

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Gilbert, a prisoner at HMP Parc, on 22 September 2025

A report by the Prisons and Probation Ombudsman

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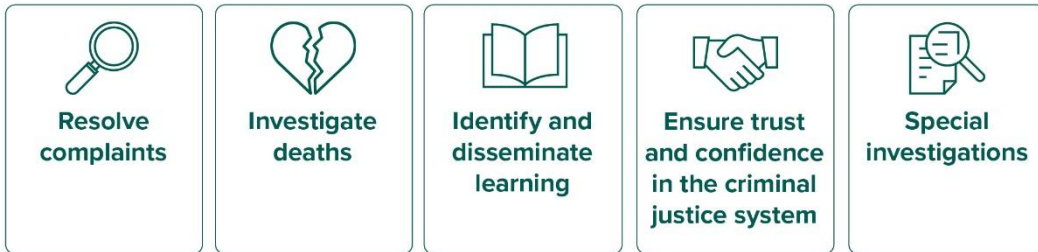
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OUR VISION

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



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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 24 July 2024, Mr Matthew Gilbert was sentenced to 16 months in prison for a sex offence. He was sent to HMP Parc.
4. Mr Gilbert died of pulmonary thromboembolus (blood clot blocking a blood vessel in the lungs) caused by deep vein thrombosis (a blood clot forming in one or more deep veins, usually in the legs) on 22 September 2025, while a prisoner at HMP Parc. He was 40 years old. We offer our condolences to Mr Gilbert's family and friends.
5. The Ombudsman's office wrote to Mr Gilbert's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She raised two concerns including the return of Mr Gilbert's prison property which HMP Parc has responded to. She asked for a copy of our report.
6. We also shared the initial report with Mr Gilbert's family. They did not make any comments.
7. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
8. Healthcare Inspectorate Wales commissioned an independent clinical reviewer, to review Mr Gilbert's clinical care at HMP Parc.
9. The clinical reviewer concluded that the clinical care Mr Gilbert received at Parc was equivalent to that which he could have expected to receive in the community. He made three recommendations not related to Mr Gilbert's death that the Head of Healthcare will wish to address.
10. The PPO investigator investigated the non-clinical issues relating to Mr Gilbert's care.
11. We did not find any non-clinical issues of concern. We make no recommendations.

Inquest

12. The inquest into Mr Gilbert's death concluded on the 8 June 2026. The coroner confirmed that Mr Gilbert died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

June 2026

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