Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Richards, a prisoner at HMP High Down, on 17 January 2025

A report by the Prisons and Probation Ombudsman

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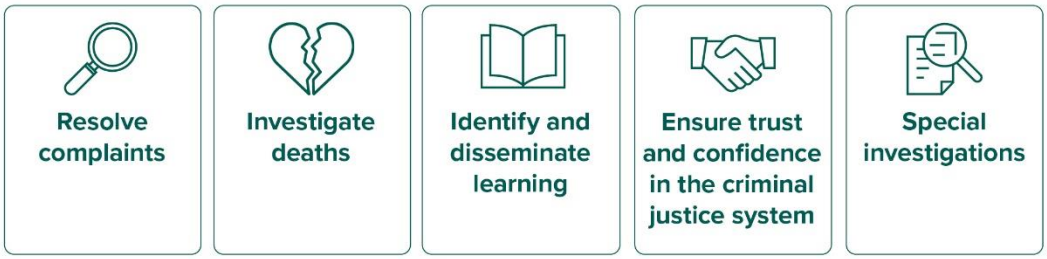
OUR VISION

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 4 March 2024, Mr Mark Richards was sentenced to two years and four months in prison for child sex offences.

4. Mr Richards died in hospital from an infective exacerbation of interstitial lung disease (the worsening of damaged, scarred lungs) on 17 January 2025, while a prisoner at HMP High Down. He was 57 years old. We offer our condolences to Mr Richards' family and friends.

5. The Ombudsman's office wrote to Mr Richards' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

6. NHS England commissioned an independent clinical reviewer to review Mr Richards' clinical care at HMP High Down.

7. As part of the investigation, the clinical reviewer and the PPO investigator interviewed one member of staff on 17 March 2025.

8. The clinical reviewer concluded that the clinical care Mr Richards received at High Down was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made three recommendations which were not related to Mr Richards' death but which the Head of Healthcare will want to address.

9. The investigator investigated the non-clinical issues relating to Mr Richards' care.

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

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

Governor to note

12. On 18 December 2024, Mr Richards was restrained when he was escorted to hospital, even though healthcare staff had objected to the use of restraints. High Down told us that this was caused by human error. We bring this to the Governor's attention.

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

Record of inquest

13. The inquest into Mr Richards' death was held on 17 September 2025 and a verdict of natural causes was recorded.

14. The coroner concluded that Mr Richards' death was due to infective exacerbation of interstitial lung disease. The coroner recorded that Mr Richards had ischemic heart disease, heart failure and diabetes which were contributory factors.

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