symptoms and circumstances where a medical emergency code should be called and that there is no delay in calling an ambulance in a life-threatening situation.

The Investigation Process

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

8. The investigator obtained copies of relevant extracts from Mr Lloyd's prison and medical records. She interviewed two members of staff by telephone on 2 July 2015.

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

10. We informed HM Coroner for North and West Cumbria of the investigation who gave us the post-mortem report. We have sent the coroner a copy of this report. Our investigation was suspended until the results of toxicology tests were received. We are sorry for the consequent delay with the issue of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Lloyd's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Lloyd's mother asked if he had received his prescribed medication, if doctors had refused to prescribe pain relief mediation to Mr Lloyd when he was in the segregation unit, and for information about the emergency response on 10 March. She said that a couple of days before his death, Mr Lloyd had written to her and complained of chest pain. She wanted to know what action the prison had taken.

12. Mr Lloyd's mother received a copy of the initial report. She identified one factual inaccuracy, which has been amended.

13. The initial report was shared with the Prison Service. They identified three factual inaccuracies, which have been amended.

Background Information

HMP Haverigg

14. HMP Haverigg is a medium security prison, which can hold 644 sentenced men. Cumbria Partnership NHS Foundation Trust provides healthcare services at the prison. The Gables Medical Practice provides GP services and Cumbria on-call medical service for out-of-hours cover. Nurses provide care between 7.30am and 6.30pm.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Haverigg was in January 2014. The report described Haverigg as probably the Prison Service's most isolated prison. Inspectors found that health services were adequate. There was a good range of daily primary care clinics and well-man checks for older patients. Care of patients with lifelong conditions, such as asthma, diabetes, and heart disease, was good. Drug tests results indicated some problems with Subutex (buprenorphine,) cannabis and diverted medication. There was also increasing evidence that 'Spice' (a synthetic cannabinoid) was being used by prisoners. Inspectors found good information sharing between security and health care departments, and that the prison had taken appropriate steps to address the diversion of prescribed medication.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to November 2014, the IMB reported that the healthcare premises were inadequate and staff shortages had affected attendance at outpatient hospital appointments. The IMB was concerned about some prescribing procedures, particularly when prisoners with long-prescribed medication had had this stopped when they arrived at Haverigg.

Previous deaths at HMP Haverigg

17. Mr Lloyd was the first prisoner to die of natural causes at Haverigg since the start of 2015. Since his death, there has been one other death from natural causes at the prison. There were no similarities with the circumstances of Mr Lloyd's death.

Key Events

18. Mr Steven Lloyd had been in prison since 2006. He was serving an indeterminate sentence for public protection with a minimum term to serve of three years before he could be considered for release. Mr Lloyd spent time in several prisons before moving to HMP Haverigg on 26 February 2014. The Parole Board had never considered Mr Lloyd's risk of re-offending had reduced enough for release.

19. At an initial health screen at Haverigg, a nurse noted that Mr Lloyd suffered from asthma, chronic lower back pain, and irritable bowel syndrome (IBS). Doctors prescribed tramadol (to treat moderate to severe pain), mobervirine (for IBS), and inhalers for asthma. Mr Lloyd had smoked heavily for many years but declined help and advice to give up. He had a history of substance misuse, using heroin and crack cocaine and using non-prescribed medication in prison. He had previously completed a methadone detoxification programme for opiate dependency.

20. On 27 February, a nurse saw Mr Lloyd to review his health and medication. Mr Lloyd had a history of chest pains, which had been investigated by electrocardiogram (ECG) tests, which measures the electrical activity and rhythm of the heart, an exercise tolerance test, and blood tests. The results were all normal.

21. On 10 March, a prison GP reviewed Mr Lloyd's medication for lower back pain. The GP noted there was no evidence of sciatica or a significant spinal problem and that Mr Lloyd had a history of drug seeking behaviour. He planned to reduce the dose of tramadol over time. When he told Mr Lloyd this, Mr Lloyd became verbally abusive.

22. On 22 April, Mr Lloyd's blood pressure readings showed he was at risk of developing hypertension. The GP noted that staff should monitor Mr Lloyd's blood pressure over the next 24 hours and referred him for an ECG test.

23. On 24 April, the ECG test showed normal results. Blood pressure tests showed Mr Lloyd had mild hypertension (high blood pressure). The GP advised Mr Lloyd about a weight loss and exercise programme to reduce his blood pressure.

24. On 3 May, Mr Lloyd complained of chest pain. A nurse assessed him and noted that his blood pressure reading was slightly high. His pulse rate and oxygen saturation level was normal. Mr Lloyd had another ECG test with normal results.

