Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Waterman, a prisoner at HMP Swansea, on 7 October 2025

A report by the Prisons and Probation Ombudsman

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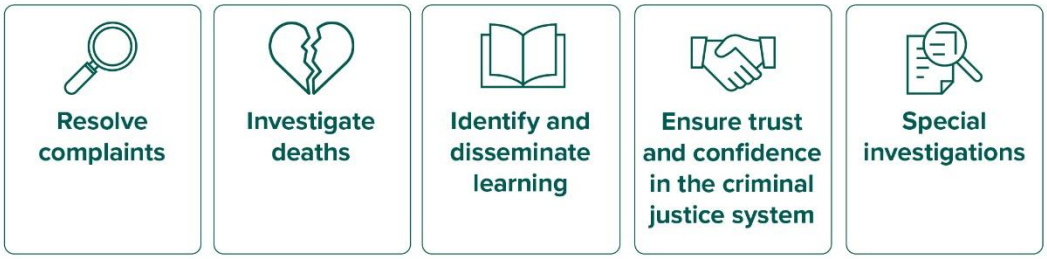
OUR VISION

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 11 June 2025, Mr Mark Waterman was remanded in prison charged with arson. He died in hospital from cancer on 7 October, while a prisoner at HMP Swansea. He was 54 years old. We offer our condolences to Mr Waterman's family and friends.

4. The Ombudsman's office wrote to Mr Waterman'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. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Waterman's clinical care at Swansea.

6. The clinical reviewer concluded that the clinical care Mr Waterman received at Swansea was not equivalent to that which he could have expected to receive in the community. He found that there was a delay in healthcare staff referring Mr Waterman for further investigations into his unexplained weight loss and abnormal blood test results. We recommend:

   - **The Head of Healthcare should review how the GP service manages abnormal blood markers in the context of unintentional weight loss.**

   - **The Head of Healthcare should establish a formal dietetic referral pathway for any prisoner experiencing unintentional weight loss.**

7. The clinical reviewer made 11 other recommendations not related to Mr Waterman's death which the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Waterman's care. We did not find any non-clinical issues of concern.

9. We shared our initial report with HMPPS and the prison's healthcare provider, Swansea Bay University Health Board. They found no factual inaccuracies. They queried the wording of one of the recommendations in the clinical review report, which has been amended. Swansea Bay University Health Board provided an action plan which is annexed to this report.

10. At the inquest, held on 1 April 2026, the Coroner concluded that Mr Waterman died from natural causes.

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

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