Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Peter Hopkins, a prisoner at HMP Doncaster, on 12 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

# 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. Mr Peter Hopkins died of bilateral pneumonia (infection in both lungs) on 12 December 2024, while a prisoner at HMP Doncaster. Frailty and metastatic renal cancer (cancer that started in the kidneys and then spread to other parts of the body) contributed to but did not cause Mr Hopkins' death. He was 84 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Hopkins received at Doncaster was partially equivalent to that which he could have expected to receive in the community. She found that the healthcare team did not follow up with hospital appointments, that there was a delay in referring Mr Hopkins to the multidisciplinary forum (MPCCC) and that they did not identify Mr Hopkins' risk of malnutrition. The clinical reviewer made several recommendations, some of which we have included below.

5. We also found that Mr Hopkins' compassionate release application was delayed due to staff being unclear about their own responsibilities and not being proactive in completing the application.

## Recommendations

- The Head of Healthcare should review the current *Local Operational Procedure: Outside Hospital Appointments* and the *live cancer tracker* to seek assurance that they are sufficiently robust, effective and fit for purpose. An audit should then be completed within three months of the completion of the review.

- The Head of Healthcare and Lead GP should ensure that staff are aware of and adhere to *Local Operating Procedure for referral to MPCCC* so that referrals are completed in timely manner and staff report significant updates with the wider team.

- The Head of Healthcare should ensure that staff receive training in recognising and managing prisoners at risk of malnutrition.

- The Director and the Head of Healthcare should review the ERCG application process, ensuring that all staff are aware of their responsibilities and are tenacious in obtaining the information needed.

# The Investigation Process

6. HMPPS notified us of Mr Hopkins' death on 12 December 2024.

7. NHS England commissioned an independent clinical reviewer, to review Mr Hopkins' clinical care at Doncaster. The clinical review is attached as Annex 1.

8. The PPO investigator investigated the non-clinical issues relating to Mr Hopkins' care. She interviewed one member of staff from Doncaster. The investigator and clinical reviewer jointly interviewed three members of healthcare staff.

9. 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 asked about Mr Hopkins' healthcare treatment in prison and the delays in applying for his compassionate release. These issues are covered in this report and the clinical review.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

11. Mr Hopkins' family received a copy of the draft report. They did not make any comments.

## Previous deaths at HMP Doncaster

12. In the three years before Mr Hopkins' death, there were 12 deaths at Doncaster. Of the previous deaths, seven were from natural causes and five were self-inflicted. We found a similar issue about delays in applying for compassionate release in a previous investigation. There have been four deaths since that of Mr Hopkins up to the end of April 2025. Three of these were due to natural causes and the other cause of death is currently unascertained.

## Early release on compassionate grounds (ERCG)

13. Early release on compassionate grounds is the means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

# Key Events

14. Mr Peter Hopkins was remanded to HMP Doncaster in November 2016, charged with sexual offences. The following month, he was sentenced to an extended sentence of 25 years imprisonment and 2 years on licence. Mr Hopkins appealed and, in January 2017, his sentence was amended to 20 years imprisonment and 1 year on licence.

15. Mr Hopkins had several long-term conditions, such as diabetes, hypertension (high blood pressure), osteoarthritis (inflammation to joints), oesophageal (food pipe) ulcers, and difficulty in swallowing food, drink and sometimes saliva.

16. In October 2018, the hospital urology team (a specialist team which focus on the urinary and reproductive systems) found a tumour in Mr Hopkins left kidney. This looked like it could become cancerous, so he had regular scans to monitor it.

17. In March 2020, Mr Hopkins had a CT scan and healthcare staff noted that the tumour had grown significantly, was cancerous and that the left kidney should be removed. This happened in April.

18. Follow-up tests confirmed that the cancer had not spread to other parts of the body. Mr Hopkins continued to be monitored by the urology department.

19. In November 2021, a specialist consultant advised that a follow up CT scan should happen in December and, if there were no concerns, then Mr Hopkins should be reviewed six months later. In December, the healthcare team at Doncaster received a letter with the plan, but no CT scan appointment. Staff did not follow this up.

