REPORT OF AN INVESTIGATION INTO THE CIRCUMSTANCES OF AN ACT OF SELF HARM BY AR AT HMP NORWICH

COMMISSIONED BY THE SECRETARY OF STATE FOR JUSTICE IN ACCORDANCE WITH ARTICLE 2 OF THE EUROPEAN CONVENTION ON HUMAN RIGHTS

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The experience of considerable trauma in AR's early life was not followed by help that was effective to overcome the impact of these experiences. These experiences were central to his subsequent act of self-harm.

AR had committed offences from an early age and was well known to the local criminal justice services. Records indicate that he could be threatening and disruptive, but that he could also be a trusted inmate with a good work record.

On one occasion in 2013 he had been placed on an ACCT following an incident of possible self-harm, although he denied that his actions were intended as self-harm.

In 2016 AR disclosed to medical staff that he experienced mental health problems and he was correctly referred to a service to address these issues. He was given information on how to access a similar service in the community although he did not.

Screenings undertaken around the time of AR's reception to HMP Norwich showed he was questioned about thoughts of suicide or self-harm, which he denied any intention to act upon. He settled into the prison routine and received regular visits.

Prior to the incident, AR's behaviour had been good and there were no indications that he was planning to harm himself. Staff believed him to be in a good frame of mind.

It was not possible to tell definitively what caused AR to commit to such a serious act of self-harm having previously appeared reasonably content, although it seems probable that it was connected to a telephone call that was made. After the call, on returning to his cell, he wrote two lengthy letters which explain the reasons he had decided to take his own life. He explicitly said that no one was to blame other than himself.

During a routine roll check AR was found by the officer on duty to be suspended by a ligature. The officer appropriately called for help, entered the cell, cut the ligature, and started to perform CPR. Other officers arrived promptly.

All prison staff interviewed who knew AR expressed shock at what had happened, testifying that there had been no signs that he had been contemplating harming himself.

Mandatory actions that follow an incident of serious self-harm were commenced but not concluded. AR's family were not provided with information which they could reasonably have been. Staff were also left without an opportunity to account for their actions and feel that the matter was closed. Any potential learning was not considered. No member of the management team at HMP Norwich took responsibility for the required investigation or made any enquiry as to why it had not been produced.

The contents of ARs cell were not subject of any review, although the letters contained there were significant.

A transcript of a telephone call between AR and his partner, which was significant to the understanding of his actions was produced and read by some members of staff, although HMP Norwich could not locate the transcript for the investigation.

THE REASON FOR THE INVESTIGATION

The investigation concerns AR, a young man who suffered a serious cognitive impairment following an act of self-harm whilst a serving prisoner at HMP Norwich.

AR was 29 years old on arrival as a remand prisoner at HMP Norwich on 20 August 2018 charged with new offences and as a recalled prisoner in breach of his release licence conditions. He was subsequently sentenced to 44 months imprisonment on 18 September 2018. He was housed on E wing, at HMP Norwich which is a standard location.

On 25 October AR was found by prison staff suspended by a ligature. Paramedics attended and he was taken to hospital by emergency ambulance. He was subsequently diagnosed with a significant hypoxic brain injury resulting from hanging with a prognosis of poor neurological recovery.

AR served the remainder of his sentence until 16 May 2022 on temporary licence (ROTL), home detention curfew (HDC), and on licence at various medical facilities and ultimately at his mother's home due to his poor medical condition. He remains in need of constant medical attention.

HMP Norwich reported the incident in accordance with policies in place at the time but failed to conduct a simple investigation into the circumstances of the incident.

This failure meant that no definitive account of the incident was produced. Potential lessons for the prison were not explored and AR's family were left with unanswered questions concerning the incident.

This investigation was commissioned on 19 October 2021, with the first batch of evidence being provided on 27 January 2022.

TERMS OF REFERENCE

The terms of reference for this investigation are:

- to examine the circumstances of the incident on 25 October 2018 in which AR sustained a life-threatening injury, and in so far as it is relevant, his management by HMP Norwich from the date of reception on 20 August 2018 until that date, in the light of the policies and procedures applicable at the relevant time

- to examine relevant health issues during the period spent in custody at HMP Norwich from 20 August 2018 until 25 October 2018, including mental health assessments and AR's clinical care up to the point of life-threatening injury on 25 October 2018

- to consider, within the operational context of His Majesty's Prison and Probation Service (HMPPS), what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved

- to provide a draft and final report of my findings including the relevant supporting documents as annexes

- to provide my views, as part of the draft report, on what I consider to be an appropriate element of public scrutiny in all the circumstances of this case. The Secretary of State will take my views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the European Convention on Human Rights (ECHR).

I sought and received clarification that the terms of reference should include an examination of the way HMP Norwich followed policy and procedure after 25th October and their subsequent interactions with AR and his family.

The commissioning letter states that this is an Article 2 investigation and must be conducted in an open, transparent and even-handed manner. These principles have underpinned every aspect of the investigation.

