Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Sykes, a prisoner at HMP Ranby, on 5 April 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

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.

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.

Mr Luke Sykes died after being found hanged in his cell at HMP Ranby on 5 April 2024. He was 43 years old. I offer my condolences to Mr Sykes' family and friends.

Mr Sykes transferred from HMP Lincoln to Ranby two days before he took his own life. During his short time at the prison, Mr Sykes presented as untroubled, sought minimal support from staff and revealed nothing to suggest his intentions. While he had a long history of mental health issues, he received support to address his needs. I am satisfied that prison staff could not reasonably have foreseen Mr Sykes' actions.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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

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Summary

Events

1. Mr Luke Sykes had been in prison several times. He had paranoid schizophrenia (he experienced hallucinations), was under the care of the community mental health team and prescribed antipsychotic and antidepressant medications. He also had a history of substance misuse. He had last been monitored under suicide and self-harm procedures, known as ACCT, when in prison in November 2018.

2. Mr Sykes was remanded into custody for driving offences on 27 November 2023, and was sent to HMP Leicester. In January 2024, Mr Sykes was convicted and received a sentence of 20 months. On 22 January, Mr Sykes transferred to HMP Lincoln. He remained under the care of the mental health team and antidepressant and antipsychotic medications prescribed to him were continued.

3. On 3 April, Mr Sykes transferred to HMP Ranby. No concerns were raised during his initial prison reception and health screenings. He was located on the Induction Wing in a shared cell.

4. On 4 April, a mental health nurse assessed Mr Sykes. While Mr Sykes said that he heard voices (this was constant during his time in prison), he said he had no thoughts of suicide or self-harm. Neither prison nor healthcare staff raised any concerns about Mr Sykes during his time at Ranby.

5. On the afternoon of 5 April, Mr Sykes' cellmate left their cell to visit the library. On his return, Mr Sykes' cellmate found that their cell door had been locked by Mr Sykes from the inside. He alerted staff who responded and found Mr Sykes hanging from the bunk bed. An officer radioed a medical emergency code and staff responded quickly. Staff tried to resuscitate Mr Sykes until paramedics arrived and took over. They were unable to resuscitate Mr Sykes and pronounced that he had died.

Findings

6. Mr Sykes had several risk factors for suicide and self-harm. He had a history of attempted suicide and self-harm, substance misuse and depression and a diagnosis of paranoid schizophrenia.

7. Neither prisoners nor prison staff at Ranby observed any obvious signs that Mr Sykes was in crisis in the three-day period (which consisted of only one full day) leading to his death. We have concluded that, while it was clear that staff were still trying to get to know Mr Sykes, he hid the extent of any concerns he had, and it was reasonable that staff did not identify him to be an imminent risk of suicide.

8. The clinical reviewer concluded that Mr Sykes' healthcare was of a good standard and at least equivalent to that he could have expected to receive in the community.

9. We make no recommendations.

The Investigation Process

10. HMPPS informed us of Mr Luke Sykes' death on 8 April 2024. The investigator issued notices to staff and prisoners at HMP Ranby informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Sykes' prison and medical records, CCTV footage, phone records and body worn video camera (BWVC) footage. He also obtained ambulance service records and information from the police.

12. The investigator interviewed one prisoner and seven members of staff at Ranby in May 2024. He also interviewed a further prisoner via video conference in June 2024.

13. NHS England commissioned a clinical reviewer to review Mr Sykes' clinical care at the prison. The clinical reviewer and investigator jointly interviewed staff.

14. We informed HM Coroner for Nottingham City and Nottinghamshire of our investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's office contacted Mr Sykes' family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Sykes' family did not raise any questions.

16. Mr Syke's family received a copy of the initial report. They did not make any comments.

17. 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.

Background Information

HMP Ranby

18. HMP Ranby is a category C training and resettlement prison in Nottinghamshire. Nottinghamshire Healthcare NHS Foundation Trust provides primary and mental health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Ranby was in March and April 2022, which was followed up by a review of progress inspection in January 2023.

20. Inspectors found that new arrivals were treated well, and access to the 'tuck shop' in reception reduced potential debt issues as prisoners did not have to borrow items. Reception and induction staff established a good rapport with arriving prisoners and completed the necessary processes without undue delay.

