Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Maqsood Asif, a prisoner at HMP Stafford, on 18 November 2021

## A report by the Prisons and Probation Ombudsman

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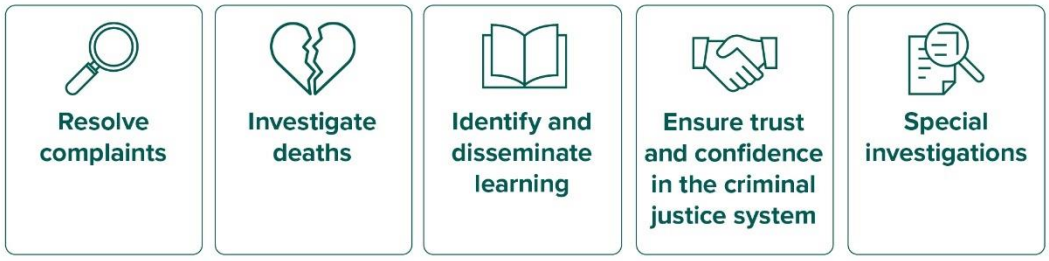
## OUR VISION

**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

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.

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

Mr Maqsood Asif died in hospital of heart failure on 18 November 2021, while a prisoner at HMP Stafford. He was 60 years old. I offer my condolences to Mr Asif's family and friends.

When Mr Asif was moved to Stafford from HMP Isle of Wight on 21 April 2021, he had already been on the waiting list for heart surgery for six months. After Mr Asif's transfer, his consultant at Southampton wrote to Stafford to say Mr Asif's surgery was now urgent. However, Mr Asif had still not had his surgery when he died almost seven months later.

I accept that the initial delay in Mr Asif's heart surgery was down to hospital backlogs due to COVID-19. However, subsequent delays could have been avoided had both prisons handled this case properly. Isle of Wight failed to consider using the clinical hold process to prevent Mr Asif from being transferred while he was awaiting heart surgery and failed to do a proper handover to Stafford.

Stafford then delayed referring Mr Asif to the local cardiology team and failed to provide complete information about Mr Asif's condition and the time he had already spent on the surgery waiting list. This could have avoided Mr Asif going through all the same tests again and then being told he needed surgery, a year after his Southampton consultant had told him this.

The clinical reviewer found that the care Mr Asif received for his heart condition was not equivalent to that which he could have expected to receive in the community. I consider that Mr Asif was badly let down by both prisons. Had they handled this case properly, it is highly likely that Mr Asif would have got the surgery he needed.

I am also concerned that bedwatch officers did not provide Mr Asif with a call to his family while in hospital, despite a manager having approved it.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Sue McAllister, CB**
**Acting Prisons and Probation Ombudsman** **July 2022**

# Contents

# Summary

## Events

1. In March 2020, Mr Maqsood Asif was sentenced to 18 years imprisonment for sexual offences. In May, he was moved to HMP Isle of Wight.

2. In October, Mr Asif was diagnosed with severe aortic stenosis (narrowing of one of the valves in the heart) and told he needed aortic valve replacement surgery. However, it was delayed due to the COVID-19 pandemic.

3. On 29 March 2021, a member of prison healthcare staff contacted Southampton Hospital for an update on Mr Asif's surgery. The hospital said there was a backlog of appointments caused by the COVID-19 pandemic and they would ring the prison in the next couple of weeks to book an appointment.

4. On 21 April, Mr Asif was moved to HMP Stafford.

5. On 26 April, Mr Asif's consultant at Southampton Hospital sent Stafford a letter saying Mr Asif's outstanding surgery was urgent.

6. On 9 May, a prison GP at Stafford sent a referral to the local cardiology department at Stafford Hospital.

7. On 25 May, Stafford Hospital sent the prison GP a letter requesting further information about Mr Asif's cardiology tests results, completed while he was at Isle of Wight. There was no record these were sent.

8. In June, Mr Asif attended several appointments at Stafford Hospital to assess his heart condition. In September, a consultant told him he needed aortic valve replacement surgery.

9. On 9 November, a prison nurse saw Mr Asif, after he reported chest pain and breathlessness which had worsened in recent weeks. Prison staff had already called an emergency ambulance. The paramedics arrived and were concerned that Mr Asif might have COVID-19, so took him to hospital. He tested negative for COVID-19 but was kept in hospital for further observations.

10. On 12 November, Mr Asif asked to speak with his family. A Custodial Manager (CM) approved a phone call for the following day. There was no record that bedwatch officers provided Mr Asif with this call.

11. Mr Asif's condition continued to deteriorate, and he died in hospital on 18 November.

12. The post-mortem report concluded that Mr Asif died from heart failure caused by severe aortic stenosis.

## Findings

13. Despite Mr Asif being told in October 2020 that he needed heart surgery, he did not have it before he died, over a year later. We accept that initially, the delays in

surgery were due to COVID-19 backlogs, but by April 2021, Mr Asif was high priority for surgery at Southampton Hospital. However, he was moved to Stafford, where the process of getting his heart condition diagnosed and onto a waiting list for surgery started all over again.

