Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Gerald Ludlam, a prisoner at HMP The Verne, on 13 February 2025

## A report by the Prisons and Probation Ombudsman

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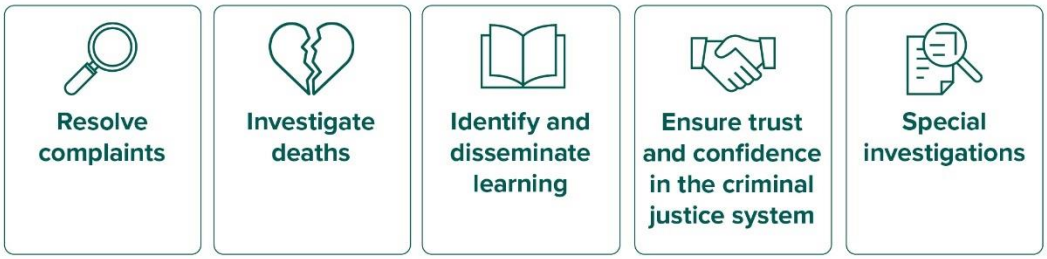
## OUR VISION

**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 2022, Mr Gerald Ludlam was sentenced to 24 years in prison for sex offences. He died of acute heart failure (caused by ischaemic heart disease and high blood pressure) on 13 February 2025, while a prisoner at HMP The Verne. He was 65 years old. We offer our condolences to Mr Ludlam's family and friends.

4. The Verne informed us that Mr Ludlam had no identified next of kin.

5. NHS England commissioned an independent clinical reviewer to review Mr Ludlam's clinical care at The Verne.

6. The clinical reviewer concluded that the clinical care Mr Ludlam received at The Verne was of a good standard and was equivalent to that which he could have expected to receive in the community. He concluded that Mr Ludlam's death could have been prevented if he had consistently engaged with health services. He found that Mr Ludlam was offered repeated opportunities to improve his health management. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Ludlam's care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

**Good practice**

9. As there is no 24-hour healthcare service at The Verne, prison staff were responsible for responding to the emergency until paramedics arrived. The clinical reviewer found that the emergency response was well led and organised, with tasks delegated effectively and efficiently. The Ambulance Service also gave positive feedback about the prison's delivery of cardiopulmonary resuscitation.

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

11. At an inquest held on 7 August 2025, the Coroner concluded that Mr Ludlam died of natural causes.

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

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