Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frederick Williams, a prisoner at HMP The Verne, on 12 January 2024

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 failure.

3. On 10 November 2021, Mr Frederick Williams was sentenced to nine years in prison for indecent assault. He died of peritonitis (an infection of the inner lining of the stomach) and pneumonia (a lung infection) caused by a large bowel perforation (a hole in the lining of the bowel) on 12 January 2024, at HMP The Verne. He was 86 years old. We offer our condolences to Mr Williams' family and friends.

4. The Ombudsman's office wrote to Mr Williams' wife to explain the investigation and to ask if she had any matters she wanted us to consider. She asked why Mr Williams was being given palliative care when his causes of death were treatable.

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

6. NHS England commissioned an independent clinical reviewer to review Mr Williams' clinical care at HMP The Verne.

7. The clinical reviewer concluded that the clinical care Mr Williams received at The Verne was partially equivalent to that which he could have expected to receive in the community. She found that, while there was evidence that treatment escalation plans were discussed with Mr Williams, this could have been improved by translating these discussions into a formal end of life/advanced care plan in line with national guidelines.

8. The clinical reviewer made recommendations not related to Mr Williams' death that the Head of Healthcare will wish to address. We make two recommendations related to his death:

   The Head of Healthcare should ensure that an end-of-life register is in place at HMP The Verne that enables early identification of those patients with palliative care needs and to proactively plan for end-of-life care.

   The Head of Healthcare should ensure that all patients who have life limiting conditions have an advanced care plan in accordance with NICE guidelines.

9. The inquest into Mr William' death concluded on 29 April 2025, returning a verdict of natural causes.

Adrian Usher **July 2024**
Prisons and Probation Ombudsman

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