Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Penfold, a prisoner at HMP Highpoint, on 10 March 2025

A report by the Prisons and Probation Ombudsman

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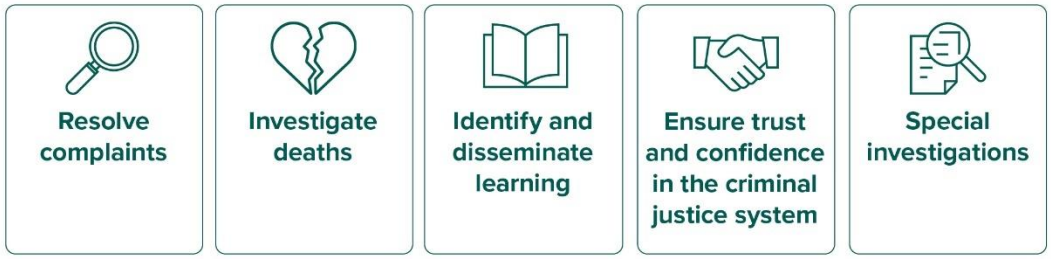
OUR VISION

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 29 January 2025, Mr Mark Penfold was sentenced to three years imprisonment for fraud. He died of heart failure caused by various heart and lung conditions on 10 March, at HMP Highpoint. He was 65 years old. We offer our condolences to Mr Penfold's family and friends.

4. The Ombudsman's office wrote to Mr Penfold's next of kin to explain the investigation. The only specific question was about the cause of Mr Penfold's death.

5. NHS England commissioned an independent clinical reviewer to review Mr Penfold's clinical care at Highpoint.

6. The clinical reviewer concluded that in his relatively short time at Highpoint, the clinical care Mr Penfold received was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made a recommendation not related to Mr Penfold's death, about clinical observations on reception, that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Penfold's care. We did not find any non-clinical issues of concern. We make no recommendations.

8. A copy of the initial report was sent to Mr Penfold's next of kin. She reported no factual inaccuracies but queried a matter of detail, which has been addressed in correspondence.

9. We shared the initial report with HMPPS. They found no factual inaccuracies.

Governor to note

10. The investigation found that the operational support night staff who conducted the early morning welfare check did not call an emergency code as they genuinely believed Mr Penfold was in a deep sleep, as was common for a lot of the men, so they radioed for help to rouse him. There was a significant delay of around eight minutes before the response officers arrived at the cell, as they were unlocking the prison's front gate and had to draw keys and radios before returning to the wing, which was some distance away.

11. We are satisfied that the staff involved were fully conversant with the procedures to be followed in the event of concerns and their decision not to call an emergency code was a matter of fine judgement. Indeed, having reflected, they volunteered that in a similar situation in future, they would err on the side of caution and radio a code to ensure a timely response. We therefore make no further comment, but the Governor might wish to review the location of response staff during night shifts.

Inquest

12. At an inquest held on 30 March 2026, the coroner concluded that Mr Penfold died from natural causes.

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

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