

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Andrew Betsworth, a prisoner at HMP Dartmoor, on 17 November 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*



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## 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Betsworth died of liver failure as a result of the spread of cancer on 17 November 2019 at Dartmoor. He was 74 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Betsworth received at Dartmoor was equivalent to that which he could have expected to receive in the community. She made a number of recommendations about clinical issues which are not directly related to Mr Betsworth's death, but which the Head of Healthcare will need to address.
5. We did not find any non-clinical issues of concern and make no recommendations.

### Investigation Process

6. NHS England commissioned a clinical reviewer to review Mr Betsworth's clinical care at HMP Dartmoor.
7. The PPO investigator has investigated the non-clinical issues in Mr Betsworth's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Betsworth's next of kin to explain the investigation. They did not have any specific questions.
9. We shared the initial report with the Prison Service. There was one factual inaccuracy in the clinical review which has been amended accordingly.
10. Mr Betsworth's next of kin received a copy of the initial report. They pointed out two factual inaccuracies in the clinical review, which has been amended accordingly. They raised a question that did not impact on the factual accuracy of this report which has been addressed through separate correspondence.

### Previous deaths at Dartmoor

11. There were three deaths from natural causes and two self-inflicted deaths at HMP Dartmoor in the two years before Mr Betsworth's death. There are no significant similarities with these deaths.

## **Key Events**

12. On 9 August 2019, Mr Andrew Betsworth was sentenced to four years in prison for sex offences and was sent to HMP Exeter. On 30 August, he was transferred to HMP Dartmoor.
13. On 21 October, a prison GP referred him to hospital under the NHS suspected cancer pathway (which requires patients with suspected cancer be seen by a specialist within two weeks) because Mr Betsworth was short of breath, had lost weight and had a poor appetite.
14. On 7 November, a hospital consultant diagnosed Mr Betsworth with very advanced cancer of the liver and lungs and no treatment was possible. Mr Betsworth had an advanced palliative care plan in place in which he noted that he preferred to die at Dartmoor, with supportive care. He therefore returned to Dartmoor, where he died on 17 November of liver failure because of the spread of cancer.
15. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Caroline Mills**  
**Assistant Ombudsman**

**May 2020**

