Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Gale, a prisoner at HMP Stafford, on 12 May 2023

A report by the Prisons and Probation Ombudsman

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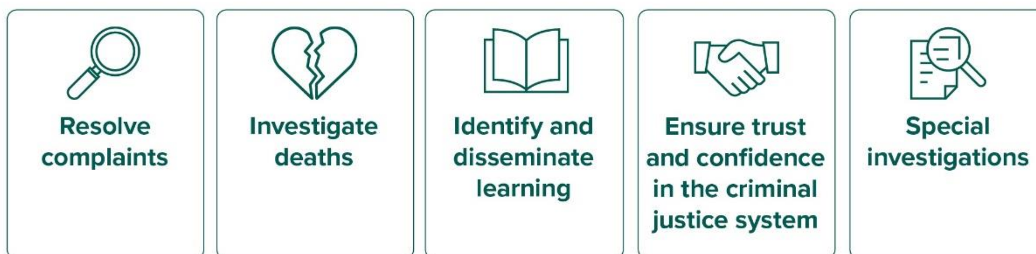
OUR VISION

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

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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. If my office is to best assist HM Prison and Probation Service in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Alan Gale died at HMP Stafford on 12 May 2023, of heart failure caused by ischaemic heart disease. He was 62 years old. He also had Type 2 diabetes which contributed to but did not cause his death. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Gale received at Stafford was of a good standard and equivalent to that which he could have expected to receive in the community. However, she found that there were two aspects of Mr Gale’s end-of-life care, namely his bowel management and the prescribing of anticipatory medication that did not meet the national and local palliative guidance for optimum symptom relief.

5. Mr Gale frequently went to hospital for tests, treatment, and medical emergencies, during which he was restrained with either a single cuff or an escort chain despite having many long-term serious health conditions and poor mobility.

Recommendations

- The Head of Healthcare should ensure that all patients who are at risk of or experiencing opioid induced constipation are discussed and documented within MPCCC meetings, referencing and acting upon the national and local palliative care treatment guidance.

- The Head of Healthcare should implement an improved system of prescribing anticipatory medication with the community palliative care team so that there are no delays, as per national and local guidance.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk he presents at the time.

The Investigation Process

6. On 12 May 2023, the PPO was informed of Mr Gale's death.

7. NHS England commissioned an independent clinical reviewer to review Mr Gale's clinical care at Stafford.

8. The PPO investigator investigated the non-clinical issues relating to Mr Gale's care.

9. The PPO family liaison officer wrote to Mr Gale's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Gale's wife asked questions about his pain relief and end of life care.

10. We shared the initial report with the Prison Service. There were no factual inaccuracies.

11. We shared the initial report with Mr Gale's wife. She did not respond.

Previous deaths at HMP Stafford

12. In the three years before Mr Gale's death, there were 22 deaths from natural causes, three of which were related to COVID-19, and two self-inflicted deaths at Stafford. There has been a death from natural causes and a self-inflicted death at the prison since Mr Gale's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

13. On 25 August 2021, Mr Alan Gale was sentenced to 18 years in prison for sex offences and was sent to HMP Leeds. On 24 November, he was transferred to HMP Stafford.

14. Mr Gale had heart failure, high blood pressure, high cholesterol, angina (chest pain caused by reduced blood flow to the heart), Type 2 diabetes, asthma, anxiety and depression and gastric reflux.

15. Mr Gale used a wheelchair and two walking sticks to mobilise and became breathless on minor exertion. He was independent with his care needs. At his secondary health screen, a nurse referred Mr Gale for a GP review and inclusion in the prison Multi-Professional Complex Case Caseload (MPCCC) review meetings. A nurse created care plans for heart failure, hypertension, diabetes and asthma.

16. On 24 May 2022, Mr Gale was admitted to the Specialist Care Unit (SCU - an eight-bed unit that includes two palliative care beds for short term intervention to rehabilitate prisoners or to avoid hospital admission for prisoners at end-of-life) because his heart disease symptoms worsened, and he was struggling with mobility and personal care because of fluid retention. A nurse created a care plan for fluid retention. Mr Gale received social care four times a day.

17. On 10 June, a GP at Stafford sent Mr Gale to hospital because he had gross fluid retention and unstable angina. Hospital staff said that Mr Gale had end-stage heart failure as his heart was only working at 38% capacity, causing severe limitations to his daily life. They concluded that he had a short life expectancy and would now require planned palliative care. On 28 June, Mr Gale went back to Stafford to the SCU.

18. On 21 July, a palliative care nurse saw Mr Gale and completed an advanced care plan (a structured discussion with patients and their families or carers about their wishes and thoughts for the future).

19. On 28 July, after Mr Gale’s lung function and mobility improved, he returned to a normal cell location and was allocated a cell with adjustments to help those with reduced mobility.

20. From January 2023, Mr Gale frequently went to hospital for tests and treatment. The Head of Operations and Security decided on every occasion that Mr Gale be escorted by two officers and restrained with a single cuff or an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). On 5 January, a member of healthcare staff objected to the use of restraints and noted that Mr Gale had frailty and reduced mobility. Despite this, restraints were used.

21. On every other occasion that Mr Gale went to hospital, there was very little information in the healthcare section of the escort risk assessment, with no medical objections to the use of restraints and little indication of Mr Gale’s current health and mobility.

