Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Waters, a prisoner at HMP Dartmoor, on 29 October 2023

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 August 2017, Mr Michael Waters was sentenced to life imprisonment for sexual offences. He died on 29 October 2023, of coronary artery atherosclerosis (a blockage of the artery supplying blood to the heart) and chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), at HMP Dartmoor. He was 85 years old. We offer our condolences to Mr Waters' family and friends.

4. The PPO family liaison officer wrote to Mr Waters' 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. NHS England commissioned an independent clinical reviewer to review Mr Waters' clinical care at HMP Dartmoor.

6. The clinical reviewer concluded that the clinical care Mr Waters received at the Dartmoor was not equivalent to that which he could have expected to receive in the community. This is because while she identified equivalence in some areas, she did not in relation to wound management. Although this was not related to Mr Waters' death, the clinical reviewer made recommendations on this and other matters that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Waters' care. We did not find any non-clinical issues of concern that related to Mr Water's death that required a recommendation.

Governor to Note

8. There were only six entries (four of which related to key work contact) in Mr Water's prison record in the two years before his death. Key work has been an issue in previous cases that the PPO has investigated. The Governor of Dartmoor said that due to improved resourcing, in January 2024, they were carrying out eight and a half as many key working sessions as the previous January. We note this positive development and make no recommendations at this time but draw the Governor's attention to the lack of key work sessions that Mr Waters had.

Inquest

9. The inquest into Mr Water's death concluded on 4 September 2025 and found that he died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

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