Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Domeney, a prisoner at HMP Isle of Wight, on 31 December 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

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 February 2018, Mr Wayne Domeney was sentenced to 12 years in prison for sexual offences. In September 2018, he was transferred to HMP Isle of Wight.

4. Mr Domeney died of pneumonia with left-sided pleural empyema (collection of pus around the lung) on 31 December 2024. He was 58 years old. We offer our condolences to Mr Domeney's family and friends.

5. The Ombudsman's office wrote to Mr Domeney's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions about the circumstances of Mr Domeney's death but asked for a copy of our report.

6. We shared the initial report with Mr Domeney's family. They did not identify any factual inaccuracies. We also shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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

8. NHS England commissioned an independent clinical reviewer to review Mr Domeney's clinical care at Isle of Wight.

9. The clinical reviewer concluded that the clinical care Mr Domeney received at Isle of Wight was not of the required standard and not equivalent to that which he could have expected to receive in the community. She found that there was a lack of a documented mental health assessment when Mr Domeney began to self-neglect in the last week of his life. The clinical reviewer also found that there were knowledge and training gaps for healthcare staff regarding local procedures when prisoners declined healthcare appointments and a lack of escalation to senior clinical staff. We make the following recommendation:

   The Head of Healthcare should review local policies and training needs to ensure that staff understand their roles and responsibilities when prisoners neglect their health, including that they understand when and how to make timely assessments and referrals to safeguard prisoners, and when to escalate to senior clinicians.

10. The inquest into Mr Domeney's death concluded on 11 May 2026, recording a verdict of natural causes.

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

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