

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roger Giles a prisoner at HMP Norwich on 31 January 2016

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

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*



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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 Roger Giles died on 31 January 2016 of pneumonia and a lung infection, while a prisoner at HMP Norwich. He was 85 years old. I offer my condolences to Mr Giles' family and friends.

Mr Giles was in declining health when he was moved to the specialist facility for older prisoners at Norwich in 2013, where staff looked after him well during his declining years. I am satisfied that Mr Giles received a good standard of care at the prison, at least equivalent to that 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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

August 2016

Contents

- Summary 1
- The Investigation Process 2
- Background Information 3
- Key Events 4
- Findings..... 6

Summary

Events

1. On 18 November 2000, Mr Roger Giles was remanded to HMP Hewell. He was 70 at the time. On 23 March 2001, he received a discretionary life sentence for sexual offences. From about 2008, records show that his health declined.
2. Mr Giles spent time at other prisons before he moved to the older prisoners unit at HMP Norwich on 3 December 2013, after his health declined significantly and he needed 24-hour care. At his initial health screen, a GP prescribed medication for diabetes, eczema, high cholesterol and pain relief. He had treatment plans for leg ulcers and incontinence. Healthcare staff created an older person's care plan to manage his conditions. Two days after he arrived at Norwich, Mr Giles decided that he did not want anyone to try to resuscitate him if his heart or breathing stopped.
3. Over the next two years Mr Giles' health continued to decline and he became increasingly frail. His mental health was also affected, with signs of senility.
4. In August 2015, hospital investigations indicated Mr Giles had fluid in his lung. Doctors arranged a CT scan to determine if the fluid was indicative of cancer. Mr Giles had the CT scan in September but did not want it and was not well enough to have any invasive investigation. His condition was treated with medication and monitoring by X-ray.
5. On the evening of 29 January 2016, Mr Giles' temperature was high and a nurse gave him paracetamol. Staff monitored him during the night and helped to bring his temperature down. The next day he said he felt better. On 31 January, he chose to stay in bed. At 2.50pm, nurses checked him and settled him in his bed. When a nurse checked him at approximately 6.45pm, he was unresponsive and it was apparent that he had died.

Findings

6. We are satisfied that Mr Giles received a good standard of care at Norwich and that the prison met his health needs. Healthcare and prison staff treated him with compassion, dignity and respect and appropriately involved Mr Giles in decisions about his care. The clinical reviewer was satisfied that Mr Giles' care was equivalent to that he could have expected to receive in the community.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Giles' prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Giles' clinical care at the prison.
10. We informed HM Coroner for Norfolk of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Giles' daughter, to explain the investigation. She had no specific issues for the investigation to consider.
12. Mr Giles' family were informed the initial report was available, but did not wish to receive a copy or make any comment.
13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Norwich

14. HMP Norwich is a multi-function prison, which predominantly serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides healthcare services. There is a healthcare centre, which provides 24-hour nursing cover and a dedicated unit for older prisoners.

HM Inspectorate of Prisons

15. The most recent inspection of Norwich was in August 2013. Inspectors reported that the prison had progressed since the last inspection. Relations between staff and prisoners were mostly positive and the inpatient and older prisoner units provided good care. However, although the nurse practitioner service was very good, there was a concern about the high use of locum GPs which could lead to inconsistencies in treatment, care and prescribing.

Independent Monitoring Board

16. 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 February 2015, the IMB reported that Norwich continued to improve. The IMB considered that the healthcare centre was outdated and lacked facilities but noted that the older prisoner unit continued to improve. The level of care from staff was commendable but the use of agency staff compromised continuity of care.

Previous deaths at HMP Norwich

17. As Norwich has a special unit for elderly prisoners, there are a relatively high number of deaths from natural causes at the prison. Mr Giles was the twelfth prisoner to die from natural causes at the prison since the beginning of 2014. There were no significant similarities between his and other deaths.

