

**Prisons &
Probation**

Ombudsman
Independent Investigations

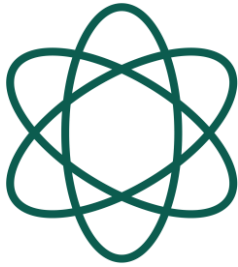
Independent investigation into the death of Mr Michael Gardner, a prisoner at HMP Peterborough, on 17 September 2022

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

OGI

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Summary

11. 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.
12. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
13. Mr Michael Gardner, who was 78 years old, died of pneumonia on 17 September 2022, while a prisoner at HMP Peterborough. We offer our condolences to Mr Gardner's family and friends.
14. The clinical reviewer concluded that the care Mr Gardner received at Peterborough was of a good standard and equivalent to that which he could have expected to receive in the community. She was, however, concerned that healthcare staff failed to maintain detailed medical records, which was not of a standard in line with the Nursing and Midwifery Council code 2015 (updated 2018). We repeat her recommendation below.
15. We did not find any non-clinical issues of concern.

Recommendation

- **The Head of Healthcare should ensure that healthcare staff keep clear and accurate records to support the management of prisoners ongoing care, in accordance with the NMC Code 2015 guidance (updated 2018) on contemporaneous record keeping.**

The Investigation Process

Investigation Process

16. NHS England commissioned an independent clinical reviewer to review Mr Gardner's clinical care at Peterborough.
17. The PPO investigator has investigated non-clinical issues, including Mr Gardner's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
18. The Ombudsman's family liaison officer wrote to Mr Gardner's next of kin, his wife, to explain the investigation. She asked the following questions.
 - was Mr Gardner's diabetes correctly monitored and treated?
 - why were there issues getting Mr Gardner's property returned to the family?
and
 - why was she not contacted by the prison until Mr Gardner had received the last rites?

We have addressed Mr Gardner's wife's questions in this report and in separate correspondence.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at Peterborough

20. Mr Gardner was the ninth prisoner to die at Peterborough since September 2020. Of the previous deaths, five were from natural causes, two were self-inflicted and one was drug related. There are no similarities between our findings in the investigation into Mr Gardner's death and our investigation findings into previous deaths.

Key Events

21. On 14 July 2022, Mr Michael Gardner was remanded to HMP Wormwood Scrubs charged with multiple historic sexual offences. He was 78 years old.
22. Mr Gardner had several pre-existing medical conditions, including type 2 diabetes, acute back pain and mobility issues caused by arthritis and sleep apnoea (a condition in which the breathing stops and starts while sleeping). He had ischaemic heart disease and had had a pacemaker fitted. A nurse carried out an initial health screen and noted his medical conditions.
23. The following day, a prison GP saw Mr Gardner. He reviewed his prescribed medications and noted that he appeared to suffer from bouts of confusion. The GP referred Mr Gardner to the prison's Mental Health Inreach Team (MHIRT) for further review.
24. On 21 July, a nurse from the MHIRT saw Mr Gardner. She considered that he may benefit from a dementia screening test. However, despite her best efforts, Mr Gardner refused to engage. Another nurse saw Mr Gardner the next day. She took a note of his INR level (International Normalisation Ratio, measures the prothrombin level S protein, a substance used by the body to clot the blood appropriately, a score of above 3.5 requires an urgent review by hospital staff), which was 8. Mr Gardner was taken to hospital by emergency ambulance.
25. Hospital staff reviewed Mr Gardner and administered vitamin K (vitamin K is a group of vitamins the body needs for efficient blood clotting) and intravenous fluids. His condition stabilised and he was discharged back to the prison later that day.
26. On 7 August, the prison GP saw Mr Gardner and noted that his INR score was borderline. He referred Mr Gardner to the hospital's haematology department.

HMP Peterborough

27. On 22 August, Mr Gardner was sentenced to 22 years imprisonment. He was transferred to HMP Peterborough.
28. A nurse carried out an initial health screen. She noted Mr Gardner's medical conditions and secondary care referrals. She also noted that he used a walking frame to move around. Healthcare staff allocated Mr Gardner a ground floor cell, reviewed his prescribed medications and updated his care plans.
29. At 7.37pm on 10 September, a nurse saw Mr Gardner after prison officers reported that he had fallen in his cell and was experiencing spasms. She noted that Mr Gardner was sweating heavily and that he appeared disorientated. She took a note of his blood sugar level, and the result was normal, but she considered that he would benefit from a hospital review. She telephoned for an emergency ambulance, but there were significant ambulance delays due to a rise in demand. The nurse reviewed Mr Gardner every hour while she waited for the emergency ambulance to arrive.

30. At 9.37pm, the nurse noted that Mr Gardner's condition had not improved. She decided to cancel the request for an emergency ambulance and telephoned for a taxi to take Mr Gardner to hospital.
31. In hospital, Mr Gardner was diagnosed with acute kidney failure and hypoglycaemia (an abnormally low level of glucose in the blood). Hospital staff administered intravenous fluids and he was admitted to hospital as an inpatient.
32. The following day, the prison appointed an officer to act as Family Liaison Officer (FLO). She contacted Mr Gardner's wife to inform her of Mr Gardner's admission to hospital and the seriousness of his condition. She arranged for a taxi to take Mr Gardner's family to the hospital. She also attended the hospital to offer them support.
33. On 12 September, Mr Gardner's family met with hospital staff and discussed his condition. They told the family that he had stopped responding to treatment and that there was no active treatment option left open to him. With the family in agreement, hospital staff signed a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) order on Mr Gardner's behalf, meaning that in the event his heart or breathing stopped, he would not be resuscitated.
34. Mr Gardner's condition continued to deteriorate in hospital. At 12.00am on 17 September, the prison staff accompanying Mr Gardner noticed that he had stopped breathing. At 1.09am, a hospital doctor confirmed his death.

Post-mortem report

35. The post-mortem report gave Mr Gardner's cause of death as pneumonia. He also had dilated cardiomyopathy (disease of the heart muscle which makes the muscle walls become stretched and thin), hypertension, diabetes mellitus and obesity, which did not cause but contributed to his death.

Inquest into Mr Gardner's death

36. The inquest into Mr Gardner's death was held on 12 June 2023, and a verdict of natural causes was recorded.
37. The coroner concluded Mr Gardner's death was due to pneumonia, dilated cardiomyopathy, hypertension, diabetes mellitus and obesity.

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June 2023

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