Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stuart Greener, a prisoner at HMP Nottingham, on 16 October 2024

A report by the Prisons and Probation Ombudsman

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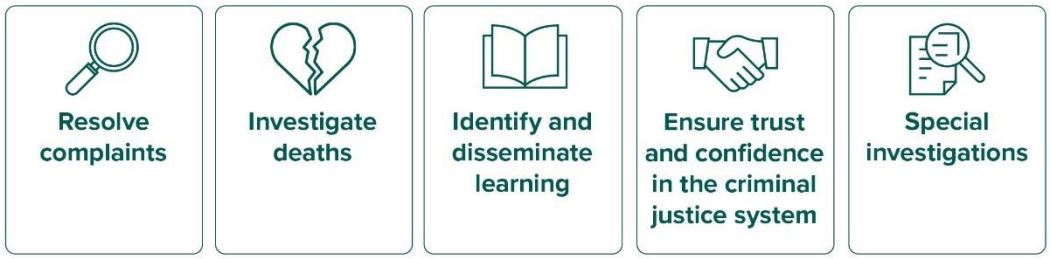
OUR VISION

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

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. 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. Mr Stuart Greener died due to metastatic colorectal cancer (cancer that started in the bowel then spreads to other parts of the body) on 16 October 2024, while a prisoner at HMP Nottingham. He was 48 years old. We offer our condolences to Mr Greener's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Greener received at Nottingham was of a good standard and was equivalent to that which he would have received in the community.

5. We found that Mr Greener was inappropriately restrained when he was admitted to the hospital on 8 October 2024. His failing health and mobility was not properly considered.

Recommendations

- The Governor and Head of Healthcare should implement a robust quality assurance process, to ensure that healthcare staff properly record and authorising managers evidence that they have taken into account medical information when completing the escort risk assessment.

The Investigation Process

6. HMPPS notified us of Mr Greener's death on 16 October 2024.

7. NHS England commissioned an independent clinical reviewer to review the clinical care Mr Greener received at Nottingham.

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

9. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The cause of death was determined at the hospital without need for post-mortem. We have sent the Coroner a copy of this report.

10. The Ombudsman's office wrote to Mr Greener's next of kin, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

Previous deaths at HMP Nottingham

11. Mr Greener was the eleventh prisoner to die at Nottingham in the last three years. Of the previous deaths, seven were from natural causes, one was from drugs toxicity, two were self-inflicted and one was a homicide. To the end of February 2025, there has been one more natural cause death at Nottingham.

12. In three recent investigations, we have highlighted that escort risk assessments did not properly consider the health and mobility of the prisoner when determining whether restraints were required during hospital visits. In their action plan to our most recent recommendation, which we received in October 2023, Nottingham said that they were reviewing their local escort risk assessment to ensure that appropriate consideration of prisoners' health and mobility were recorded, including that healthcare staff complete the medical assessment.

Key Events

13. On 27 April 2017, Mr Stuart Greener was sentenced to 12 years imprisonment for attempted murder.

14. In January 2023, Mr Greener was released on licence. In June 2023, he was recalled and sent to HMP Nottingham.

15. At the time of his arrival, healthcare staff documented that Mr Greener had been diagnosed in July 2022 with stage four terminal colon cancer with multiple secondary tumours. He remained under the care of Nottingham City Hospital for palliative chemotherapy.

16. In July 2023, Mr Greener was informed by his oncologist that his prognosis had reduced from two to three years to nine to twelve months.

17. Mr Greener was supported by the prison healthcare team, hospital and community specialists. He remained relatively well and able to self-care on the wing, until August 2024.

18. On 9 August, Mr Greener was admitted to hospital for significant disease progression and, due to this rapid decline, he was transferred to Hayward House, a specialist palliative care unit, for end of life care. After a few weeks, Mr Greener's health had improved so that he was well enough to return to Nottingham on 29 August.

19. On 2 September, Mr Greener was admitted to hospital again due to partial blockage of his lower bowel. Mr Greener was advised to have a palliative stoma (surgery allowing waste to leave the body) to relieve the symptoms, but he declined. He did agree to have a new colonic stent inserted and a liquid diet to aid with his bowel blockage to allow his return to Nottingham on 9 September

20. On 1 October, healthcare staff identified extensive distension of the abdomen (stomach abnormally swollen or enlarged) and oedema of the legs (swollen legs).

