

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Siberry, a prisoner at HMP Leeds, on 2 June 2025

A report by the Prisons and Probation Ombudsman

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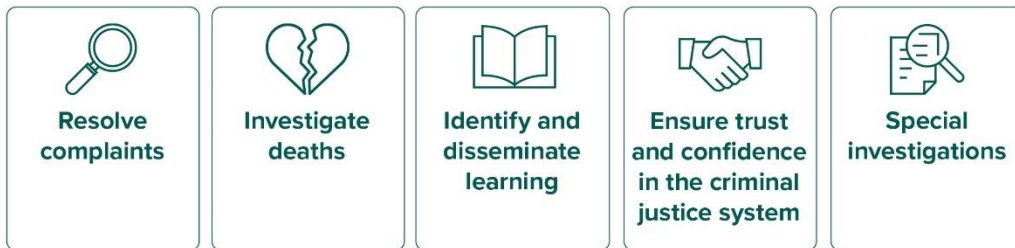
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OUR VISION

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 3 March 2025, Mr Andrew Siberry was remanded to HMP Leeds for sexual offences. He died of ischaemic heart disease caused by coronary artery atheroma, on 2 June 2025, at HMP Leeds. He was 61 years old. We offer our condolences to Mr Siberry's family and friends.
4. The Ombudsman's office wrote to Mr Siberry's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Siberry's family asked questions about his mental health, what support was in place for him when he was released in February 2025, and they asked for a copy of our report. These questions have been addressed in the clinical review.
5. NHS England commissioned an independent clinical reviewer, to review Mr Siberry's clinical care at HMP Leeds. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Siberry received at Leeds was of a good standard and equivalent to what he could have expected to receive in the community. She found that the prison and healthcare team put plans in place to manage Mr Siberry's unclean living conditions and that the mental health team explored possible reasons for his behaviour. The clinical reviewer made a recommendation not related to Mr Siberry's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Siberry's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
10. Mr Siberry's family received a copy of the draft report. They raised issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Inquest

11. At the inquest held on 28 July 2025, the Coroner concluded that Mr Siberry died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

February 2026

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