Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr David Greenslade, a prisoner at HMP Parc, on 1 June 2015

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

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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 David Greenslade died at HMP Parc on 1 June 2015, of skin cancer that had spread to his brain. He was 66 years old. I offer my condolences to Mr Greenslade's family and friends.

I am satisfied that Mr Greenslade's condition was appropriately diagnosed. He refused active treatment to help prevent the cancer spreading and I consider his end of life care at Parc was of a high standard, at least equivalent to that he could have expected to receive in the community. However, I am not satisfied that decisions to restrain Mr Greenslade when he went to hospital fully took into account how his health and condition affected his risk of escape.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2015**

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Summary

Events

1. Mr David Greenslade was remanded to HMP Parc on 17 November 2012, charged with sexual offences. He was subsequently convicted and sentenced to 11 years and six months imprisonment.

2. On 5 September 2014, a prison GP examined a swelling on Mr Greenslade's wrist, suspected skin cancer and referred him urgently to a dermatology specialist. On 1 October, a biopsy revealed that it was an invasive and aggressive malignant cancer. Mr Greenslade refused to accept follow up chemotherapy or radiotherapy treatment to help prevent the cancer spreading. On 20 January 2015, after Mr Greenslade suffered a seizure, a scan showed malignant tumours in his brain.

3. On 17 February, prison healthcare staff referred Mr Greenslade to the hospital palliative care service. A palliative medicine consultant visited Mr Greenslade and advised on his care and medication. When Mr Greenslade's condition worsened on 8 April, he moved to the prison's palliative care suite, where he received 24-hour one to one nursing until he died on 1 June.

Findings

4. Mr Greenslade's decision to refuse active treatment meant that only palliative care was possible. Staff at the prison supported him well, ensured he was comfortable and cared for him in partnership with community palliative care services. We are satisfied that Mr Greenslade had the capacity to decide not to accept active treatment and that his clinical care after his diagnosis was at least equivalent to that he could have expected to receive in the community.

5. Mr Greenslade attended many hospital appointments between September 2014 and March 2015. Escort officers were instructed to use double or single handcuffs on all but one occasion. Twice, he was restrained in spite of medical objections by prison healthcare staff. We are concerned that security decisions taken after Mr Greenslade's diagnosis were not fully justified by his level of risk at the time, an issue we have raised with Parc before.

Recommendation

- The Director and Healthcare Manager should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Parc informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

7. The investigator obtained copies of relevant extracts from Mr Greenslade's prison and medical records.

8. Health Inspectorate Wales reviewed Mr Greenslade's clinical care at the prison.

9. We informed HM Coroner for Powys, Bridgend and Glamorgan Valleys of the investigation, who gave the cause of death as metastatic malignant melanoma with diabetes mellitus type 2 as a contributory factor. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers wrote to Mr Greenslade's son, to explain the investigation. Mr Greenslade's son had no specific issue for the investigation to consider.

11. The investigation has assessed the main issues involved in Mr Greenslade's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

12. Mr Greenslade's family received a copy of the initial report. They did not make any comments.

13. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Parc

14. HMP Parc is a medium security private prison run by G4S, which holds around 1,600 convicted men and young adults on remand or convicted. There is 24-hour general healthcare, a palliative care suite and cells adapted to fit hospital beds and to accommodate prisoners with disabilities. A local GP practice provides out-of-hours cover.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Parc was in July 2013. Inspectors found that the prison was safe and, overall, the standard of health services was good, with an impressive new healthcare unit. Prisoners had access to mobility and health aids and there was very good care for prisoners with palliative and end of life needs.

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 published annual report, for the year to February 2014, the IMB reported that HIW was positive about the quality of end of life l care provided at the prison. They noted that waiting times for healthcare appointments and the number of missed appointments had reduced.

Previous deaths at HMP Parc

17. Mr Greenslade was the sixth prisoner to die from natural causes at Parc since the beginning of 2014. We have made previous recommendations about the use of restraints on seriously ill prisoners without comprehensive risk assessments to justify their use.