22. On 31 March 2023, a nurse sent Mr Gale to hospital because he was very short of breath, had a fast heartbeat and a National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) of 7, which indicated a high clinical risk. Mr Gale tested positive for COVID-19. Before Mr Gale went to hospital prison staff completed an escort risk assessment. A nurse completed the medical section, did not object to the use of restraints and noted that Mr Gale was breathless. A senior manager authorised that handcuffs be removed when Mr Gale tested positive for COVID-19, but for them to be reapplied when he tested negative. On 6 April, Mr Gale returned to Stafford.

23. On 25 April, Mr Gale returned to the SCU because he was very weak, short of breath and had little appetite.

24. On 27 April, Mr Gale told a GP at Stafford that he had discomfort with constipation. The GP prescribed a microlax enema to relieve faecal impaction.

25. On 4 May, the palliative care nurse assessed Mr Gale, who said that he did not want to transfer to hospital as his preferred place of death was the SCU. The Head of Operations and Security authorised that Mr Gale's cell door be open and unlocked 24-hours for healthcare staff to have access for treatment.

26. On 10 May, the palliative care nurse prescribed Mr Gale anticipatory medication (medicines prescribed in advance for a patient with a known terminal illness to ensure that they remain as comfortable as possible as life comes to an end) to reduce his discomfort and agitation.

27. At 3.00am on 12 May, a Healthcare Assistant (HCA) heard Mr Gale shout out in pain. She noted that Mr Gale was distressed, agitated, disorientated, frightened and panicked. She calmed Mr Gale with breathing techniques and a nurse gave him morphine and he went back to sleep. At 4.55am, the HCA noted that Mr Gale was pale, cold and unresponsive. She could not find a pulse. At 5.00am, a nurse saw that Mr Gale showed no signs of life. At 6.36am, ambulance paramedics confirmed that Mr Gale had died.

Post-mortem report

28. There was no post-mortem examination. A prison GP recorded that Mr Gale died of heart failure caused by ischaemic heart disease. He also had Type 2 diabetes which contributed to but did not cause his death.

Inquest

29. At an inquest held on 21 February 2024, the Coroner concluded that Mr Gale died from natural causes.

Findings

Clinical care

30. The clinical reviewer concluded that the overall clinical care that Mr Gale received at Stafford was of a good standard and was equivalent to that which he would expect to receive in the community.

31. However, the clinical reviewer found that Mr Gale experienced increasing painful and distressing constipation, due to the opioid pain relief he was prescribed, in the last two weeks of his life. She also found that there was a systematic delay in the prescribing of anticipatory medication and, when prescribed, these were not administered to him to relieve the symptoms of distress and agitation. The clinical review found that these two aspects of Mr Gale's end-of-life care did not meet the national and local palliative guidance for optimum symptom relief. We make the following recommendation:

    The Head of Healthcare should ensure that all patients who are at risk of or experiencing opioid induced constipation are discussed and documented within MPCCC meetings, referencing and acting upon the national and local palliative care treatment guidance.

    The Head of Healthcare should implement an improved system of prescribing anticipatory medication with the community palliative care team so that there are no delays, as per national and local guidance.

Head of Healthcare to note

32. At 5.00am on 12 May, a nurse confirmed that Mr Gale showed no signs of life and at 6.36am, an ambulance crew went to Stafford and verified that Mr Gale had died. There was not a GP at Stafford on duty at that time to verify the death. The Head of Healthcare said that the out-of-hours GP service was called as well as the Ambulance Service, but the Ambulance Service on this occasion arrived first and verified the death. It is not the best use of an ambulance to be called to a prison solely to pronounce life extinct of a prisoner. The Head of Healthcare may wish to consider training sufficient healthcare staff to verify the death of a prisoner.

Restraints, security and escorts

33. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

34. Mr Gale was an older prisoner who used a wheelchair or two walking sticks to mobilise. He was receiving palliative care for end-stage heart failure which caused severe limitations to his daily life, and a short life expectancy.

35. Mr Gale had many escorts to hospital for tests, treatment and for medical emergencies. The investigator has reviewed ten escort risk assessments for the period January to March 2023. On 5 January, a member of healthcare staff objected to the use of restraints and noted that Mr Gale had frailty and reduced mobility. However, on every other subsequent escort risk assessment healthcare staff did not object to the use of restraints, only sometimes noting that Mr Gale had mobility issues. Mr Gale was assessed as a low risk of escape.

36. A senior manager decided that, on each occasion, Mr Gale should be escorted by two officers and restrained with a single cuff or an escort chain (other than when restraints were briefly removed when Mr Gale tested positive for COVID-19).

37. The Head of Operations and Security said that escort risk assessments are dynamic based on current intelligence and routinely endorsed by either himself or the duty governor each day. He said that Stafford is a Category C establishment where restraints are routinely used for escorts. As part of the risk assessment the healthcare team assess the person’s age, mobility and medical condition, which is presented to the security team, who consider the use of restraints factoring in the Graham Judgement and those with life threatening illnesses. He said he thought that Mr Gale was not palliative when he went out to hospital and was fully mobile so would have been recommended to be handcuffed unless advised by the healthcare team. He believed that Mr Gale’s health deteriorated at hospital, and he came back into the prison SCU, where once he was placed on the end-of-life pathway he reviewed having the cell door open and authorised this to take place.

38. Poor communication and healthcare completion of the escort risk assessment appears to have given authorising managers incomplete information about Mr Gale’s health and mobility. Healthcare staff should have identified Mr Gale’s long-term health conditions and his poor mobility and identified these as a reason not to handcuff Mr Gale.

39. Given that Mr Gale was accompanied by two prison officers at hospital and posed a low risk of escape, the use of restraints was not justifiable in the circumstances. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk he presents at the time.

Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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