Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Sargeant, a prisoner at HMP Swansea, on 21 December 2022

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

Summary

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 12 December 2022, Mr Steven Sargeant was sentenced to eight months imprisonment for theft and drug offences. On 21 December 2022, he died of bronchopneumonia, on a background of bullous emphysema (lung disease) at HMP Swansea. He was 46 years old. We offer our condolences to Mr Sargeant's family and friends.

4. The PPO family liaison officer wrote to Mr Sargeant's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not reply.

5. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Sargeant's clinical care at HMP Swansea.

6. The clinical reviewer concluded that the clinical care Mr Sargeant received at Swansea was equivalent to that which he could have expected to receive in the community. He found that Mr Sargeant received timely reception health screens, as well as prompt access to the GP and medication. The clinical reviewer made recommendations unrelated to the cause of Mr Sargeant's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Sargeant's care.

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

9. The initial report was shared with HM Prison and Probation Service (HMPPS). They reported two drafting errors in the clinical review report, which have been amended.

Governor to note

10. Staff conducting routine roll counts should be satisfied that each prisoner is alive and well. It seems that the officer who conducted the count on the morning of Mr Sargeant's death made only a cursory check. This does not appear to have affected the outcome, as Mr Sargeant was likely to have died some time before that, but it is a key lesson for the prison to consider.

Inquest

11. At an inquest held on 4 July 2025, the Coroner concluded that Mr Sargeant died of natural causes.

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

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