THE INVESTIGATION METHODOLOGY

The investigation commissioning letter establishes the terms of reference and parameters of the methodology. These include:

- the involvement of AR, through his legal representative and/or next of kin
- access to AR's prison and any other relevant documents held by the secretary of state, including local or national policy documents
- access to relevant health care records
- interviews with relevant members of HMPPS staff
- interviews with relevant staff not employed by HMPPS via their employer

The investigation began on receipt of documentation from HMP Norwich concerning AR's time there. I was also provided with documents setting out some of the relevant policy framework.

Contact was made with AR's legal representative. In due course interviews were arranged with AR and his family. Letters from AR to his family that were in his cell at the time of the incident were shared with the investigation by AR's Mother.

Interviews were conducted with 11 members of staff from HMP Norwich who either had regular contact with AR prior to the incident, were involved directly in the incident and its aftermath or held relevant management positions. These interviews were recorded with transcripts sent to the participants, which were subsequently agreed as a true record with the participants.

Following several of the interviews with staff from HMP Norwich, requests were made for further documentation. Points of clarification were also sought from the Safer Custody section of HMPPS.

The structure of Prison records

It is worth noting that records regarding prisoners are held on various databases depending on the purposes to which they will be put. Some are fully digitised whilst others are hand-written. There is a 'core record' which contains much information, but there is no single system that records a day-by-day chronology of the prisoners' activities.

All information about a prisoner will not be held on the core record. There is also an 'intelligence system' (Mercury) which holds information about security issues.

Access to police records

Information from Norfolk Constabulary was gathered with regard AR's arrest and detention prior to his remand in custody on 20 August 2018, this was forthcoming and has assisted the investigation.

Access to medical records

Access to AR's 'SystmOne' medical records were provided to me by HCRG care group who are now responsible for health care at HMP Norwich. At the time of the incident services were provided by Virgin Healthcare. An interview was conducted with a manager from the Norfolk and Suffolk NHS Foundation Trust.

COMMENT ON A SUFFICIENT LEVEL OF PUBLIC SCRUTINY

The commissioning letter for the investigation requires me to include my views as to what I consider to be an appropriate level of public scrutiny in all the circumstances of the case.

My objectives for the investigation have been:

- to provide a thorough and independent review of the full facts of the case
- to establish if there were any serious shortcomings in the management of AR arising from either policy or practice
- to identify if there are any lessons to be learned that may reduce the likelihood of such incidents occurring.

In pursuit of these objectives, I have interviewed AR's mother, Ms X and his sister Ms. Y, as well as relevant staff from HMP Norwich who remain employed by HMPPS. I have also interviewed staff from other authorities involved with AR.

I was not able to speak with two people I identified as witnesses. The officer who found AR suspended by a ligature and performed life-saving CPR has left the service. She declined to be interviewed, having found the experience of the incident extremely traumatic.

A second potential witness was AR's partner at the time. Correspondence was sent to her last known address but failed to illicit any response.

Despite this I am content that the publication of this report will meet the proper requirement for public scrutiny.

INTERESTED PARTIES

Interested parties to the investigation are:

- AR represented by his Mother and Sister, assisted by his legal representative from Fletchers and Co Solicitors.
- HMPPS
- HCRG Care Group (responsible for health care at HMP Norwich)

INVESTIGATORS

Mark Boother, Lead Investigator.

Andy Barber, Assistant Investigator.

Please note that I have not used the real initials of the man at the heart of this investigation or any of the witnesses to protect their identity.

Mark Boother

BA (Hons), MSt. (Cambs) Applied Criminology, Penology and Management

THE INVESTIGATION REPORT

PART ONE

Prior to the most recent reception at HMP Norwich

Background Information

AR had experienced considerable trauma in his early life. Correspondence[1] seen by the investigation between AR and his family show that these experiences had an enduring impact on his frame of mind. His mother explained[2] that he had witnessed a friend being killed in a road traffic accident when he was five years old, that a close family member had been murdered, and that his sister had been killed in a house fire when he was 10. More recently his partner at the time appeared to have experienced a pregnancy that did not result in a birth which he also found traumatic.

Despite these traumatic experiences as a child, it does not seem that AR had received effective professional help to overcome any on-going issues he may have had. His mother confirmed that in the years leading up to the incident there had not been any attempts whist he was in the community to pursue any treatment or services in connection with his past experiences.

AR had committed offences from a young age[3]. He was well known to the local prison and probation services and had previously been designated a prolific and priority offender (PPO), meaning he was more closely monitored whilst under supervision in the community.

The historical prison and medical records of AR

Prison records indicated that AR had been held at Norwich prison during six of his seven custodial sentences[4]. His experiences and behaviour during these earlier sentences will have shaped his expectations of custody and in certain respects have impacted on the way he was managed during his most recent sentence.

Each time a prisoner is taken into custody several checks and assessments are undertaken. These are principally to ensure that the legal basis for the incarceration is present, to identify the next of kin, assess whether it is safe for the prisoner to share a cell, establish what needs the prisoner might have through use of a basic custody screening tool (BCST), and a medical assessment.

The cell sharing risk assessments[5] undertaken on multiple occasions when he was received into custody mention that there were two arson offences from 2003 and one from 2005 and

[1] Letter to family 1
[2] Testimony of Ms X.
[3] Testimony of Ms X.
[4] PDF Serious self-harm incident review annex A
[5] PDF 16. AR CSRA Redacted

a conviction for racially motivated violence. These factors indicated that he would not be eligible to share a cell.

