Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Omar Farooq, a prisoner at HMP/YOI Chelmsford, on 8 August 2025

A report by the Prisons and Probation Ombudsman

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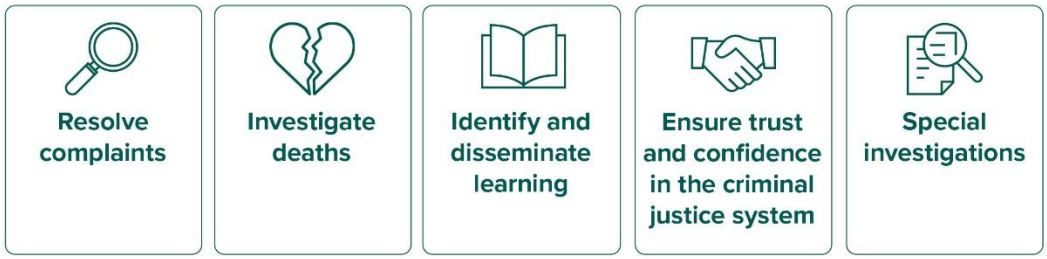
OUR VISION

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

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. In July 2018, Mr Omar Farooq was sentenced to life imprisonment and received a minimum term of seven years for robbery. He died of advanced clinical frailty on 8 August 2025, while a prisoner at HMP/YOI Chelmsford. He was 70 years old. We offer our condolences to Mr Farooq's family and friends.

4. The Ombudsman's office wrote to Mr Farooq's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Farooq's clinical care at HMP Chelmsford.

6. The clinical reviewer and the PPO investigator jointly interviewed the interim Head of Primary Care at Chelmsford on 6 November 2025.

7. The clinical reviewer concluded that the clinical care Mr Farooq received at Chelmsford was of a reasonable standard and was at least equivalent to what he could have expected to receive in the community. She found that the healthcare team provided strong oversight and support to Mr Farooq as his health needs deteriorated. The clinical reviewer made three recommendations not related to Mr Farooq's death that the Head of Healthcare will wish to address.

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

9. We did not find any non-clinical issues of concern. We make no recommendations.

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

11. HMPPS/Castle Rock Group pointed out a factual inaccuracy with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

12. Mr Farooq's family received a copy of the initial report. They did not make any comments.

Inquest

13. At the inquest held on 18 March 2026, the coroner concluded that Mr Farooq died from natural causes.

Adrian Usher
Prison and Probation Ombudsman

April 2026

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