21. Following COVID-19 restrictions, a group induction had resumed, with an officer giving a short briefing on the first morning after arrival and a peer worker holding a fuller session. Gym staff spoke briefly with new arrivals and a chaplain visited each prisoner on the day after arrival. However, inspectors found that the induction provision was not sufficiently engaging or comprehensive.

22. The progress inspection report highlighted that the amount of time out of cell had improved for many prisoners since the previous inspection. Those in work were unlocked for around five or six hours on weekdays. However, unemployed prisoners were unlocked for only around two hours a day and for meal collection, and those on the induction wing for as little as one hour a day.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2024, the IMB reported that the reception process for newly arrived prisoners was carried out with professionalism and care. All the relevant checks and processes were in place to ensure prisoners were passed through the system quickly and efficiently.

Previous deaths at HMP Ranby

24. Mr Sykes was the fifth prisoner to die at Ranby since April 2021. Of the previous deaths, two were self-inflicted, one was from natural causes and one was from an accidental overdose of medication. None of the investigations following these deaths raised issues relevant to Mr Sykes' death. Since Mr Sykes' death, and up until the end of July 2024, there has been a further self-inflicted death at Ranby which we are currently investigating.

Key Events

Background

25. Mr Luke Sykes had a history of offending dating back to 2011 and had been in prison several times. He had paranoid schizophrenia (he experienced auditory hallucinations) and had spent time in a secure mental health hospital. He was under the care of community and prison mental health teams and prescribed antipsychotic (olanzapine) and antidepressant (mirtazapine) medications, although it was noted that he frequently refused to comply with his treatments. He also had a history of substance misuse, namely crack cocaine, psychoactive substances and prescribed medications. Mr Sykes was last monitored under prison suicide and self-harm procedures, known as ACCT, in November 2018.

26. Mr Sykes was last released from HMP Lincoln in June 2022 where he had spent three years in prison for driving offences.

HMP Leicester

27. On 27 November 2023, Mr Sykes was remanded to HMP Leicester for driving offences. When he arrived at Leicester, staff that completed Mr Sykes' reception and first night interview noted no concerns about him.

28. Healthcare staff noted that Mr Sykes had a diagnosis of schizophrenia and he reported that he constantly heard voices and had a substance misuse history. He was prescribed olanzapine and mirtazapine. Mr Sykes said he had no thoughts of suicide or self-harm. He was referred to the mental health team and placed under the care of mental health and psychiatrist services.

29. Mr Sykes tested positive for opiates and was prescribed and started on a methadone detoxification programme. A member of the substance misuse team spoke to Mr Sykes.

30. When a mental health nurse saw Mr Sykes on 30 November, he told her that he had stopped taking his olanzapine medication because it made his leg shake. He said he heard voices telling him that his food had been poisoned. However, staff had seen him eating his meals. He disclosed that he had been sexually abused as a child but did not want any support for this. The nurse noted that Mr Sykes had a history of attempted suicide (his records did not contain any further information about method) but had no current thoughts to harm himself. The nurse referred Mr Sykes to the psychiatrist.

31. On 4 December, Mr Sykes' substance misuse detoxification programme ended. Staff recorded that Mr Sykes had been non-compliant with taking his methadone medication and had missed a number of doses.

32. On 11 December, during a key work session, Mr Sykes said that he wanted to move to a quieter wing as this would help with his mental health. He said that he had sleeping problems and was hearing voices. His key worker passed this information on to the mental health team. At his key work session on 18 December, Mr Sykes said he had settled on his current wing and got on well with his peers.

33. On 19 December, a psychiatrist assessed Mr Sykes. Mr Sykes spoke about auditory verbal hallucinations which he said he had experienced since he was 25 years old. He said that his antipsychotic medication had helped him until 2018 when the voices had become more constant. He described them as coming from the television or from inside his head, sometimes telling him to harm himself. Mr Sykes said that he had never acted upon these instructions. His main issues were the ongoing distressing voices (which he said were also bothering him during the review), akathisia (restlessness) which he attributed to his olanzapine medication, and insomnia. The psychiatrist agreed to change Mr Sykes' medication from olanzapine to quetiapine and prescribed a short-term sedative (zopiclone) to help him sleep better.

