Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Anthony Allen a prisoner at HMP Guys Marsh on 8 August 2015

**A report by the Prisons and Probation Ombudsman**
**Nigel Newcomen CBE**

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

## 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*

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 Anthony Allen died from heart disease on 8 August 2015, while a prisoner at HMP Guys Marsh. He was 81 years old. I offer my condolences to Mr Allen's friends.

Mr Allen had many chronic health conditions, including heart failure. For the most part, prison healthcare staff managed his heart disease well, with advice from hospital specialists, although they found it difficult to meet his social care needs. Overall, I am satisfied that Mr Allen received a generally good standard of care at the prison. However, there is a need to improve arrangements for anticoagulant monitoring and the provision of social care at the prison. I am also concerned that, when staff suspected Mr Allen had had a stroke, they did not follow the expected emergency procedures.

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** **May 2016**

## Contents

# Summary

## Events

1. Mr Anthony Allen had been at HMP Guys Marsh since 16 February 2011, serving a life sentence for murder.

2. Mr Allen had several complex health conditions, including heart disease, which healthcare staff managed in consultation with hospital specialists. His health gradually declined and his mobility decreased. The prison found it difficult to meet his considerable social care needs, but he did not want to move to another prison. Another prisoner voluntarily helped him with his personal care.

3. Mr Allen had periodic blood tests to monitor the effectiveness of warfarin, an anticoagulant, used to reduce the risk of blood clots. On 2 August 2015, he fell in his cell, bruised his head and had a small cut. Due to an oversight, Mr Allen had missed a blood test in July, and an emergency test on 6 August indicated that he was at increased risk of bleeding. The next day, a prison GP sent Mr Allen to hospital for an injection to counteract the effects of warfarin.

4. At about 8.45am on 8 August, the officer who unlocked Mr Allen's cell found him seriously unwell. The officer called for healthcare assistance, but did not use an emergency code. The prison called an ambulance and Mr Allen was taken to hospital. He died in hospital at 10.40pm that evening.

## Findings

5. Healthcare staff managed Mr Allen's heart disease under the guidance of a cardiology specialist. Treatment plans were appropriate and he was involved in planning his medical and social care. A friend supported him informally with his daily personal care, but we consider there is a need for improvements in social care arrangements at the prison.

6. Mr Allen should not have missed a blood test in July 2015, which made him vulnerable to bleeding. Although he had treatment to counteract this, there was a delay in this happening. Mr Allen had some bleeding in his brain, possibly caused by his fall on 2 August. While in itself, this would not have been sufficient to cause his death, there is a need to improve warfarin monitoring arrangements at the prison. Apart from the anticoagulant monitoring, we are satisfied that, overall, Mr Allen's standard of healthcare at the prison was equivalent to that he could have expected to receive in the community.

7. The officer who found Mr Allen unwell on 8 August did not use the appropriate emergency code. This meant that nurses did not take emergency equipment with them and the control room did not know to request an ambulance immediately. Although this was unlikely to have changed the outcome for Mr Allen, it is important that staff use the appropriate emergency codes to ensure a timely and appropriate response.

## Recommendations

- The Head of Healthcare should ensure that there are appropriate and effective arrangements for INR testing, which takes place at the required frequency.
- The Governor and the Head of Healthcare should liaise with the local authority to ensure that there is sufficient social care provision to meet prisoners' identified. Where prisoner carers are used, they should be appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care.
- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance and that responding staff bring appropriate emergency equipment.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Guys Marsh informing them of the investigation and asking anyone with relevant information to contact her. A prisoner and an older prisoners' group leader spoke to the investigator by telephone.

9. The investigator visited Guys Marsh on 12 August and obtained copies of relevant extracts from Mr Allen's prison and medical records.

10. The investigator and a colleague interviewed seven members of staff at Guys Marsh on 30 September. The investigator interviewed two members of staff by telephone on 24 August and 1 October.

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

12. We informed HM Coroner for Dorset of the investigation. The investigation was suspended until 8 December, until we received the results of the post-mortem examination. We regret the consequent delay. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers wrote to Mr Allen's next of kin, a friend, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Allen's friend wanted to know what action had been taken when a prisoner in a neighbouring cell had pressed his cell bell the night before Mr Allen was found unwell. She said that she was pleased with the standard of care Mr Allen had received in prison and very happy with contact from the prison after his death.