14. We consider that healthcare staff at Isle of Wight should have considered using the clinical hold process for Mr Asif (where a prisoner is withheld from prison transfer for medical reasons) given he was awaiting surgery for a life-threatening condition. If holding him at Isle of Wight was not considered appropriate, then at the very least, they should have done a proper handover to Stafford, giving full details of Mr Asif's condition and how long he had already been on the waiting list for surgery. This did not happen.

15. Healthcare staff at Stafford then not only delayed making a referral to the local cardiology team at Stafford Hospital, but also failed to set out in the referral full details of Mr Asif's condition and how long he had already been waiting for surgery. They also failed to respond to a request from Stafford Hospital for further information about Mr Asif's cardiology tests results. Instead, Mr Asif went through a series of tests again to then be told that he needed surgery, which he had been told almost a year before.

16. The clinical reviewer found that the care Mr Asif received for his heart condition was not equivalent to that which he could have expected to receive in the community. We consider that Mr Asif was badly let down by both prisons. Had his case been handled differently, it is highly likely he would have had the surgery he needed.

17. We are also concerned that bedwatch officers did not provide Mr Asif with a phone call he requested to his family while in hospital, despite this being approved. We are also concerned the family liaison officer (FLO) did not make the family aware of financial support available for funeral expenses following his death until prompted by the PPO investigator.

## Recommendations

- The Head of Healthcare at Isle of Wight should ensure that staff consider using clinical hold where a prisoner is awaiting surgery for a life-threatening condition and record this in the medical records.

- The Head of Healthcare at Isle of Wight should ensure that healthcare staff arrange a proper handover to the receiving prison where a prisoner has more complex health care needs.

- The Head of Healthcare at Stafford should ensure that where prisoners are already under the care of a hospital consultant when they arrive, staff:

  - make hospital referrals promptly;

  - include all relevant information about the stage of treatment and time spent on the waiting list for surgery if applicable; and

  - provide information requested by hospitals promptly to avoid delays in treatment.

- The Governor of Stafford should ensure that officers taking over bedwatch duties read the bedwatch log at the start of their shift, so they are aware of any ongoing issues.

- The Governor of Stafford should ensure that family liaison officers make families aware of the financial support available to them for funeral expenses following a death in custody.

# The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

19. The investigator obtained copies of relevant extracts from Mr Asif's prison and medical records.

20. NHS England commissioned a clinical reviewer to review Mr Asif's clinical care at the prison.

21. We informed HM Coroner for Staffordshire of the investigation. The coroner provided the cause of death. We have sent the coroner a copy of this report.

22. The Ombudsman's family liaison officer contacted Mr Asif's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any questions but asked for a copy of the report.

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

24. Mr Asif's wife received a copy of the initial report. She did not make any comments.

# Background Information

## HMP Stafford

25. HMP Stafford holds approximately 750 men who have been convicted of sexual offences. Practice Plus Group provides a 24-hour healthcare service.

## HMP Isle of Wight

26. HMP Isle of Wight is made up of two former prisons, Parkhurst and Albany. The prison holds approximately 1,000 men, mainly convicted of sexual offences. Practice Plus Group provides healthcare services at the prison. There is an inpatient healthcare unit at the former Albany site, providing 24-hour care for prisoners.

## HM Inspectorate of Prisons

27. The most recent inspection of Stafford was in January 2020. Inspectors reported that overall, the prison provided a safe environment, in which prisoners were respected. They reported that healthcare provision had improved since their previous inspection in February 2016.

28. The most recent inspection of Isle of Wight was in April and May 2019. Inspectors reported that healthcare was very good at the prison and that their services were delivered by a team who knew their patients well.

## Independent Monitoring Board

29. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently.

30. In its latest annual report for Stafford, for the year to 30 April 2021, the IMB reported that demand for cells that could be accessed without using stairs outstripped supply. The Board were aware of two prisoners who had arrived at Stafford who clearly could not manage stairs even though the sending prison had categorised them as fit and well. This was unfair on the prisoner and placed unfair pressure on staff.

31. In the IMB's most recent report for Isle of Wight, for the year to 31 December 2020, they reported that at least 80% of prisoners were satisfied with the healthcare services provided.

## Previous deaths at HMP Stafford

32. Mr Asif was the 13th prisoner to die at Stafford since November 2019. All the deaths were from natural causes. There are no similarities between our findings in this investigation and our investigation findings from the previous deaths.

# Key Events

33. In March 2020, Mr Maqsood Asif was convicted of sexual offences and was sentenced to 18 years imprisonment. On 20 May, Mr Asif was moved to HMP Isle of Wight.

