Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Reynolds, a prisoner at HMP Leyhill, on 26 October 2023

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

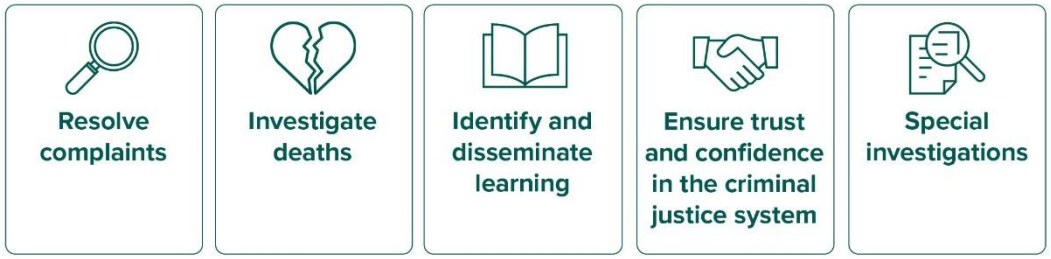
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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 HM 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. Mr William Reynolds was sentenced to 14 years in prison for sexual offences. He died of metastatic prostate cancer on 26 October 2023 while a prisoner at HMP Leyhill. He was 82 years old. We offer our condolences to Mr Reynolds' family and friends.

4. The PPO family liaison officer wrote to Mr Reynolds' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Reynolds' clinical care at HMP Leyhill. The clinical reviewer concluded that the clinical care Mr Reynolds received at HMP Leyhill was of a good standard and equivalent to that which he could have expected to receive in the community.

6. The clinical reviewer made four recommendations which were not related to Mr Reynolds' death but which the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Reynolds' care. We did not find any non-clinical issues of concern. We make no recommendations.

8. Mr Reynolds' family received a copy of the draft report. They did not make any comments.

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 7 January 2025, the Coroner concluded that Mr Reynolds died of natural causes.

Adrian Usher **April 2026**
Prisons and Probation Ombudsman

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