Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Fabian, a prisoner at HMP Winchester, on 14 September 2025

A report by the Prisons and Probation Ombudsman

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

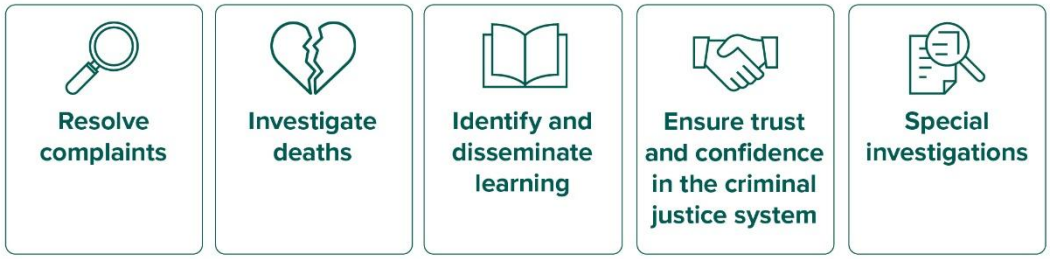
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

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 16 November 2024, Mr Michael Fabian was remanded to HMP Winchester for breach of a restraining order.

4. Mr Fabian died at Winchester of acute on chronic cardiac failure (long term heart failure), on 14 September 2025. He was 81 years old. We offer our condolences to Mr Fabian's family and friends.

5. No next of kin were identified following Mr Fabian's death.

6. NHS England commissioned an independent clinical reviewer to review Mr Fabian's clinical care at Winchester. The clinical reviewer's report is attached as Annex 1.

7. The clinical reviewer concluded that the clinical care Mr Fabian received at Winchester was of a good standard and equivalent to that which he could have expected to receive in the community. She found that the healthcare team provided coordinated and compassionate care, supporting Mr Fabian's physical comfort and overall wellbeing throughout the progression of his illness.

8. The clinical reviewer made one recommendation not related to Mr Fabian's death that the Head of Healthcare will wish to address.

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

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

11. We shared the initial report with HM Prison and Probation Service (HMPPS). They pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

12. At the inquest held on 3 June 2026, the Coroner concluded that Mr Fabian died from natural causes.

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

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