34. On 18 June, a prison GP made an urgent referral to Southampton University Hospital's Cardiology Department after Mr Asif complained of chest and back pain.

35. On 28 October, following various tests, a hospital consultant told Mr Asif he had severe aortic stenosis (narrowing of one of the valves in the heart which restricts blood flow) and needed aortic valve replacement surgery. The consultant told him he should not exert himself in any way, including using stairs, until after surgery. The prison moved Mr Asif to a ground floor cell the same day.

36. On 20 January 2021, a healthcare administrative assistant contacted the hospital for an update on Mr Asif's surgery. The hospital said they were only undertaking urgent surgery due to the COVID-19 pandemic.

37. On 29 March, a healthcare administrative assistant contacted the hospital again for an update. The hospital's case manager said there was a backlog of appointments and they would ring the prison in the next couple of weeks to book an appointment for Mr Asif.

38. On 21 April, Mr Asif was moved to HMP Stafford. Stafford was unaware of Mr Asif's heart condition until he told them when he arrived, and they had no cells available on the ground floor. He agreed to a cell upstairs for the night and the prison moved Mr Asif to a ground floor cell the following day.

39. On 26 April, Southampton University Hospital's Cardiology Department sent Stafford a letter saying that Mr Asif required urgent aortic valve replacement and that his priority for surgery had recently increased due to him showing symptoms of aortic stenosis.

40. On 9 May, a prison GP sent a referral to the cardiology department at Stafford Hospital.

41. On 25 May, Stafford Hospital sent the prison GP a letter asking for further information about Mr Asif's cardiology tests results, completed while at Isle of Wight. There was no record these were sent.

42. In June, Mr Asif had several tests at Stafford Hospital to assess his heart condition. In September, a consultant told him he needed aortic valve replacement surgery.

43. On 31 October, a prison nurse and healthcare assistant attended Mr Asif's cell as he was struggling to breathe and had chest pain. They completed observations and requested an emergency ambulance. Paramedics arrived and completed an electrocardiogram (ECG - used to check the heart's rhythm) and found it to be abnormal. Mr Asif was taken to hospital where a hospital doctor diagnosed him with musculoskeletal pain and discharged him later that day.

44. On 3 November, a prison nurse arranged for Mr Asif to be taken to A&E after he reported chest pain. A hospital doctor diagnosed him with musculoskeletal pain and discharged him the same day.

45. On 9 November, a prison nurse saw Mr Asif at the healthcare unit where he complained of breathlessness, struggling to sleep and muscular pain. The nurse was aware he had an appointment with the prison GP later that day and said he should raise this with him. The GP prescribed Mr Asif pain relief.

46. That evening, a prison nurse attended the wing to see Mr Asif, as he continued to report chest pain and breathlessness. Prison staff had already called an emergency ambulance. The paramedics arrived and were concerned that Mr Asif might have COVID-19, so took him to hospital. He tested negative for COVID-19 but was admitted to hospital for further observations.

47. On 12 November, Mr Asif asked to contact his family. An officer, who was on bedwatch duty, spoke with a Custodial Manager (CM) at Stafford, who approved a phone call for the following day. The officer recorded this in the bedwatch log.

48. The investigator asked the officer if he told officers taking over his shift about the approved phone call. He said he did. The officers taking over the shift told the investigator they were not aware of any approved phone calls.

49. At approximately 6.00pm on 18 November, a hospital consultant spoke with Mr Asif and told him he was very poorly and surgery to replace his aortic valve was booked for the following day. He explained Mr Asif's family should be made aware of his condition as soon as possible. An officer on bedwatch duty spoke with his family following this.

50. At 10.10pm, Mr Asif suddenly deteriorated, and a hospital crash team came to assist. At 10.36pm, Mr Asif was pronounced dead.

## Contact with Mr Asif's family

51. On 19 November, the prison appointed a family liaison officer (FLO).

52. At approximately 9.00am, the prison Imam contacted the family, as Mr Asif was a Muslim. The family gave him the name of the funeral directors they had appointed, and he provided this to the FLO. The family requested for the body to be released that day so a funeral could be held immediately, as per Muslim practices.

53. The FLO did not explain the financial support available towards funeral expenses to the family.

54. The investigator raised this with the FLO, and, on 11 January 2022, she sent a letter to the family to explain the financial support available.

## Support for prisoners and staff

55. After Mr Asif's death, the Head of Operations & Security debriefed the staff that were supervising Mr Asif in hospital at the time of his death to ensure they had the

opportunity to discuss any issues arising and to offer support. They were also signposted to the staff care team.

56. The prison posted notices informing other prisoners of Mr Asif's death, and offering support.

## Post-mortem report

57. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Asif's cause of death as heart failure, caused by severe aortic stenosis.

