Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Bingley, a prisoner at HMP Rye Hill, on 11 July 2025

A report by the Prisons and Probation Ombudsman

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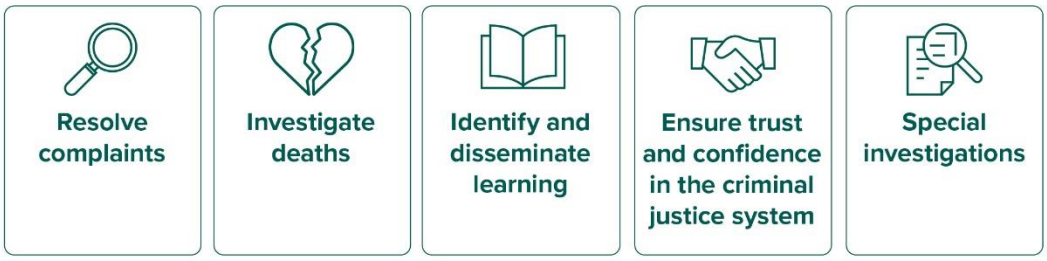
OUR VISION

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

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. In December 2016, Mr Stephen Bingley was sentenced to 20 years imprisonment for sexual offences. He died in hospital from a perforated bowel on 11 July 2025, while a prisoner at HMP Rye Hill. He was 66 years old. We offer our condolences to Mr Bingley's family and friends.

4. The Ombudsman's office wrote to Mr Bingley's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer, to review Mr Bingley's clinical care at HMP Rye Hill. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Bingley received at Rye Hill was of a good standard and was equivalent to that which he could have expected to receive in the community. However, there had been a delay in actioning a referral for a stool test for Mr Bingley. The prison's healthcare provider, Practice Plus Group, identified during their post-incident review that there was a high volume of unactioned referrals with the administration team. Practice Plus Group has since put measures in place to address this and therefore we make no recommendation.

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

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

9. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

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

Inquest

At the inquest, held on 28 January 2026, the Coroner concluded that Mr Bingley died from natural causes.

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