There was evidence in the prison intelligence system[6] that he had previously threatened other prisoners. In May 2011 AR had told officers he intended to harm another prisoner

against whom he held a grudge. The following day the threatened prisoner asked to be moved for his own safety.

On one occasion in August 2013, he had been placed on an assessment, care in custody teamwork (ACCT) plan[7]. This is a way of managing prisoners who are thought to be at increased risk of self-harm. This was as a result of his informing staff he had taken 28 Naproxen tablets.

He told staff he:

'had taken these as he wanted a good nights-sleep and thought they would make him drowsy, he was adamant that this was not an attempt of self-harm/suicide and says he had read a bit about the medication first and did not think they would kill him. He states the only reason he then informed staff was as he wasn't feeling very well and was getting abdomen pain'.[8]

Staff took advice from the NHS 111 service who suggested he should be taken to hospital. An ambulance was called, and he was taken to the local hospital for tests. The record indicated that:

'*throughout all of this AR remained calm, laughing and joking with staff*'

He was returned to HMP Norwich several hours later without the need for further treatment. Subsequently, information was received from the hospital indicating that AR's tests:

'had all been normal and that the tests were normal and did not suggest he had actually taken the amount of tablets he was claiming'.

The ACCT plan was closed after one day.

Nearly two years prior to the incident, on reception for an earlier sentence on 25 October 2016 AR made a number of disclosures to medical staff about his antecedents. He gave a comprehensive account of the factors in his life that he believed were the root cause of his problems. He told staff that he had[9]:

'generalised anxiety disorder, that the slightest thing can make him go from feeling annoyed to very angry where he would want to kill someone'

[6] PDF 11. AR Mercury report redacted
[7] PDF 19. AR ACCT redacted
[8] PDF Prison Medical Record - pages 23 & 24
[9] PDF Prison Medical Record - page 41

The record indicated that he recognised that this was not normal thinking. The nurse suggested he would benefit from a referral to the psychological wellbeing practitioner to address:

'depression and low mood, stress and anxiety… and possible post-traumatic stress disorder (PTSD).

During this short sentence AR was seen several times by a wellbeing practitioner, who assisted him with what was described as 'self-led work' by the manager of the service, Health Care Manager F in her testimony[10]. The contact came to an end when he was released. At this point he was given information about how to continue to receive either counselling or cognitive behavioural therapy in the community, although these options had not been pursued.

During his next remand in custody on 15 August 2017 he refused to be seen by medical staff on reception. He was subsequently sentenced to 15 months custody for an offence of burglary dwelling on 21 Sept 2017.

During this sentence in January 2018, he garnered some unusually fulsome praise about his work record[11]:

'AR has consistently been the top performer in his time working in the call centre. He is always polite and professional on the phone and sets a great example to the others working in the centre. He always works the Friday morning session and never causes any issues.'

Also '*Another great reporting period for AR, he really is an ideal offender'.*

Licence period 17 January to 20 August 2018

AR was released on 17 January 2018 on licence with a home detention curfew (HDC) for the initial period. This meant that he had to wear an electronic tag on his ankle that required him to be present at an agreed address during certain time periods.

Ms X's account of this period[12], was that he secured work after his release, and for nearly all the HDC period appeared to be making good progress.

There was an incident after the HDC expiry where it seems AR was assaulted by his partner and he moved back to live with his mother. This was short-lived and he moved back into his partner's address again. Shortly after he returned to his mother's address again.

Ms X describes his relationship with his then partner as turbulent. At this time, he started to fail his probation appointments and was in breach of his licence.

Ms X told the investigation that police had visited her address on multiple occasions looking for him as he was being sought for further offences. She confirmed that she had told officers

[10] Testimony of Health Care Manager F.
[11] PDF 8. Page 17. NOMIS transfer report redacted
[12] Testimony from Ms X.

that '*he was not in a good place'.* Her testimony is that the officer responded: *'well unless he admits there's something wrong, there's nothing we can do'*.

AR was eventually located at his mother's address, but he escaped custody by fleeing through the back garden. He was then actively sought by the police for two weeks.

Arrest and detention by police 19 August 2018

Documentary information concerning AR's arrest and transfer to Norwich Magistrates' court was supplied to the investigation by Norfolk Constabulary[13].

AR was located, arrested, and taken to the Police Investigation Centre. The first record of his arrival is at 03.18am on a risk assessment form completed by the custody sergeant. This record indicates that he required medical attention and had scratches to his face and neck. A taser had been discharged during the arrest and the barb on the weapon had to be removed.

The risk assessment consists of standard questions about mental health and self-harm which I include here, along with the answers given:

Do you have any mental health issues?	*Yes*
What are your mental health issues?	*Paranoid schizophrenia*
Have you had, or are you receiving treatment for this?	*No*
Are you taking or supposed to be taking any medication for mental health issues?	*Yes*
Have you ever tried to harm yourself?	*Yes*
What did you do?	*Overdoses/cutting*
How are you feeling now?	*OK*

This information appeared contradictory in that AR disclosed that he had a recognised mental health condition which he stated he was not (and had not) been treated for. Despite receiving no treatment, he stated that he was supposed to taking medication.

