Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Smith, a prisoner at HMP Norwich, on 18 March 2025

A report by the Prisons and Probation Ombudsman

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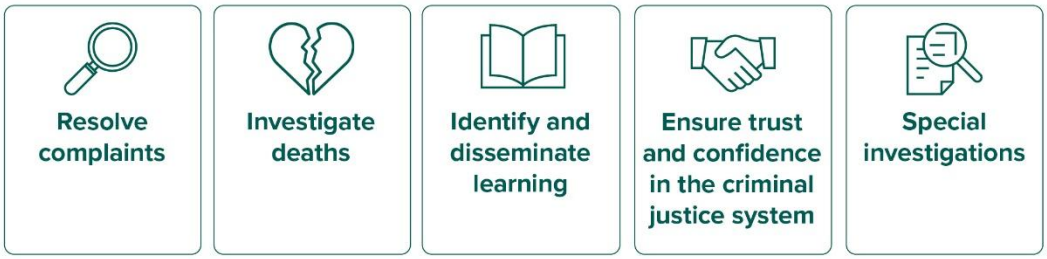
OUR VISION

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. In September 2021, Mr Michael Smith was sentenced to 21 years in prison for sex offences. He died of pancreatic cancer, on 18 March 2025, while a prisoner at HMP Norwich. He was 68 years old. We offer our condolences to Mr Smith's family and friends.

4. The Ombudsman's office wrote to Mr Smith's son 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 Smith's clinical care at HMP Norwich.

6. The clinical reviewer concluded that the clinical care Mr Smith received at Norwich was of a good standard and equivalent to that which he could have expected to receive in the community. Healthcare staff put care plans in place and provided appropriate medication for pain management. They regularly discussed Mr Smith's case at multi-professional complex care meetings and took prompt action to address his needs. The clinical reviewer also noted effective communication between healthcare staff and the community palliative care team, which ensured Mr Smith's end-of-life care needs were met. She made no recommendations.

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

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

9. Mr Smith's family received a copy of the draft report. They did not make any comments.

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

Inquest

10. At the inquest held on 9 January 2026, the Coroner concluded that Mr Smith died from natural causes.

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