

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Andrew Lloyd, a prisoner at HMP Full Sutton, on 19 November 2020

**A report by the Prisons and Probation Ombudsman**

## 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*



© Crown copyright 2021

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Andrew Lloyd died of COVID-19 interstitial pneumonia at HMP Full Sutton on 19 November 2020. He had congestive cardiac failure, hypertensive heart disease and morbid obesity which contributed to but did not cause his death. He was 37 years old. I offer my condolences to his family and friends.

Mr Lloyd died six days after transferring to Full Sutton from a secure psychiatric hospital. He was diagnosed with several physical health conditions and was defined as clinically extremely vulnerable and at high risk from COVID-19. He appropriately began a period of isolation when he arrived at Full Sutton.

While Mr Lloyd did not display any symptoms of COVID-19 (and the disease was not identified until after his death), I am concerned that he did not receive an initial health screen on arrival and that daily welfare checks and clinical observations that should have taken place during his isolation period were not appropriately completed or recorded. For these reasons, the clinical reviewer concluded that the care Mr Lloyd received at Full Sutton was not equivalent to that which he could have expected to receive in the community.

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

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

**July 2021**

## **Contents**

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	9

# Summary

## Events

1. On 3 March 2006, Mr Andrew Lloyd was remanded in custody and later received a life sentence. In August 2017, Mr Lloyd was admitted under the Mental Health Act to St Andrew's Secure Hospital.
2. In 2019 and 2020, Mr Lloyd experienced several asthma exacerbations, some of which required general hospital admission. He was also diagnosed as clinically obese and sometimes experienced low oxygen saturation. As a result, he was considered to be clinically extremely vulnerable to the risks of COVID-19.
3. In August 2020, Mr Lloyd's return to prison was planned. Hospital and prison staff held a conference and shared reports about his physical and mental health care. On 12 November, the day before his transfer, Mr Lloyd tested negative for COVID-19.
4. On 13 November, Mr Lloyd was transferred to Full Sutton. A nurse from St Andrew's travelled with him and provided a handover to a prison nurse in Reception. The Head of Healthcare asked for Mr Lloyd's clinical observations to be taken on his arrival, but this did not happen.
5. COVID-19 procedures require prisoners to self-isolate during their first two weeks in prison. (This is known as reverse cohorting.) The Head of Healthcare told us that healthcare staff complete daily welfare checks during this period which do not include taking clinical observations unless the prisoner exhibits symptoms. No checks were recorded for Mr Lloyd.
6. At around 9.13am on 19 November, a pharmacy technician delivering medication to his cell discovered that Mr Lloyd had died.

## Findings

### Physical health care

7. The clinical reviewer concluded that the care Mr Lloyd received at Full Sutton was not equivalent to that which he could have expected to receive in the community.
8. Mr Lloyd did not receive an initial health assessment on his first day at Full Sutton and there was no care plan appropriate to his complex physical health needs.
9. Mr Lloyd appropriately began a period of isolation on arrival at Full Sutton. However, daily welfare checks and clinical observations were not recorded as they should have been.

### Roll checks

10. The night patrol officer did not complete the required early morning roll check on the day of Mr Lloyd's death.

## Recommendations

- The Head of Healthcare should ensure that appropriate daily clinical observations are completed for all newly arrived prisoners who are reverse cohorting and that these are properly recorded in SystemOne.
- The Head of Healthcare should ensure that all newly arrived prisoners receive an initial health assessment and that appropriate care plans are created for those with complex physical health needs.
- The Governor should ensure that night staff complete roll checks in line with local procedures.
- The Governor should conduct a disciplinary investigation into Officer A's actions on the morning of 19 November 2020.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Full Sutton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Lloyd's prison and medical records.
13. The investigator interviewed three members of staff at Full Sutton in January 2021.
14. NHS England commissioned a clinical reviewer to review Mr Lloyd's clinical care at the prison. The clinical reviewer and investigator jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the restrictions during the COVID-19 pandemic.
15. We informed HM Coroner for Hull and the East Riding of Yorkshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.
16. The Ombudsman's family liaison officer contacted Mr Lloyd's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions about the circumstances of Mr Lloyd's death.
17. We shared aspects of this report with Full Sutton, in line with our advanced disclosure process.
18. We shared the initial report with Mr Lloyd's partner and sister. They did not make any comments.
19. We also shared the initial report with HM Prison and Probation Service. They did not find any factual inaccuracies.

