Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Waterfield, a prisoner at HMP Bure, on 18 March 2025

A report by the Prisons and Probation Ombudsman

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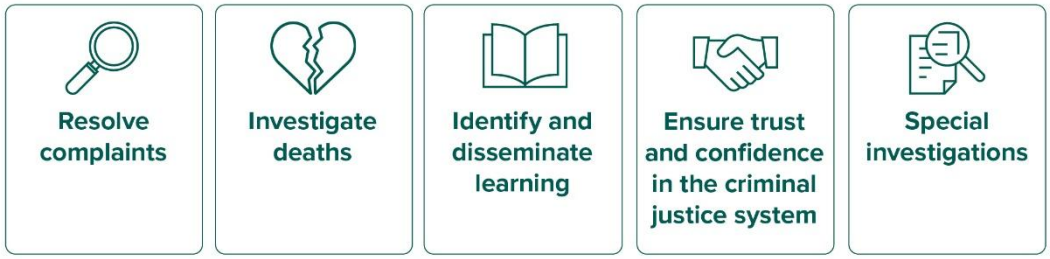
OUR VISION

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. On 16 December 2016, Mr Colin Waterfield was sentenced to 21 years in prison for sex offences. He died from severe pneumonia on 18 March 2025, while a prisoner at HMP Bure. He was 78 years old. We offer our condolences to Mr Waterfield's family and friends.

4. The PPO family liaison officer wrote to Mr Waterfield's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

5. NHS England commissioned an independent clinical reviewer, to review Mr Waterfield's clinical care at HMP Bure. The clinical review is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care that Mr Waterfield received at Bure was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. He found that Mr Waterfield was appropriately transferred to hospital when his care needs could not be met at Bure, and he received compassionate care from staff. The clinical reviewer made no recommendations.

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

8. We did not identify any non-clinical learning and we make no recommendations.

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

10. At an inquest held on 3 September 2025, the Coroner concluded that Mr Waterfield died of natural causes.

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

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