Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rakeem Malik, a prisoner at HMP Long Lartin, on 20 May 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 7 April 1999, Mr Rakeem Malik was convicted of attempted murder and sentenced to life in prison.

4. Mr Malik died of diabetic ketoacidosis and chronic kidney disease while a prisoner at HMP Long Lartin. He was 56 years old. We offer our condolences to Mr Malik's family and friends.

5. The Ombudsman's office contacted Mr Malik'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.

6. NHS England commissioned an independent clinical reviewer to review Mr Malik's clinical care at Long Lartin.

7. The clinical reviewer concluded that the clinical care Mr Malik received at HMP Long Lartin was of a reasonable standard and at least equivalent to what he could have expected to receive in the community. Mr Malik had poor compliance with his prescribed medication, which contributed to the poor control of his diabetes and kidney function. Healthcare staff followed up his non-attendance for medication, ensured they discussed the risks to his health and documented the reasons for his refusal. The clinical reviewer made recommendations relating to other aspects of Mr Malik's care which the Head of Healthcare will need to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Malik's care.

Governor to note

9. The investigator reviewed the escort risk assessment for 15 May 2024 and noted it was not clear on the cuffing arrangements when Mr Malik was escorted to the hospital. The prison has since reviewed the risk assessment and agreed it was not clear regarding the use of handcuffs. The prison said that they would review and rewrite the instructions for staff. The Governor will wish to assure themselves that this action is taken and that risk assessments are clear.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

11. At the inquest held on 5 December 2024 the coroner concluded Mr Malik died of natural causes.

Adrian Usher **November 2024**
Prisons and Probation Ombudsman

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