# Background Information

## HMP Full Sutton

20. HMP Full Sutton is a high security prison that holds up to 626 adult men. Spectrum Community Health CIC provides health services, and healthcare staff are on duty 24 hours a day.

## HM Inspectorate of Prisons

21. The most recent inspection of HMP Full Sutton was in February to March 2020. Inspectors reported that the management and monitoring of long-term health conditions was effective, and most patients were satisfied with the health services they received. Inspectors also found that mental health services had improved and met most prisoners needs.

## 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 December 2019, the IMB reported that the healthcare provider faced challenges in recruiting and retaining staff, with nearly half of all mental health and general nursing posts vacant at the end of the reporting year.

## Previous deaths at HMP Full Sutton

23. Mr Lloyd was the eighth prisoner to die at Full Sutton since November 2018, and the sixth prisoner to die of natural causes in this time. There are no significant similarities between any of these deaths and Mr Lloyd's and there have been no other COVID- related deaths at Full Sutton.

## Coronavirus (COVID-19)

24. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
25. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)
26. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically

suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

### **Reverse Cohort Units**

27. During the COVID-19 pandemic, HMPPS took steps to help prisons to manage the threat of large numbers of prisoners and staff becoming infected and to reduce the likelihood of the infection spreading throughout the prison system. All prisons were required to establish designated areas for specific groups of prisoners. One of these areas, known as a Reverse Cohort Unit, provided for the temporary separation of newly arrived prisoners for up to 14 days to allow the prison to be sure that the individual did not have symptoms of COVID-19.
28. During their 14-day 'reverse cohorting' period, prisoners must receive a minimum of 30 minutes time in the open air every day, have access to a telephone, and access to a shower at least once a week. At the end of the reverse cohorting period, prisoners who are not symptomatic are allowed to mix with the general population.

## Key Events

29. In December 2006, Mr Andrew Lloyd received a life sentence for murder, with a tariff of 24 years.
30. In August 2017, Mr Lloyd was admitted to St Andrew's Secure Hospital under the Mental Health Act.
31. In October and November 2019, Mr Lloyd experienced several asthma exacerbations for which he was admitted to hospital.
32. In March 2020, Mr Lloyd experienced two asthma exacerbations which required treatment with a nebuliser (a device used to administer medication into the lungs). St Andrew's staff also recorded that Mr Lloyd had a very high Body Mass Index (BMI, a measure to determine if an individual's weight is healthy).
33. On 30 April, Mr Lloyd was admitted to hospital after his oxygen saturation level fell to 65 per cent. (A normal oxygen saturation level is at least 95 per cent.) He was treated in a high dependency unit before returning to St Andrew's.
34. In June, staff at St Andrew's recorded that Mr Lloyd's oxygen saturation levels were low at night, but otherwise there were no indications of ill health. They monitored his physical observations (such as blood pressure and temperature) four times per day.
35. On 27 August, staff at Full Sutton held a conference call with St Andrew's ahead of Mr Lloyd's proposed return to prison. Mr Lloyd was required to return to prison following a "significant breach in procedural and relationship security" after he began a relationship with a member of staff at St Andrew's. A nurse recorded that they discussed Mr Lloyd's mental health care and prescription medication and identified that he also had physical health complexities. She asked St Andrew's to send them relevant reports and details of Mr Lloyd's care plans.
36. On 17 September, Mr Lloyd had an ECG scan to assess his heart function. The scan showed that he had an abnormal heart rhythm, but that he did not need another ECG.
37. On 23 October, staff at St Andrew's completed a Care Programme Approach report, summarising Mr Lloyd's clinical care. They shared it with Full Sutton. The report noted that he remained obese but that his respiratory function had improved since he had stopped using electronic cigarettes in June.
38. On 12 November, Mr Lloyd tested negative for COVID-19, the day before his return to prison. Staff at Andrew's completed a discharge summary, highlighting Mr Lloyd's asthma, his recent hospital admissions, and his very high BMI.