Findings

The diagnosis of Mr Greenslade's terminal illness and informing him of his condition

18. Mr David Greenslade was remanded to HMP Parc on 17 November 2012, charged with historical sexual offences. (He was later convicted and sentenced to eleven years and 6 months in prison.) Mr Greenslade had several chronic health problems, including diabetes, high blood pressure and depression, which healthcare staff monitored and treated.

19. On 5 September 2014, a prison GP, examined a one centimetre swelling on the back of Mr Greenslade's wrist, which Mr Greenslade said had been growing over the last six months. The GP suspected that it was either an inflammation of immune cells or squamous cell carcinoma (cancer of the outer layer of the skin). He referred Mr Greenslade to the Dermatology Department at the Princess of Wales Hospital, Bridgend, under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks. The GP suggested that the lump be removed and a biopsy taken to examine the tissue.

20. On 15 September, a consultant dermatologist diagnosed that the nodule was skin cancer and arranged for it to be removed under local anaesthetic on 1 October.

21. On 13 October, the consultant dermatologist informed the GP that, unexpectedly, the biopsy result had revealed the nodule was an invasive and aggressive malignant melanoma. The consultant dermatologist said he would discuss Mr Greenslade at the next multidisciplinary team meeting and refer him to a plastic surgeon for further surgery. He would then make another appointment to tell Mr Greenslade the results and the plan for treatment.

22. On 24 October, the consultant dermatologist told Mr Greenslade that he had malignant skin cancer that would require further surgery and possibly chemotherapy.

23. We are satisfied that the prison GP immediately recognised the possibility of skin cancer and referred Mr Greenslade to a specialist, who diagnosed and informed him of his condition promptly.

Mr Greenslade's medical treatment

24. On 13 November, Mr Greenslade had an initial appointment with a consultant plastic and reconstructive surgeon at Morriston Hospital, Swansea, who listed him for an operation to remove a larger area of skin and clear lymph nodes on his elbow and under his arm. He had the operation at Morriston Hospital on 16 December and went back to Parc two days later. Healthcare staff drained and dressed his wounds, as directed in the hospital discharge letter.

25. On 21 December, Mr Greenslade complained that, since he had been discharged from hospital, the rigidity of the system at Parc had left him in pain. A nurse noted that he had received regular pain relief and that he was due to attend an appointment with the prison GP on 9 January, to review this. (At the

medication review on 9 January, a doctor agreed to prescribe dihydrocodeine, an opioid painkiller, which resolved the matter.)

26. On 6 January 2015, Mr Greenslade went to the outpatient plastic surgery clinic at Morriston Hospital. In a follow up letter, dated 8 January, a consultant plastic surgeon, indicated that, although there was no evidence of any remaining cancer in Mr Greenslade's wrist, he had told him he was concerned that it might recur and spread in the future. However, Mr Greenslade had declined any further cancer treatment and did not want to have chemotherapy or radiotherapy. The surgeon examined a lump in the right side of Mr Greenslade's neck and arranged for an ultrasound scan as he considered him at high risk of the cancer spreading. The scan result showed it was not cancer.

27. The consultant dermatologist and the plastic surgeon had copied their correspondence to a consultant oncologist at Velindre Hospital, Cardiff. On 22 January, the oncologist reviewed Mr Greenslade and said he had made an excellent recovery. He suggested a course of radiotherapy and regular scanning for early detection and treatment of any spread of the disease. Mr Greenslade told him that as he was likely to be in prison for several years, he did not want to have any active cancer treatments or scans. The oncologist discharged Mr Greenslade, but made it clear that he could change his mind at any time and he would reinstate further investigations.

28. When he got back to the prison that day, Mr Greenslade discussed with a nurse his decision to refuse further active treatment and signed a disclaimer about this. The nurse told him that healthcare staff would support him and recorded that he was aware of the consequences of this action. Two GP's assessed him on 23 January and concluded that he was mentally competent to refuse treatment and fully understood the implications. Healthcare staff assessed his mental capacity several times during his illness.

