Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Greenfield, a prisoner at HMP Moorland, on 6 December 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. On 3 February 2025, Mr William Greenfield was sentenced to ten years in prison for sex offences. He died from advanced prostate and bladded cancer, contributed but not caused by ischaemic heart disease on 6 December 2025, while a prisoner at HMP Moorland. He was 78 years old. We offer our condolences to those who knew him.

4. NHS England commissioned an independent clinical reviewer, to review Mr Greenfield's clinical care at HMP Moorland. The clinical review is attached as Annex 1.

5. The clinical reviewer concluded that the clinical care Mr Greenfield received at Moorland was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. The clinical reviewer found that healthcare put appropriate care plans in place to meet Mr Greenfield's health needs, and found evidence that healthcare regularly liaised with hospital staff while Mr Greenfield was an inpatient. The clinical reviewer made one recommendation not related to Mr Greenfield's death that the Head of Healthcare will want to address.

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

7. We did not find any non-clinical issues of concern. We make no recommendations.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). Practice Plus Group pointed out one factual inaccuracy in the clinical review report and this has been amended accordingly.

9. At an inquest held on 2 June 2026, the Coroner concluded that Mr Greenfield died of natural causes.

Adrian Usher **July 2026**
Prisons and Probation Ombudsman

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