Following this assessment, AR was immediately seen by a nurse, who concluded that he was: *'not really engaging with assessment, history of paranoid schizophrenia, states he does not take his prescribed medication. Alert and orientated'.*

The nurse recommended AR be seen by the force medical examiner (FME). He was seen by FME doctor at 09.10am who recorded the following:

'seen in cells as refuses to come out of his room and see me. Lies on his bench and refuses to be examined, stating he feels ok and does not want to be seen. Alert and coherent.'

Another health care professional from the Liaison & Diversion team (Mental Health Services) tried to engage with AR later that morning but again he declined to be seen.

[13] E-mail evidence from police

There were no further medical assessments while in police custody. He was charged with new offences at 00.45am on 20 August. He was then held in police custody until 07.31am when he was collected to be taken to court.

Transfer to court and detention at HMP Norwich

AR was transported to Norwich Magistrate's Court on the 20 August 2018. The Person Escort Record (PER) form completed at 01:24 hours is clearly marked 'Paranoid Schizophrenic' and signed by the custody sergeant.[14]

The PER indicated that welfare checks were completed several times between leaving police custody and arriving at HMP Norwich. These entries included: '*fine, no intention to self-harm'* and *'fine, doesn't seem to want to talk anymore'.*

Summary of part 1

The experience of considerable trauma in AR's early life was not followed by help that was effective to overcome the impact of these experiences. These experiences were central to his subsequent act of self-harm.

AR had committed offences from an early age and was well known to the local criminal justice services. While in the community he was capable of holding a job and acting responsibly for significant periods of time. Despite this, he struggled to overcome setbacks and frequently lapsed into offending behaviour.

This pattern of behaviour continued in prison, where records indicate he could be threatening and disruptive, but that he could also be a trusted inmate with a good work record. Cell sharing risk assessments correctly identified that it was not appropriate for him to share a cell.

On one occasion in 2013 he had been placed on an ACCT as a result of an incident of possible self-harm, although he denied that his actions were intended as self-harm. The decision to close the ACCT after one day was appropriate.

In 2016 AR disclosed to medical staff that he experienced mental health problems and he was correctly referred to a service to address these issues. He attended appointments while in custody although he did not choose to follow up a similar service in the community.

On his arrest prior to the most recent sentence, he disclosed to police that he suffered from paranoid schizophrenia, although he also claimed never to have received treatment. He was seen by three medical professionals who attempted to assess him, but each time he declined to engage in the process. This information was appropriately passed on to the escort service which transported him to court, and then prison.

[14] PDF 18. Escort log 18.09.2018

PART TWO

From reception at HMP Norwich to the incident

Arrival on remand in August 2018

AR was received into HMP Norwich as a remand prisoner at 18:11 on 20 August 2018. He was imprisoned for 66 days prior to the incident.

Reception records showed[15] that he identified his partner Ms. Z as his next of kin.

A medical screening on reception[16] indicated that the information from the police stating that he had disclosed that he was suffering from paranoid schizophrenia had been passed to the prison. He was recorded as saying:

'Fine to be here, I don't want to be here, but here I am'.

The nurse recorded that he '*denies thoughts of deliberate self-harm nor suicide ideations*'.

A cell sharing risk assessment[17] was completed. This assessed him as a *'no increased risk'* as none of the trigger behaviours were present. These behaviours were listed as: psychosis, extremely disturbed behaviour, failure to engage with health process, agitation, aggression or other reasons; however, it did indicate that he had previous convictions for arson leading to him being assessed as unsuitable to share a cell.

On his first night in custody AR was given a behaviour warning, Officer H recorded:[18]

'After I came on duty AR introduced himself to me by screaming at his door, saying he knows how the system works, he has mental health issues and wants another TV. After calmly explaining to him that this was not possible at 23:30 he proceeded to spit at the door. This was very unwelcome'.

In interview Officer H[19] indicated that this type of behaviour was not uncommon on the first night and that AR quickly settled down. The next day, 21 August 2018 AR was seen by the chaplaincy who recorded: '*religion confirmed, no concerns*'.

A follow-up medical assessment on 22 August contained more information. A nurse noted:

'referred by reception as patient self-reports having paranoid schizophrenia: many sentences at HMP Norwich going back to 2005 - only one mention in contemporaneous notes of schizophrenia being the reception on 20/08/18 - no evidence of acute mental health illness - no confirmation on GP summary to confirm diagnosis of Schizophrenia - no apparent contact with community MH teams - no apparent admissions to psychiatric hospital - no mental

[15] PDF 2. Core record part 2 redacted
[16] PDF Prison Medical Record - pages 57 & 58
[17] PDF16. AR CSRA Redacted
[18] PDF 7. Case note history
[19] Testimony Officer H

health medication prescribed currently or historically - no current or historical thoughts of self-harm or suicide - appears to have never been on an ACCT - ….. no apparent clinical rationale for AR to be seen by the MH team at this time - his needs should be adequately supported by primary care GP service - I note he has an appointment with the GP on 24 August 2018 who can refer to the MH team should this be deemed appropriate.[20]

In this assessment it was correctly noted that although AR had reported that he suffered from paranoid schizophrenia there was no evidence to support this from a medical professional.

