

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Greatbanks, a prisoner at HMP Stocken, on 10 February 2025

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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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. In March 2013, Mr Paul Greatbanks was sentenced to life in prison for murder. He died of hypertensive heart disease on 10 February 2025, at HMP Stocken. He was 60 years old.
4. The prison told us that Mr Greatbanks had no identified next of kin. We offer our condolences to those who knew Mr Greatbanks.
5. The PPO investigator investigated the non-clinical issues relating to Mr Greatbanks' care. We did not find any significant non-clinical issues of concern.
6. NHS England commissioned an independent clinical reviewer, to review Mr Greatbanks' clinical care at Stocken. They interviewed four members of healthcare staff between 3 and 24 April 2025.
7. The clinical reviewer concluded that the clinical care Mr Greatbanks received at Stocken was not equivalent to that which he could have expected to receive in the community. He found that despite concerns about Mr Greatbanks' hypertension, his care plan was not reviewed and there was a lack of professional curiosity around his attitudes to compliance with treatment. He also found that due to Mr Greatbanks' non-compliance, his mental capacity should have been assessed and his medication in possession status should have been reviewed. We make the following recommendations:

The Head of Healthcare should implement a monthly audit system, reviewing a minimum of 10 patients' records, to provide assurance that:

- **care plan reviews are completed as required;**
- **mental health capacity assessments are documented where it is possible that there is poor understanding of the implications of decisions; and**
- **data from home monitoring devices, such as blood pressure readings, are reviewed and escalated appropriately.**

The Head of Healthcare should ensure that a review is undertaken for the protocols in place relating to:

- **the management and review of in-possession medication status;**
- **the escalation process for patients reporting as unwell; and**

- **the management of non-compliance with treatment for long-term conditions.**

Governor to note

8. The officer who completed the roll check at 7.03am told us that he could only see the side of Mr Greatbanks' face, mainly his left cheek. This means that he did not have a clear view of Mr Greatbanks' face as required by the Internal Security Procedures Policy. We do not make a recommendation on this as the guidance in place at Stocken at the time of Mr Greatbanks' death did not specify this requirement. Since his death, a notice to staff has been issued which provides clarity on roll check expectations and Stocken's Local Security Strategy has been updated to reflect this.
9. There was also no body worn camera footage of the emergency response. Staff told us that this was due to the medical sensitivity of the situation. We do not make a recommendation on this as the staff statements and CCTV footage provided a clear account of the events, but we bring it to the Governor's attention.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). Practice Plus Group pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.
11. At an inquest held on 30 September 2026, the Coroner concluded that Mr Greatbanks died of natural causes.

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