Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Hughes, a prisoner at HMP Isle of Wight, on 11 November 2024

A report by the Prisons and Probation Ombudsman

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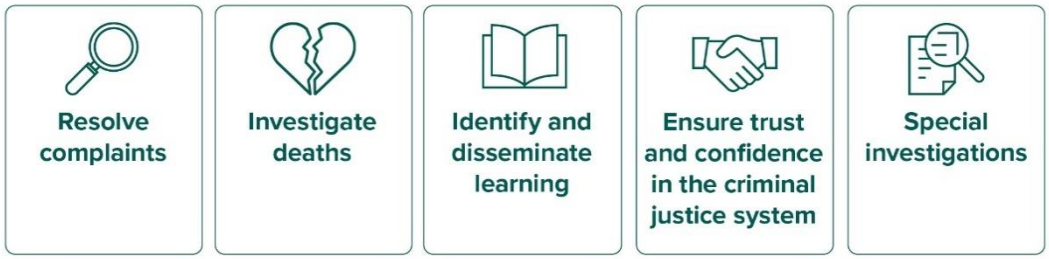
OUR VISION

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

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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. In 2015, Mr Paul Hughes was sentenced to six years in prison for sex offences. In May 2022, he was released but was recalled to prison in November for breaching of a Sexual Harm Prevention Order. He died of pneumonia on 11 November 2024, in hospital, while a prisoner at HMP Isle of Wight. He also had an ischaemic stroke (when a blood clot blocks off the blood supply to part of the brain), liver cirrhosis (scarring of the liver) and coronary artery atherosclerosis (where the arteries in your heart become narrowed) which did not cause but contributed to his death. He was 55 years old. We offer our condolences to those who knew him.

4. NHS England commissioned an independent clinical reviewer to review Mr Hughes' clinical care at HMP Isle of Wight. The clinical reviewer's report is attached as Annex 1.

5. The clinical reviewer concluded that the clinical care Mr Hughes received at Isle of Wight was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that a GP referred Mr Hughes for a brain scan scheduled for September 2024, but he declined to attend. The clinical reviewer also found that healthcare staff maintained regular contact with hospital staff when Mr Hughes was under their care. Following his diagnosis of pancytopenia (a condition where a person has low levels of red blood cells, white blood cells and platelets), she noted that healthcare staff managed his condition appropriately with medication. She also noted that Mr Hughes received ongoing mental health support during his time at Isle of Wight. The clinical reviewer made no recommendations.

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

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

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

Inquest

At the inquest held on 22 January 2026, the Coroner concluded that Mr Hughes died from natural causes. It concluded that he died from pneumonia with no other health conditions contributing to his death.

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