14. Mr Allen's next of kin received a copy of the initial report. They pointed out a factual inaccuracy, which has been amended accordingly. Mr Allen's next of kin also raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

15. The initial report was shared with the Prison Service. They highlighted a factual inaccuracy, which has been amended accordingly.

# Background Information

### HMP Guys Marsh

16. Guys Marsh is a medium security prison that holds up to 579 men. Single cells comprise about two thirds of the accommodation. Dorset University Healthcare Foundation Trust provides primary and secondary mental healthcare and commission another agency, EDP, to provide Integrated Substance Misuse Services. Healthcare staff are on duty on weekdays and at weekends from 8.30am to 6.00pm. There is a GP on duty, most Saturday mornings.

### HM Inspectorate of Prisons

17. The most recent inspection of HMP Guys Marsh was in November 2014. Inspectors were very critical of many aspects of the prison but found that healthcare services were reasonably good. Partnership working and clinical governance were effective. There was no effective mechanism to identify prisoners potentially at risk because of their physical or mental health, disability or age. There was no formal prisoner carer system to help meet the needs of older or disabled prisoners, and inspectors found examples of informal arrangements where prisoners had assisted others without appropriate safeguards.

### Independent Monitoring Board

18. 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 November 2014, the IMB reported continuing difficulties in recruiting healthcare staff. The IMB considered that prison and healthcare staff did their best to address the care needs of an increasing elderly population but noted that the residential units were not suitable for men with limited movement.

### Previous deaths at HMP Guys Marsh

19. Mr Allen was the second prisoner to die from natural causes at Guys Marsh since January 2012. There were no similarities with the circumstances of the previous death.

# Key Events

20. Mr Anthony Allen received a life sentence for murder on 16 December 2002. He had been at Guys Marsh since February 2011.

21. Mr Allen had complex health needs, including type two diabetes (which was appropriately managed), angina, kidney failure, a chronic lung condition, high blood pressure, heart failure, mitral regurgitation (a heart valve problem) and atrial fibrillation (irregular heartbeat). Mr Allen received treatment for ischaemic and hypertensive heart disease. He took many medications, including drugs to treat high cholesterol and heart failure, insulin, aspirin, and warfarin (a drug used to thin the blood to reduce the risk of blood clots and stroke). A cardiology consultant at hospital managed Mr Allen's condition and advised the prison healthcare centre about changes to his medication. Healthcare staff held multi-disciplinary team (MDT) meetings, which he attended. Mr Allen had limited mobility and relied on a wheeled walker and a wheelchair.

22. In September 2011, a prison GP discussed end of life planning with Mr Allen and advised him that his life expectancy was around two years. Hospital consultants did not consider him fit enough for heart surgery, but fitted a pacemaker in 2012.

23. Mr Allen became slower and his need for help with daily tasks, such as washing, dressing and cleaning his cell, increased. A friend on his wing acted informally as his carer, but was not trained or paid for his work. In July 2013, the prison supplied disability aids, such as a toilet frame, shower stool and a bed rail. Mr Allen's cell was not big enough to take a hospital bed and he refused to move cells, so he could have one. He had a personal call bell to get help from staff if he could not reach his cell bell.

24. Mr Allen's condition gradually deteriorated and healthcare and wing staff often spoke to him about moving to a prison better equipped to deal with his increasing health and care needs, such as one with 24-hour healthcare and a social care wing. Mr Allen refused to move, other than to an open prison, but the Parole Board had never recommended a move.

25. Healthcare staff regularly sent a blood sample to the hospital for an INR test (international normalised ratio to check how well the warfarin is working). The therapeutic INR range for Mr Allen was between two and three. If the result was too low, his blood was too thick and could cause a blood clot, and if it was too high, his blood was too thin and could cause a serious bleed or stroke. Mr Allen's INR tests throughout 2014 and in early 2015 were within the therapeutic range.

26. On 7 January 2015, a hospital cardiologist noted that Mr Allen's heart condition was stable, but advised changes to his medication, as his blood pressure was low. The doctor planned to review Mr Allen in four months, but there is no record that he received another appointment.

27. On 8 May, Mr Allen's INR was 2.3, within the therapeutic range. The anticoagulation clinic advised that his next INR test should be on 17 July.

