

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation
into the death of
Mr Mohammed Fethaullah,
a prisoner at HMP/YOI High Down,
on 13 May 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



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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. In August 2003, Mr Mohammed Fethaullah was sentenced to life imprisonment with a minimum tariff of 18 years and 316 days for murder. He died in hospital of anaemia and ischemic heart disease on 13 May 2025, while a prisoner at HMP/YOI High Down. He was 64 years old. We offer our condolences to Mr Fethaullah's family and friends.
4. The Ombudsman's office wrote to Mr Fethaullah's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
5. NHS England commissioned an independent clinical reviewer to review Mr Fethaullah's clinical care at High Down.
6. The clinical reviewer concluded that the clinical care Mr Fethaullah received at High Down was of a good standard and equivalent to what he could have expected to receive in the community. He found that Mr Fethaullah received a good standard of care co-ordination and case management for his long-standing health conditions. The clinical reviewer made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Fethaullah's care. We did not find any non-clinical issues of sufficient concern to warrant a recommendation.

Governor to note

Staff support

8. National policy states that senior managers must hold a debrief with all staff involved following a death in custody and that both on-site and off-site staff (such as escorting officers) know what support is available to them and how to access it. When Mr Fethaullah died, senior managers did not conduct a debrief with the escorting officers who were present when he died. The Safety Hub Manager, said that the escorting staff were not debriefed because Mr Fethaullah died in hospital - an approach that contradicts the guidance. The Governor will want to assure themselves that staff are debriefed and offered support following the death of a prisoner.
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

October 2025

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