



# **Independent investigation into the death of Mr Azhar Hussain, a prisoner at HMP Bedford, on 27 December 2023**

**A report by the Prisons and Probation Ombudsman**

## 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 November 2023, Mr Azhar Hussain was remanded in prison for breaching a restraining order. He died of heart failure on 27 December 2023, at HMP Bedford. He was 40 years old. We offer our condolences to Mr Hussain's family and friends.
4. The Ombudsman's office contacted Mr Hussain's family to explain the investigation and to ask if they had any matters they wanted us to consider. They were concerned about the prison's family liaison service and the way in which the news of Mr Hussain's death was broken to them. We have addressed these issues in separate correspondence with Mr Hussain's family.
5. NHS England commissioned an independent clinical reviewer to review Mr Hussain's clinical care at HMP Bedford.
6. The clinical reviewer concluded that the clinical care Mr Hussain received at Bedford was not of a satisfactory standard and was not equivalent to the care he could have expected to receive in the community. He found that healthcare staff did not calculate a NEWS2 score (a tool used to assess clinical deterioration) when Mr Hussain became unwell on 27 December. We have recommended use of NEWS2 in a previous investigation at Bedford and were told that compliance was monitored monthly. The clinical reviewer made three other recommendations which the Head of Healthcare will wish to address. We recommend:

**The Head of Healthcare should review whether the monthly compliance monitoring of staff's use of the NEWS2 scoring system is sufficiently robust.**

7. The PPO investigator investigated the non-clinical issues relating to Mr Hussain's care.
8. We found that not everyone involved in the emergency response was invited to the debrief and some staff did not feel supported. We made a similar finding in a previous investigation into a death at Bedford in November 2021. We were told that all relevant staff would be invited to the debrief following a death in custody and signposted to support. While this happened following the two deaths that occurred prior to Mr Hussain's, it did not in this case. We bring this issue to the Governor's attention.
9. We shared our initial report with Mr Hussain's brother. He did not raise any factual inaccuracies. Mr Hussain's brother clarified that the family had in fact received a good level of support from the prison's Imam but they had not realised at that time that the Imam was also in the role of the family liaison officer.

10. We shared our initial report with HMPPS and with the prison's healthcare provider, Northamptonshire Healthcare NHS Foundation Trust. They found no factual inaccuracies. Northamptonshire Healthcare NHS Foundation Trust provided an action plan which is annexed to this report.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**December 2024**

## **Inquest**

At the inquest, held on 19 to 20 August and 9 September 2025, the coroner concluded that Mr Hussain died from natural causes.



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