

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Mohammed Amir on 1 June 2025, following his release from HMP Wayland**

**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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## Summary

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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.
4. Mr Mohammed Amir died from cardiotoxicity from cocaine use on 1 June 2025, following his release from HMP Wayland on 28 May 2025. He was 44 years old. We offer our condolences to those who knew him.
5. We found that despite Mr Amir's serious and enduring mental illness and several requests to refer him to the community mental health team, he was not referred before his release. This resulted in a lack of continuity of support for Mr Amir after release.

## Recommendations

- **The Head of Healthcare at HMP Wayland should ensure there is a robust system to monitor and respond to referral requests promptly, to support timely referrals and continuation of care after release.**

## The Investigation Process

6. HMPPS notified us of Mr Amir's death on 15 June 2025.
7. The PPO investigator obtained copies of relevant extracts from Mr Amir's prison and probation records.
8. We informed HM Coroner for Bedfordshire and Luton of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. The Ombudsman's office contacted Mr Amir's next of kin to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

## Background Information

### HMP Wayland

11. HMP Wayland is a category C prison which holds male prisoners. It is managed by HMPPS. Practice Plus Group provides physical and mental healthcare. Phoenix Futures provides substance misuse treatment.

### Probation Service

12. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

## Key Events

### Background

13. On 27 January 2025, Mr Mohammed Amir was sentenced to 10 months in prison for possession of an offensive weapon. He was sent to HMP Bedford.
14. While at Bedford, healthcare staff noted that Mr Amir was engaged with the community mental health team as he had diagnoses of bi-polar affective disorder, antisocial personality traits and mental and behavioural disorder due to harmful use of substances. The psychiatrist noted that Mr Amir was receiving a monthly depot injection of antipsychotic medication, but his engagement with mental health services was sporadic.
15. On 18 February, Mr Amir was transferred to HMP Wayland.
16. At his healthcare reception screening, a nurse noted that Mr Amir had asthma, bi-polar affective disorder which he received depot medication for, and he was prescribed medication to manage the side effects.
17. On 19 February, a nurse conducted a mental health triage. She noted that Mr Amir was stable on his current medications, he denied any visual or auditory hallucinations, he had good family support and he had no thoughts of suicide or self-harm.
18. Later that day, a recovery worker from the substance misuse service met with Mr Amir to offer support, however he declined to engage.
19. On 9, 11 and 25 April, wing staff suspected Mr Amir was under the influence of drugs. Each time they called healthcare staff, who confirmed that Mr Amir was under the influence. Staff opened welfare logs and set observations. The responding nurses referred Mr Amir to the substance misuse service. Recovery workers from the substance misuse service met with Mr Amir after each incident, but he declined support from the service. The recovery workers gave Mr Amir harm reduction advice and told him to contact the service in the future if needed.
20. Because Mr Amir did not engage with the substance misuse team, he was not offered naloxone training (medication which can relieve the symptoms of an opioid overdose).

### Pre-release planning

21. On 17 February, Mr Amir's allocated Community Offender Manager (COM) referred him to Bedfordshire adult social care as she was concerned about his mental health and lack of accommodation upon release. The social care team said the prison would need to refer him so they could carry out a Care Act assessment. On 11 March, the COM emailed Mr Amir's allocated Prison Offender Manager (POM) and asked if he could explore this with the mental health team. On 24 April, the POM forwarded the email to the prison mental health team.

22. On 13 May, the COM emailed the POM and the prison healthcare team asking for an update on Mr Amir's progress and engagement with the mental health team. She asked if the mental health team could refer Mr Amir to the community mental health team. She emailed again on 16 May and 22 May and asked for updates. She told the investigator that she did not receive any responses.
23. On 21 May, the COM referred Mr Amir to Community Accommodation Service Tier 3 (CAS3 - provides short term accommodation to prison leavers). On 23 May, CAS3 confirmed an address in Bedford had been secured for Mr Amir. The COM emailed the POM to confirm that accommodation had been secured. She also emailed the prison mental health team to confirm that Mr Amir would be released to Bedford and asked again if they could refer him to the community mental health team. On 27 May, the mental health team responded and said that they were aware that a referral needed to be completed.
24. On 22 May, the COM completed Mr Amir's licence. She added additional conditions, including engaging with mental health professionals, drug testing and engaging with the community substance misuse team.

