Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Hopkins, a prisoner at HMP Cardiff, on 2 December 2023

A report by the Prisons and Probation Ombudsman

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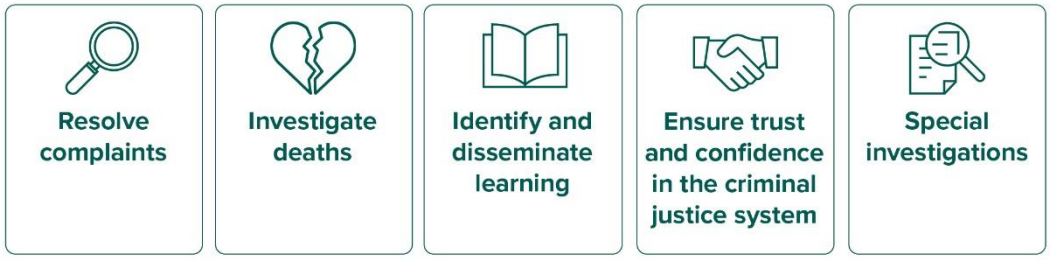
OUR VISION

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 4 November 2022, Mr Stephen Hopkins was remanded into custody at HMP Cardiff, charged with two counts of conspiracy to supply Class A drugs. He died of septic shock on 2 December 2023 while still on remand. This was caused by an anastomotic leak (a post-surgical complication) following rectal cancer surgery. He was 59 years old. We offer our condolences to Mr Hopkins' family and friends.

4. The Ombudsman's office wrote to Mr Hopkins' next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

5. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Hopkins' clinical care at HMP Cardiff.

6. The clinical reviewer concluded that the clinical care Mr Hopkins received at HMP Cardiff was of a good standard and equivalent to that which he could have expected to receive in the community. He found that Mr Hopkins had good quality healthcare in managing his cancer diagnosis and substance misuse.

7. The clinical reviewer made recommendations not related to Mr Hopkins' death that the Head of Healthcare at HMP Cardiff will want to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Hopkins' care. We did not identify any non-clinical concerns and make no recommendations.

9. However, the Governor should note that we were not provided with any staff statements or evidence that a hot debrief took place. While the bed watch officers worked at other prisons, it was HMP Cardiff's responsibility to offer support to all staff members involved in Mr Hopkins' care.

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

11. At an inquest held on 7 March 2025, the Coroner concluded that Mr Hopkins died of natural causes.

Adrian Usher **June 2024**
Prisons and Probation Ombudsman

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