Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mohammed Shabir, a prisoner at HMP Leeds, on 24 September 2025

A report by the Prisons and Probation Ombudsman

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

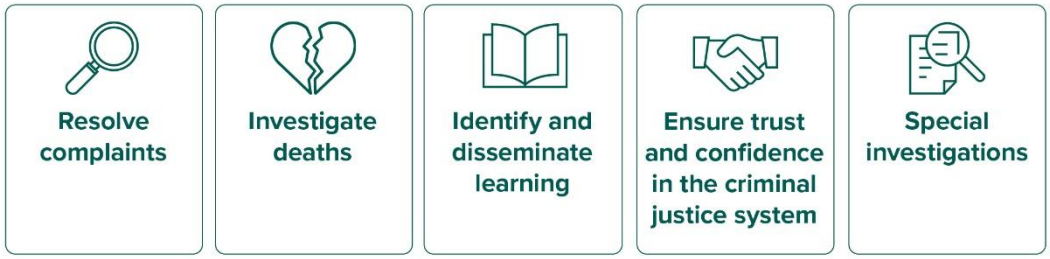
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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 28 August 2024, Mr Mohammed Shabir was remanded to HMP Leeds on charges of murder, attempted murder and arson.

4. Mr Shabir died in hospital of cardiac tamponade (fluid around the heart preventing it from pumping enough blood) caused by hemopericardium (blood accumulating in the pericardial sac which surrounds the heart) and myocardial infarction (heart attack) on 24 September 2025, while a prisoner at Leeds. He was 45 years old. We offer our condolences to Mr Shabir's family and friends.

5. The Ombudsman's office wrote to Mr Shabir's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Shabir's brother had no questions but asked for a copy of our report.

6. We also shared the initial report with Mr Shabir's family. They raised a number of issues/questions that do not impact on the factual accuracy of this report and which we have addressed through separate correspondence.

7. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. NHSE Spectrum also pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

8. NHS England commissioned an independent clinical reviewer, to review Mr Shabir's clinical care at HMP Leeds.

9. The clinical reviewer concluded that the clinical care Mr Shabir received at Leeds was partially equivalent to that which he could have expected to receive in the community. She found that general health care and the emergency response was equivalent and of a good standard.

10. However, the clinical reviewer found that the clinical care provided to Mr Shabir on 20 September 2025, when he told prison staff he felt unwell, was partially equivalent. An officer said that they contacted a response nurse to assess Mr Shabir, but no one completed this. The clinical reviewer found that it was unclear who was holding the response radio at the time and therefore uncertain who had responsibility to attend to Mr Shabir. While he was not seen, the clinical reviewer found that Mr Shabir's symptoms did not indicate that an emergency response was required.

11. The clinical reviewer made five recommendations not related to Mr Shabir's death, which the Head of Healthcare will wish to address.

12. The PPO investigator investigated the non-clinical issues relating to Mr Shabir's care. We found that the officer who told us that they made a radio call on 20 September did not record this in Mr Shabir's prison records, and there was no additional evidence recorded that they had made a call or that Mr Shabir felt unwell. This also meant that operational colleagues did not have the opportunity to identify and follow-up on the officer's request. The Governor will want to ensure that prison staff properly record important information and requests for assistance about prisoners' health.

Inquest

13. The inquest into Mr Shabir's death concluded on the 8 October 2025. The coroner confirmed that Mr Shabir died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman **June 2026**

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 I 020 7633 4100