Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Sykes, a prisoner at HMP Holme House, on 31 August 2023

A report by the Prisons and Probation Ombudsman

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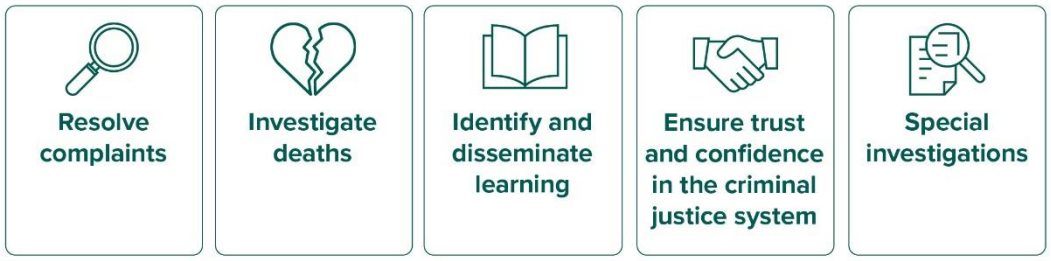
OUR VISION

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. Mr John Sykes died from mitochondrial encephalopathy, lactic acidosis and stroke like episodes (MELAS syndrome - a genetic condition primarily affecting the nervous system and muscles) on 31 August 2023, at HMP Holme House. He was 60 years old. We offer our condolences to Mr Sykes' family and friends.

4. NHS England commissioned an independent clinical reviewer to review Mr Sykes' clinical care at HMP Holme House.

5. The PPO investigator investigated the non-clinical issues relating to Mr Sykes' care.

6. The PPO family liaison officer wrote to Mr Sykes' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. We did not receive a response.

7. The clinical reviewer concluded that the clinical care Mr Sykes received at HMP Holme House was of a good standard and equivalent to what he could have expected to receive in the community. He made no recommendations.

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

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

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

Inquest

10. At the inquest held on 13 May 2024, the Coroner concluded that Mr Sykes died of natural causes.

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