Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Mace, a prisoner at HMP Dartmoor, on 11 August 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 March 2015, Mr Mace was sentenced to 204 months in prison for sexual offences. He died of bronchopneumonia on 11 August 2024, at HMP Dartmoor. He was 68 years old. We offer our condolences to Mr Mace's family and friends.

4. The Ombudsman's office wrote to Mr Mace'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. NHS England commissioned an independent clinical reviewer to review Mr Mace's clinical care at Dartmoor.

6. The clinical reviewer concluded that the clinical care Mr Mace received at Dartmoor was largely of a reasonable standard and equivalent to what he could have expected to receive in the community. He found that regular, well documented meetings were held at Dartmoor about Mr Mace's care. Healthcare staff showed him respect regarding his preferences for treatment, and those discussions were managed well. However, the missed opportunity to diagnose diabetes earlier while in another prison was not equivalent. The clinical reviewer made recommendations not related to Mr Mace's death that the Head of Healthcare will wish to address.

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

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

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

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

At the inquest held on 3 June 2025, the coroner concluded Mr David Mace died of natural causes.

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