The assertion that there were:

'*no current or historical thoughts of self-harm or suicide-appears never to have been on an ACCT'*

is clearly incorrect.

AR did see a doctor on 24 August as planned, although there was no mention in the record of this meeting of any references to mental health[21].

On 29 August 2018 he declined to participate in the second part of BCST process[22].

From early September 2018

The poor behaviour around the reception period improved significantly quite quickly as AR settled into the prison regime. There was not a great deal recorded about his day-to-day activities beyond those associated with the normal running of the prison.

He was inducted into the gym, by 03 September 2018 a 14-day review said his privileges had been '*raised to standard'* indicating he had behaved well. Later that day was said to have '*great attitude'* through-out a food safety course.[23] By 10 September 2018 he was working fitting paint tin handles. After a short while, he secured a job as the chaplaincy orderly.

This good work record is consistent with his earlier custodial experiences. No further substantive entries were recorded on his case note history prior to the incident.

From 17 September 2018 AR was housed in E wing, cell 05 which is a standard cell at ground level. E wing was a Victorian building described as:

'generally a quieter unit. So, prisoners that are perhaps older in years or… known to be less risky[24] …

[20] PDF Prison Medical Record - pages 59 & 60
[21] PDF Prison Medical Record - page 60
[22] PDF 7. Case note history
[23] PDF 7. Case note history
[24] Testimony of Governor C.

It was solely occupied by AR. There were no indications that he wished to share a cell, although had he, this would not have been allowed as a result of the cell sharing risk assessment.

Records from HMP Norwich indicate that in the nine and a half weeks from his reception until the incident, AR was visited eight times by his partner. On five occasions she was accompanied by her daughter. The final visit was one week before the incident when his partner and her daughter were accompanied by his brother-in-law[25].

From sentencing on 18 September 2018

AR was produced to court from HMP Norwich by SERCO prisoner escort services. The PER[26] shows that there was an awareness of his previous ACCT but that there were no current concerns. It was noted that he was 'underweight', although his mental health was recorded as 'Nil'. His welfare was checked by staff multiple times and he was said to be 'fine' and 'sitting on a bench, not wanting to talk….no present risk'.

At some time after his arrival at court but prior to sentencing he was said to have punched a wall with his right hand. The record indicated that it was[27]:

Painful to touch; however has movement, good capillary perfusion and warm to touch. Advised to keep hand elevated. Analgesia given 15:30hrs. Assessment completed.

AR was sentenced[28] to a total of 44 months imprisonment at Norwich Crown Court on 18 September 2018. His HDC eligibility date was 04 March 2020, conditional release was due on 16 July 2020 with a sentence expiry date of 16 May 2022.

Testimony from the Roman Catholic chaplain[29] indicates that she was one of the people who had considerable interactions with him during this period, spending time with him on several occasions each week, including the day of the incident.

'he was very efficient, he was very conscientious, he did his work really well, and he was really pleasant, a really lovely person, very polite, very respectful. He was a pleasure to be with. I did have lots of conversations with him, and you know, I really liked him… He came across as quite happy. You know, he seemed quite happy. He was, he was always talking about his family, he was always talking about his partner and his partner's daughter…. I think he said that he and his partner had had an argument, they didn't seem to be anything out of the ordinary. It seemed like he was part of a happy family. You know, with his partner and his daughter and that was his world. He couldn't wait to be with them, … he was quite comfortable in prison. He was quite at home in prison.

[25] PDF 20. Visits information for Mr. AR redacted
[26] PDF 17. Escort log 18.09.2018
[27] PDF Prison Medical Record - page 64
[28] PDF 1. Core record part 1.
[29] Testimony of Chaplain L.

The day of the incident, 25 October 2018

There was little recorded of AR's movements on the day of the incident. Testimony of the chaplain, Father K[30], states that AR was working in the chapel and was seen in good spirits leaving for his cell on E wing in the afternoon.

'I saw him, I came back to the office just as he was going. And I remember him saying that he wanted to come back the next day because he hadn't finished the job. And he wasn't scheduled to come back. And I said well, if there's somebody here, we'll get you – fine. Because that was AR all over. He was very conscientious.'

Although it has not been possible to identify the precise time, there is evidence[31] that AR had spoken to his partner Ms Z on the phone in the late afternoon. Ms X. states in her testimony[32] that she was told by Ms Z that the telephone call was around quarter past five. This is consistent with the routine movements within the prison which would suggest this was likely to be sometime before 18:00. There is no evidence to suggest any staff were aware of the phone call or any issues arising from the phone call at the time.

Sometime before 18:00 AR returned to his cell. By this time inmates had received their meals and would not have expected to leave the cell again that evening.

Officer M had been on duty from 13.00 on another wing. They were responsible for E wing from 17:00[33]. The situation once prisoners were back in their cells was known as a 'patrol state'. In the case of E wing, this meant that a single officer, with suitable communications equipment was considered sufficient staffing as there was no planned movement of prisoners.

Available information about the incident

HMP Norwich had not produced a comprehensive account or report of the incident. Some information that HMP Norwich should have considered in such a report was not known to the prison, and other important materials had been lost. Officers involved were not formally interviewed at the time, and therefore in most cases their detailed accounts were not recorded at the time. I will return to these issues in Part 3 of this report.

