

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr James Greenwood a prisoner at HMP Wymott on 7 July 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*



© Crown copyright 2020

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## 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. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr James Greenwood, who was 49 years old, died of metastatic oesophageal carcinoma (cancer of the oesophagus) in hospital on 7 July 2019 while a prisoner at HMP Wymott. We offer our condolences to Mr Greenwood's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Greenwood received was of a good standard and equivalent to that which he could have expected to receive in the community. She has made two recommendations about second reception screenings (which we have not endorsed) and nutritional needs.
5. We did not find any non-clinical issues of concern.

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

## Recommendation

- **The Head of Healthcare should ensure the nutritional needs of patients are assessed and that NICE guidance is followed to ensure that appropriate management and care planning is in place.**

## Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Greenwood's clinical care at HMP Wymott. Her clinical review is annexed to this report.
7. The PPO has investigated non-clinical issues, including Mr Greenwood's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. Our family liaison officer wrote to the prisoner's next of kin and partner to explain the investigation and to ask whether they had any matters they wanted to be considered. The prisoner's next of kin asked if Mr Greenwood had seen a doctor or nurse at HMP Altcourse, where he lived from 10 October 2016 to 19 March 2019, as this is where family members thought that his cancer had started. The clinical reviewer has addressed this in her report.
9. The prisoner's next of kin received a copy of the draft report. They did not have any comments.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

### **Previous deaths at Wymott**

9. There have been six deaths from natural causes and four non-natural deaths at HMP Wymott in the last two years. One prisoner has died of natural causes since Mr Greenwood died. There are similarities relating to health screens between our findings in the investigation of Mr Greenwood's death and two other deaths.
10. Mr Greenwood's late secondary screening took place in August 2018. Since that time, in May 2019 and July 2019, we have made two recommendations that prisoners are offered a secondary health screen within seven days of arriving at Wymott. These recommendations were accepted by the prison and, therefore, we do not repeat this recommendation.

### **Key Events**

11. On 12 December 2000, Mr Greenwood was sentenced to life imprisonment for murder. Mr Greenwood served part of his sentence at HMP Altcourse. He was transferred from HMP Altcourse to HMP Wymott on 19 March 2018.
12. On 19 March, Mr Greenwood had a transfer reception screening. A nurse noted that he had a history of hiatus hernia (a condition where part of the stomach moves into the chest) and chronic back pain in 2010.
13. On 1 August, a nurse completed Mr Greenwood's secondary reception screen. She noted that Mr Greenwood had no current mental health or substance misuse issues.
14. On 22 November, Mr Greenwood was diagnosed with oesophageal carcinoma (cancer of the oesophagus).
15. On 14 December, Mr Greenwood was admitted to hospital for tests. While in hospital, he was told that the cancer had spread to his shoulder blade and skin.
16. On 7 February 2019, Mr Greenwood was discharged from hospital and was happy to return to a standard wing at Wymott. Mr Greenwood had oral chemotherapy treatment for palliative purposes.
17. On 30 April, a Consultant Clinical Oncologist at the hospital gave Mr Greenwood a prognosis of between three to five months to live.
18. On 3 May, a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) was completed. Mr Greenwood was involved in the decision-making process.
19. On 22 May, staff applied to the Public Protection Casework Section (PPCS) of the Her Majesty's Prisons and Probation Service (HMPPS) for Mr Greenwood's early release on compassionate grounds.
20. On 4 June, Mr Greenwood was admitted to hospital as healthcare staff at Wymott were unable to manage his pain relief.

21. On 7 June, the PPCS refused Mr Greenwood's application for early release on compassionate grounds.

22. Mr Greenwood died in hospital on 7 July 2019 at 4.40pm.

23. No post-mortem was conducted. The Coroner accepted the doctor's cause of death as metastatic oesophageal carcinoma (cancer of the oesophagus).

### **Clinical Findings**

24. The clinical reviewer concluded that the care that Mr Greenwood received at HMP Wymott was equivalent to that he could have expected to receive in the community. However, she found that Mr Greenwood did not have a second reception screening within 7 days of being transferred to Wymott and that nutritional needs needed to be monitored but that National Institute for Clinical Excellence (NICE) guidelines were not followed. The clinical reviewer's full findings are set out in his report at Annex 1.

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**January 2020**

# **Annex 1**

Clinical review into the death of Mr James Greenwood