Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerald Sherwin, a prisoner at HMP Elmley, on 25 September 2024

A report by the Prisons and Probation Ombudsman

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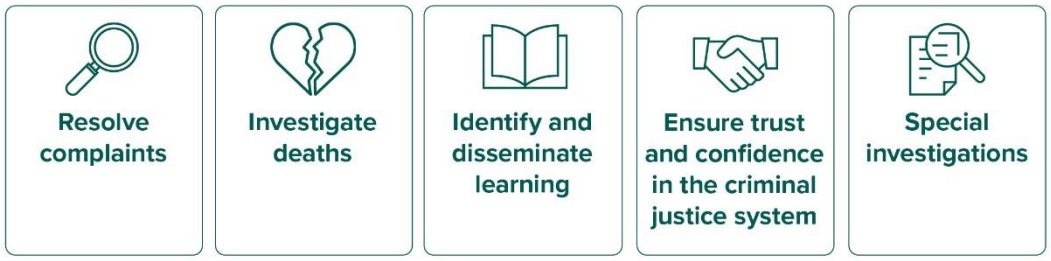
OUR VISION

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 July 2024, Mr Gerald Sherwin was charged with sexual offences and remanded into custody. He died in hospital of pneumonia and congestive cardiac failure on 25 September 2024, while a prisoner at HMP Elmley. He was 72 years old. We offer our condolences to his family and friends.

4. The Ombudsman's office wrote to Mr Sherwin's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He asked why he was not informed of Mr Sherwin's imprisonment at Elmley, given that he was in poor health. Elmley told us that they would only contact a prisoner's next of kin if he became seriously ill. They also said that Mr Sherwin did not provide his next of kin's contact details and they had to contact the police for assistance in contacting him once Mr Sherwin became seriously unwell. Mr Sherwin's brother also had concerns about his medical treatment at Elmley.

5. NHS England commissioned an independent clinical reviewer to review Mr Sherwin's clinical care at Elmley.

6. The clinical reviewer concluded that the clinical care Mr Sherwin received at HMP Elmley was of a good quality and equivalent to that which he could have expected to receive in the community. He found that Mr Sherwin received appropriate care for his various medical conditions and healthcare staff recognised and acted on Mr Sherwin's episodes of clinical deterioration quickly. The clinical reviewer did not make any recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Sherwin's care. We did not identify any non-clinical issues of concern and 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 Sherwin's family received a copy of the draft report. They raised an issue that does not impact on the factual accuracy of this report and has been addressed through separate correspondence.

10. At an inquest on 28 May 2025, the Coroner concluded that Mr Sherwin died of natural causes.

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

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