Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Davies, a prisoner at HMP Rye Hill, on 15 January 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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. On 5 March 2004, Mr Michael Davies was sentenced to life in prison for the rape of a child. He died of a ruptured atherosclerotic abdominal aortic aneurysm (where blood leaks from a major artery) on 15 January 2025, while a prisoner at Rye Hill. He was 70 years old. We offer our condolences to Mr Davies' family and friends.

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

5. NHS England commissioned an independent clinical reviewer to review Mr Davies' clinical care at HMP Rye Hill.

6. The PPO investigator investigated the non-clinical issues relating to Mr Davies' care.

7. As part of the investigation, the clinical reviewer and PPO investigator interviewed two members of healthcare staff on 14 March 2025.

8. The clinical reviewer concluded that the clinical care that Mr Davies received at Rye Hill was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made three recommendations about Mr Davies' death which the Head of Healthcare will need to address.

9. We did not identify any non-clinical learning.

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

Good practice

11. The family liaison officers at Rye Hill were concerned about the welfare of Mr Davies' next of kin and appropriately reported their concerns to social services.

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

Inquest

12. The inquest into Mr Davies' death was held on 27 July 2026 and a verdict of natural causes was recorded. The coroner concluded that Mr Davies' death was due to a ruptured atherosclerotic abdominal aortic aneurysm.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100