

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert Girdlestone a prisoner at HMP Garth on 26 June 2019

**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*



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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Robert Girdlestone, who was 76 years old, died in hospital of sepsis, pneumonia and lung cancer on 26 June 2019, while a prisoner at HMP Garth. We offer our condolences to Mr Girdlestone's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Girdlestone received was equivalent to that which he could have expected to receive in the community. She has, however, made three recommendations to the Head of Healthcare.
5. The clinical reviewer noted that Mr Girdlestone could not attend his hospital appointment on 2 May for an urgent chest X-ray because of a lack of staff available to escort him. He was seen three weeks later. Although the clinical reviewer was satisfied that this did not affect the outcome for Mr Girdlestone, she made a recommendation to the Head of Healthcare about prioritising urgent hospital investigations. We consider that the Governor also has responsibility for ensuring that escorting staff are made available for urgent hospital appointments and have amended this recommendation accordingly.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff carry out a reception health screen when a prisoner transfers in from another prison and carry out a secondary health screen within seven days.
- The Head of Healthcare should ensure that prisoners who present for medical attention because of a fall, or report recurrent falls, or demonstrate abnormalities of gait and/or balance are offered a multifactorial falls risk assessment .
- The Governor and Head of Healthcare should ensure that:
  - healthcare and prison staff communicate to ensure that prison staff understand which appointments are clinically urgent or essential; and
  - appropriate arrangements are in place to enable prisoners to attend hospital appointments when required.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Girdlestone's clinical care at HMP Garth.
7. The PPO has investigated the non-clinical issues in Mr Girdlestone's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. One of our family liaison officers wrote to Mr Girdlestone's next of kin, his daughter, to explain the investigation. She did not have any specific questions for us to consider.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

### **Previous deaths at Garth**

10. Mr Girdlestone was the ninth prisoner to die at Garth since June 2017. Of the previous deaths, three were from natural causes, three were self-inflicted and two were drug-related. There has been one death since, from natural causes. There are no similarities between our findings in the investigation into Mr Girdlestone's death and the other deaths.

## Key Events

11. On 25 May 2018, Mr Robert Girdlestone was sentenced to 16 years in prison for sexual offences. He was moved to HMP Garth on 30 January 2019.
12. On 23 April, a prison GP referred Mr Girdlestone for urgent investigations after he complained of pain in his right side and lower ribs. The hospital gave Mr Girdlestone an appointment for 2 May, but the prison did not have enough staff available to take him. The X-ray service visited him in prison on 22 May and the scan revealed a mass in his lungs.
13. In June 2019, hospital doctors diagnosed Mr Girdlestone with lung cancer. He was admitted to hospital while investigations continued to find out where the cancer had started, but his condition was considered terminal. Prison staff made contact with Mr Girdlestone's family and arranged visits.
14. Prison staff considered applying for Mr Girdlestone's early release on compassionate grounds. However, clinicians could not provide a prognosis until they knew the cancer's source. Also, Mr Girdlestone had not completed any appropriate behaviour management programmes. The prison did not therefore apply for Mr Girdlestone's early release on compassionate grounds.
15. Mr Girdlestone died in hospital at on 26 June 2019. Hospital staff pronounced his death at 5.24pm.
16. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital. The hospital doctor recorded the cause of death as sepsis, caused by pneumonia, with lung cancer a contributory factor.

**Louise Richards**  
**Assistant Ombudsman**

**December 2019**