Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sidney Matthews, a prisoner at HMP The Verne, on 13 April 2025

A report by the Prisons and Probation Ombudsman

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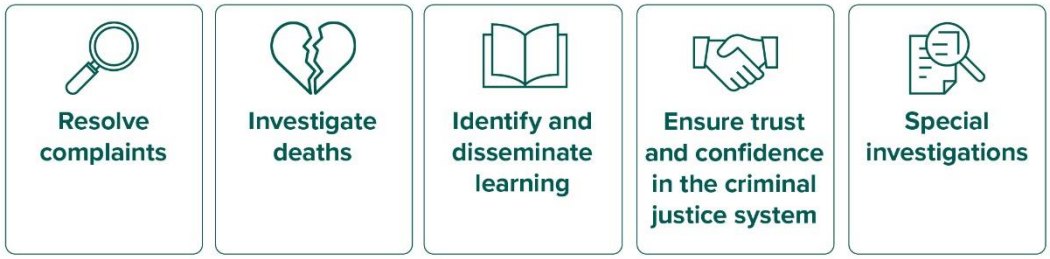
OUR VISION

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. On 19 November 2024, Mr Sidney Matthews was sentenced to fourteen years in prison for rape. He died from severe pneumonia on 13 April 2025, while a prisoner at HMP The Verne. He was 90 years old. We offer our condolences to Mr Matthews' family and friends.

4. The Ombudsman's office wrote to Mr Matthews' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Matthews' clinical care at HMP The Verne. The clinical review is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care that Mr Matthews received at The Verne was of a good standard and was at least equivalent to that which he could have expected to receive in the community. He found that HMP Exeter (his previous prison) and The Verne managed Mr Matthews' medical conditions effectively.

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

8. We did not identify any non-clinical learning and we make no recommendations.

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

10. At an inquest held on 13 November 2025, the Coroner concluded that Mr Matthews' died of natural causes.

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

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