21. On 8 October, Mr Greener was admitted to hospital as he had stopped passing urine and had vomited faecal matter. Prison staff completed an escort risk assessment before Mr Greener left for hospital, and concluded that he should be restrained using an escort cable (a length of strong metal cable with a handcuff at either end, one attached to the prisoner's wrist and the other to an officer).

22. The medical assessment section of the escort risk assessment was blank. Prison staff told us that it was completed separately but they could not locate it after Mr Greener died. In the escort risk assessment, prison staff assessed that Mr Greener was a low risk of escape and to the public.

23. On 11 October, a palliative stoma was arranged but Mr Greener declined the intervention because of the pain he was experiencing.

24. On 12 October, bedwatch staff recorded that Mr Greener's condition continued to decline, that his stomach and legs were severely swollen and that his mobility was

extremely limited. An operational manager authorised that the handcuffs should be removed.

25. On 15 October, Mr Greener continued to deteriorate, becoming drowsy and requiring oxygen therapy. He was placed onto the end-of-life care pathway. Mr Greener declined the opportunity to contact his next of kin.

26. On 16 October, Mr Greener died in hospital.

Post-mortem report

27. The Coroner chose not to request a post-mortem examination and relied on the cause of death proposed by the hospital. The was recorded as metastatic colorectal cancer (cancer that started in the bowel and spreads to other parts of the body).

Findings

Clinical findings

28. The clinical reviewer considered that the care Mr Greener received at Nottingham was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer commended Mr Greener's named nurse for her consistent professionalism and compassion to ensure that Mr Greener received optimal palliative care within the prison environment.

Restraints, security and escorts

29. 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. It said 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.

30. Mr Greener was a 48-year-old man, who had a history of poor health and a terminal cancer diagnosis. When he was admitted to hospital on 8 October 2024, he had oedema (swollen legs) which affected his mobility and his admission was following a period in which he had vomited faecal matter (indicating a serious health issue).

31. The medical assessment of the escort risk assessment is missing, and we do not therefore know the extent to which Mr Greener's current health and mobility were considered in the escort risk assessment. Nevertheless, his symptoms and medical history on that occasion, in line with the High Court judgement, meant that it is likely that his risk could have been effectively managed by the officers accompanying him without the use of restraints. The decision to restrain him was not proportionate to his risk.

32. We frequently raise concerns about how well healthcare staff understand, or feel empowered, to make a meaningful contribution to the risk assessment process, such as in this case. In March 2024, we recommended that NHS England develop national guidance for establishments to develop local standard operating procedures for healthcare input into restraints risk assessments. This recommendation was accepted, and NHS England told us that they are working with HMPPS to review the Prevention of Escapes – External Escorts Policy Framework, with particular focus on the escort risk assessment. We also welcome the work that the Operational Security Group Director has undertaken to review and amend the national risk assessment form, mandate its use and provide additional guidance to staff responsible for making decisions about the use of restraints.

33. We have made previous recommendations about the use of restraints at Nottingham, and particularly about proper completion and consideration of the

medical assessment. In their response to our most recent recommendation (received in October 2023), Nottingham said that they were reviewing the local escort risk assessment and providing refresher training to staff responsible for completing risk assessment sections. They said that their review would ensure that every risk assessment was fully completed before discharge to hospital, including that healthcare staff complete the medical assessment with the prisoners' current medical condition and whether it affects their mobility and ability to escape. Nottingham said that their training would include sessions for authorising managers to include evidencing that healthcare information had been considered.

34. Although Nottingham has taken this action, it is apparent from Mr Greener's case that escort risk assessments do not always consider pertinent health information. It is important that staff properly consider the prisoner's health and mobility when determining the appropriate use of restraints. We make the following recommendation:

The Governor and Head of Healthcare should implement a robust quality assurance process, to ensure that healthcare staff properly record and authorising managers evidence that they have taken into account medical information when completing the escort risk assessment.

Inquest

35. The inquest into Mr Greener's death concluded on 14 January 2025, and returned a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **July 2025**

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