

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Smith a prisoner at HMP The Verne, on 14 March 2025

A report by the Prisons and Probation Ombudsman

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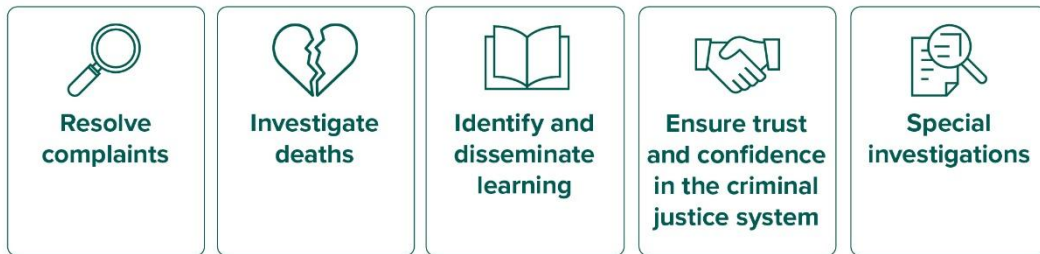
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OUR VISION

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 2 November 2017, Mr William Smith was sentenced to 12 years in prison for indecent assault. On 14 March 2025, while a prisoner at HMP The Verne, he died from carcinomatosis (cancer which has spread to other parts of the body), caused by carcinoma of the lung. This was contributed to but not caused by severe chronic obstructive pulmonary disease. Mr Smith was 74 years old. We offer our condolences to Mr Smith's family and friends.
4. The Ombudsman's office wrote to Mr Smith's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
5. NHS England commissioned an independent clinical reviewer, to review Mr Smith's clinical care at The Verne. The clinical review is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Smith received at The Verne was of a good standard and at least equivalent to that which he could have expected to receive in the community. She found that Mr Smith received good end-of-life care but also found that healthcare did not assess his mental capacity. She made three recommendations not related to Mr Smith's death that the Head of Healthcare will want to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Smith's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Governor to note

10. On 10 May 2024, The Verne began an early release on compassionate grounds (ERCG) application for Mr Smith, and it was submitted to the Public Protection Casework Section (PPCS) on 9 July 2024. On 7 January 2025, PPCS responded and informed The Verne that the application was missing key healthcare information such as the prognosis and life expectancy. The Verne provided this information on 13 March, however Mr Smith died the next day.
11. The ERCG Policy Framework says that the application should provide a prognosis and an indication of life expectancy, and all information must be provided in support of the application to PPCS to avoid unnecessary delays. The Verne should have

provided the information in the initial application, and once the issue was identified, the Offender Management Unit or healthcare should have promptly responded to PPCS' email in January. We bring this to the Governor's attention.

Adrian Usher
Prisons and Probation Ombudsman

November 2025

10. At an inquest held on 20 January 2026, the Coroner concluded that Mr Smith died of natural causes.

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