# Findings

## Clinical care

58. The clinical reviewer found that the care Mr Asif received for his heart condition was not equivalent to that he could have expected to receive in the community.

59. Mr Asif was under the care of a consultant at Southampton University Cardiology Department and was awaiting aortic valve replacement surgery when he was transferred to Stafford. He had been waiting for surgery since October 2020, as it was delayed due to the COVID-19 pandemic. We are concerned that Mr Asif's transfer to Stafford in April 2021 had a detrimental impact on his chances of having the urgent surgery he needed. He did not have his surgery before he died.

60. Prison Service Order (PSO) 3050, Ensuring continuity of healthcare for prisoners, says healthcare staff must ensure, "current healthcare needs are assessed, and continuity of care ensured when prisoners are transferred between establishments...". It also says there should be a system for clinical hold, where prisoners can be withheld from transfer for a period of time for clinical reasons. The policy gives the example of prisoners awaiting an urgent cancer referral but also says that it can include awaiting other appointments.

61. The investigator and clinical reviewer asked the Head of Healthcare at Isle of Wight whether clinical hold was considered for Mr Asif. He said it was not because clinical hold was considered only for cancer referrals, life-saving treatment and occasionally where there had been a long wait to arrange coordinated care for a complex case. He said Mr Asif did not meet the criteria.

62. Given that Mr Asif had a very serious and life-threatening condition, we are of the view that clinical hold should have been considered. We recommend:

    **The Head of Healthcare at Isle of Wight should ensure that staff consider using clinical hold where a prisoner is awaiting surgery for a life-threatening condition and record this in the medical records.**

63. PSO 3050 says that an up to date summary of current health concerns should be sent with a prisoner when they transfer prisons. Where health concerns are more complex, it says it may be appropriate for prison healthcare teams to speak directly with each other ahead of transfer. The clinical reviewer found no evidence that Isle of Wight did a handover to Stafford to let them know about Mr Asif's heart condition and outstanding surgery.

64. As Stafford were unaware of Mr Asif's heart condition until he arrived, they did not realise that he required a ground floor cell and were unable to provide this on his first night. We recommend:

    **The Head of Healthcare at Isle of Wight should ensure that healthcare staff arrange a proper handover to the receiving prison where a prisoner has more complex health care needs.**

65. Despite Southampton Hospital writing to Stafford on 26 April saying that Mr Asif was awaiting urgent heart surgery, it was not until 9 May that the GP referred Mr

Asif to the local cardiology team in Stafford. Also, PSO 3050 says in the clinical hold section, "Patients may sometimes be transferred after having waited a considerable time for hospital treatment. In these circumstances details of the wait should be included in the referral letter from the new establishment to determine whether this may be taken into account at the new hospital. Clinicians should attempt to reach agreement that the waiting time will not be reset when the patient is transferred to a new list". The clinical reviewer found no evidence that the referral included this information.

66. Also, she found no evidence of the GP providing the cardiology tests results requested by Stafford Hospital on 25 May. We consider this may have further delayed Mr Asif's treatment. We recommend:

**The Head of Healthcare at Stafford should ensure that where prisoners are already under the care of a hospital consultant when they arrive, staff:**

- **make hospital referrals promptly;**
- **include all relevant information about the stage of treatment and time spent on the waiting list for surgery if applicable; and**
- **provide information requested by hospitals promptly to avoid delays in treatment.**

## Bedwatch handovers

67. On 12 November, three days after being taken to hospital, Mr Asif requested a call to his family, which a CM approved for the following day. The officer recorded this in the bedwatch log and said he told the oncoming shift officers about it during his handover.

68. Both oncoming shift officers said they were unaware of an approved phone call. This is despite one of them having signed the bedwatch log to confirm he had read it and been given a handover. We are concerned that the oncoming shift officers did not read the bedwatch log when starting their shift.

69. Officers should have given Mr Asif the phone call to his family, as agreed. His family were not aware that he was in hospital until 18 November, and this may have given them the opportunity to visit him sooner. We recommend:

**The Governor of Stafford should ensure that officers taking over bedwatch duties read the bedwatch log at the start of their shift, so they are aware of any ongoing issues.**

## Liaison with Mr Asif's family

70. Prison Service Instruction (PSI) 64/2011 on Safer Custody says that when a death in custody occurs, the family of the deceased are entitled to financial support of up to £3,000 towards funeral expenses from the prison. It says that any funeral expenses should be paid directly by the prison to the funeral directors once an original invoice is received.

71. We are concerned that the FLO did not make the family aware of the financial support available to them until prompted by the investigator. We recommend:

**The Governor of Stafford should ensure that family liaison officers make families aware of the financial support available to them for funeral expenses following a death in custody.**

## Inquest

72. The inquest, held from 2 to 4 June 2025, concluded that Mr Asif died from natural causes.

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