

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adam Benton, a prisoner at HMP Stafford, on 15 January 2025

A report by the Prisons and Probation Ombudsman

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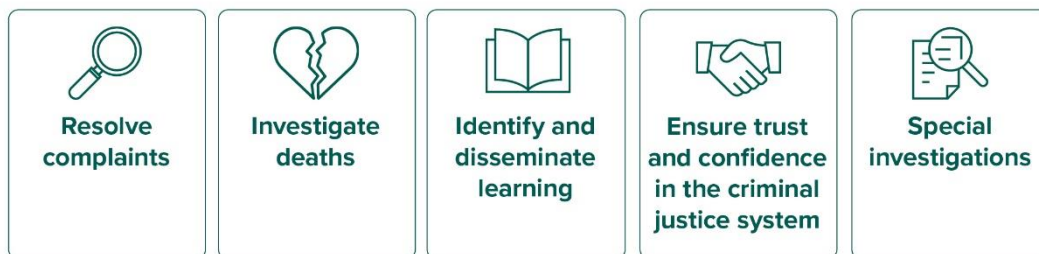
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OUR VISION

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



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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. On 16 September 2024, Mr Adam Benton was sentenced to twelve years and nine months in prison for sexual offences. He began his sentence in HMP Birmingham before being transferred to HMP Stafford on 4 October.
4. Mr Benton died of high-grade glioma of brain (an aggressive type of brain cancer) on 15 January 2025. He was 51 years old. We offer our condolences to Mr Benton's family and friends.
5. The Ombudsman's office contacted Mr Benton's brother, his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Benton's brother did not respond.
6. The PPO investigator investigated the non-clinical issues relating to Mr Benton's care. We did not find any non-clinical issues of concern.
7. NHS England commissioned an independent clinical reviewer, to review the clinical care that Mr Benton received at Stafford. The clinical reviewer's report is attached as Annex 1. The clinical reviewer concluded that the clinical care Mr Benton received at Stafford was of a good standard and more than equivalent to that which he would have received in the community. She identified evidence of a very good multidisciplinary team approach to Mr Benton's care, which was provided with compassion.
8. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.
9. The inquest into Mr Benton's death concluded on 27 June 2025, and recorded a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

August 2025

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