The investigation was initially provided with some documentation from the time of the incident. Other documents came to light during the investigation.

The account of the incident below utilises all the documentation provided, as well as interviews with those who either knew AR directly or were involved in the management of the incident. These interviews were conducted over three and a half years after the

[30] Testimony of Father K.
[31] Testimony Governor B.
[32] Testimony of Ms X. Page 11
[33] PDF 21 Page 6. HMP Norwich 25.10.2021 full detail schedule

incident, with the obvious problem that witnesses memory may have faded over time and they may have forgotten some of the details of their involvement.

The Incident

The document that should commence any investigation into an incident of serious self-harm is known as the Serious Self-harm Incident Questionnaire (SSHIQ). In this case, this document, which was not dated, states that AR was:[34]

'Found in cell suspended by a ligature from his window by Officer M at 19:36 conducting the roll check. She immediately called a code blue, entered the cell on her own and cut AR down; she immediately performed CPR'.

Calling a 'code blue' alerted other staff in the prison that assistance was immediately required as a result of an incident involving a lack of oxygen.

Testimony from Officer I[35] stated that he and Governor C, both of whom had been on A wing had arrived on the scene within minutes of the code blue call. Seeing that the door was open to cell 5, the officers were able to identify where the incident was. Officer M was in cell 5. Officer I took over the CPR after a short while. He was himself relieved by a member of medical staff. He stayed with AR until ambulance staff arrived.

Governor C's testimony[36] confirmed Officer I's account of the minutes after the incident. In addition to his testimony, Governor C also made a written statement two days after the incident[37] so that he could accurately answer any questions that may arise.

The decision as to whether a member of staff should enter a cell alone in these circumstances would have been made by the member of staff themself, depending on the circumstances. In this case Officer M made the decision to act alone and immediately. This decision was accurately described by Governor C as:[38]

'a bold, brave decision to enter that cell on her own rather than waiting for staff, which obviously in hindsight, seemed to me like the right thing to do.'

As the senior member of staff, Governor C stated that he took charge of the immediate situation, arranging for a defibrillator and ensuring an ambulance was called. He stated that he was a trainer in first aid and assessed that Officer M was performing CPR effectively. He oversaw the transfer of the responsibility for CPR when he thought Officer M should be relieved. His statement confirmed that the ambulance arrived at 19:53, approximately 16 minutes after the alarm was raised. Duty Governor B arrived on the scene and assisted. Ambulance staff left with AR at 20:23, he was unconscious but breathing.

[34] PDF SSHI Questionnaire
[35] Testimony of Officer I.
[36] Testimony of Governor C. Page 2
[37] PDF AR Brief statement
[38] Testimony of Governor C. Page 2

AR's cell was sealed by Officer I, meaning that it could only be opened with a special key with restricted access to preserve any relevant evidence.

A property and drug evidence log[39] showed that on 29 October 18 the ligature strips described as *'platted bed sheet tied in a knot'* were stored in an evidence cabinet. There was no mention of any other items being cleared from the cell, or records of where they were placed. The record indicated that the strips were subsequently '*destroyed/returned*' on 31 July, although it was not possible to discern the year as it was poorly recorded by hand.

Duty Governor B held what was described as a 'hot debrief' at 20:40. His note of the meeting stated he:[40]

'thanks staff involved and the brave actions of Officer M. It is without question the actions of staff this evening saved AR from dying at the scene'.

After a serious incident of self-harm, several actions are required of the duty governor. Governor B made a contemporaneous note of his actions[41] following the incident. The National Operations Unit of HMPPS was informed by telephone at approximately 20:45, followed up by an e mail sent to Area Office, the deputy governor was also informed. AR's next of kin was identified through the prison record completed on his most recent reception to HMP Norwich as Ms Z, his partner. At 21:00 a call was made to Ms Z.

During this call Governor B learnt of the phone call made earlier between AR and Ms Z. According to his testimony,[42] when she was informed of what had happened, she said:

'I've just spoken to him, has he done something silly? But he's always saying something, but he never does anything'.

Ms X's testimony[43] is that Ms Z telephoned AR's family to inform them of the incident so they were all able to attend the hospital.

Evidence concerning AR's frame of mind at the time of the incident

Although AR was seen during the investigation, he was not able to communicate with investigators due to his cognitive impairment.

One of the staff who had frequent contact with AR in the weeks leading up to the incident was Chaplain L. Their testimony[44] was that they saw no irrationality or even sadness in his demeanour, and that the news of the incident came as *'a complete and utter shock'*.

Similar sentiments were expressed by Officer J[45].

[39] PDF 27. Security information page 2
[40] PDF AR Hot debrief redacted
[41] PDF Decision log AR
[42] Testimony of Governor B.
[43] Testimony of Ms X.
[44] Testimony of Chaplain L.
[45] Testimony of Officer J.

'I *was as shocked as everyone else. You know, I couldn't quite believe that AR had done what he'd done. I had known him for a while. We'd always had good relations. The staff had always had good relations with AR and it was a big shock.'*

The last member of staff identified as interacting with AR prior to the incident was the chaplain Father K. This was a matter of hours before the incident. His evidence is that AR gave no indication of any intent to self-harm and was speaking about his intention to return to tasks in the chapel the next day.

