

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Piran Khan, a prisoner at HMP Wakefield, on 21 February 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. On 10 May 2024, Mr Piran Khan was sentenced to life in prison for murder.
4. Mr Khan's formal cause of death was not available when we issued this report. He was diagnosed with lung cancer in June 2024 and was receiving palliative care when he died at Wakefield on 21 February 2025. Mr Khan was 76 years old. We offer our condolences to his family and friends.
5. The Ombudsman's office contacted Mr Khan's daughter, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
6. The PPO investigator investigated the non-clinical issues relating to Mr Khan's care. We did not find any non-clinical issues of concern.
7. NHS England commissioned an independent clinical reviewer, to review the clinical care Mr Khan received at Wakefield. The clinical reviewer concluded that the clinical care Mr Khan received at Wakefield was of a good standard and equivalent to that which he would have received in the community. She identified some areas of good practice, including the use of appropriate care plans to cover all of Mr Khan's essential care needs.
8. The clinical reviewer identified that, in October 2024, Mr Khan missed two days of his oral chemotherapy medication. He kept his medication in his cell to take as prescribed and did not inform staff that he had run out or reorder the medication in line with usual practice (and in line with the community). Healthcare staff also did not immediately identify that Mr Khan had run out of his medication. This was a specialist medication that is supplied directly by the hospital and collected by prison staff when required. The Head of Healthcare has since arranged with the hospital pharmacy that they will directly contact the prison when a medication prescribed and dispensed by hospital clinicians is ready to collect. We do not therefore make a recommendation.
9. Towards the end of Mr Khan's life, a GP at Wakefield completed a do not attempt CPR (DNACPR) agreement with him, as his poor prognosis and health meant that any resuscitation attempt would probably be futile. The clinical reviewer noted that no Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) was completed, which provides for the patient to discuss their wishes regarding personalised treatment and care with the health professionals involved in their care. The clinical reviewer noted that this process is recommended by the Resuscitation Council UK. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners with a life limiting diagnosis and/or at end of life are given the opportunity to contribute to a ReSPECT document, and this is recorded in the clinical record.

10. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.
11. The inquest into Mr Khan's death concluded on 26 August 2026, returning a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

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