Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Giles, a prisoner at HMP Wayland, on 7 December 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

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.

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.

Mr Alan Giles died of citalopram (prescribed antidepressant medication) toxicity on 7 December 2023 at HMP Wayland. He was 71 years old. I offer my condolences to Mr Giles' family and friends.

Mr Giles was prescribed citalopram throughout his time in prison and had been stable on the same dosage for over three years. No clinical concerns with his dosage were raised and healthcare staff reviewed him regularly. The healthcare team were satisfied that Mr Giles was taking his medication appropriately. There is no evidence that Mr Giles was at risk of suicide and self-harm or that he intentionally took more citalopram than he should have done.

The clinical reviewer concluded that the clinical care Mr Giles received at Wayland was good and equivalent to what 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.

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

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Summary

Events

1. On 19 November 2019, Mr Alan Giles was remanded to HMP Chelmsford charged with shooting and wounding with intent to do grievous bodily harm. On 29 May 2020, he was sentenced to 10 years in prison. He remained at Chelmsford until he was transferred to Swaleside in July 2020, he then later transferred to Wayland in April 2023.

2. Mr Giles had pre-existing medical conditions which included depression and hypertension. He was managed appropriately by healthcare staff for his conditions. Mr Giles was prescribed 40mg of citalopram (antidepressant), which he was allowed to keep in his cell.

3. Between April and September, the GP at Wayland considered whether Mr Giles' citalopram dose should be reduced to 20mg (in line with national guidance related to the maximum citalopram dosage for people aged over 65). The GP conducted tests and concluded that the dose should remain at 40mg.

4. At around 11.40am on 7 December, an officer found Mr Giles unresponsive in his bed. The officer raised the alarm and staff attended. Healthcare staff identified signs that Mr Giles had died and so stopped resuscitation efforts. At 12.41pm, the paramedics confirmed that Mr Giles had died.

Findings

5. The clinical reviewer concluded that the clinical care Mr Giles received at Wayland was good and equivalent to what he could have expected to receive in the community.

6. Mr Giles was prescribed citalopram throughout his time in prison. The clinical reviewer concluded that the GP's decision to keep Mr Giles on the higher dose of citalopram was reasonable and based on a clinical decision that the benefits outweighed the risks.

7. There were no concerns highlighted from the healthcare team that Mr Giles was not taking his medication appropriately.

8. The Head of Healthcare, and the pharmacist at Wayland, could not confirm whether Mr Giles had taken more than his daily dose of citalopram because his medication was not returned to healthcare following the cell clearance after Mr Giles died.

9. There is no evidence that Mr Giles was at risk of suicide and self-harm or that he intentionally took more citalopram than he should have done.

The Investigation Process

10. HMPPS notified us of Mr Giles' death on 7 December 2023.

11. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Giles' prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Giles' clinical care at the prison.

14. We informed HM Coroner for Norfolk of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's office contacted Mr Giles' family to explain the investigation and to ask if they had any matters they wanted us to consider. The family did not raise any concerns but asked for a copy of our report.

16. 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.

17. Mr Giles family received a copy of the initial report. They did not make any comments.

Background Information

HMP Wayland

18. HMP Wayland is a category C prison which holds convicted adult men. Practice Plus Group provides the physical and mental healthcare services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Wayland was in April 2022. Inspectors reported that health services were well led and partnership working between health care teams and the wider prison had improved since the last inspection. They also reported complex patients were reviewed regularly through a strong multidisciplinary approach. Daily handovers were well attended by representatives from all services and provided a forum for sharing pertinent patient information and service updates.

Independent Monitoring Board

20. 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 May 2023, the IMB reported that prisoners' attitudes towards general healthcare was not encouraging. They reported a low proportion of prisoners found it easy to contact healthcare and two thirds of prisoners reported a dissatisfaction with healthcare surgeries.