Key Events

18. On 18 November 2000, Mr Roger Giles was remanded to prison. He was 70 years old at the time. On 23 March 2001, he received a discretionary life sentence for sexual offences.
19. From about 2008, records show that Mr Giles' health declined. He was frail and in poor health. He suffered from type 2 diabetes and developed severe varicose ulcerations in both legs. Towards the end of 2012, he transferred from HMP Whatton to HMP North Sea Camp (an open prison).
20. Mr Giles did not manage well at North Sea Camp and the health facilities were less suitable than at Whatton. His clinical condition began to deteriorate and he asked to go back to Whatton in February 2013. At the time, he could not bear his weight because of his leg ulcers. He had eczema, diabetes and suffered from stress. Mr Giles stayed at Whatton until December 2013, when his health declined further and he transferred to the older prisoners unit at HMP Norwich for 24-hour health care.
21. On 3 December 2013, when Mr Giles arrived at Norwich, a nurse carried out a full health screen and healthcare staff created an older person's care plan. A GP prescribed medication for conditions including diabetes, eczema, and high cholesterol and for pain relief. There were treatment plans for his leg ulcers and incontinence. On 5 December, Mr Giles said he did not want anyone to attempt to resuscitate him if his heart or breathing stopped and his decision was formally recorded.
22. Throughout 2014 and 2015, Mr Giles' overall condition continued to deteriorate. He became increasingly frail. His incontinence worsened and he had a catheter fitted. His mental health also declined and there were some signs of senility.
23. On 16 July 2015, a prison GP reviewed Mr Giles, who had a persistent cough and loss of appetite. The doctor noted that a recent X-ray had indicated the possibility of some fluid in his lung and referred him urgently to hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
24. On 3 August 2015, Mr Giles attended the respiratory clinic at hospital. (Records show that he was not restrained for any hospital visits after he arrived at Norwich.) Investigative tests found fluid in Mr Giles' pleural cavity and doctors referred him for a CT scan to investigate if the fluid was indicative of a cancer.
25. Mr Giles CT scan was arranged for 17 August, but he would not stand with a hoist support and the scan could not go ahead. On 9 September, after support and encouragement from prison staff, Mr Giles had a CT scan, which confirmed he had fluid on his lungs. Mr Giles did not want, and was not well enough, to have any invasive further investigation. Mr Giles agreed with a consultant physician at the respiratory clinic that he would have non-invasive care, with medication and regular chest X-rays.
26. Over the next four months, healthcare staff saw Mr Giles frequently to monitor and care for him as his health declined further.

27. On the evening of 29 January 2016, a nurse noted Mr Giles had a high temperature and gave him paracetamol. Healthcare staff monitored his temperature throughout the night and helped to bring it down. The next morning his temperature had reduced and Mr Giles told nurses that he felt better.
28. On 31 January, Mr Giles decided to stay in bed, as he did not feel well. Nurses checked him at 2.50pm, when they turned and settled him in his bed. A nurse checked him at 6.49pm and he was unresponsive. He had no pulse, was cold to the touch and the nurse considered he had died. In line with Mr Giles' decision, she did not attempt resuscitation. An out of hours GP attended and confirmed Mr Giles' death.

Contact with Mr Giles' family

29. A prison manager acted as the prison's family liaison officer. Mr Giles had had no recent contact with his family, but he had named his daughter as his next of kin. The contact details he had given were insufficient and the manager asked the police for help, but the name given did not correspond with the address. She contacted Mr Giles' solicitor and his last known visitor but neither of them had any contact details for his daughter.
30. On 13 February, the police told the prison manager that they had traced Mr Giles' daughter and had informed her of her father's death. After some difficulty getting in contact, she eventually spoke to Mr Giles' daughter's partner on 26 February and offered her condolences and support. He informed her that his partner did not want to deal with the prison directly. The prison arranged and paid for Mr Giles' funeral, which was held on 2 March 2016.

Support for prisoners and staff

31. After Mr Giles' death, the prison manager debriefed the staff involved and offered her support and that of the staff care team.
32. The prison posted notices informing staff and prisoners of Mr Giles' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Giles' death.

Post-mortem report

33. A post-mortem examination revealed Mr Giles had died of pneumonia and empyema (a lung infection) with a background of chronic ischaemic heart disease and a urinary tract infection.

Findings

Clinical care

34. Mr Giles was an elderly man with a number of complex and debilitating conditions. The clinical reviewer considered that he received competent and attentive treatment throughout his time at the prison. His medical issues were identified early and quickly investigated. The treatment he received took into consideration his age and frailty.
35. Mr Giles died a peaceful natural death. His medical records show that he received frequent and attentive care over the last days of his life. Healthcare staff attended to his personal needs and he was kept comfortable and hydrated. The clinical reviewer considered he received all necessary care.
36. Although he could sometimes be a difficult patient, healthcare staff at Norwich treated Mr Giles with compassion, dignity and respect. Where appropriate, he was consulted and involved in decisions about his care. We are satisfied that Mr Giles' care was equivalent to that he could have expected to receive in the community.

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