Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Khalid Mahmood, a prisoner at HMP Oakwood, on 6 August 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Khalid Mahmood died on 6 August 2020 of ischaemic heart disease at HMP Oakwood. He was 62 years old. I offer my condolences to Mr Mahmood's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Mahmood received at Oakwood was of a good standard and equivalent to that which he could have expected to receive in the community. She made one recommendation.

5. We found no non-clinical issues of concern.

Recommendation

- **The Head of Healthcare should review the reception and secondary screening policy and procedure to ensure that screenings of prisoners are recorded in healthcare documents.**

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Mahmood's clinical care at HMP Oakwood.

7. The PPO investigator has investigated non-clinical issues, including Mr Mahmood's location, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Mahmood's next of kin, his two sons, to explain the investigation. They did not have any specific questions for us to consider.

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

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

Background

Previous deaths at HMP Oakwood

11. Mr Mahmood was the tenth prisoner to die at Oakwood since August 2018. Of these deaths, eight were from natural causes and one was a drug related death. There are no similarities between our findings in the investigation into Mr Mahmood's death and our investigation findings for the previous deaths.

Key Events

12. In 1996, Mr Khalid Mahmood was sentenced to life imprisonment for murder. He had a history of heart disease and had had a heart attack in 2008, due to underlying ischaemic heart disease. He had a stent inserted to keep his artery open and was diagnosed with impaired left ventricular function.

13. On 6 June 2018, Mr Mahmood transferred to HMP Oakwood. Healthcare staff created care plans based on his heart condition and monitored him every 8-12 weeks which included blood tests, pulse and blood pressure checks, weight and checks for new or worsening symptoms.

14. In June, Mr Mahmood was taken to hospital for review. A consultant cardiologist diagnosed him with moderate to severe left ventricular function and recommended that his condition should continue to be monitored.

15. In September, a prison GP completed a review and noted that Mr Mahmood's condition was stable, and that his blood test results were within the normal range.

16. In June 2019, Mr Mahmood complained of feeling dizzy. Healthcare staff arranged for a range tests to be completed to check his blood and thyroid levels. The thyroid test results were within the normal range, but his blood pressure was low. A prison GP decided to reduce the dosage of his blood pressure medication which then stabilised Mr Mahmood's blood pressure and he later reported that his dizziness had improved.

17. On 16 January 2020, Mr Mahmood had a full cardiovascular review. This included a medication review, observations check and an ECG. A prison GP concluded that all test results were within the normal range with no new or worsening of his existing symptoms. Following a further review on 3 March, the GP noted that Mr Mahmood reported reduced light-headedness and his blood pressure was slightly lower. She advised healthcare staff that should he experience shortness of breath or dizziness, they should consider making a referral for a specialist cardiovascular review.

18. On 20 April, a prison GP reviewed Mr Mahmood again. His observations were in the normal range and she recorded that no further action was needed.

19. On 12 May, Mr Mahmood was offered an alternative regime which included 12 weeks of shielding, in response to the COVID-19 pandemic. He decided not to comply with the recommendations because he felt that they were too restrictive, and he signed a disclaimer to that effect. Mr Mahmood understood the implications of not fully shielding and was assessed as being capable of making an informed decision about his care. There is nothing to suggest that this decision played any part in his death.

20. In July, healthcare staff continued to check Mr Mahmood's blood pressure and his results were normal.

21. On 6 August, a prison officer unlocked Mr Mahmood's cell and found him unresponsive with signs of rigor mortis. The officer radioed an emergency code blue (indicating that a prisoner is unresponsive or having breathing difficulties).

Healthcare staff attended and concluded that any attempts at resuscitation would be futile. Paramedics arrived, and at 8.26am, they confirmed that Mr Mahmood had died.

Post-mortem report

22. The Coroner concluded that Mr Mahmood died of ischaemic heart disease.

Lisa Burrell
Assistant Ombudsman **February 2021**

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