25. Nurses continued to see Mr Lloyd regularly to monitor his asthma, blood pressure and to review his medication.

26. On 8 December, prison officers found Mr Lloyd in possession of codeine, which he had not been prescribed. On 12 December, the GP reviewed Mr Lloyd's medication and further reduced his dose of tramadol. On 14 December, Mr Lloyd was verbally abusive to a nurse about this and officers had to intervene to allow the nurse to leave the wing.

27. On 24 December, Mr Lloyd was verbally abusive towards the GP about the reduction of his tramadol. Because of his behaviour, managers decided that healthcare staff should only see Mr Lloyd when accompanied by an officer.

28. On 9 January 2015, Mr Lloyd told a nurse he had been taking illicitly obtained Subutex (buprenorphine, which is used to treat opiate addiction) to relieve his back pain. He asked if a doctor could prescribe methadone and the nurse referred him to the substance misuse team.

29. On 16 January, a substance misuse nurse assessed Mr Lloyd using the clinical opiate withdrawal score (COWS). Drug tests results were negative and the nurse noted that Mr Lloyd did not show any signs of opiate withdrawal. The nurse concluded that Mr Lloyd did not need methadone.

30. On 3 February, Mr Lloyd told the GP he had used non-prescribed medication and wanted methadone. The GP referred Mr Lloyd to the substance misuse team again.

31. On 4 February, Mr Lloyd complained of chest pain. A nurse assessed him and noted his temperature, pulse rate and oxygen saturation levels were normal. An ECG test also showed normal results.

32. On 5 February, a drug test showed Mr Lloyd had taken non-prescribed opiates and on 9 February, Mr Lloyd told a substance misuse nurse he had taken codeine. The nurse completed another COWS assessment and noted that Mr Lloyd did not show any signs of opiate withdrawal. On 17 February, the GP concluded Mr Lloyd was not suitable for methadone, as he was not showing signs of any opiate withdrawal.

33. On 23 February, Mr Lloyd climbed on the prison roof to protest about not being prescribed methadone. After he came down, he was taken to the segregation unit and segregated under the provisions of Prison Rule 45, which allows prisoners to be kept apart from others to maintain good order or discipline. Nurses saw him daily in the segregation unit and gave him his prescribed medication. While in the segregation unit, Mr Lloyd did not mention any concerns about his physical health or ask for any additional pain relief medication. Doctors assessed him and considered that Mr Lloyd was fit to remain in the segregation unit.

Events of 10 March

34. At 9.00pm on 9 March, an operational support grade (OSG) was the night patrol officer in the segregation unit and checked Mr Lloyd in his cell. When she spoke to him, he said he had no concerns. She checked Mr Lloyd again at 10.00pm and 11.00pm and had no concerns about his welfare.

35. At 12.00am on 10 March, the OSG checked Mr Lloyd again. Mr Lloyd was standing up, rubbing his chest, breathing fast and looked in pain. He said he had chest pain, difficulty breathing, and both arms were hurting. Mr Lloyd said he was not having an asthma attack. She contacted a custodial manager, who was orderly officer in charge of the operation of the prison that night. He advised her to radio Officer A for help.

36. At 12.10am, Officer A and a colleague arrived at Mr Lloyd's cell. Mr Lloyd told Officer A he had been sick and was finding it increasingly difficult to breathe. He contacted the custodial manager, who asked them to wait for another officer to attend before opening Mr Lloyd's cell, as he had a recent history of threatening behaviour towards staff. However, a few minutes later, before another officer arrived, Mr Lloyd cried out and fell onto his bed. Both officers immediately went onto the cell and Officer A radioed for an emergency ambulance. This was 12.19am.

37. The prison's control room immediately rang for an emergency ambulance. The ambulance service was unable to give an estimated time of arrival and could not give a time when control room staff rang again at 12.44am.

38. At 1.03am, an ambulance crew arrived and took control of Mr Lloyd's care. At 1.15am paramedics also arrived. An ECG showed abnormal results. After assessing Mr Lloyd and trying to stabilise him, paramedics took Mr Lloyd from his cell to the ambulance at 1.50am. Mr Lloyd then had a cardiac arrest and the paramedics begin cardiopulmonary resuscitation (CPR). At 2.22am, the ambulance left the prison. Two officers went with Mr Lloyd in the ambulance and one officer assisted with CPR on the way to the hospital. One of the paramedics administered emergency medication. At 3.05am, the ambulance arrived at the hospital. Mr Lloyd did not recover and at 3.16am, the hospital recorded that Mr Lloyd had died.