28. On 28 May, the acting Head of Healthcare referred Mr Allen to Dorset adult social care and support services to assess his social care needs, as he needed significant help with personal care and reminders to take his medications. On 23 June, a social worker and an occupational therapist assessed Mr Allen. They considered a care package of a daily, 30-minute visit by a carer would meet his basic care needs, with wing staff, nurses, or his friend helping him at other times. A carer was arranged.

29. On 17 July, a prison GP reviewed Mr Allen, who felt nauseous. The GP thought he might be dehydrated. Mr Allen had a blood test to check his kidney function, but there is no evidence that a sample was taken for INR testing.

30. On 28 July, Mr Allen said he was unhappy with his agency carer and did not want her to help him. The agency tried to find a replacement, but had not found one by the time Mr Allen died.

31. On 2 August, Mr Allen said he had hit his head and hurt his back after falling out of bed during the night. He had left his personal call bell on the windowsill, so he had not been able to alert staff. A nurse assessed him and noted he looked pale and had two marks on his scalp, a bruise and a small superficial cut on his head.

32. On 5 August, the anticoagulation clinic wrote to say that Mr Allen's INR test was overdue and that they had sent a reminder two weeks before. It seems that healthcare staff had overlooked scheduling this. A nurse took a finger prick test (used to test INR in emergencies) which gave an immediate INR reading of eight. She tried to contact the anticoagulation clinic for advice, but was unable to get through.

33. The next day, staff sent a blood sample to the anticoagulation clinic. At 5.38pm, a healthcare assistant noted that someone from the clinic had telephoned to say that Mr Allen's INR was higher than 10. The clinic instructed that Mr Allen should not take warfarin for the next three days, then take a low dose on the fourth day and have his INR re-checked.

34. At about 6.35pm, a worker from the anticoagulation clinic telephoned the duty prison manager to say that she was concerned, as Mr Allen's highest normal level was four. She advised the manager to consult healthcare staff about the correct treatment. There were no healthcare staff on duty at that time and the manager was unable to contact the acting Head of Healthcare at home.

35. The duty prison manager rang the NHS advice line. At 7.30pm, a member of the NHS advice team gave her questions to ask Mr Allen about his INR tests and medication and said they would telephone her later. She got all the necessary information, but no one called back before she finished her shift at 9.00pm. She then handed the information to the night manager. The NHS advice team did not ring back that night and neither the duty prison manager nor the night manager tried to ring them back.

36. The next morning, Friday 7 August, Mr Allen took his usual dose of warfarin. A nurse noted in Mr Allen's record that the message that he should not take it had arrived too late. A prison GP told the clinical reviewer that he was fairly certain that Mr Allen had been told not to take it. Afterwards, Mr Allen told healthcare

staff that he had vomited, felt nauseous, lightheaded and shaky. The GP sent Mr Allen to hospital for a Vitamin K injection, to counteract the affects of the warfarin.

37. Mr Allen got back to his wing at about 10.00pm that evening with an officer, who had escorted him to the hospital. The officer had thought that Mr Allen might be admitted to hospital but a doctor had said that was not necessary. The officer left the discharge letter from the hospital with the night manager, who was the night manager again on 7/8 August. The officer asked the night patrol officer to keep an eye on Mr Allen. He said that Mr Allen said that he was fine and did not want anything to eat or drink, when he got back.

38. The night patrol officer checked Mr Allen every hour and a half, when he patrolled the wing. For the first few hours, he was lying in his bed. He said Mr Allen gave him no cause for concern. Mr Allen raised his hand to indicate he was fine when the officer looked into his cell and he did not press either his cell bell or personal call bell during the night. The night manager said she had checked Mr Allen at about 2.00am on 8 August, and said he was asleep in his wheelchair next to his bed.

39. A prisoner who lived in the cell opposite Mr Allen's told the investigator that Mr Allen had collapsed in his cell, around the time that the night manager checked him and he had been unable to reach his cell bell. He said that Mr Allen had banged on the wall and another prisoner had pressed his cell bell to call staff. He said the night patrol officer and night manager attended, but did not help Mr Allen. Guys Marsh does not have computerised records of cell bells and there is no CCTV on the wing to check. The night patrol officer said he did not hear any banging and Mr Allen was not on the floor during any of the checks.

40. The night patrol officer last checked Mr Allen at 6.00am. He said Mr Allen was in his wheelchair and raised his hand when he asked him if he was all right.