20. In March 2022, the urology team sent a letter to the healthcare team to say that Mr Hopkins had missed his CT scan, but no other CT was scheduled. Again, healthcare staff at Doncaster did not follow this up.

21. The urology department cancelled an appointment on 17 May due to the doctor being unwell. The healthcare team received a new appointment on 27 June for 1 November. At this appointment, Mr Hopkins presented as well and asymptomatic. The consultant organised a CT scan for 30 December, which the prison subsequently rearranged to 17 January 2023, due to a lack of available escorting staff. Mr Hopkins attended this appointment. The urology team did not share the results with Mr Hopkins or healthcare staff at Doncaster. As such, they were not aware that a small lung nodule (a growth which can be benign or cancerous) had been identified in the scan.

22. In July, Mr Hopkins had another CT scan, which revealed multiple nodules in his lungs. The results were only shared with healthcare staff at Doncaster on 13 November, although there is no evidence that staff chased the results before this date. (The reason for the delay in the hospital's communication with Doncaster falls outside the remit of this investigation.) The hospital had scheduled Mr Hopkins an appointment for 17 October but the prison was unaware of this. Dr A, GP, reviewed the hospital letter on 13 November and sent a task to the administrative team ensuring that Mr Hopkins attended his next urology appointment as he may have metastatic cancer. She did not document this information in Mr Hopkins' clinical

record or refer Mr Hopkins to the multi professional complex case clinic (MPCCC – a weekly multidisciplinary meeting to assist clinicians to decide on a plan of care).

23. Mr Hopkins attended a hospital appointment on 21 November, when staff told him that the cancer had spread to his lungs. The specialist consultant said he would refer Mr Hopkins to an oncology (cancer) specialist to discuss his treatment options. When Mr Hopkins returned to prison, there is no evidence that a nurse saw him. It is unclear if the escorting officers notified healthcare staff of his diagnosis.

24. The urology team wrote to healthcare staff on 14 December to confirm Mr Hopkins' diagnosis and treatment plan. Staff were unaware of the diagnosis until Mr Hopkins' sister called the prison to bring this to their attention, on 19 December, as they had not read the letter. The Deputy Head of Healthcare referred Mr Hopkins to the MPCCC.

25. On 30 January 2024, Mr Hopkins had an oncology appointment and hospital staff discussed his treatment plan with him. He had a CT scan on 2 February and the first cycle of treatment started in early March. He became more unwell and moved to the social care unit in the prison on 4 April. On 16 April, hospital staff stopped the treatment as Mr Hopkins had reacted badly to it. On 19 April, Officer A was appointed as family liaison officer and rang Mr Hopkins' family.

26. On 20 April, Mr Hopkins was admitted to hospital due to him deteriorating. Prison staff were aware that Mr Hopkins was unwell and may die soon. Therefore, prison staff started an application for Mr Hopkins' early release on compassionate grounds (ERCG).

27. On 23 April, Mr A, Head of Offender Management Delivery, who was collating the evidence for the ERCG application, contacted Officer A and told her he had started the application. The next day, Officer A explained this to Mr Hopkins' next of kin. On 28 April and 1 May the next of kin requested updates on the application. On 2 May, Officer A told them that they were still collating evidence for the application.

28. On 10 May, Mr Hopkins returned to Doncaster. On 11 June, healthcare staff completed their section of the ERCG application.

29. On 26 June, Mr Hopkins had a telephone appointment with an oncology specialist who considered that he was not fit enough for further treatment. The consultant noted that if Mr Hopkins had further symptoms which needed controlling, input from the palliative care team would be appropriate. Mr Hopkins was accompanied by a healthcare support worker who did not update the wider team as they should have.

30. On 14 August, hospital staff informed the prison that Mr Hopkins had been discharged from the oncology team. The healthcare team only updated their paperwork on compassionate release at this point.