34. On 21 December, Mr Sykes attended an education class. He told staff that that he wanted to learn but struggled within a classroom environment. Staff noted that Mr Sykes would be more suited to in-cell education work. This information was passed onto the job allocation team.

35. On 5 January 2024, a mental health nurse reviewed Mr Sykes and noted that he displayed no evidence of thought disorder and appeared well. Mr Sykes said that he was still hearing voices, but his paranoia had decreased. He said his mood was low and he felt depressed. Mr Sykes requested his dose of mirtazapine was increased. Mr Sykes said he was supported by his father and partner. He said he had no thoughts of suicide or self-harm. It was agreed that Mr Sykes would be reviewed by the mental health team every two to three weeks.

36. On 18 January, Mr Sykes attended court and was sentenced to 20 months imprisonment. Prison and healthcare staff completed a welfare check on his return to prison. Mr Sykes raised no concerns.

37. On 22 January, Mr Sykes transferred to HMP Lincoln. During his reception screening and induction, staff raised no concerns. Mr Sykes told staff that he had no thoughts of suicide or self-harm.

38. Mr Sykes' key worker attempted to see him on 30 January, however he was on a social visit. The key work session was rescheduled.

39. On 19 February, a mental health nurse reviewed Mr Sykes. Mr Sykes said that he was hearing voices, which were 'mean and derogatory'. He said that he was struggling to be around others due to an increase in his paranoia. He wanted to complete education in his cell only and not have to attend work. He said he had no thoughts of suicide or self-harm. The nurse referred him to the psychiatrist.

40. On 20 February, a neurodiversity and reading specialist saw Mr Sykes and completed an in-depth screening for learning disabilities and difficulties. This identified that he required no additional support from subject instructors or neurodiversity and reading specialists.

41. During key work sessions on 12 and 29 March, Mr Sykes said that he had not attended his assigned workplace due to his mental health. He said that he had completed the relevant exemption form to exclude him from this. Despite this, staff recorded that Mr Sykes' mood was positive. He asked for information about how to

get a transfer to HMP Ranby or HMP Fosse Way but did not state why he wanted to move prisons. His key worker explained the process to him.

42. On 14 March, Mr Sykes failed to attend his mental health appointment. He gave the nurse no reason for his non-attendance.

43. On 31 March, staff noted that Mr Sykes had attempted to keep his afternoon medications rather than take them. No further information was recorded.

44. On 2 April, a psychiatrist reviewed Mr Sykes. Mr Sykes reported that he was still hearing voices, mainly coming through the television. He said that the voices had got worse since he had been in prison and were telling him that he had been poisoned and would go blind. The psychiatrist agreed to increase Mr Sykes' dose of quetiapine from 300mg to 400mg daily.

HMP Ranby

3 April

45. On the afternoon of 3 April, Mr Sykes transferred to HMP Ranby. The Head of Safer Custody told the investigator that this was a routine transfer and that there were no issues or concerns associated with it.

46. When he arrived, the Digital Person Escort Record (DPER) that accompanied Mr Sykes indicated that he had a history of attempted suicide and self-harm, but this was historic, happened years ago and he said he had no currents thoughts of suicide or self-harm. The DPER also noted that Mr Sykes had a history of mental health problems: schizophrenia, hearing voices, depression and anxiety and had spent time in a psychiatric unit ten years ago. Staff noted on the DPER that he was currently prescribed quetiapine and mirtazapine.

47. Prison staff that booked Mr Sykes into Ranby, recorded that he had been convicted of driving offences, was serving a 20-month sentence and was due for release in April 2024. They noted that Mr Sykes said he had no thoughts of suicide or self-harm, no substance misuse concerns and had no neurodiversity needs.

48. At 2.19pm, a nurse completed Mr Sykes' first reception health screen. Mr Sykes stated that he had not tried to harm himself in prison and had no thoughts of suicide or self-harm. He said that he had not received treatment in a psychiatric hospital (which contradicted information recorded elsewhere in his records). He said that he took his medication to maintain positive mental health. The nurse prescribed his quetiapine medication. He confirmed to the investigator that he gave Mr Sykes 300mg of quetiapine during the screening, although his prescription had been increased to 400mg the day before. (The medication that had transferred with Mr Sykes from Lincoln was a 300mg tablet and a 400mg tablet was not available, so Ranby ordered the medication to be delivered.) He referred Mr Sykes to the mental health team because of his diagnosis of schizophrenia.

