

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Anthony Gardner, a prisoner at HMP Stafford, on 31 March 2023**

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

## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO



## WHAT WE VALUE



© Crown copyright, 2024

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.

## 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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Anthony Gardner died of a lower respiratory tract infection on 31 March 2023 at HMP Stafford. He was 85 years old. We offer our condolences to Mr Gardner's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Gardner received at Stafford was of a very good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Gardner was cared for with compassion by confident, competent staff. She made no recommendations.
5. We found no non-clinical issues of concern. We make no recommendations.

## **The Investigation Process**

6. HMPPS notified us of Mr Gardner's death on 31 March 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Gardner's clinical care at Stafford.
8. The PPO investigator investigated the non-clinical issues relating to Mr Gardner's care.
9. The PPO family liaison officer wrote to Mr Gardner's next of kin, his niece, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
10. The initial report was shared with HMPPS. There were no factual inaccuracies.

## **Previous deaths at HMP Stafford**

11. Mr Gardner was the twenty-sixth prisoner to die at Stafford since March 2020. Of the previous deaths, 23 were from natural causes and two were self-inflicted.

## Key Events

12. On 14 January 2021, Mr Anthony Gardner, aged 82, was sentenced to 20 years imprisonment for sexual offences. He was sent to HMP Hewell.
13. In October, Mr Gardner was admitted to hospital for problems with his mobility and confusion. When he was discharged on 15 November, he was sent to HMP Stafford and located in the Specialist Care Unit (SCU) due to his increased health needs.
14. On 2 December, Mr Gardner was assessed by a dementia nurse. The nurse suspected that Mr Gardner had vascular dementia (caused by reduced blood flow to the brain) and ordered an MRI test to confirm this. The MRI results later confirmed a diagnosis of mixed dementia (vascular dementia and Alzheimer's disease).
15. On 18 January 2022, a nurse saw Mr Gardner as he had been found on the floor by night staff the previous evening. Mr Gardner was confused, his speech was slow, and he was unable to sit up straight. The healthcare team sent him to hospital.
16. While in hospital, Mr Gardner received treatment for pneumonia (an infection in the lungs), acute kidney injury (AKI - where the kidneys stop working properly) and heart failure. The doctors did an MRI scan, which showed Mr Gardner had atrophy (shrinking of the brain) and changes to the blood vessels in the brain. He returned to Stafford on 27 January.
17. On 13 August, Mr Gardner said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. This remained in place.
18. On 12 February 2023, a nurse saw Mr Gardner due to a recent increase in falls. The nurse noticed that Mr Gardner had swelling in his ankles and hands. She took his clinical observations, which were outside normal range. The nurse sent Mr Gardner to hospital for further assessment.
19. Mr Gardner was seen by a hospital doctor, who said his symptoms were due to heart failure. The doctor prescribed medication to help manage the symptoms and Mr Gardner returned to Stafford the same day.
20. On 9 March, following a multi-agency meeting, staff referred Mr Gardner to the palliative care team as his cognition was declining. The prison started the Early Release on Compassionate Grounds paperwork for Mr Gardner. However, his health deteriorated before this was completed.
21. On 14 March, Mr Gardner was seen by the palliative care nurse. She confirmed that Mr Gardner was deteriorating and would not recover.

22. Later in the day, a GP at Stafford saw Mr Gardner following concerns from nursing staff. The GP found Mr Gardner's breathing rate was increased and his heartbeat was irregular. He arranged for Mr Gardner to be taken to hospital for further assessment. Mr Gardner was admitted to hospital and was treated for sepsis (a life-threatening reaction to an infection), secondary to cellulitis (an infection in the deeper layers of skin). Mr Gardner was discharged from hospital on 22 March with a likely prognosis of between three to six months.
23. On 23 March, the healthcare team saw Mr Gardner in his cell. They were concerned about his consciousness and breathing. They took his clinical observations, which showed his condition was declining. The healthcare team contacted the hospital to seek advice, but as Mr Gardner was receiving palliative care, it was decided that he should remain in the SCU.
24. On 31 March, Mr Gardner deteriorated further. The healthcare team assessed that he was approaching the end of his life and contacted his next of kin, his niece, and arranged a visit for her. At 11.47am, Mr Gardner died. His niece was with him.

## **Cause of death**

25. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Gardner's cause of death as lower respiratory tract infection caused by dementia. Frailty, osteoarthritis, chronic kidney disease and hypertension were listed as contributory factors.

# Findings

## Good practice

26. Due to the rapid decline in Mr Gardner's health, he was unable to communicate his preferred place of care. The Clinical Services Manager at the SCU spoke to Mr Gardner's niece to understand her wishes about his care. On 31 March, when Mr Gardner began to deteriorate, the healthcare team contacted Mr Gardner's niece and arranged her visit to be brought forward to ensure she could be with him when he died. The prison's family liaison officer, a prison chaplain and a nurse were present with his niece to offer support. The engagement and support provided by Stafford to Mr Gardner's niece is considered good practice.
27. When Mr Gardner was in his final days of life, the healthcare team at Stafford ensured that he was never left on his own. This demonstrates the compassionate care delivered by the team and is considered good practice.
28. The clinical reviewer found further areas of good practice relating to the healthcare Mr Gardner received, including the transfer arrangements to Stafford SCU, and both frailty and pain management. She concluded that staff had provided a high standard of clinical care to Mr Gardner.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**September 2023**

## Inquest

The inquest, held on 18 January 2024, concluded that Mr Gardner died from natural causes. The Coroner amended Mr Gardner's medical cause of death to heart failure, with dementia and ischaemic heart disease as contributory factors.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100