

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Turon Miah, a prisoner at HMP Fosse Way, on 11 December 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 27 February 2024, Mr Turon Miah was sentenced to six years and nine months in prison for drug-related charges. He began his sentence in HMP Leicester before being transferred to HMP Ranby on 14 March, then to HMP Fosse Way on 25 April.
4. Mr Miah died due a posterior circulation stroke (a type of stroke affecting the back part of the brain) following coronary angiography (a procedure to examine heart arteries), compounded by hypertensive heart disease (heart problems caused by high blood pressure) and severe coronary artery disease (narrowing of the heart's arteries). Contributing factors included hypertension (high blood pressure), type 2 diabetes (a condition causing high blood sugar), and aspiration of stomach contents with hypoxia (inhaling stomach contents, leading to low oxygen levels). He died on 11 December 2024, at Glenfield Hospital, Leicester. He was 48 years old. We offer our condolences to Mr Miah's family and friends.
5. The Ombudsman's office contacted Mr Miah's partner, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Miah's partner had questions regarding the clinical care that Mr Miah received at Fosse Way, as well as other questions unrelated to his death. These have been addressed in the clinical review, and by the PPO investigator in separate correspondence.
6. NHS England commissioned an independent clinical reviewer to review the clinical care Mr Miah received at Fosse Way. The clinical reviewer concluded that the clinical care Mr Miah received at Fosse Way was of a reasonable standard and was equivalent to that which he would have received in the community.
7. The PPO investigator investigated the non-clinical issues relating to Mr Miah's care. We did not find any non-clinical issues of concern.
8. We make no recommendations.
9. At the inquest, held on 26 January 2026, the jury concluded that Mr Miah had died as a result of complications during the necessary angiography procedure for treatment of his known severe coronary artery disease.

Adrian Usher
Prisons and Probation Ombudsman

July 2025

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100