Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Gerrard, a prisoner at HMP Isle of Wight, on 19 June 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 September 2023, Mr Simon Gerrard was sentenced to 14 years in prison for sexual offences. He died of bladder cancer on 19 June 2024, at HMP Isle of Wight. He was 54 years old. We offer our condolences to Mr Gerrard's family and friends.

4. The Ombudsman's office wrote to Mr Gerrard's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. The PPO investigator investigated the non-clinical issues relating to Mr Gerrard's care. We did not find any non-clinical issues of concern.

6. NHS England commissioned an independent clinical reviewer to review Mr Gerrard's clinical care at HMP Isle of Wight.

7. The clinical reviewer concluded that the clinical care Mr Gerrard received at Isle of Wight was of a good standard and equivalent to that which he could have expected to receive in the community.

8. However, he found that Mr Gerrard was transferred from HMP Liverpool to Isle of Wight while under active investigation for blood in his urine. Information about this was not passed to the healthcare team at Isle of Wight and a referral was not made by Isle of Wight until a month later. The clinical reviewer considered it unlikely that this delay affected the outcome but that the poor information sharing should be addressed. We recommend:

   The Head of Healthcare at HMP Liverpool should ensure that when a prisoner is awaiting or undergoing investigations at hospital:

   - **staff should consider the use of medical hold and record their decision; and**

   - **if medical hold is not considered appropriate and a transfer goes ahead, staff should handover details of the outstanding referrals/ongoing investigations to the receiving prison.**

9. We shared our initial report with HMPPS and Spectrum Community Health CIC. They found no factual inaccuracies. Spectrum Community Health CIC provided an action plan which is annexed to this report.

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

Inquest

At the inquest, held on 29 December 2025, the Coroner concluded that Mr Gerrard died from natural causes.

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