Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Bennett a prisoner at HMP Winchester on 15 March 2020

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 I 020 7633 4100
F I 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*

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 Peter Bennett, who was 80 years old, died in hospital from sepsis on 15 March 2020, while a prisoner at HMP Winchester. We offer our condolences to Mr Bennett's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Bennett received at Winchester was at least equivalent to that which he could have expected to receive in the community. He made one recommendation which is not directly related to Mr Bennett's cause of death and has not been included in our report.

5. We found no non-clinical issues of concern. We make no recommendations.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Bennett's clinical care at HMP Winchester. The clinical review is attached to this report as Annex 1.

7. The PPO investigator has investigated the non-clinical issues in Mr Bennett's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. One of the PPO's family liaison officers wrote to Mr Bennett's next of kin, his wife and son, to explain the investigation. They did not respond.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at Winchester

10. Mr Bennett was the ninth prisoner to die at Winchester since March 2018. Of the previous deaths, four were from natural causes, and four were self-inflicted. There are no similarities between the previous deaths and Mr Bennett's.

Key Events

11. On 22 November 2019, Mr Peter Bennett was sentenced to five years and ten months imprisonment for sexual offences and sent to HMP Winchester.

12. Mr Bennett had been diagnosed with prostate cancer in September, which had spread to his bones. He was put on hormone therapy with a view to beginning chemotherapy in December.

13. However, after entering prison Mr Bennett's health declined rapidly. On 10 December, after an appointment at the hospital, Mr Bennett's oncologist (cancer specialist) said that he was too frail for chemotherapy. Mr Bennett also had cellulitis (a serious bacterial skin infection) in his legs which was very resistant to treatment. The oncologist recommended that Mr Bennett should be treated in hospital for this. He was admitted to hospital the same day and stayed there until 17 December.

14. Three days after returning to Winchester, Mr Bennett was sent to HMP The Verne. This was intended to be a permanent move, but on 23 December, he was sent back to Winchester. The Verne said Mr Bennett needed 24-hour nursing care and they were unable to manage his needs there.

15. Mr Bennett was sent to hospital on 29 December, after becoming very confused, and he had further treatment for his cellulitis. He was found to have bone fractures, which were a complication of his cancer. Mr Bennett had operations for this and he did not return to prison until 11 February 2020.

16. Following his return to prison, the clinical emphasis was on pain management as Mr Bennett's cancer could not be cured. An end of life long term care plan was created.

17. On 3 March, Mr Bennett was sent to hospital due to increasing pain and to check for further bone fractures. None were found and Mr Bennett was returned to Winchester the same day. On 5 March, he had two falls, and although he was not seriously injured, he was finding it increasingly difficult to cope in prison.

18. A prison GP assessed Mr Bennett's deterioration on 7 March, and sent him back to hospital. By 13 March, he was no longer responding to treatment and he was put on an end of life care pathway.

19. On 15 March at 5.55am, Mr Bennett was pronounced dead.

20. There was no post-mortem examination as the coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as sepsis, caused by cellulitis and prostate carcinoma with multiple metastases (cancer of the prostate that had spread to multiple sites in the body).

Louise Richards **June 2020**
Assistant Ombudsman