41. At about 7.30am on Saturday 8 August, Officer A checked that all prisoners were present on the wing. When he looked through the observation panel in Mr Allen's cell door he was sitting in his wheelchair with his back towards the door. He did not appear to have any clothes on the top half of his body. He asked him if he was okay and Mr Allen raised his arm in acknowledgement.

42. At 8.30am, Officer A started to unlock the cells for the day and said he reached Mr Allen's cell at about 8.40am. When he opened the door, Mr Allen was in his wheelchair and there was excrement on the floor. A prisoner then arrived and said he would clean Mr Allen and his cell. The officer came back later with cloths and disinfectant. When he got back, Mr Allen was leaning against the wall and the prisoner was trying to support him. Mr Allen was naked, his arm was limp and his jaw had drooped. He was able to talk but the officer thought that he might have had a stroke.

43. At 9.03am, Officer A radioed for immediate healthcare assistance. A custodial manager heard the message, checked it was for Mr Allen and asked whether they needed an ambulance. The officer confirmed this and the manager radioed staff in the communications room, who called an ambulance at 9.05am.

44. At 9.07pm, a healthcare assistant said she was in the healthcare centre when they received a telephone call asking someone to go to Mr Allen's cell, as he had been incontinent and had vomited. She did not take any emergency equipment, as it appeared to be a routine call to help clean him up. When she got there, she thought it appeared that he had had a stroke as his speech was slurred. She tested his blood sugar level as he had a machine in the cell and asked an officer to call a nurse, who joined her. The nurse did not take any emergency equipment, but someone had brought the emergency grab bag. The nurse also thought Mr Allen had had a stroke. She said they checked his blood pressure and his blood sugar level again. He did not need oxygen. They monitored Mr Allen until the ambulance arrived, shortly after, at 9.32am.

45. Paramedics assessed Mr Allen and left the prison to take him to hospital at 10.05am. One officer accompanied him and no restraints were used.

46. Mr Allen arrived at hospital at 10.30am. He had a scan and a hospital consultant diagnosed a bleed on the brain. At 4.15pm, he was admitted to the intensive care unit. Mr Allen died at 10.40pm that evening.

### Contact with Mr Allen's family

47. The duty manager on 8 August telephoned Mr Allen's next of kin, a friend, to inform her that Mr Allen was seriously ill in hospital. At 4.30pm, she rang again to let her know he had been admitted to the intensive care unit.

48. As Mr Allen's friend lived about four and a half hours away from the prison, the duty manager asked a manager at HMP Norwich (which was closer to his friend's home) if someone could visit her to break the news of his death. Norwich had no family liaison officers available, so she asked the local police. The police tried twice to contact Mr Allen's friend and eventually informed her of Mr Allen's death, at about 9.30am on Sunday 9 August.

49. The duty manager rang Mr Allen's friend, but was unable to contact her until about 5.30pm. She offered her condolences and explained that the prison's family liaison officer would be in touch the next day. The family liaison officer offered ongoing support to Mr Allen's friend. In line with Prison Service policy, the prison contributed to the cost of the funeral, which was held on 26 August.

### Support for prisoners and staff

50. The Governor of Guys Marsh debriefed the officer who had been with Mr Allen when he died. The care team offered support to all staff.

51. The prison posted notices informing the other prisoners of Mr Allen's death, and offering support. A prison manager informed Mr Allen's friend on the evening he died. Staff reviewed all prisoners thought to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Allen's death.

### Post-mortem report

52. The post-mortem report indicated that Mr Allen died of ischaemic and hypertensive heart disease. Other contributory factors were subdural and

subarachnoid haemorrhage (bleeding in the brain), warfarin therapy (maintaining a therapeutic level of warfarin) and type 1 diabetes.

# Findings

## Clinical Care

53. Mr Allen suffered from numerous chronic health problems, which had a significant impact on his mobility and ability to care for himself. Despite being told he only had two years to live in 2011, Mr Allen survived a lot longer than expected and his heart disease remained relatively stable until 2015. We found that Mr Allen received a generally good standard of healthcare at Guys Marsh. Treatment plans for his heart disease were appropriate and healthcare staff took account of his preferences about his treatment. The clinical reviewer said that the combination of Mr Allen's medical conditions was likely to result in sudden death from vascular disease and that his death was therefore predictable, but not preventable. He noted that Mr Allen received all the treatment that was available for ischaemic and hypertensive heart disease and appropriate management of diabetes. Apart from anticoagulant monitoring, he considered that the clinical care Mr Allen received at Guys Marsh was equivalent to that he could have expected in the community.

