Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sydney Mimer, a prisoner at HMP Littlehey, on 26 March 2025

A report by the Prisons and Probation Ombudsman

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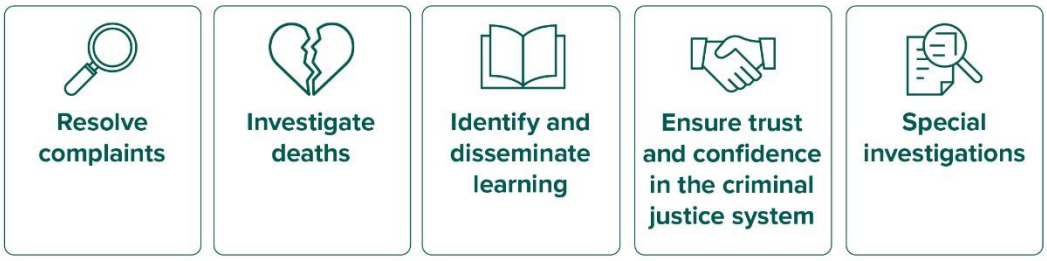
OUR VISION

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. In July 2017, Mr Sydney Mimer was sentenced to 15 years in prison for sex offences. He died from sepsis on 26 March 2025, while a prisoner at HMP Littlehey. This was caused by osteomyelitis (infection in a bone) of the foot, which was in turn caused by peripheral vascular disease (a disorder of the blood vessels) and type 2 diabetes. He was 77 years old. We offer our condolences to those who knew Mr Mimer.

4. Littlehey told us that Mr Mimer had no identified next of kin.

5. NHS England commissioned an independent clinical reviewer, to review Mr Mimer's clinical care at Littlehey.

6. The clinical reviewer concluded that the clinical care Mr Mimer received at Littlehey was of a good standard and was equivalent to that which he could have expected to receive in the community. She found that Mr Mimer had appropriate care plans in place, his ongoing health concerns were addressed and healthcare responded promptly and proactively to his needs. The clinical reviewer did not make any recommendations.

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

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

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. Northamptonshire Healthcare NHS Foundation Trust pointed out one factual inaccuracy in the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

10. At an inquest held on 24 July 2025, the Coroner concluded that Mr Mimer died of natural causes.

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

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