

Independent investigation into the death of Mr Gordon Weis, a prisoner at HMP The Verne, on 5 August 2024

A report by the Prisons and Probation Ombudsman

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



complaints



Investigate deaths



Identify and disseminate learning



and confidence in the criminal justice system



investigations

WHAT WE VALUE

Ambitious thinking

Professional curiosity

Diversity & inclusion

Transparency

Teamwork



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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 8 June 2017, Mr Gordon Weis was sentenced to eight years in prison for sex offences. He died from pneumonia on 5 August 2024, while a prisoner at HMP The Verne. He was 72 years old. We offer our condolences to Mr Weis' family and friends.
- 4. The Ombudsman's office wrote to Mr Weis' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They declined further involvement in the investigation.
- 5. NHS England commissioned an independent clinical reviewer, to review Mr Weis' clinical care at The Verne.
- 6. The clinical reviewer concluded that the clinical care Mr Weis received at The Verne was of a high standard and was at least equivalent to that which he could have expected to receive in the community. He found that healthcare staff managed Mr Weis' care using a co-ordinated approach. The clinical reviewer made no recommendations.
- 7. The PPO investigator investigated the non-clinical issues relating to Mr Weis' care.
- 8. We did not find any non-clinical issues of concern 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. Mr Weis' family received a copy of the draft report. They did not make any comments.
- 11. At an inquest held on 14 August 2025, the Coroner concluded that Mr Weis died of natural causes.

Adrian Usher **Prisons and Probation Ombudsman.**

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