### HMP Full Sutton

39. On 13 November, Mr Lloyd was transferred to Full Sutton. At the time, Full Sutton did not test newly arrived prisoners for COVID-19. (These tests were introduced on 25 November, on a voluntary basis, for all newly arrived prisoners.) In line with national guidance, Mr Lloyd began a 14-day period of 'reverse

cohorting', which meant that he would spend this period in isolation to reduce the risk of transmission of COVID-19. He was allocated a single cell.

40. A mental health nurse met Mr Lloyd in Reception and received a handover from a hospital nurse who had travelled with him. She recorded that the hospital nurse told her that Mr Lloyd should use inhalers but would sometimes need a nebuliser or oxygen. A formal reception health screen was not completed.
41. The Head of Healthcare told us that she asked for baseline clinical observations to be taken when Mr Lloyd arrived, but that this did not happen due to a communication issue.
42. The Head of Healthcare said that during a prisoner's reverse cohorting, healthcare staff visit them daily to complete a COVID-19 welfare check. She said that this involved speaking to the prisoner, but they did not take clinical observations unless the prisoner presented with symptoms. No such conversations with Mr Lloyd were recorded in his medical or prison records.
43. On 17 November, an officer recorded that he had spoken to Mr Lloyd as part of a weekly welfare check. He recorded that Mr Lloyd was happy after having received a new aerial for his television.

#### **19 November 2020**

44. Officer A was the night patrol officer on C Wing on 18 to 19 November. The night patrol officer is required to complete a roll check of prisoners at around 6.00am. CCTV footage shows that he did not complete this count. He signed to confirm that the roll was correct.
45. At around 6.40am, another officer relieved Officer A. At 6.43am, he completed a roll check. In his incident statement, the officer recorded that Mr Lloyd appeared asleep in bed.
46. At 8.35am, Officer B briefly looked in Mr Lloyd's cell. He recorded that he intended to ask Mr Lloyd if he wanted a shower or to use the telephone, but as Mr Lloyd appeared asleep in bed, he left with the intention of returning later that morning.
47. At 9.13am, a pharmacy technician and Officer C visited Mr Lloyd's cell to give him his morning medication. The officer unlocked the door and the pharmacy technician stood in the doorway and spoke to Mr Lloyd. He recorded that Mr Lloyd did not respond and did not appear to be breathing. He asked the officer to request emergency medical assistance.
48. Officer C then called to Officer B to radio a medical emergency code blue. (Officer C was not assigned a radio that morning.) The control room operator telephoned for an ambulance.
49. The pharmacy technician went into the cell and recorded that Mr Lloyd was cold to the touch and that there was "mottling" on his body. Two nurses attended and recorded that Mr Lloyd was stiff (indicating rigor mortis) and that there were no signs of life. A prison GP confirmed that rigor mortis was established and that Mr Lloyd had died.

### **Contact with Mr Lloyd's family**

50. At around 10.50am, a prison family liaison officer telephoned Mr Lloyd's partner and told her of his death. (Family liaison officers usually break the news of a death in person but were instructed to do so by telephone during the COVID-19 pandemic.)
51. Full Sutton contributed to the costs of Mr Lloyd's funeral in line with Prison Service instructions.

### **Support for prisoners and staff**

52. After Mr Lloyd's death, a senior 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.
53. The prison posted notices informing other prisoners of Mr Lloyd's death and offering support.

