Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Penton, a prisoner at HMP Warren Hill, on 14 November 2024

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 1 April 2014, Mr Simon Penton was sentenced to life imprisonment for manslaughter. On 17 February 2021, he was transferred to HMP Warren Hill.

4. Mr Penton died on 14 November 2024, due to squamous cell carcinoma of the tonsil (a type of cancer in the tonsil's lining cells), with ischaemic heart disease (reduced blood supply to the heart) as a contributing factor. He was 54 years old. We offer our condolences to Mr Penton's family and friends.

5. The Ombudsman's office contacted to Mr Penton's partner, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

6. NHS England commissioned an independent clinical reviewer, to review the clinical care Mr Penton received at Warren Hill. The clinical reviewer's report is attached as Annex 1. The clinical reviewer concluded that the clinical care Mr Penton received at Warren Hill was of a reasonable standard and was equivalent to that which he would have received in the community. He found that healthcare staff managed Mr Penton with compassion and care.

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

8. The inquest into Mr Penton's death concluded on 3 October 2025, returning a verdict of natural causes.

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

Prisons & Probation Ombudsman
Independent Investigations

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