Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Hughes, a prisoner at HMP Risley, on 6 January 2025

A report by the Prisons and Probation Ombudsman

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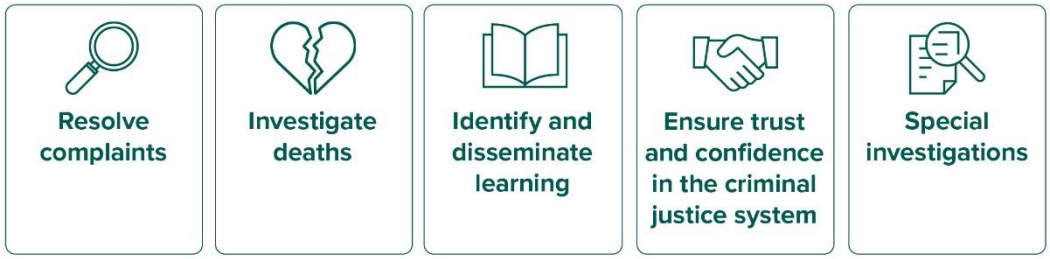
OUR VISION

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 8 February 2017, Mr Alan Hughes was recalled to prison for breach of licence conditions (following a previous Scottish courts sentence of eight years for assault and robbery). He was remanded to HMP Durham for attempted kidnap and false imprisonment with intent to commit a sexual offence.

4. On 28 April, Mr Hughes was sentenced to ten years in prison, reduced on appeal to eight years with an extended five-year licence period. His conditional release date was 20 April 2025.

5. On 6 May 2022, Mr Hughes was transferred to HMP Risley.

6. Mr Hughes died in hospital on 6 January 2025. His cause of death was heart failure caused by ischaemic (reduced blood flow to heart) and hypertensive (high blood pressure) heart disease, coronary artery atheroma (build-up of fatty deposits within the coronary arteries) and hypertension. Type 2 diabetes mellitus and an old cerebral infarction (stroke) were contributing factors. Mr Hughes was 67 years old. We offer our condolences to his family and friends.

7. The Ombudsman's office contacted Mr Hughes' daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

8. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.

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

10. NHS England commissioned an independent clinical reviewer, to review Mr Hughes' clinical care at HMP Risley.

11. The clinical reviewer concluded that the clinical care Mr Hughes received at Risley was partially equivalent to that which he could have expected to receive in the community. She found that the care he received for his long-term health conditions, including type 2 diabetes, high blood pressure, heart condition and kidney disease, was of a good standard. She also identified good continuity of care from the healthcare team, especially a primary care GP who was a good enabler in supporting engagement with Mr Hughes' medical care.

12. However, the clinical reviewer found that care around Mr Hughes' regional bed referral (for a bed in a prison healthcare inpatient facility) was not equivalent to that

which he could expect to receive in the community. Healthcare staff first referred Mr Hughes for a regional bed in July 2024. This was not discussed further or escalated until they made a second referral in December.

13. The clinical reviewer also found that a discharge plan following Mr Hughes' discharge from hospital in December 2024 was not enacted. We make the following recommendations:

The Head of Healthcare should ensure that there is a local process to maintain oversight of regional bed referrals and any required escalation.

The Head of Healthcare should undertake an audit of hospital discharge plans to ensure that the agreed plan has been enacted and develop an action plan based on the findings.

Inquest

14. The inquest into Mr Hughes death concluded on the 15 July 2025. The coroner confirmed that Mr Hughes died of natural causes.

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

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