Contact with Mr Lloyd's family

39. On 10 March, the prison appointed a prison chaplain as their family liaison officer. Mr Lloyd had named his mother as his next of kin but there was uncertainty about the address and the chaplain asked Cheshire Police to ask for help.

40. Later that day, the police informed Mr Lloyd's sister of his death, before they had given the family liaison officer her contact details. The chaplain telephoned Mr Lloyd's sister, gave his condolences and offered to visit, which she declined. He then spoke to Mr Lloyd's mother to offer condolences and support and visited her on 17 March. He remained in contact with Mr Lloyd's family.

41. Mr Lloyd's funeral was on 31 March and the prison contributed to the costs in line with national policy.

Support for prisoners and staff

42. After Mr Lloyd's death, the custodial manager debriefed the staff involved in the emergency response to give them the opportunity to discuss any issues arising, and to offer his support and that of the staff care team.

43. The prison posted notices informing staff and prisoners of Mr Lloyd's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Lloyd's death.

Post-mortem report

44. A post-mortem found that the cause of death was acute myocardial infarction (a heart attack) and coronary artery atheroma (narrowing of the arteries leading to the heart). Toxicology tests did not detect the presence of alcohol or drugs in Mr Lloyd's body.

Findings

Clinical care

45. The clinical reviewer noted that Mr Lloyd suffered from asthma, chronic lower back pain, and irritable bowel syndrome. Doctors prescribed appropriate medication for these conditions. Mr Lloyd was sometimes abusive to healthcare staff when doctors reduced or refused to prescribe specific medication, which made assessing and treating him increasingly challenging.

46. Mr Lloyd had a history of intermittent chest pain. The clinical reviewer considered that these pains were not associated with typical cardiac symptoms of pain radiating down the arm or to the throat, sweating, or pallor. She was satisfied that each time Mr Lloyd reported chest pain, prison doctors arranged appropriate investigations, including blood tests and ECG tests, which were always normal.

47. Although Mr Lloyd claimed to have two slipped discs from a road traffic accident many years earlier, an MRI scan on 12 November 2014 indicated that he did not have slipped discs. He had some 'wear and tear' of the bones in his spinal column and he was advised not to do any work that might involve heavy lifting. Mr Lloyd's tramadol medication for pain relief was reduced. The clinical reviewer was satisfied that there were appropriate clinical reasons documented in his medical records to support this decision. There were no grounds to prescribe Mr Lloyd methadone, which he had requested.

48. The clinical reviewer considered that the standard of care Mr Lloyd received at Haverigg was equivalent to that he could have expected to receive in the community and we are satisfied he received appropriate care.

Emergency response

49. Prison Service Instruction (PSI) 03/2013 - Medical Emergency Response Codes, contains a mandatory instruction that prison staff should use a code blue (or code one) for any emergency where a prisoner has symptoms including chest pain and difficulty in breathing. This should result in the control room or communications room calling an ambulance immediately, without waiting for further information. Haverigg has an appropriate local protocol.

50. When Mr Lloyd complained of chest pain, breathlessness and pain in both arms shortly after midnight on 10 March, the OSG did not regard it as an emergency or a life-threatening situation, as Mr Lloyd was fully coherent. She therefore did not use an emergency code but immediately requested help. Two officers came to the unit quickly. The night orderly officer originally advised them to wait for a third officer to arrive before opening Mr Lloyd's cell but the officer went into the cell without waiting, when Mr Lloyd's condition appeared to deteriorate. They then asked the control room to call an ambulance. Haverigg is in a remote location and it took over 40 minutes before an ambulance arrived.

51. We understand that it can sometimes be difficult to assess whether there is an emergency when someone experiences chest pain. Mr Lloyd had often reported

chest pain previously and none of those occasions had been life threatening. However, there are no healthcare staff on duty at Haverigg at night and the symptoms Mr Lloyd described are associated with the symptoms of a possible heart attack. While we understand why the OSG sought help from prison officers, it is not clear how they would have been able to assist Mr Lloyd. We consider that the staff should have called an ambulance sooner, or at least sought advice from the prison's out of hours GP service. PSI 3/2013 says that it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required.

52. The clinical reviewer did not consider that the delay in calling an ambulance, or the time it took the ambulance to reach Haverigg, affected the outcome for Mr Lloyd. Paramedics were on hand when he had a cardiac arrest and administered appropriate emergency treatment. Nevertheless, we consider it is important the prison staff understand the symptoms and circumstances in which an emergency code should be called and do not delay calling an ambulance. We make the following recommendation:

The Governor should ensure that prison staff understand the symptoms and circumstances where a medical emergency code should be called and that there is no delay in calling an ambulance in a life-threatening situation.

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