49. An officer completed Mr Sykes' induction interview. He recorded that Mr Sykes disclosed that he was dyslexic, and had schizophrenia, depression and anxiety. The officer also noted that Mr Sykes had suffered from childhood abuse and had low self-esteem.

50. At interview with the investigator, the officer said that he had no concerns about Mr Sykes, who had told him that he was familiar with Ranby. Mr Sykes raised no issues during his reception interview and the officer recorded that he said he had no thoughts of suicide and self-harm.

51. Mr Sykes completed the Fair Treatment Department's questionnaire and wrote that he was from the Traveller community and had difficulties with reading and writing and was dyslexic. (The Fair Treatment Department forward any concerns raised in the questionnaire to healthcare staff, the Neurodiversity Lead, any other departments as relevant or prison mentors, to assess a prisoner's needs.)

52. At 4.43pm, while still in reception, Mr Sykes made a short phone call to a friend using his prison phone account and raised no concerns.

53. Mr Sykes was located on House Block One, the Induction Wing, and shared a cell with Prisoner A.

54. That evening, Mr Sykes made two phone calls to family members. In the first, he said the prison was "rough" and he did not like it, but he would only be there for three weeks. In his second call, the conversation was very general, and he said he was okay.

4 April

55. On 4 April, Mr Sykes' induction continued. He was out of his cell for around an hour in the morning (participating in induction groups) and up to two hours in the afternoon to socialise with other prisoners.

56. Prisoner B, the prison's Traveller's representative, saw Mr Sykes as part of his induction. He told us that he spoke to Mr Sykes for around ten minutes about Ranby and the regime and facilities. During their conversation, prison staff issued Mr Sykes with a laptop. He assisted Mr Sykes in setting up the laptop, showed him how to use it and helped him order his meals. He told us that he had no concerns about Mr Sykes. Mr Sykes asked him to visit him the next day, which he agreed to do.

57. At 10.33am, a mental health nurse assessed Mr Sykes. He noted that Mr Sykes had some insight into his mental health needs and admitted that he needed support. During the assessment, Mr Sykes said that he was hearing voices (that were calling him a rapist and paedophile). The nurse also assessed whether Mr Sykes needed to be monitored under ACCT procedures. He concluded that ACCT monitoring was not necessary at that time as Mr Sykes did not appear to be acutely unwell and he denied any thoughts of suicide or self-harm. Mr Sykes stated that he had no current substance misuse problems.

58. A member of the chaplaincy team also saw Mr Sykes as part of his induction. They raised no concerns. At 1.31pm, Mr Sykes phoned a friend, and they had a general conversation about Ranby.

59. A registered general nurse later saw Mr Sykes and completed a secondary health screen. A mental health nurse was also present. Aside from Mr Sykes requesting to

be reviewed by a GP for a previous nose injury, Mr Sykes raised no concerns. The mental health nurse administered Mr Sykes' quetiapine (at 300mg).

60. That evening, Mr Sykes called another friend. They had a general conversation in which Mr Sykes said he was okay but did not like prison. He asked his friend to bring some clothes in for him when she visited him and discussed his release from prison on a monitoring tag. Mr Sykes also rang his mother to wish her a happy birthday.

61. At interview, Mr Sykes' cellmate told the investigator that Mr Sykes was a relaxed and easy-going person. He said he helped Mr Sykes with his laptop as he could not read and write very well. He recalled no problems or issues with Mr Sykes.

Events of 5 April

62. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 5 April. He also obtained information from the East Midlands Ambulance Service. The following account has been taken from all sources.

63. On 5 April, association on the Induction Wing was scheduled to take place from 2.00pm to 4.00pm. Until then, all prisoners were locked in their cells unless they had a prison job or a pre-arranged appointment.

64. At 9.29am, Officer A responded to Mr Sykes' cell bell. At interview, she could not remember why Mr Sykes or his cellmate had pressed the bell, although she recalled no specific issues or concerns.