'They called me to say there had been an incident that evening. I actually said AR? I do remember being quite stunned because I'd seen him, and AR was not the sort of person who I would….if you say, okay, take all of your 745 prisoners, line them up in the order you think most likely to make an attempt on their life, he would be right at the far end'[46]

The clearest indication of AR's frame of mind at this time was contained in letters that were written by him immediately prior to the incident. Ms X provided these letters to the investigation. Ms X's testimony[47] is that she had been given these letters in a prison issue bag along with other items of AR's personal belongings significantly after the incident, around his release date.

The investigation found no evidence that HMP Norwich staff had been aware of the letters or their contents, despite them being in AR's cell, being stored with his other possessions and their obvious significance. There was no mention of the letters in any official record provided to the investigation.

The three letters were addressed to 'Mum and everyone', 'Ms Z (partner) and her daughter' and 'Daddy's No1 Girls'. The letters are all between 3 and 4 pages long. Although it was not possible to ascertain precisely when the letters were written, the one to Ms Z and her daughter starts:

'*Today is the 25th October and the time is 17:55'*.[48]

The letter was effectively a suicide note which talks about him '*finding peace'* and being:

'with my sister once more as well as other family to (sic), but the most important thing I will appreciate is I will get to meet our son'.

The letter went on:

'everything that has happened has been the result of my behaviour and nobody should feel like they are responsible in any way'.

The letter 'To mum and everybody'[49] was not dated but is in a similar vein to the first letter. His main concern being to acknowledge the pain he has caused everyone, that his partner was not to blame and urging everyone to stick together.

[46] Testimony of Father K
[47] Testimony of Ms X. Page 11
[48] Letter to family 1
[49] Letter to family 2

I judged that these two letters which appeared to have been written with the same pen were probably written at the same time.

The third letter[50] is in the form of a short story for a child and detailed his own childhood trauma, consistent with the account of his early years given by his mother, Ms X. This letter was unfinished and written in a different pen. I judged this was probably written earlier.

The letters are very clearly written, without any crossings out or corrections in legible handwriting on standard issue prison paper. They do not appear to be written in anger, rather they indicate a certain calmness and determination to bring his life to an end.

I judge that these letters should be taken at face value as a clear indication of AR's considered decision to end his own life.

Summary of Part 2

Medical screenings undertaken around the time of AR's reception to HMP Norwich showed that staff were aware that he claimed to suffer from paranoid schizophrenia. He was questioned about any thoughts of suicide or self-harm which he denied. Reasonable efforts were made to establish if he did suffer from paranoid schizophrenia, and it was correctly concluded that he did not.

The cell sharing risk assessment indicated that although there were no current concerns about his behaviour, he should not share a cell due to historical convictions and behaviours. His next of kin was confirmed according to his wishes at the time.

His behaviour on the first night in custody was poor, leading to a disciplinary charge being made against him. Despite this, his behaviour quickly improved, and he settled into the prison routine. He received regular visits from his partner and her daughter.

After his initial trouble settling to the regime there was one other example of problematic behaviour. Whilst at court awaiting sentence, he appeared to have become frustrated and angry and was recorded as punching a wall and injuring his hand. This injury was not so serious that it required treatment other than pain killers.

Prior to the incident, AR's behaviour had been good and there were no indications that he was planning to harm himself. On the contrary, he seemed well settled and to be enjoying his work. Staff believed him to be in a good frame of mind.

It was not possible to tell definitively what caused AR to commit to such a serious act of self-harm having previously appeared reasonably content, although it seems probable that it was connected to the telephone call that was made.

On returning to his cell, he wrote two lengthy letters which explain the reasons he had decided to take his own life. He explicitly says that no one is to blame other than himself.

[50] Letter to family 3

There was no evidence that HMP Norwich were aware of the contents of the letters which were belatedly returned to Ms X.

During a routine roll check AR was found by the officer on duty to be suspended by a ligature. The officer appropriately called for help, entered the cell, cut the ligature, and started to perform CPR. Other officers arrived promptly, followed by an ambulance crew who took AR to hospital in a critical condition. It was immediately clear that the injuries to AR were very serious.

Contact was made to the next of kin. HMP Norwich staff learned of the telephone call that had been made between AR and Ms Z.

All the prison staff interviewed who knew AR expressed shock at what had happened, testifying that there had been no signs that he had been contemplating harming himself.

PART THREE

After the incident

The period immediately following the incident

Staff that responded to the incident directly expressed a great deal of relief and satisfaction that their actions had saved the life of AR. It was immediately clear that there had been a very serious incident, and at the time AR left the prison it was not certain that he would survive. Governor B completed an Incident Management Decision Record[51] on the day which clearly identified the actions he had taken and who he had informed.

Although there was no official prognosis, it was clear by the morning after the incident that a very significant injury had been sustained by AR. He was being treated at the local hospital in an induced coma, reliant on a ventilator to breath.