Previous deaths at HMP Wayland

21. Mr Giles was the fifth prisoner to die at Wayland since December 2021. Of the previous deaths two were self-inflicted and two were natural causes. Up to the end of August 2024, there have been two further deaths since Mr Giles' death, one was from natural causes, and one was self-inflicted.

Key Events

22. On 19 November 2019, Mr Alan Giles was convicted of shooting and wounding with intent to do grievous bodily harm and was remanded to HMP Chelmsford.

23. On 29 May 2020, Mr Giles was sentenced to 10 years in prison.

24. Mr Giles had a significant medical history including a previous diagnosis of depression. He was appropriately prescribed medication to manage his medical conditions.

HMP Wayland

25. On 5 April 2023, Mr Giles was transferred to HMP Wayland.

26. A nurse completed Mr Giles' initial health assessment. She noted that he was well in himself and did not express any thoughts of suicide or self-harm. She noted that he had suffered with recurrent psychotic depression since 1996 and was prescribed citalopram (antidepressant) in the community. She referred Mr Giles to the prison's mental health team. Healthcare staff completed a medication reconciliation review. It was noted that Mr Giles had been taking 40mg of citalopram for the past three years and no concerns were raised. They prescribed him 40mg of citalopram, and following a risk assessment he was allowed to keep his medication in his cell.

27. On 6 April, a member of the mental health team saw Mr Giles for a mental health review. She noted that he said that he had had no recent contact with the mental health team. He said that he suffered with depression, but this was well managed with 40mg of citalopram. Following the assessment, Mr Giles was discharged from the mental health team's care.

28. On 17 April, a GP at the prison emailed the pharmacy team to question Mr Giles' dose of citalopram due to his age and the risks associated with a higher dose and requested a medical review. The GP saw Mr Giles on 9 May. Mr Giles said that he found the current dose of 40mg of citalopram helpful, so he did not change the dose.

29. On 18 September, a prison GP received an email from the community pharmacist, who advised that the maximum advised dosage of citalopram for a person over 65 was 20mg. The GP arranged a face-to-face appointment with Mr Giles and completed an ECG (electrocardiogram). The ECG results were within a normal range and no other clinical concerns were identified. The GP decided to continue with higher dose (40mg) of citalopram. Because the ECG results were normal there was no need for healthcare staff to consider treatment risks any further, which was in line with the relevant guidance.

30. The GP told us that Mr Giles' mental health was stable and due to him recently having been transferred to Wayland, a change to the dosage of citalopram was not made. He said that Mr Giles' ECG results were within the normal limits, so he was clinically satisfied that there was no evidence of harm with the prescribed dose at that time. He also said that if Mr Giles' dose was reduced, it could have impacted on his mental health. He considered the risks and benefits of the current dose outside of the recommended dose and made the clinical decision to continue with 40mg.

31. No concerns were raised about Mr Giles' health over the months that followed. He continued to collect his prescriptions on time and healthcare staff considered that he was taking his medication as prescribed.

32. On 21 November 2023, Mr Giles collected his 28-day prescription of citalopram from the medications hatch and no concerns were raised.

Events of 7 December 2023

33. At around 11.40am on 7 December, an officer was told that Mr Giles had not collected his lunch, so she went to his cell and called his name, but Mr Giles did not respond. She approached his bed and noticed he was very pale and unresponsive.

34. The officer attempted to radio a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties), but due to another transmission taking place at the same time, her message was not transmitted. Another prisoner was nearby, so she asked him to press the general alarm and she shouted, 'code blue'. A Supervising Officer (SO) and another officer attended.

35. The other officer and the SO attempted to get a verbal response from Mr Giles but were unsuccessful. The officer said that Mr Giles felt warm to touch. At approximately 11.50am, he radioed a code blue, and an ambulance was called. A nurse attended and, with the help of the officer, moved Mr Giles to the floor.

