**Independent review**

**Mr Azizi - HMP Norwich**

# Bedfordshire, Cambridgeshire & Norfolk Group

May 2024

– Regional Safety Lead

# Overview

On 24 September 2021, Mr Mohammed Azizi was sentenced to five years imprisonment for arson. Mr Azizi had Crohn's disease and before he arrived at Norwich, he was admitted to hospital for treatment of a life-threatening inflammation of the stomach and a suspected bowel obstruction. Whilst in hospital Mr Azizi continuously refused to take medication for his conditions and he was also assessed by the mental health team who deemed that he had capacity to make decisions.

On 11 August 2022, he was moved to HMP Norwich. Throughout his time at Norwich, Mr Azizi continued to refuse all medical treatment and despite attempts from staff to encourage Mr Azizi, he continued to eat only a limited amount and frequently refused blood tests and clinical observations. Mr Azizi was admitted to outside hospital on numerous occasions during his time in Norwich but continued to refuse treatment even when he was very unwell.

Mr Azizi's condition continued to deteriorate, and on 15 May, he died in hospital.

The subsequent PPO report found that the care Mr Azizi received whilst at Norwich was of a very good standard and was equivalent to that which he could have expected to receive in the community. They found that the healthcare team at Norwich cared for Mr Azizi with compassion and dignity in difficult circumstances.

The PPO report made no recommendations.

# Coroners court – inquest

Samantha Goward, Area Coroner for the coroner area of Norfolk commenced an investigation and inquest on 23 May 2023.

At the end of the inquest on 25 April 2024 the medical cause of death was:

- Cardiac Atrophy and Failure
- Malnutrition, Crohn's Disease and Self-Neglect
- Pulmonary Thromboembolism and Infarction

The conclusion of the inquest was: Mr Azizi died of cardiac atrophy and failure with contributing factors of malnutrition, Crohn's disease, self-neglect and a pulmonary thromboembolism and infarction due to his continued refusal of treatments.

The inquest found that Mr Azizi was placed under an ACCT on two occasions while at HMP Norwich. The second of these was opened on 26.03.23. However, during the course of the inquest, one of the Officers called to give evidence, indicated that she was not familiar with the ACCT document, and that there was in fact a second ACCT document of the same date, with the same reference number, that had been opened by her.

The Officer's evidence was that, although the document originally disclosed bore what appeared to be her signature, this had not in fact been signed by her. She reported that when she was asked to prepare a witness statement for the purpose of the inquest in December 2023, she was provided with both copies of the document, and raised a concern that one was not completed or signed by her.

She also gave evidence that she thought the document not signed by her may have been a photocopy of her signature.

Upon inspecting the two original documents, neither was a photocopy and both appear to have been completed in pen. The member of staff who closed the ACCT then also gave evidence and he also advised that the document originally disclosed to the Court (and PPO) which appeared to bear his written and electronic signature, had not been signed by him.

As a result of the investigation it revealed matters giving rise to concern. The coroner recorded a risk that future deaths could occur unless action is taken. Subsequently she issued a Regulation 28: REPORT TO PREVENT FUTURE DEATHS to HMP Norwich.

Reg 28 Report - After
Inquest AZIZI M A 15(

## Independent review

Following the receipt of the regulation 28 report to prevent future deaths as per attached the Prison Group Director requested an independent review of actions taken and information available.

This independent review was completed by the regional group safety specialist.

As part of an independent review, we assessed the following documents:

- Regulation 28
- PPO report
- ACCT documentation
- Local management enquiry
- Statement of actions taken by Security Governor
- Local data loss logs

# Responses to matters of concern

The MATTERS OF CONCERN raised in regulation 28 are as follows:

*A document has been created, which two witnesses said under oath bears what appears to be their signatures, but both confirmed they did not in fact sign those documents.*

- Our inquiry has concluded that this is the case, two ACCT documents were open at the same time. The second document was opened in good faith by a member of staff who genuinely believed that the original document had been misplaced. However, the process for opening a duplicate document wasn't effectively followed which did cause confusion.

*The evidence was that any enquiries into the concern raised by the Officer in December 2023 were limited, as it was felt that it was simply a misunderstanding and some documents had been photocopied. We had the original documents in Court, and both appear to have been handwritten in pen and one is not a photocopy of anything else. The prison have been unable to provide an explanation as to when, how or by whom, the second document was created.*

- Our inquiry has concluded that a member of staff did complete a duplicate ACCT document. This was not a photocopy version of the original ACCT; it was a duplicate version which the member of staff created from the best of her knowledge in the genuine belief that the original document had been mislaid. Our enquiries have also raised concerns into the depth of investigation that took place at the time of the incident and accept this should have been thoroughly looked at.

