Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerald Martin, a prisoner at HMP Wymott, on 28 January 2026

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



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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 25 November 2016, Mr Gerald Martin was convicted of sexual offences and sentenced to 20 years in prison. He died in hospital of severe heart failure on 28 January 2026, while a prisoner at HMP Wymott. He was 76 years old. We offer our condolences to Mr Martin's family and friends.

4. The Ombudsman's office contacted Mr Martin's wife to explain the investigation and to ask if she had any matters she wanted us to consider. A family friend responded and asked questions about Mr Martin's decline in health and his transfer between prisons. These questions have been addressed in the clinical review. Mr Martin's wife asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Martin's clinical care at HMP Wymott. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Martin received at Wymott was of a good standard and was equivalent to that which he could have expected to receive in the community. She found that Mr Martin was well supported in both his health and social care needs and, when he was unwell, he was supported to access hospital in a timely manner.

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

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

9. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

10. We also shared the initial report with Mr Martin's wife. She raised some issues/questions that do not impact on the factual accuracy of this report and which we have addressed through separate correspondence.

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

Inquest

At an inquest held on 19 October 2026, the coroner concluded that Mr Martin died from natural causes.

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