

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rana Khan, a prisoner at HMP Wandsworth, on 5 April 2024

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. On 30 August 2023 Mr Rana Khan was remanded at HMP Wandsworth, having been charged with stalking and harassment offences.
4. Mr Khan died of ischaemic heart disease caused by hypertension, diabetes mellitus and high cholesterol on 5 April 2024 at HMP Wandsworth. He was 60 years old. We offer our condolences to Mr Khan's family and friends.
5. The Ombudsman's office contacted Mr Khan's family to explain the investigation and to ask if they had any matters they wanted us to consider. We did not receive a response.
6. NHS England commissioned a clinical reviewer to review Mr Khan's clinical care at the prison. She concluded that the clinical care Mr Khan received at Wandsworth was acceptable, but the management of his sudden illness prior to his cardiac arrest was not entirely equivalent to what he could have expected to receive in the community.
7. We make the following recommendations.

The Head of Healthcare, the lead GP and the senior pharmacist should review the glyceryl trinitrate and aspirin PGDs to ensure that staff are able to use these emergency medications in all situations where they are indicated and ensure that the inclusion criteria takes account of the additional presentation of a cardiac event without pain in diabetic patients.

The Head of Healthcare and the lead GP should identify if there is a need for additional guidance and training for staff to support them to escalate the requirement for senior staff to support rapid assessment of undifferentiated sudden illness.

The Head of Healthcare and the lead GP should issue guidance on the management of suspected acute cardiac events which makes clear the schedule of prioritisation of emergency treatment and transfer of patients to appropriate emergency care.

The Head of Healthcare, lead GP and lead pharmacist should review the 'homely remedies' protocol to ensure that it makes reference to checking a prisoner's prescribed medication to ensure no contraindications before the provision of a 'homely remedy'.

8. The PPO investigator investigated the non-clinical issues relating to Mr Khan's care. We did not find any non-clinical issues of concern and we make no recommendations.
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 2024

Inquest

10. At the inquest held on 5 June 2025, the Coroner concluded that Mr Khan died of natural causes.

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