Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Governor of HM Prison Norwich** **Knox Road** **Norwich** **Norfolk** **NR1 4LU**
1	**CORONER** I am Samantha GOWARD, Area Coroner for the coroner area of Norfolk
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 23 May 2023 I commenced an investigation into the death of Mohammed Amin AZIZI aged 32. The investigation concluded at the end of the inquest on 25 April 2024. **The medical cause of death was:** 1a) Cardiac Atrophy and Failure 1b) Malnutrition, Crohn's Disease and Self-Neglect 1c) 2) 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.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Mr Azizi's death are summarised in the finding of the jury that "Mr Azizi had a diagnosis of Crohn's disease (2012) and Deep Vein Thrombosis (DVT) (May 2022) as a result he was transferred to the healthcare wing at His Majesty's Prison, Norwich on the 11th August 2022 to have access to 24 hour healthcare. Whilst at His Majesty's Prison, Norwich Mr Azizi was admitted on multiple occasions to the Norfolk and Norwich University Hospital for these conditions. Mr Azizi repeatedly refused food, monitoring, investigations and treatment. The risks to Mr Azizi's physical health were known to him and he was judged to have capacity to understand that the outcome of his decisions could result in death. Mr Azizi was admitted to Norfolk and Norwich Hospital on the 24th April 2023 where he remained until his death on the 15th May 2023. He died of cardiac atrophy and failure". Mr Azizi was placed under an ACCT on two occasions while at HMP Norwich. The second of these was opened on 26.03.23. Prior to the Inquest, disclosure was provided by the prison, and this included an ACCT document dated 26.03.23 which was closed 27.03.23. However, during the course of the inquest, one of the Officers called to give evidence regarding that

	ACCT, indicated that she was not familiar with the ACCT document in the disclosure bundle, 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. It then transpired that both the Coroner and the PPO (which had separately investigated this death) had only been provided with one of these two documents. The copy of the second document was produced at Court, and in due course, the originals of both documents. 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. Her evidence was that she was told not to refer to the second document. 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 prison were unable to provide any evidence of why they did not disclose both versions of the document, how there came to have been two documents, who had created the second one or details of the investigation carried out in to the concern of a signature being added by someone other than the Officer. A Senior Officer 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.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** 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. • 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 hand written 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. • 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. 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. • 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

	regarding the document that was disclosed. Had the Officer in question not been called to give evidence in Court and her statement simply read in to 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. • 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. • 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by June 26, 2024. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mr Azizi's family HCRG Norfolk and Norwich University Hospitals NHS Foundation Trust Norfolk and Suffolk Foundation Trust [redacted] I have also sent it to: Ministry of Justice HM Inspectorate of Prisons HM Prison and Probation Service The Independent Advisory Panel on Deaths in Custody who may find it useful or of interest.

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 01/05/2024**  **Samantha GOWARD** **Area Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH