Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Lloyd a prisoner at HMP Whatton on 4 December 2020

A report by the Prisons and Probation Ombudsman

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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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Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Robert Lloyd died in hospital of kidney failure on 4 December 2020, while a prisoner at HMP Whatton. He was 78 years old. I offer my condolences to Mr Lloyd's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Lloyd received at Whatton was equivalent to that he could have expected to receive in the community. She made two recommendations but as these were not directly related to Mr Lloyd's death, we have not included them in this report.

5. We found no non-clinical issues of concern.

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

The Investigation Process

7. NHS England commissioned an independent clinical reviewer, to review Mr Lloyd's clinical care at Whatton. The clinical reviewer's report is attached as Annex 1.

8. The PPO investigator has investigated non-clinical issues, including Mr Lloyd's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Lloyd's next of kin, his son, to explain the investigation. He did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Whatton

11. Mr Lloyd was the 13th prisoner to die at Whatton since December 2018. All the previous deaths were from natural causes.

Key Events

12. On 23 October 2006, Mr Robert Lloyd was given an indeterminate prison sentence for sexual offences. He was released on licence in November 2011, but recalled in October 2012, following poor behaviour. On 19 November 2013, he was taken to HMP Whatton.

13. In May 2015, Mr Lloyd began to suffer memory problems. He underwent tests and was referred to both the mental health team and hospital dementia services. In December 2016, he was diagnosed with Alzheimer's Disease.

14. On 10 October 2020, Mr Lloyd had vomiting and diarrhoea. Blood tests showed a kidney abnormality. On 20 October, Mr Lloyd was admitted to hospital with blood in his urine and was diagnosed with end stage renal (kidney) failure. He had a blood transfusion, but no reversible cause of the renal failure could be identified. Dialysis was not an option as Mr Lloyd was considered too frail to travel.

15. On 30 October, Mr Lloyd was returned to Whatton for palliative care, initially in isolation having tested positive for COVID-19 in hospital. He continued to deteriorate and on 20 November, staff placed him on the end of life register. A senior manager authorised Mr Lloyd's cell door could remain open. In addition to prison nursing staff, Mr Lloyd was supported by healthcare support workers during the day and by agency staff at night.

16. The prison did not apply for compassionate release because Mr Lloyd was already under consideration for release on parole. The Parole Board was aware of Mr Lloyd's deteriorating health and supported his release. A move to a local care home was arranged but, when his release was confirmed, healthcare staff considered Mr Lloyd too ill to move.

17. On 4 December at 4.00am, a healthcare assistant checked on Mr Lloyd and noticed a change in his breathing. She checked on him 30 minutes later and again at 4.55am, when she found that he had stopped breathing. She did not attempt to resuscitate him as Mr Lloyd had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place.

18. There was no post-mortem examination as the Coroner accepted the cause of death provided by a doctor. The doctor gave the cause of death as end stage renal failure caused by chronic kidney disease. He also listed dementia as a contributory factor.

Louise Richards **March 2021**
Assistant Ombudsman

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