

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Norris, a prisoner at HMP Bristol, on 15 July 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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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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.

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.

Mr Michael Norris was found hanging in his cell at HMP Bristol on 15 July 2023. Prison and healthcare staff and paramedics tried to resuscitate him but were unsuccessful. He was 34 years old. I offer my condolences to Mr Norris's family and friends.

Mr Norris was the sixth person to take their own life at Bristol in three years and was the fourth of six self-inflicted deaths there during 2023.

I am satisfied that Mr Norris gave no indication to staff that he was at risk of suicide in the weeks leading up to his death and that staff could not have foreseen his actions.

Staff delivered a high standard of emergency care to Mr Norris when he was found hanging and tried their best to resuscitate him. I commend them for their actions.

I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman

April 2024

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Summary

Events

1. On 3 March 2023, Mr Michael Norris was recalled to prison after allegedly assaulting his ex-partner and breaching his licence conditions. He had been released in 2016, but as he had previously been given an Imprisonment for Public Protection (IPP) sentence (an indeterminate sentence), he was subject to a life licence. He was sent to HMP Bristol.
2. When he arrived at Bristol, Mr Norris told the reception nurse that he had taken a deliberate overdose a few weeks before. The nurse started suicide and self-harm procedures (known as ACCT) and sent a referral to the prison's mental health team.
3. Staff continued ACCT monitoring until 14 March. Mr Norris continued to receive support from the prison's mental health team and engaged well.
4. On 14 July, Mr Norris had a video call with his children, facilitated by Children's Services. The officer who monitored the call told us that he had a long conversation with Mr Norris afterwards. He said Mr Norris was grateful that the call had been arranged and was looking forward to the next one. He gave no cause for concern.
5. The next day, at around 5.10pm, Mr Norris spoke with his partner on the phone for around 40 minutes. During the call he said he was in a dark place and became upset when discussing his children, though he ended the call by saying that he would be all right.
6. CCTV shows that Mr Norris left his cell to use the bathroom at around 6.00pm. He returned seven minutes later. Half an hour later, he stepped outside his cell and looked through the observation panel in his cell door for a few seconds before going back in his cell and shutting the door.
7. At around 9.10pm, while carrying out a routine check of all prisoners, an operational support grade (OSG) noticed that Mr Norris's observation panel was covered. He could see through a small gap that Mr Norris was sitting on the floor. He knocked on the door several times, but Mr Norris did not respond. He radioed for prison staff to attend the cell, and two officers arrived around one minute later.
8. The officers entered the cell and found Mr Norris in a seated position at the back of his cell with a ligature around his neck. As Mr Norris was unresponsive, they called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and started CPR.
9. At 9.14pm, two members of healthcare staff arrived and continued CPR. The healthcare staff and prison officers took it in turns to give Mr Norris chest compressions while they waited for paramedics to arrive.
10. Approximately two minutes later, paramedics arrived and continued to work on Mr Norris but were unable to resuscitate him. At 9.40pm, they pronounced that Mr Norris had died.

Findings

11. Mr Norris was an IPP prisoner, recalled to prison after a period in the community. IPP prisoners are recognised to be at increased risk of suicide. However, Mr Norris gave no indication to staff that he was at risk of suicide in the weeks leading up to his death. Staff were unaware of the nature of his conversation with his partner hours before he died, and we are satisfied that they could not have foreseen his actions.
12. Ambulance paramedics commented on the high standard of emergency care that prison and healthcare staff gave to Mr Norris when they found him hanging. Staff tried hard to resuscitate Mr Norris and we commend them for responding so well in such distressing circumstances.
13. We make no recommendations.

The Investigation Process

14. HMPPS notified us of Mr Norris's death on 15 July 2023.
15. The investigator issued notices to staff and prisoners at HMP Bristol informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. The investigator visited Bristol on 20 July. She obtained copies of relevant extracts from Mr Norris's prison and medical records.
17. The investigator interviewed one prisoner at Bristol on 20 July, two members of staff on 26 September, and one member of staff on 13 November.
18. NHS England commissioned an independent clinical reviewer to review Mr Norris's clinical care at Bristol. The investigator and the clinical reviewer interviewed two members of healthcare staff on 26 September and one on 30 October.
19. We informed HM Coroner for Avon of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
20. The Ombudsman's family liaison officer contacted Mr Norris's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She had questions about the ACCT process, whether Mr Norris was under the care of the prison substance misuse team, and whether CCTV was available for the period before Mr Norris's death. These questions have been addressed within the report. She also had questions around the physical and mental health care Mr Norris received at Bristol. These have been addressed in the clinical review.
21. Mr Norris's family received a copy of the draft report. The solicitor representing Mr Norris wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
22. The initial report was shared with HMPPS. HMPPS did not find any factual inaccuracies.

Background Information

HMP Bristol

23. HMP Bristol is a category B reception and resettlement prison which holds up to 580 adult men. Oxleas NHS Foundation Trust provides physical and mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Bristol was in July 2023. Following the inspection, the Chief Inspector of Prisons invoked the Urgent Notification (UN) process because he was so concerned about conditions there. He noted that the UN process had been invoked after the last inspection in 2019 and many of the failings highlighted then were also observed during the 2023 inspection. Despite this, there were many excellent, dedicated staff in the prison who were doing their best to support the men in their care. The issues highlighted included:
- Staffing across the prison was insufficient to ensure the delivery of a safe and purposeful regime.
 - The number of self-inflicted deaths and reported levels of self-harm were much too high.
 - Most prisoners spent 22 hours a day locked up, with half of them sharing cramped cells designed for one.
 - Wing staff did not develop effective relationships with prisoners. The prison was not delivering key work, wing staff had little time to advocate for prisoners who needed their help, and they lacked the capability and confidence to manage behaviour more effectively.
 - Work to help prisoners rebuild ties with their families and significant others was too limited and poorly resourced.
25. A high number of prisoners at risk of self-harm were supported by Assessment, Care in Custody and Teamwork (ACCT) case management, reflecting the high levels of self-harm and reported mental health issues in the population. Care plans for these prisoners were reasonably good and informed by sufficient exploration of the risks and triggers for each individual. Staff made efforts to engage them in purposeful activity, and some had involved their families where appropriate. They also sought input from the mental health team, substance misuse service or other relevant departments. Oversight of ACCT case management had improved since the last inspection, and robust quality assurance and a programme of staff training were driving improvement.
26. Inspectors reported that there were staff shortages on the mental health team, which was struggling to meet increased demand. Referrals to the team had doubled in the previous six months with patients in crisis prioritised.

Independent Monitoring Board

27. 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. In its latest annual report, for the year to 31 July 2023, the IMB reported that there had been an increase in deaths, self-harm and violence and more prisoners than the previous year were on ACCT and constant supervision. There had been high levels of overcrowding (over 50% all year) with two prisoners in cells built for one person and staffing was below the required levels, which affected the consistent delivery of a full daily regime, resulting in more prisoners spending time in their cells. Activities were often cancelled on the day and key working had not yet been re-established. The Board reported that there were insufficient staff in the mental health team to support the mental health needs of all prisoners. Priority was given to the most unwell.

Previous deaths at HMP Bristol

28. Mr Norris was the tenth prisoner to die at Bristol since July 2020, and the seventh self-inflicted death. One of the previous deaths was also of an IPP prisoner, who died on the same wing. There had been another two self-inflicted deaths at Bristol by the end of 2023.
29. As a result of these self-inflicted deaths and the Urgent Notification issued by HMIP, Bristol is receiving additional support and monitoring from regional and national safety teams.

Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.
31. As part of the process, a care plan (plan of care, support and intervention) is put in place. The ACCT should not be closed until all the actions on the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Imprisonment for Public Protection (IPP) sentences

32. Imprisonment for Public Protection (IPP) sentences were introduced in 2005 and abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently

reduced their risk. The abolition was not applied retrospectively. There are about 3000 IPP prisoners, of which half have never been released.

33. Since June 2022, the Secretary of State for Justice must approve all Parole Board recommendations for the release or return to open conditions of prisoners serving indeterminate sentences.

Key Events

34. On 19 May 2008, Mr Michael Norris was convicted of grievous bodily harm and was given an imprisonment for public protection (IPP) sentence. (Those with IPP sentences must remain in custody until the Parole Board decides they are no longer a risk to the public. Once released, their licence remains in force indefinitely and if breached, they can be recalled to custody at any time.)
35. On 1 March 2016, Mr Norris was released from prison on licence.
36. On 3 March 2023, Mr Norris was recalled to prison for an alleged assault on his ex-partner and for breaching his licence conditions. He was sent to HMP Bristol.
37. When he arrived at Bristol, Mr Norris told the reception nurse that he had been in hospital after taking an intentional overdose a few weeks before. When the nurse asked Mr Norris if he had any current thoughts of suicide or self-harm he said, "I can't answer that, I don't know". As the nurse was concerned for his safety, she started suicide and self-harm prevention procedures (known as ACCT) with observations set at three an hour. She also sent a referral to the mental health team.
38. The next day, a Supervising Officer (SO) held the first ACCT review alongside a nurse from the mental health team. Mr Norris said that his recent overdose was due to him finding it difficult to cope with his bipolar diagnosis and relationship breakdowns. Mr Norris said he was on medication to manage his bipolar symptoms in the community, and that he had continued this medication in prison. Mr Norris said that he was focused on his future and that his three children were his main reason for living. Mr Norris said that he would like help in regulating his emotions and managing personal relationships. After the review, the mental health nurse emailed the therapies team to ask if Mr Norris could be triaged for therapy. He was added to the therapies schedule for an initial assessment that week. The SO set Mr Norris's observations at one an hour.
39. On 9 March, a Custodial Manager (CM) saw Mr Norris for an ACCT review after the self-inflicted death of an IPP prisoner on his wing. A mental health practitioner also attended. Mr Norris became emotional when discussing the death and said that he could relate to how the deceased must have felt. Mr Norris also spoke about his bipolar diagnosis, and how he managed this in prison. He said that his medication was working well but that he was still experiencing symptoms of mania. Mr Norris said that he had a good relationship with prison staff and that he would be confident to speak to staff if he was struggling with his emotions. The CM scheduled another review for the following day, and the mental health practitioner referred Mr Norris to the mental health team's crisis caseload. The CM kept observations at one an hour.
40. On 10 March, the mental health team discussed Mr Norris at a multidisciplinary meeting and added him to their crisis caseload for additional psychological support.
41. The same day, Mr Norris attended his scheduled ACCT review with a SO and a mental health worker. Mr Norris said that he was eating, drinking, and sleeping well at night. He talked about the future, about his children, and said that he would like to work while at Bristol. When asked, Mr Norris said that he did not have any

thoughts of harming himself and said that he was “feeling absolutely fine”. The SO reduced the level of observations to one every two hours.

42. On 14 March, Mr Norris attended his scheduled ACCT review with a SO and the mental health practitioner. As Mr Norris had questions relating to his recall, his Prison Offender Manager (POM) also attended. Mr Norris said that he was initially very overwhelmed when he came back to prison, but he was now feeling much better and was receiving the support he needed. The mental health practitioner said that he was having weekly visits with the crisis team, completing in-cell packs and was due to start some one-to-one therapeutic work. Mr Norris said that he had a positive relationship with both the offender management unit and the mental health team, and he was feeling more at ease with his situation. It was agreed by all present that Mr Norris’s ACCT should be closed, but that the same avenues of support would remain in place.
43. On 21 March, Mr Norris attended his post-closure review. He said that he felt in a much better place and was looking forward to receiving a visit (the ACCT does not specify who from) in a few days’ time. He said that he felt settled at Bristol and had support from staff, peers on his wing and from his friends and family in the community. The ACCT remained closed.
44. On 23 March, a POM served Mr Norris with a notice stating that he must not contact his ex-partner, and a Person Posing a Risk to Children (PPRC) notification. The PPRC stated that Mr Norris was not permitted to have any contact with his children until approved by the Public Protection Unit (PPU) and Children’s Services. The POM explained both notifications to Mr Norris, and Mr Norris signed to say that he understood them.
45. On 13 April, Mr Norris’s children’s social worker contacted his Community Offender Manager (COM) to discuss facilitating contact between Mr Norris and his children. The social worker said that the children would like to have contact with their father through letters and supervised visits. It was agreed that Mr Norris could have contact with his children, and arrangements were made for him to have a video call with his children, facilitated by social services.
46. On 27 April, a recovery worker from the substance misuse service (SMS) tried to complete an initial assessment with Mr Norris, but Mr Norris said that he did not want help from their service. The recovery worker gave Mr Norris an alcohol in-cell pack and told him how he could access SMS support in the future should he change his mind.
47. Over the next two months, Mr Norris continued to see the mental health team regularly, completed in cell workbooks and attended a ‘managing moods’ workshop.
48. On Friday 7 July, two nurses from the mental health team saw Mr Norris to review his medication. Mr Norris said that he was having trouble sleeping and that he was stressed, irritable and finding it difficult to regulate his emotions. The nurse prescriber agreed to increase his antidepressant medication (sertraline) and changed his antipsychotic medication (quetiapine) from immediate release to a modified release, to help with his sleep. The nurse asked Mr Norris if he had any thoughts of suicide or self-harm, and he said he did not.

49. As Mr Norris's prescription was changed late on a Friday and the pharmacy was closed over the weekend, Mr Norris did not receive his mental health medication on 7, 8 or 9 July. He resumed taking his mental health medication on Monday 10 July when the pharmacy reopened.
50. On 14 July, Children's Services facilitated a video call between Mr Norris and his children. The prison officer monitoring the call said he had a lengthy conversation with Mr Norris following the call. The officer said that Mr Norris was grateful the call could be accommodated as it had been a lengthy process to arrange, and that he was looking forward to the next call which had been scheduled for the following Friday. The officer said that Mr Norris seemed happy and that he raised no concerns that might indicate he was at risk of harming himself.

Events of 15 July

51. CCTV shows that during the afternoon of 15 July, Mr Norris left his cell frequently, and he shared food and chatted with his peers on the wing.
52. At approximately 5.00pm, an officer carried out a routine check of all prisoners. He opened the door of Mr Norris's cell, put his head inside the cell, and then locked the door behind him.
53. At approximately 5.10pm, Mr Norris spoke with his partner on the phone for around 40 minutes. The investigator listened to this phone call in which he spoke about the video call he had the previous day with his children. He told his partner that the children were upset during the call and that he wanted to "get into the screen" and cuddle them. Mr Norris was in tears when talking about this and said that he felt hopeless and alone. Mr Norris told his partner that he was in a dark place but ended the call by saying that he "will be alright" and that he loved her. (Although all prisoners' telephone calls are recorded, staff listen to only a random sample. They would have been unaware of the contents of this call until after Mr Norris's death.)
54. CCTV shows that at approximately 6.00pm, Mr Norris left his cell to use the toilet. (Mr Norris was on B Wing, which does not have sanitation in cells, and during night state, prisoners have to press a button in their cell to be let out to use the toilet.) He returned seven minutes later. He entered his cell and closed the door behind him.
55. Around 30 minutes later, Mr Norris briefly stepped outside his cell and partly closed the door behind him (he would have had to ask to use the toilet again in order for his cell door to be unlocked). He looked through the observation panel in his own cell door for around five seconds and then went back into his cell and shut the door behind him.
56. At approximately 9.10pm, while carrying out a routine check, an Operational Support Grade (OSG) noticed that Mr Norris had covered his observation panel. He said that there was a small slit in the observation panel covering and that when he looked closely, he could see Mr Norris sitting on the floor of his cell. He said that initially this did not concern him, and he knocked on the door to get a verbal response from Mr Norris. When he did not receive a response after knocking several times, he called over his radio for additional officers to attend the cell. He continued checking other prisoners until officers arrived, approximately one minute later.

57. Two officers attended Mr Norris's cell and unlocked his door. They found Mr Norris in a seated position at the back of his cell with a ligature around his neck. As Mr Norris was unresponsive, one officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and started CPR.
58. At 9.14pm, two members of healthcare staff arrived. A nurse applied a defibrillator to search for a shockable pulse, however none was detected, and no shock was advised. She tried to clear Mr Norris's airway with an I-gel machine, however, was unable to do so due to the machine getting blocked by vomit. The healthcare staff and prison officers continued to take it in turns to give Mr Norris chest compressions while they waited for paramedics to arrive.
59. Approximately two minutes later, the first ambulance arrived, and paramedics took over the care of Mr Norris, shortly followed by two more ambulances. Paramedics continued to work on Mr Norris for around 20 minutes but were unable to resuscitate him. At 9.40pm, they pronounced that Mr Norris was dead.
60. Mr Norris left a note in his cell addressed to his children, which asked for their forgiveness.

Contact with Mr Norris's family

61. The prison appointed an officer as the family liaison officer on 16 July. That morning, the officer and the Governor of Bristol visited the home of Mr Norris's mother to break the news of her son's death. She was not at home, and they were told to come back at 2.00pm. They returned at 2.00pm and informed Mr Norris's mother of his death.
62. The prison offered a contribution towards the funeral costs in line with national guidance.

Support for prisoners and staff

63. After Mr Norris's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
64. The prison posted notices informing other prisoners of Mr Norris's death and offering support. Additional support was offered to prisoners on B Wing who were close to Mr Norris, and a service was held in his memory.

Post-mortem report

65. The post-mortem report concluded that Mr Norris died from suspension by ligature (hanging).

Findings

Management of Mr Norris's risk of suicide and self-harm

66. When Mr Norris arrived at Bristol on 3 March, staff correctly identified that he was at risk of suicide and self-harm and started ACCT procedures, which continued until 14 March. He had appeared settled after that and engaged well with the mental health team. There was no indication that he was at risk of suicide or self-harm after 14 March.
67. Mr Norris had a video call with his children on 14 July and he became upset when talking about this with his partner the next day. However, the officer who monitored the video call told us that Mr Norris gave no cause for concern and said he was looking forward to the next call with his children. Staff were not monitoring Mr Norris' phone calls and so did not hear him say he was in a dark place to his partner. We are satisfied that Mr Norris gave no indication to staff that he was at risk of suicide and that they could not have foreseen his actions.

Clinical care

68. The clinical reviewer found that the mental health care Mr Norris received at Bristol was of a good standard. She found that he was regularly seen by the mental health team who had a good understanding of his past mental health history and responded appropriately to his needs.
69. The clinical reviewer noted that Mr Norris was left without his antipsychotic medication for a period of three days, after his prescription was changed on Friday 7 July. Antipsychotic medication is classed as a 'critical' medication, which means that when it is not given it can cause potential harm to the patient, though the clinical reviewer found no evidence that Mr Norris experienced any adverse effects. The clinical reviewer made several recommendations which the Head of Healthcare will wish to address.

Governor to Note

Covered observation panels

70. Observation panels in cell doors allow staff to carry out regular safety checks on prisoners when they are locked in their cells. HMPPS's Safety Briefing on Observation Panels says that every time staff approach a prisoner's cell, they must ensure that the observation panel is clear, in case of an emergency. When staff discover that a panel has been blocked, they should ask the occupant of the cell to remove the blockage. If a prisoner does not comply, staff must take immediate action to remove the obstruction and check on the prisoner's welfare. The Safety Briefing says that prisons should have local safety measures in place to explain what staff should do if the occupant of the cell cannot be seen due to the observation panel being blocked. We asked Bristol for its local policy, and they told us they did not have one.

71. At interview, the OSG said that around 50% of prisoners at Bristol cover their observation panels overnight, especially those who live on B Wing. (Prisoners on B Wing do not have toilets in their cells. If let out during the night to use the toilets, they can open the observation panels on other cells, which the occupant is unable to close unless they ask to be let out themselves, and once opened, light from the landing shines into the cell and disturbs the occupant's sleep, hence why prisoners cover them.) He said that he knew prisoners should not be blocking their observation panels but there was not enough time to ask every prisoner to uncover their observation panel and that he would probably be met with resistance, especially as prisoners had been doing this for a long time.
72. The OSG said that if a prisoner had blocked their observation panel and he could not see them, he would knock and wait for a verbal response to confirm that they were safe. He did this when he found Mr Norris's blocked observation panel and then called for staff when Mr Norris did not respond. We consider that was the correct course of action in the circumstances and there was minimal delay in entering Mr Norris's cell once he raised the alarm.
73. Nevertheless, the prevalence of covered observation panels at Bristol is a concern as is the lack of guidance to staff about what to do about them. We bring this to the Governor's attention.

Good practice

74. We found that the emergency response was delivered to a very high standard by all those involved. Medical emergency procedures were appropriately followed, and an ambulance was onsite within five minutes of the code blue being called. The paramedics described the quality of care given by the prison and healthcare staff as exemplary, and we therefore wish to highlight the conduct of all staff involved to the Governor.

Inquest

75. At the inquest, held from 28 September to 8 October 2026, the jury concluded:

"Michael Norris died by suicide. We find the following stressors to have contributed to his death. The consequences and uncertainties of his IPP status, including the uncertainties as to Michael's release date. Communications by Michael with those out of prison, not made through the prison's communication channels. The failure of the prison to screen email communication to Michael, resulting in him receiving a communication contrary to his bail conditions.

We found that the actions taken by the professionals in contact with Michael were appropriate and in line with the information available to them at the time."

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100