### **Post-mortem report**

54. A post-mortem examination identified the cause of death as COVID-19 interstitial pneumonia, with congestive cardiac failure, hypertensive heart disease and morbid obesity listed as secondary factors.

# Findings

## Physical healthcare

### *COVID-19*

55. Due to his physical health conditions, Mr Lloyd was defined as clinically extremely vulnerable and was considered at very high risk from COVID-19. He tested negative for COVID-19 on his last day at St Andrew's and was not tested on arrival at Full Sutton. (Around two weeks later, voluntary COVID-19 tests were introduced for all new receptions to the prison.)
56. Following his arrival at Full Sutton, Mr Lloyd began reverse cohorting for two weeks. The Head of Healthcare told us that healthcare staff complete a daily welfare check on all prisoners who are reverse cohorting. This involves speaking to the prisoner. Clinical observations are only taken if the prisoner presents with symptoms of COVID-19. No welfare checks were recorded in Mr Lloyd's clinical record. The clinical reviewer noted that good practice would involve making a daily entry detailing any checks that had taken place, including a record of the prisoner's temperature.
57. There is no record that Mr Lloyd presented with any symptoms of COVID-19 at Full Sutton and we do not know when, where or how he contracted it. Shortly before Mr Lloyd arrived at the prison, one prisoner had tested positive for COVID-19. This prisoner lived in the healthcare centre. No other cases were recorded during Mr Lloyd's time at Full Sutton.

### *General physical healthcare*

58. National Institute for Health and Care Excellence (NICE) guidelines for the physical health of people in prison (NG57) state that a healthcare professional should carry out a health assessment for every prisoner at first reception into prison. The aim is to identify any immediate physical health needs. The guidelines also state that the reception screen should ensure continuity of care for people transferring from one custodial setting to another.
59. On his arrival at Full Sutton, Mr Lloyd was met by a prison mental health nurse, who received a handover from a hospital nurse who travelled with him. This was good practice, although the clinical reviewer noted that the handover should have been better recorded. However, no reception health assessment was completed, and baseline clinical observations requested by the Head of Healthcare were not recorded.
60. There is no evidence that Mr Lloyd's clinical observations were taken at any stage during his time at Full Sutton, whereas they had been measured four times a day at St Andrew's. The clinical reviewer also noted that there was no evidence of a care plan for Mr Lloyd's physical health needs. This would have been particularly important during the COVID-19 pandemic as he was clinically extremely vulnerable.

61. The clinical reviewer concluded that the care Mr Lloyd received at Full Sutton was not equivalent to that which he could have expected to receive in the community.

62. We make the following recommendations:

**The Head of Healthcare should ensure that appropriate daily clinical observations are completed for all newly arrived prisoners who are reverse cohorting and that these are properly recorded in SystemOne.**

**The Head of Healthcare should ensure that all newly arrived prisoners receive an initial health assessment and that appropriate care plans are created for those with complex physical health needs.**

### Roll checks

63. Night staff at Full Sutton are required to complete a roll check of prisoners at around 6.00am. Staff are expected to take appropriate action if they identify a medical emergency, but they are not expected to attempt to wake prisoners to check their wellbeing if they appear safe and well.

64. Officer A did not complete the required roll check on the morning of 19 November.

65. Another officer completed a roll check at around 6.43am. He recorded that Mr Lloyd appeared to be asleep in bed. When he was discovered around two and a half hours later (seemingly lying in the same position that the officer had observed), rigor mortis was present. Rigor mortis can occur from within two to six hours of death, and it is therefore possible that Mr Lloyd was already dead when the officer completed his check. From his description of Mr Lloyd's position, we are satisfied that it was reasonable that the officer believed him to be asleep and not to have taken any further action.

66. We make the following recommendations:

**The Governor should ensure that night staff complete roll checks in line with local procedures.**

**The Governor should conduct a disciplinary investigation into Officer A's actions on the morning of 19 November 2020.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations