

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Cope, a prisoner at HMP Usk, on 4 September 2025

A report by the Prisons and Probation Ombudsman

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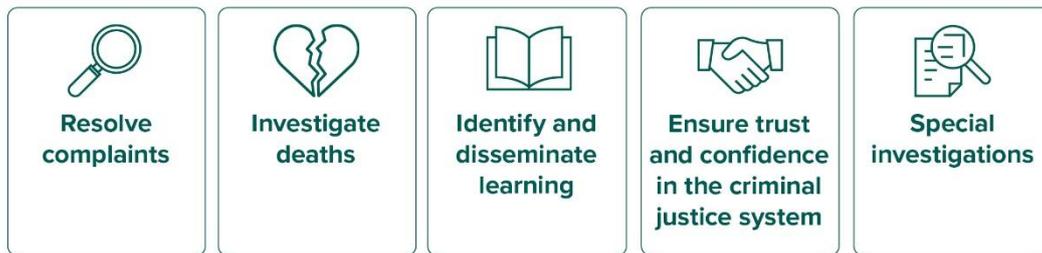
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OUR VISION

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



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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. In June 2007, Mr Thomas Cope was sentenced to life imprisonment for sexual offences. He died in hospital of lung cancer on 4 September 2025, while a prisoner at HMP Usk. He was 72 years old. We offer our condolences to Mr Cope's family and friends.
4. The Ombudsman's office wrote to Mr Cope's nominated next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for details of the events that led to Mr Cope's cancer diagnosis. This is addressed in the clinical review.
5. Healthcare Inspectorate Wales commissioned an independent clinical reviewer to review Mr Cope's clinical care at HMP Usk. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Cope received at Usk was of a high standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer found that there had been a delay in prison healthcare staff chasing up a chest X-ray referral, though the delay had no impact on the timing of Mr Cope's lung cancer diagnosis. The clinical reviewer made two recommendations that the Head of Healthcare will wish to address.
7. There were also delays by the hospital in arranging scans and communicating scan results to Mr Cope. However, issues relating to the care provided by the hospital are outside the scope of the PPO investigation.
8. The PPO investigator investigated the non-clinical issues relating to Mr Cope's care.
9. We did not find any non-clinical issues of concern. We make no recommendations.
10. We shared our initial report with HMPPS and the prison's healthcare provider, Aneurin Bevan University Health Board (ABUHB). ABUHB pointed out some factual inaccuracies in the clinical review. This has been amended and has been reattached as an annex.
11. At the inquest, held on 20 February 2026, the Coroner concluded that Mr Cope died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

March 2026

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