

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Sturgess, a prisoner at HMP Rye Hill, on 31 March 2026

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



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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. On 29 September 2016, Mr Kenneth Sturgess was convicted of sexual offences and sentenced to 16 years in prison. He died in hospital of pneumonia, on 31 March 2026, while a prisoner at HMP Rye Hill. Mr Sturgess also had heart failure, type 2 diabetes and ischaemic heart disease (a condition where the heart muscle does not get enough oxygen-rich blood) which contributed to but did not cause his death. He was 87 years old. We offer our condolences to Mr Sturgess' family and friends.
4. The Ombudsman's office wrote to Mr Sturgess' sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.
5. NHS England commissioned an independent clinical reviewer, to review Mr Sturgess' clinical care at HMP Rye Hill. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Sturgess received at Rye Hill was of a reasonable standard and was partially equivalent to that which he could have expected to receive in the community. She noted that Mr Sturgess lived in an appropriate cell with disabled access facilities which supported his care and mobility needs, and that the care plans in place for Mr Sturgess' long-term conditions were reviewed appropriately. The clinical reviewer also found that while Mr Sturgess had a wing buddy (a prisoner to support him with daily living) and received twice daily social care visits from the healthcare team, no formal social care assessment was completed. She additionally noted that there was no evidence that a safeguarding referral, made due to concerns about self-neglect and repeated falls, was followed up. The clinical reviewer made two recommendations not related to Mr Sturgess' death, that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Sturgess' care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
10. We also shared the initial report with Mr Sturgess' sister. She did not make any comments.
11. At an inquest held on 6 May 2026, the coroner concluded that Mr Sturgess died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

September 2026



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