65. At 11.08am, Mr Sykes made a short phone call to his friend. She explained to him that she had previously booked a visit at Lincoln to see him and that this would now have to be rearranged to Ranby. Mr Sykes raised no concerns about his.

66. A nurse discussed his assessment of Mr Sykes at the mental health team's allocations meeting. The nurse agreed to case manage Mr Sykes and build up a relationship with him. A neurodevelopmental Disorders Specialist noted that Mr Sykes had previously been assessed as not requiring their service.

67. Prisoner A told us that he had no concerns about Mr Sykes during the morning and they had both remained in their cell. In his police statement, he stated that Mr Sykes had asked him to use the laptop to book a "clothing parcel" for him. Mr Sykes had also spoken about his mother's birthday and said that his daughter planned to visit him soon.

68. At 11.17am, an officer unlocked Mr Sykes' cell for Mr Sykes and his cellmate to collect their lunch. They left their cell and returned at 11.24am when an officer locked them in their cell.

69. At 11.50am, Officer A completed the lunch time routine check. She had no concerns about Mr Sykes or his cell mate.

70. Around 1.30pm, Prisoner B attempted to visit the Induction Wing to see Mr Sykes as they had agreed. Staff refused his entry because he had not received the necessary prior permission from the Diversity and Inclusion team.

71. At the same time, staff on the Induction Wing started to unlock those prisoners who had pre-arranged appointments. At 1.31pm, Prisoner A pressed his cell bell to remind prison staff that he needed to be unlocked to attend a pre-booked visit to the library. At 1.32pm, Officer A responded. Two minutes later, she unlocked the cell, he left, and she relocked the cell. The officer said that, at the time, Mr Sykes was lying in bed (top bunk) and looked as if he had just woken up. He sat up upon seeing her, looked at her and then proceeded to lay back down in bed, when it was apparent that she had only attended the cell to collect his cellmate.

72. At 2.00pm, Officer A unlocked Mr Sykes' cell door so he could socialise with other prisoners. He was still laid on his bed and appeared asleep. At 2.02pm, the cell door was pushed closed from the inside. Only Mr Sykes was in the cell.

73. At 3.06pm, Prisoner A arrived back from the library. When he got to his cell he noticed that the privacy lock was on, and the cell door observation panel was covered. (Cell doors have a privacy lock that can be used by the prisoner to lock the door from the inside. This can be overridden by prison staff.) He asked Officer B to open his cell door.

74. Officer B went straight to the cell and unlocked and opened the cell door. Mr Sykes was hanging from a ligature made from a bed sheet tied around his neck, attached to the top bunk bed. He immediately radioed a code blue emergency (used when a prisoner is unconscious or having difficulty breathing) and used his anti-ligature knife to try and cut the ligature. The control room recorded the emergency call at 3.07pm. Staff in the control room immediately called an ambulance and requested the prison healthcare team to attend Mr Sykes' cell.

75. Officer B removed the ligature from around Mr Sykes' neck. Additional staff, including a Supervising Officer (SO) and a mental health nurse (who had been working on the wing) attended within 25 seconds. The SO assisted the officer and supported Mr Sykes' body, and they laid him on the floor. Mr Sykes showed no signs of life. The SO started cardiopulmonary resuscitation (CPR) and rotated this with other staff present.

76. At interview, the mental health nurse told us that from his initial observations, Mr Sykes was unresponsive and looked slightly blue. The nurse quickly collected the medical emergency bag and defibrillator and returned to the cell within one minute. Along with the assistance of another nurse, they used emergency equipment to treat Mr Sykes.

77. The first ambulance paramedics arrived at the prison at 3.19pm. Due to delays progressing through the locked prison gates, they got to Mr Sykes' cell 14 minutes later and took over his care. An air ambulance team arrived at 3.30pm. At 3.56pm, the air ambulance doctor confirmed that Mr Sykes had died.

Contact with Mr Sykes' family

78. The prison appointed two family liaison officers (FLOs). Mr Sykes' next of kin was recorded as his father. The FLOs left the prison around 6.00pm to attend Mr Sykes' father's home address in Leicester. When they attended the address, they were informed that Mr Sykes' father no longer lived at the address. The FLOs phoned Mr Sykes' father, who confirmed that he had moved. The FLOs arrived at his new

address at 7.30pm and broke the news of Mr Sykes' death. Other family members were present. In line with HMPPS policy, Ranby offered a contribution to the cost of Mr Sykes' funeral.