*We also had evidence from another Officer who said that as part of a Quality Assurance review, she was asked to add notes to an ACCT document after it had been closed, she thought roughly six weeks later (that was to the document that the witnesses said had not been signed by them). This raises concerns that an Officer was asked to recreate sections of a document and effectively back date them, without making it clear that this is a retrospective entry and for what reason.*

- As part of our inquiry we are unable to substantiate this claim. Although the member of staff was spoken to be a senior leader prior to the inquest there is no clear evidence that the conversation directed the member of staff to add notes to the document. However as a result all future support and advice for staff will be provided by the SPOC and regional safety specialist only.

*The Court was advised by Counsel for the prison that this system has changed, but there was no evidence from the prison to support this and confirm why this could not happen again.*

- Our inquiry found that systems have now changed specifically regarding ACCT documentation to ensure that all concerns are identified and addressed at the earliest opportunity. Regional assurance support visits have also increased in conjunction with the local quality assurance system. As a result the safety team ensure that targeted actions are taken which are evidenced through relevant meetings and escalated where necessary. Operational staff briefings are more targeted to ensure staff are aware of their responsibilities and there is now published guidance for to support delivery.

*There are also concerns about disclosure of documents and how it came to be that both the Court and the PPO received just one of 2 documents that existed for the same date, and that neither was advised of the concerns previously raised Regulation 28 – After Inquest Document Template Updated 30/07/2021 regarding the document that was disclosed. Had the Officer in question not been called to give evidence in Court and her statement simply read into evidence, the Court would never have been aware of the existence of the second ACCT document nor the issues surrounding it and nor would the PPO, which is of significant concern. The Court was not provided with evidence to explain how this occurred, who disclosed the documents and why they only disclosed one, or how only one came to have been scanned on to the electronic system that was used to then provide disclosure. While it may not have been causative in Mr Azizi's case, the importance of a document such as an ACCT may well have greater significance in other situations.*

- Our inquiry found that there were concerns around documentation not being supplied to the PPO to support the completion of the independent review of death in custody. A review of previous deaths in custody has evidenced that this appears to be an isolated case and documentation was supplied as soon as located which unfortunately was post the PPO investigation. This isn't acceptable, all sites will be written to by the PGD to remind them of their responsibilities in supplying documentation when requested without delay.

*It is unclear whether the two versions were in use at the same time. Both have sections completed by different Officers, which may suggest they were, although none of the witnesses who gave evidence were aware of this or had ever been aware of this in their career. However, the existence of 2 documents, were it to happen, would also give rise to concern as no single document would contain a full and complete picture.*

- As part of our inquiry, we can conclusively state there were two ACCT documents that ran simultaneously from the evidence seen. Therefore, following the interviews with staff as part of the management enquiry where no staff report that this was the case we can only conclude that the original document was missing and only located later following the PPO investigation.

*If the Coroner and PPO investigations are hampered by a lack of full disclosure and potentially inaccurate or recreated documents, there is a risk that a full picture is not received and any findings, conclusions and lessons learnt from those enquiries may not fully address all concerns and risks, and that could lead to the same things happening again and therefore a risk of future deaths.*

- A senior SPOC will always be appointed to any future cases who will have full responsibility for ensuring full access/disclosure of any documents requested. All sites will be written to by the prison group director to remind them of the importance of allowing PPO colleagues unfettered access to documentation.

# Conclusions

The care Mr Azizi received whilst at Norwich was of a very good standard and was equivalent to that which he could have expected to receive in the community.

Our enquiry found that there were in fact two ACCT documents opened for Mr Azizi. It is clear that the rationale behind this was that staff genuinely believed that the original document had been misplaced.

The process for opening a duplicate ACCT was poor and did not clearly evidence why this had taken place.

The original ACCT document was not reported as a data loss, there is concerns that this potentially this could happen again without necessary action.

The presence of two ACCT documents in no way contributed to Mr Azizi's death.

The disclosure of documentation and process to the PPO was not acceptable.

## Recommendations

The member of staff involved to receive advice and guidance by the site and from the group safety specialist.

All future support and advice for staff during an inquest will be provided by the SPOC and regional safety specialist only.

There is a need locally for all management grades to be supported and reminded of the process of reporting and requirements in the identification of data losses to ensure compliance with policy.

All sites in region will be written to by the PGD to remind them of their responsibilities in supplying documentation when requested without delay.