Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Bentley, a prisoner at HMP High Down, on 10 March 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T l 020 7633 4100

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

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 process failure.

3. Mr Bentley died of lung cancer at St Helier hospital on 10 March 2023, while a prisoner at HMP High Down. He was 63 years old. We offer our condolences to Mr Bentley's family and friends.

4. The PPO investigator investigated the non-clinical issues relating to Mr Bentley's care. We did not find any non-clinical issues of concern.

5. NHS England commissioned an independent clinical reviewer to review Mr Bentley's clinical care at High Down.

6. The PPO family liaison officer wrote to Mr Bentley's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Bentley's family asked about the clinical care he received after a hospital scan discovered a lump on his neck in 2019, while at HMP The Mount. This has been addressed by the clinical reviewer in her report, which sets out the care Mr Bentley received in 2019 leading to an MRI appointment where results were recorded as normal. Mr Bentley's family asked for a copy of our report.

7. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy, and this report has been amended accordingly.

8. The clinical reviewer concluded that the clinical care Mr Bentley received was of the standard reasonably expected and equivalent to that which he could have expected to receive in the community.

9. The clinical reviewer made one recommendation not related to Mr Bentley's death, that the Head of Healthcare will wish to address. She also made one recommendation related to Mr Bentley's death:

Recommendation

- The Head of Healthcare should ensure that all patients who have a terminal diagnosis (irrespective of prognosis) have an advanced care plan in place in accordance with the NICE guideline [NG142] for 'end of life care for adults: service delivery' (2019).

Inquest

10. The inquest into Mr Bentley's death concluded on the 24 April 2024. The coroner confirmed that Mr Bentley died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

July 2024

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T l 020 7633 4100