29. On 28 January, Mr Greenslade became disorientated and had a seizure. Healthcare staff thought he might have had a stroke and called an ambulance. Paramedics took him to the Princess of Wales Hospital, where a CT scan revealed two malignant tumours in his brain. He went back to the prison that evening. Mr Greenslade was left with some weakness of his mouth and face, but remained mobile.

30. Mr Greenslade continued to refuse intervention. On 16 February, staff were concerned that he had refused to take medication and gave him enhanced support, with multidisciplinary reviews, for two weeks.

31. On 17 February, healthcare staff referred Mr Greenslade to the hospital palliative care service. On 5 March, a consultant in palliative medicine at Princess of Wales Hospital, visited him at Parc. Mr Greenslade told her that he wanted supportive care on his wing, but no interventions to extend his life as he had a long sentence and expected to die in prison anyway. The consultant was satisfied that he fully understood his situation and wrote to the prison, recommending a palliative treatment plan and medication.

32. On 9 March, Mr Greenslade changed his mind and said he wanted treatment for the brain tumours. The same day, healthcare staff sent an urgent referral to the

neurological department of the Princess of Wales Hospital. A CT scan on 10 March, showed an increase in the size and number of the lesions in Mr Greenslade's brain.

33. After a hospital appointment on 19 March, escort staff told a nurse that the hospital had estimated Mr Greenslade's life expectancy to be between six weeks to six months. On 22 March, a wing officer told another nurse that staff were concerned about a loss in Mr Greenslade's mobility and functioning. The nurse noted he should have a further needs assessment.

34. Healthcare staff had also re-referred Mr Greenslade to the plastic surgeon, but the doctor advised the hospital on 25 March that he had since changed his mind about pursuing this. On 31 March, Mr Greenslade told the doctor that Velindre Hospital had told him his life expectancy was two to three months. He said that he was happy with the support from the palliative care service and would ask for help if he noticed any new symptoms.

35. In the early hours of 8 April, staff found Mr Greenslade weak and lethargic after falling in his cell. The GP reviewed him later that morning and spoke to his consultant. They agreed that he should remain at Parc, but would need a hospital bed. Healthcare staff moved him to the prison's palliative care suite that evening. They created several new care plans, primarily to control his nausea, diabetes and prevent pressure sores. The plans also stipulated 24-hour one to one nursing and that his door should be left open at all time to facilitate this. Staff also ordered a syringe driver, which gives medication continuously under the skin. The GP completed an order to indicate that Mr Greenslade did not want to be resuscitated if his heart or breathing stopped.

36. On 21 May, after Mr Greenslade's condition had worsened, healthcare staff fitted the syringe driver and created a new palliative care plan. From 23 May, they withdrew all unnecessary medication, as Mr Greenslade just wanted to be kept comfortable. On 28 May, the nurse noted that all care was under the last days of life pathway. Just after 1.00am on 1 June, Mr Greenslade stopped breathing. The GP confirmed his death at 2.00am.

37. We are satisfied that Mr Greenslade received a high standard of care at Parc. Healthcare staff devised and reviewed his care plans. They gave him full information about his illness to enable him to make decisions and appropriately reviewed his mental capacity when he decided not to have treatment. They worked in partnership with specialist services, such as the hospital's palliative care team and Macmillan nurses. Mr Greenslade received one to one care in the last two months of his life. We agree with the clinical reviewer that his care was of a high standard and equivalent, if not better, than that which he could have expected to receive in the community.

Mr Greenslade's location

38. When Mr Greenslade went back to Parc on 18 December, after surgery, healthcare staff put in place a supported living plan, noting his reduced mobility since his operation and that he was not suitable for a top bunk. Mr Greenslade gave permission for healthcare staff to share relevant information with operational staff.

39. On 3 February, after Mr Greenslade's seizure and the diagnosis of his brain lesions, a nurse carried out a disability assessment. They discussed the possibility of a move to a ground floor cell, as the nurse was concerned that Mr Greenslade was too frail to manage the stairs. However, he preferred to remain on the third landing of his residential wing with his friends and he did not consider himself to be at risk. On 14 February, during a discussion about his end of life care, he told The GP that he was happy for the prison to deliver his care and did not want to transfer elsewhere.