Support for prisoners and staff

79. Ranby initiated postvention procedures. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. This included a hot debrief, chaired by a prison manager, for staff involved in the emergency response and Listeners (prisoners trained by the Samaritans to provide confidential peer-support) identified and spoke to prisoners most affected by Mr Sykes death. The staff care team also offered support. The prison posted notices informing other prisoners of Mr Sykes' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Sykes' death.

Post-mortem report

80. The post-mortem report concluded that Mr Sykes died from hanging. Toxicology results found mirtazapine and quetiapine at a therapeutic level (in line with his prescriptions) in his system. No other drugs were found in his system.

Findings

Assessment of risk of Mr Sykes

81. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, sets out the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and the procedures (known as ACCT) that staff must follow when they identify a prisoner at risk. Mr Sykes had a number of these risk factors: a history of attempted suicide, substance misuse issues and mental health issues, including a diagnosis of paranoid schizophrenia and he had previously been admitted to a psychiatric hospital.

82. However, Mr Sykes had no recent history of attempted suicide or self-harm and in the weeks leading up to his death displayed no overt signs of distress or anxiety. He did not give staff any cause to be concerned. Staff at Lincoln did not pass on any concerns to Ranby when he transferred and during his reception screening at Ranby, staff noted he seemed calm and relaxed. In the three days that Mr Sykes was at Ranby, there were no known problems with other prisoners, no identified substance misuse incidents and no known debt issues. Mr Sykes' cellmate also had no concerns about him. We identified no evidence to suggest that staff should have assessed him as a risk of suicide and therefore we have concluded that they could not have foreseen his death.

Clinical care

83. The clinical reviewer concluded that the clinical care Mr Sykes received was of a good standard and was equivalent to that which he would have received in the community.

Mental healthcare

84. When he arrived at Ranby, Mr Sykes was appropriately assessed and accepted onto the mental health team's caseload. Assessments raised no concerns that Mr Sykes was a risk to himself or others. The mental health team appropriately continued his antipsychotic and antidepressant medications, and he was supported by their services during his short stay at Ranby.

85. A nurse ensured that Mr Sykes was seen ahead of the referral waiting list due to the seriousness of his mental health diagnosis. He agreed to accept Mr Sykes onto his caseload so that he could develop a consistent relationship with him. The mental health team also ensured that Mr Sykes was immediately prescribed quetiapine medication, albeit at the dose of 300mg, when the 400mg tablets were not yet available. The clinical reviewer concluded that this approach was appropriate.

Governor to note

Delay in paramedics getting to cell

86. While we note that the emergency response was timely and appropriate, it took paramedics 14 minutes to get from the prison front gate to Mr Sykes' cell, which

included a reported four-to-five-minute delay at the prison gate. The delay was encountered because the opening of the various gates between the prison entrance and Mr Sykes' wing was not coordinated.

87. The Induction Wing is the furthest point away from the main gate and there are up to five gates to get through. At the time of the incident, prisoners were also moving around the prison on free-flow, and it would have been necessary for some staff to hold their positions at wing entry and exit gate ways to ensure prison security was maintained. This meant that there were less staff to respond to the emergency with Mr Sykes.

88. While it seems unlikely that the delay affected the outcome for Mr Sykes, given the healthcare team's immediate response and commencement of medical care, the Governor will wish to familiarise herself with the Managing Conveyance policy framework, that makes clear that a prison's local security strategy should include instructions on how to escort any emergency vehicles during prisoner movements to ensure there is no delay in similar circumstances.

Inquest

89. An inquest was concluded on 19 May 2025 which concluded that Mr Syke's death was due to suicide. The coroner gave a verdict in which she said:

"Mr Sykes hanged himself whilst alone in cell 28. He used a ligature made out of a green prison issue bedsheet that he attached to the highest part of the bunkbed. The jury is in unanimous agreement that Mr Sykes intended to take his own life and did so by hanging himself. Mr Sykes was therapeutically medicated with Quetiapine at the time of his death and his failure to take it on four occasions in the days leading up to his death did not cause or contribute to his death."

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