31. Mr A told the investigator that having collated all the necessary evidence for the ERCG application, the Deputy Director said they could not support the application because there was not a clear plan on where Mr Hopkins would live. Mr A contacted the Public Protection Casework Section (PPCS) who process applications, to ask if they needed a firm address and release plan prior to submitting the application. On 21 August 2024, PPCS confirmed they did.

32. On 17 September, Mr Hopkins agreed with healthcare staff that, given his declining health, he should not be resuscitated if his heart and breathing stopped. Over the following months, Mr Hopkins' condition continued to deteriorate.

33. On 11 October, staff had a multidisciplinary meeting to discuss Mr Hopkins' ERCG application. The actions from that meeting were unclear, but the main concern seemed to be disclosure of Mr Hopkins' offences to any potential hospice and how stringent licence conditions could be managed in that setting.

34. On 21 November, Nurse A assessed Mr Hopkins and noted that the level of oxygen in his bloodstream was low, so she gave him oxygen therapy. She noted that Mr Hopkins had a NEWS2 (a tool that helps healthcare staff to determine the urgency of the situation) score of nine, which warranted an immediate transfer to hospital. Staff facilitated this.

35. On 26 November, Mr Hopkins returned to Doncaster. His sister called healthcare staff as she was concerned he was in pain. Staff scheduled an appointment for 2 December to review his pain and to consider prescribing anticipatory medication (medicine which is often prescribed at the end of life in case distressing symptoms develop).

36. On 28 November, Nurse B assessed Mr Hopkins and his NEWS2 score was five (meaning that Mr Hopkins was at medium risk of deterioration and needed to be urgently reviewed by a clinician with expertise in acute illness assessment). Staff requested an ambulance and paramedics arrived several hours later. Mr Hopkins refused to go to hospital and said he felt 'fine'.

37. On 2 December, Dr B, GP, reviewed Mr Hopkins. He said he was not in pain or discomfort. She assessed that Mr Hopkins did not need to be prescribed anticipatory medication yet. She requested that healthcare staff monitor Mr Hopkins' blood pressure.

38. On 4 December, healthcare staff assessed Mr Hopkins and his NEWS2 score was five, so they called an ambulance and asked Mr Hopkins to eat and drink. Mr Hopkins said he had no appetite. When paramedics arrived, they reiterated what healthcare staff had said and assessed that Mr Hopkins did not need to go to hospital.

39. Later that day, Dr C, GP, reviewed Mr Hopkins. He noted that his condition was relatively stable, he was comfortable and did not need to be prescribed anticipatory medicine yet. Healthcare staff continued to observe him in the following days.

40. On 9 December, Dr B reviewed Mr Hopkins. She noted that he was frail and she had been informed that he was refusing to eat or drink. His observations were normal. She told the clinical reviewer that she was concerned about Mr Hopkins and she asked the Deputy Head of Healthcare to contact Dr C about his end-of-life care. Dr C did not recall being contacted.

41. On 11 December, healthcare staff assessed Mr Hopkins and his NEWS2 score was seven (indicating that he was significantly deteriorating and needed an emergency assessment by a clinical team). Nurse C decided that Mr Hopkins should continue to be monitored and assessed further the next day. Throughout the night Mr

Hopkins was agitated and confused. Staff decided to handover this information to day staff rather than seek medical advice during the night.

42. On 12 December at 8.00am, healthcare staff assessed Mr Hopkins. He had low oxygen in his blood and he was not alert. His NEWS2 score was 12 (indicating that he was at very high risk of deterioration). Healthcare staff suspected he had pneumonia. Nurse B radioed an emergency medical code, staff called an ambulance and paramedics quickly arrived.

43. Paramedics concluded that, due to Mr Hopkins' condition, it would not be in his best interests to go to hospital. They spoke to Dr B who agreed Mr Hopkins should remain at Doncaster to receive end of life care. She had not had the training to prescribe anticipatory medication. Around 2.00pm, Dr D, psychiatrist, prescribed this medication, which was not needed in the end as Mr Hopkins remained pain free.

44. The prison informed Mr Hopkins' family about his condition and they visited him in prison that day. Mr Hopkins died, with healthcare staff present, at 7.08pm.