### *INR testing*

54. Healthcare staff tested Mr Allen's INR level regularly to ensure he was on the appropriate dose of warfarin. In July 2015, he missed an INR test, which resulted in a gap of 13 weeks between tests. The next test on 5 August showed he had a high INR level, which meant he was at increased risk of bleeding, either spontaneously or because of a trauma and should therefore stop his warfarin for a period. There was some confusion as to whether Mr Allen was told on 6 August not to take his next dose of warfarin, but he did so on 7 August, further increasing his risk of complications. The post-mortem report indicated that Mr Allen had suffered some bleeding in his brain. We do not know if Mr Allen's fall on 2 August had caused the bleed, but it was possibly linked to this and his high INR. The clinical reviewer noted that it is important to note that these bleeds would not have been sufficient to cause death on their own.

55. The test in July should not have been missed. The clinical reviewer considered that if finger prick testing was the norm at Guys Marsh (it is currently only used in emergencies), Mr Allen's high INR reading could have been spotted sooner and treated straight away. He added that this method of INR testing is well established in British General Practice and is nationally commissioned by the Department of Health. We make the following recommendation:

    **The Head of Healthcare should ensure that there are appropriate and effective arrangements for INR testing, which takes place at the required frequency.**

## Social Care

56. By 2013, Mr Allen had significant social care needs, which increased over the next two years. By 2015, he was frequently doubly incontinent. There was no formal carer system in place at Guys Marsh, but Mr Allen's friend voluntarily helped with his personal care. He had not been given any formal training and was not paid by the prison. In June 2015, Dorset Social Services assessed that

Mr Allen needed a carer for half an hour a day to meet his needs. An agency provided a trained carer, but Mr Allen did not get on with her and it proved difficult to find a replacement. Mr Allen was anxious about what would happen when his friend was released from prison, (his release was imminent) and there were no plans for this.

57. Prison and healthcare staff often encouraged Mr Allen to move to a bigger cell or transfer to another prison that was better suited to meet his increasing needs, but he refused to do so. In view of the difficulties in providing a carer and suitable accommodation, Mr Allen did not receive sufficient support and social care.

58. In response to a recommendation by HM Inspectorate of Prisons after their most recent inspection, Guys Marsh plans to introduce a formal buddy system to provide carers. The Prison Service has also recently issued national guidance on prisoners providing care and support. We consider that Mr Allen's social care was not optimal and the prison needs to ensure that there is sufficient social care provision to meet prisoners' needs. We make the following recommendation:

**The Governor and the Head of Healthcare should liaise with the local authority to ensure that there is sufficient social care provision to meet prisoners' identified. Where prisoner carers are used, they should be appropriately selected as part of a formal carers' scheme and trained, supervised and equipped for personal social care**

### Emergency response

59. When Officer A suspected that Mr Allen had had a stroke, he radioed for healthcare assistance, but did not convey the seriousness of the emergency. The healthcare assistant who responded initially thought she was attending a routine call. When she arrived and asked for further help, no one radioed a code blue and the nurse who responded did not bring any emergency equipment.

60. PSI 3/2013 requires prisons to have a medical emergency response code protocol and that the control room should call an ambulance immediately when a code is used. Guys Marsh's local emergency response codes protocol states that a code blue should be used if a prisoner is unconscious or not breathing, has chest pain, difficulty breathing, or there are signs of a stroke. If Officer A had radioed a code blue, healthcare staff would have been better prepared and an ambulance would have been called sooner. Fortunately, there was only a slight delay in calling an ambulance as a custodial manager checked immediately whether one was required and someone brought medical emergency equipment to Mr Allen's cell quickly after healthcare staff arrived. We are therefore satisfied that there was no significant delay in Mr Allen receiving appropriate attention. However, in other medical emergencies failure to follow the correct procedures could be critical. We make the following recommendation:

**The Governor should ensure that all prison staff understand their responsibilities during medical emergencies. Staff should use an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance and that responding staff bring appropriate emergency equipment.**

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