36. The officer started CPR while the nurse attached a defibrillator. The nurse attempted to insert an airway, but he observed rigor mortis in Mr Giles' jaw and upper arms. At 11.55am, all resuscitation attempts were stopped, and the Ambulance Service was updated. The paramedics arrived at the prison at 12.36pm and confirmed Mr Giles' death at 12.41pm.

Contact with Mr Giles' family

37. After Mr Giles' death, the prison appointed two officers as family liaison officers. Mr Giles had not provided any next of kin details when he entered prison. The family liaison officers exhausted all avenues available to locate a family member.

38. With the support of the coroner's officer, Mr Giles' brother was found. The family liaison officers contacted him on 14 December 2023 and informed him of Mr Giles' death and offered their condolences.

39. The prison contributed towards the cost of Mr Giles' funeral in line with national policy.

Support for prisoners and staff

40. After Mr Giles' death, a 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.

41. The prison posted notices informing other prisoners of Mr Giles' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Giles' death.

Post-mortem report

42. The post-mortem gave Mr Giles' cause of death as citalopram toxicity. The pathologist said that the toxicology analysis revealed a citalopram level which was outside the therapeutic range and was described as in the grey area of non-contributing and possibly fatal. The pathologist attributed Mr Giles' death to citalopram toxicity, although it was not possible to be completely certain that this was the cause of death.

Findings

Clinical care

43. The clinical reviewer concluded that Mr Giles received a good standard of clinical care which was equivalent to what he could have expected to receive in the community. Mr Giles required minimal support from healthcare staff, but he was reviewed accordingly for his medical conditions.

44. Mr Giles was prescribed citalopram throughout his time in prison. There were no concerns highlighted from the healthcare team that Mr Giles was not taking his medication appropriately. Mr Giles was 68 years old when he was prescribed citalopram in 2020 at another prison and had been stable on 40mg dosage for three years. This dose was above the recommended maximum dose for a man of his age and so the GP at Wayland carried out tests, including an ECG, before concluding that the benefits to Mr Giles' mental health outweighed the possible risk of maintaining the higher dose. The clinical reviewer concluded that this was an appropriate and reasonable clinical decision.

45. The Head of Healthcare confirmed that a medication risk assessment was completed when Mr Giles arrived at Wayland before he was authorised to keep his medication in his cell. Staff had not had any reason to suspect that he was not taking his medication as prescribed.

46. According to his medical records, Mr Giles collected a 28-day prescription of citalopram on 21 November 2023. Healthcare and pharmacy staff could not confirm whether Mr Giles had taken more than his prescribed daily dose of citalopram prior to his death because his medication was not returned to healthcare following the clearance of his cell after his death.

47. There is no evidence that Mr Giles was at risk of suicide and self-harm or that he intentionally took more citalopram than he should have done.

Governor to note

Cell clearances

48. When a prison cell is cleared, prison officers are required to return any medication to the healthcare team. We asked the Head of Safer Custody at Wayland about their cell clearance process regarding in possession medication, and whether any changes had been made to the policy following Mr Giles' death. He said that any medication found in a cell should be secured separately and returned to healthcare staff for review. He said it was not possible to say whether Mr Giles' medication was in his cell when it was cleared. He said that Wayland was reviewing the cell clearance process.

49. As a review of cell clearance processes is already underway, and staff have been reminded of the actions they should take if they find medication during a cell clearance, we make no recommendation but bring this to the Governor's attention.

Contact with Mr Giles' family

50. Mr Giles had not listed a named next of kin in his prison records. When he died, the nominated family liaison officer went to some lengths to identify a member of his family. The news of Mr Giles' death was broken to his family seven days later.

51. The prison told the investigator that after arrival at the prison it is the prisoner's responsibility to inform staff if and when they want to update their next of kin details and that staff do not regularly check. This is contrary to national policy. We make no recommendation, but the Governor will wish to assure himself that the process for identifying and checking next of kin details is sufficiently robust.

Inquest

52. At the inquest held on 6 January 2025, the coroner concluded Mr Giles died of citalopram toxicity.

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