### **Post-release management**

25. On 28 May, Mr Amir was released from Wayland with a supply of his medication and a discharge letter. He was offered a naloxone kit at reception prior to his release, but he declined.
26. Mr Amir's licence instructed him to attend Bedford probation office at 1.30pm, however he did not attend. A recall was initiated and Mr Amir's licence was revoked.
27. At 12.50pm on 29 May, Mr Amir attended Bedford probation office. The COM saw him and noted that he looked warm, was struggling to speak and appeared to be under the influence of drugs. When the COM asked Mr Amir if he had taken anything, he said no. Mr Amir said he had his depot injection the previous day. He said he had not been able to attend his probation appointment the previous day as he arrived to Bedford late. The COM told Mr Amir that his CAS3 accommodation was still available and told him to attend the address. She told the investigator that she did not confirm with the community mental health team that Mr Amir had seen them the previous day. She told the investigator that she did not rescind Mr Amir's recall and it remained in force.

### **Circumstances of Mr Amir's death**

28. On 1 June, Mr Amir's friend called the ambulance service from an address in Bedford (different to the CAS3 accommodation), to say Mr Amir was not breathing. At 3.02pm, the paramedics confirmed life extinct.
29. Witnesses told paramedics that Mr Amir had smoked crack cocaine the night before, and from 3.00am, he had been lying in the corridor outside the property. They dragged Mr Amir back into the flat and noticed that he was vomiting and minimally responsive. When Mr Amir became unresponsive, they assumed he was sleeping. However, when he did not wake later that afternoon, they called the ambulance service.

30. On 12 June, the COM made enquiries with police after she heard that that a man, matching Mr Amir's description, had died at a property near to where he was residing. She received confirmation from police that the deceased was Mr Amir.

**Post-mortem report**

31. The post-mortem report concluded that Mr Amir died from cardiotoxicity from cocaine use.

## Findings

### Substance misuse services

32. Mr Amir had a history of substance use. While at Wayland, staff observed him under the influence of drugs on four occasions. Each time, the substance misuse service offered him support, but he declined. They gave him harm reduction advice after each incident, but Mr Amir said that substance use was not problematic for him. Because Mr Amir did not engage with the substance misuse service in prison, he was not referred to the community service on release.
33. As Mr Amir did not engage with the substance misuse service, they did not deliver naloxone training. The Head of Healthcare at Wayland told the investigator that, regardless of engagement, reception staff will offer naloxone to all prisoners upon release. He confirmed that Mr Amir was offered naloxone on his day of release but he declined it.
34. The COM told the investigator that prior to his prison sentence, Mr Amir did not engage with the community substance misuse service. His previous COM had discussed the Recovery College (which offers courses and workshops on mental health wellbeing and recovery) with Mr Amir, but he declined to be referred.
35. The COM also said she did not refer Mr Amir to the community substance misuse team because he did not report to the probation office on his day of release (28 May) and when he did attend the following day (29 May), he had already been recalled.
36. We make no formal recommendation, as we are satisfied that prison and probation staff took all reasonable and appropriate steps to support Mr Amir with his drug use, which he clearly did not view as problematic.

### Mental health services

37. Mr Amir had a history of mental health issues. Before going to prison, he was engaging with the community mental health team and he was receiving monthly depot medication and medication to manage its side effects. Mr Amir's engagement with the community mental health team was sporadic, however he engaged with the mental health team at Wayland.
38. Prior to release, the COM asked the POM to explore a social care referral for Mr Amir with the prison mental health team. The POM emailed them to ask if this was a possibility but did not receive a response. The mental health clinical lead told the investigator that because the Care Act assessment request was embedded in a multi-topic email, it was overlooked. This meant no referral to adult social care was completed.
39. The COM also emailed the healthcare team at Wayland on several occasions, asking for updates on Mr Amir's progress and engagement and requesting a referral to the community mental health team.

40. The mental health clinical lead told the investigator that they only received confirmation of Mr Amir's address on 28 May, his day of release. There is evidence that the COM emailed the mental health team on 23 May to advise them of Mr Amir's release address, and they responded on 27 May. The mental health clinical lead said that although the mental health team rely on specific email requests for referrals to be completed, Mr Amir should have been referred automatically given his serious and enduring mental illness diagnosis and prescription of a depot injection. She said that Mr Amir's care coordinator tried to email a referral to the community mental health team on 28 May, but the emails bounced back. She also tried calling the service, left a voicemail asking for a callback, but did not receive a response.
41. We consider that the mental health team at Wayland could have done more to ensure continuity of mental health care for Mr Amir on release. We recommend:
- The Head of Healthcare at HMP Wayland should ensure there is a robust system to monitor and respond to referral requests promptly, to support timely referrals and continuation of care after release.**

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**December 2025**

### **Inquest**

At the inquest held on 21 January 2026, the Coroner concluded that Mr Amir died of a drug-related death.

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