40. On 8 April, Mr Greenslade moved to the palliative care suite after a fall in his cell. The specialist palliative care team and Macmillan nurses went to see him the next day and he reiterated that he wanted to remain in prison for his care. Friends from his wing visited him during his time in the suite.

41. We are satisfied that the prison appropriately took account of Mr Greenslade's preferences about his location during his illness and that his accommodation in the palliative care suite met his needs.

Restraints, security and escorts

42. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

43. Between September 2014 and March 2015, Mr Greenslade attended hospital at least 17 times. The security risk assessments concluded that he was a medium risk of escape and risk to the public (except on 2 December 2014, when he was assessed as high risk to the public). Prison staff who completed the assessment did not generally explain the reasons why they had assessed him as medium risk, but some of the forms had annotations such as, "risk to children" and "medical ability to escape unaided".

44. Until 12 December 2014, Mr Greenslade was routinely double handcuffed for his hospital appointments. (Double handcuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs and is usually used for high risk prisoners in good health.) The assessments generally indicated that, with prior management approval, escort officers could reduce this to an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) For an appointment on 30 December 2014, the deputy director authorised that single handcuffs should be used when Mr Greenslade's arm was in a cast.

45. On 6 January and 22 January 2015, despite healthcare staff indicating medical objections to the use of restraints, owing to recent surgery on his right hand, the risk assessments concluded that single handcuffs should be used, with the provision to use an escort chain for treatment. Staff reverted to the use of double handcuffs for some of his other appointments in January and March. (No restraints were used for the emergency journey to hospital after Mr Greenslade's suspected stroke on 28 January, but the risk assessment indicated that staff could use an escort chain once he was assessed and stable.) On 19 March, healthcare staff ticked the box to indicate that he had reduced mobility and stated, "...terminal illness which affects mobility" but they had gave no objections to the use of restraints. Single cuffs were authorised. For his next appointment four days later, the Head of Security noted, "single cuff/EC due to age and mobility".

46. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. The risk assessments seemed to have been based almost entirely on Mr Greenslade's offences, with little consideration of how his condition impacted on this risk, as the 2007 High Court judgement requires. Some of the assessments were inconsistent and it is not apparent why the views of healthcare staff were over-ridden in January. The Head of Security has not replied to the investigator with clarification about how decisions to use restraints were reached. We therefore cannot be satisfied that staff appropriately assessed Mr Greenslade's risk. We make the following recommendation:

The Director and Healthcare Manager should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Greenslade's family

47. On 9 April, the prison assigned chaplains as family liaison officers. The same day, one of the family liaison officers discussed with Mr Greenslade his wishes about family contact and about his funeral arrangements. Mr Greenslade said that he was not religious and did not want a funeral service. He gave the family liaison officer family contact details but said he did not want his family to know how ill he was. The family liaison officer visited him again the next day and he reiterated that he did not want the prison to contact his family.

48. When Mr Greenslade's condition deteriorated on 20 April, he agreed that the prison could contact his family. The other family liaison officer telephoned Mr Greenslade's son the same day. She told him about his father's condition and that medical staff did not expect him to live much longer. They agreed that if Mr Greenslade died during the night, one of the family liaison officer's would wait until the morning to tell him.

49. The family liaison officer telephoned Mr Greenslade's son at 7.45am on 1 June, to notify him of his father's death. She then had a more detailed discussion with him at 2.30pm, to explain the procedures and options for the arrangements.

50. The family liaison officer arranged Mr Greenslade's funeral and the prison paid the costs, in line with Prison Service policy. Mr Greenslade was cremated, with no funeral service, on 23 June, as Mr Greenslade had requested.

Compassionate release

51. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

52. The GP first broached the issue of compassionate release with prison managers on 14 February 2015. At that time, he estimated that Mr Greenslade might have three to six months to live. On 9 April, Mr Greenslade told the specialist palliative care team and the Macmillan nurses that he did not want to be released. The next day, he confirmed this decision with a prison manager.

53. We are satisfied that the prison appropriately considered the possibility of compassionate release.

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