Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Austin Hughes, a prisoner at HMP Risley, on 12 April 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

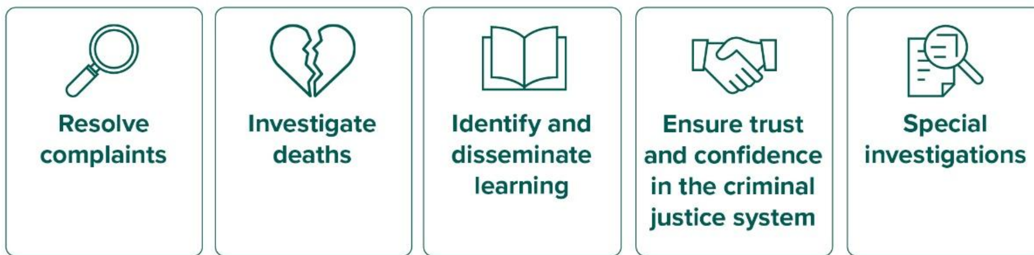
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

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

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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. On 20 March 2025, Mr Austin Hughes was convicted of sexual offences and sentenced to 32 months in prison.

4. Mr Hughes died in hospital of heart failure caused by ischaemic heart disease due to coronary artery atheroma (buildup of fatty deposits in the arteries), left ventricular hypertrophy (thickening of the left ventricle walls) and aortic valve calcification with stenosis (narrowing and restricting blood flow from the heart) on 12 April 2025, while a prisoner at HMP Risley. He was 76 years old. We offer our condolences to Mr Hughes' family and friends.

5. The Ombudsman's office wrote to Mr Hughes' daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

6. We also shared the initial report with Mr Hughes' family. They raised a number of issues that do not impact on the factual accuracy of this report and which we have addressed through separate correspondence.

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

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

9. The clinical reviewer concluded that the clinical care Mr Hughes received at Risley was of a good standard and equivalent to that which he could have expected to receive in the community. She found that in Mr Hughes' short time in prison, healthcare staff promptly assessed his needs and appropriately referred him for a social care assessment. The clinical reviewer made one recommendation not related to Mr Hughes' death that the Head of Healthcare will wish to address.

10. The PPO investigator investigated the non-clinical issues relating to Mr Hughes' care.

11. We did not find any non-clinical issues of concern. We make no recommendations.

Inquest

The inquest into Mr Hughes' death concluded on the 19 February 2026. The coroner confirmed that Mr Hughes died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

March 2026

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