## Post-mortem report

45. At the time of writing, the post-mortem report was not available. However, the Coroner confirmed Mr Hopkins' cause of death as bilateral pneumonia. Frailty and metastatic renal cancer also contributed to Mr Hopkins' death.

# Findings

## Clinical care

46. The clinical reviewer concluded that Mr Hopkins' care was partially equivalent to that which he could have expected to receive in the community. She concluded that healthcare staff managed his long-term conditions in line with national guidance, involved Mr Hopkins and his family in his care towards the end of his life and the emergency response when his condition deteriorated was appropriate.

47. However, she also found that there were several occasions where healthcare staff did not follow up on Mr Hopkins' hospital appointments. In interview, Ms A, Head of Healthcare, confirmed that, since Mr Hopkins' death, several trackers had been put in place to prevent this. Despite this, further improvements still need to be made to ensure policies are robustly followed. We recommend that:

    **The Head of Healthcare should review the current *Local Operational Procedure: Outside Hospital Appointments* and the *live cancer tracker* to seek assurance that they are sufficiently robust, effective and fit for purpose. An audit should then be completed within three months of the completion of the review.**

48. The clinical reviewer found that healthcare staff should have referred Mr Hopkins to the MPCCC on 13 November 2023, when it was suspected that he had cancer. She also noted that after Mr Hopkins' oncology appointment on 26 June 2024, when he was informed that he was no longer fit for cancer treatment, the wider healthcare team was not informed of this. They only became aware of this on 20 August. This caused a delay in care planning. We recommend that:

    **The Head of Healthcare and Lead GP should ensure that staff are aware of and adhere to *Local Operating Procedure for referral to MPCCC* so that referrals are completed in timely manner and staff report significant updates with the wider team.**

49. The clinical reviewer also found that healthcare staff did not appropriately identify that Mr Hopkins was at high risk of malnutrition after losing a significant amount of weight, and did not escalate this appropriately. This meant Mr Hopkins' weight was not adequately monitored towards the end of his life.

    **The Head of Healthcare should ensure that staff receive training in recognising and managing prisoners at risk of malnutrition.**

50. The clinical reviewer also made several other recommendations which the Head of Healthcare will want to address.

## Early release on compassionate grounds (ERCG)

51. When Mr Hopkins went to hospital on 20 April 2024, prison staff thought that he could be approaching the end of his life, so they started to gather evidence to apply for compassionate release to PPCS. This was good practice. However, the process seems to have stalled once Mr Hopkins returned to prison.

52. Staff were not clear about certain aspects of the process which led to delays and miscommunication. Multidisciplinary discussions should have happened earlier to determine whose responsibility it was to complete certain actions. Since Mr Hopkins died, Mr A told us that the prison has developed a new flow chart to clarify the process of applying for ERCG. A multidisciplinary meeting should now happen within 10 working days of identifying that an ERCG application should be made. We welcome this improvement to practice.

53. In a multidisciplinary meeting on 11 October, staff identified that due to Mr Hopkins' offences he could present a risk to others and that he would be subject to stringent licence conditions, should he be released. Staff considered that this would most likely be a barrier in securing a hospice bed for him. However, we found that no one was tasked with looking for accommodation for Mr Hopkins and these concerns were not discussed with potential hospices.

54. Mr Hopkins' family often sought updates about Mr Hopkins' ERCG application from healthcare staff. This was understandable as there was good communication between the two parties. However, since the application for ERCG was a prison led process, prison staff, such as the family liaison officer, should also have routinely been updating Mr Hopkins' family. We make the following recommendation:

    **The Director and the Head of Healthcare should review the ERCG application process, ensuring that all staff are aware of their responsibilities and are tenacious in obtaining the information needed.**

## Good Practice

55. We commend Nurse D, Nurse E, Nurse F and Healthcare Support Worker, Mr B for providing compassionate care to Mr Hopkins in the final hours of his life and remaining with him as he died.

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

## Inquest

The inquest hearing was held on 3 December 2025. The Coroner concluded that Mr Hopkins died of natural causes.

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