A decision was made by the head of the offender management unit, Governor D, to appoint a Family Liaison Officer (FLO). This was normal practice where a life-threatening injury had occurred. It was the task of the FLO to act as a conduit for information between the prison and family members, so that as much information as was possible within legal constraints could be shared to minimise the distress of the family. The allocated member of staff was FLO G.

The testimony of Governor D[52] is that he was aware of the existence of a tape recording of the conversation between AR and Ms Z, although he had not heard it himself. He stated that:

'I've never listened to the tape myself, so my briefing from the Head of Safer Custody at the time was, that he had said he was going to go and kill himself, and Ms Z had not acknowledged that, and she didn't phone in or do anything like that.'

There was evidence that a transcript was made of the phone call between AR and Ms Z and passed to the family liaison officer (FLO) G.[53]

'I was passed a transcript of a telephone call made with AR that day which I read'

FLO G's testimony[54] is that she started to familiarise herself with the case immediately. Part of that familiarisation concerned a transcript of the telephone call.

HMP Norwich has not been able to provide a copy of the transcript to the investigation. They were unable to located it and the details contained within it are unfortunately lost.

It became apparent to FLO G that there might be some tension concerning the designation of the next of kin. On his most recent reception AR had indicated that Ms Z should be

[51] Decision log AR PDF
[52] Testimony of Governor D. Page 2
[53] FLO log AR 002
[54] Testimony of FLO G.

regarded as his next of kin, but on multiple other previous occasions it had been his mother, Ms X.

Ms X had telephoned the prison and clearly wanted as much information as was available. A decision was taken that both Ms Z and Ms X should be treated as next of kin. In the circumstances, this was an appropriate decision. Clearly this was a time of great emotional stress for all concerned.

When AR was taken to hospital, he was still technically in custody, with the local prison having little discretion as to the management of the prisoner. In this case, it became clear quite quickly that AR had suffered a life changing injury and that prognosis was very poor. An application for compassionate release[55] was made on 30 October 2018 which included a diagnosis from the doctor caring for AR, of a:

'hypoxic (lack of oxygen) injury to the brain…It is likely that he will be bed bound and fully cared for in a best case scenario'.

This application for compassionate release was not granted. I consider this decision to be outside of my terms of reference and make no comment on it.

The fact that there was no decision to release AR on compassionate grounds meant that visitors needed to be approved by the prison. There were also security issues and two uniformed officers had to be deployed at the hospital, which in this case lasted for approximately the first month. Eventually this was reduced to staff not in uniform, and eventually a single member of staff.

In addition to the rules of the prison, hospital rules also apply to such matters as the number of visitors and the times visits were permitted. Evidence from the testimony of Ms X and FLO G both indicate that there were tensions between Ms Z and family members over visiting times.

FLO G described herself as feeling[56]:

'stuck in the middle of the mother and the girlfriend. So, if we had any updates or anything needed to be done, I would phone Ms Z. If she didn't answer, I then phoned Ms X, leave messages with both of them.'

Although he was still very ill, AR's condition improved to the extent that he was no longer in need of a ventilator to breath by 04 November 2018.

The final entry on the FLO log was 17 December 2018, when FLO G recorded that she had received an angry phone call from a family member. Around this time a decision was taken that the best person to have contact with the family was the chaplain, Father K. As by this time it appeared that AR's injuries were no longer life threatening, there was no formal requirement for a FLO.

[55] PDF 10. Early release on compassionate grounds
[56] Testimony of FLO G.

AR was released on a special purpose temporary licence on compassionate grounds from 7 January 2019[57]. There were several variations to facilitate visits to different medical facilities and visits to his mothers' address. He was released on HDC on 04 March 2020, with a sentence expiry date of 16 May 2022.

The response of HMP Norwich to the incident

Prison Service Instruction (PSI) 15-2014[58] titled *'investigations and learning following incidents of serious self-harm or serious assaults'* established certain required actions of the prison governor following an incident of serious self-harm. The first of these is that the incident is reported immediately, which it was, by Governor B. The second requirement is to commence a Serious Self-harm Incident Questionnaire (SSHIQ).[59] The third is to:

'*ensure that an appropriate level of investigation is commissioned and ensure that any lessons are learned from the incident*.'

HMP Norwich were initially unable to locate the SSHIQ; however, it was produced during an interview as part of the investigation. The SSHIQ (version July 2014) did not require that the date be entered on the form, consequently, the form was undated. It seemed likely that it was produced and signed by Governor E soon after the event.

The final required piece of information on the SSHIQ was the name of the person who would be completing the local fact-finding report. This was completed as Governor E. These actions represent the first two stages of complying with the requirements of PSI 15-2014.

No fact-finding report was in fact produced by Governor E or any other member of staff at HMP Norwich. This was a significant failing. During her interview[60], when asked if she was responsible for completing the report, Governor E stated that '*the report can be done by anybody in the safer custody team*'. When asked if there was any evidence of who was asked to complete the report she could not remember.

Ultimately the responsibility for the completion of the report lies with the Governing Governor A. In his interview[61], Governing Governor A stated that:

'*I have someone that is in charge of safer custody and they are their own experts in that area and you rely on them to largely do the right thing'.*

Unfortunately, in this incidence, the right thing was not done.

Although several of the staff interviewed by the investigation had made a record of their actions in anticipation of an investigation or inquiry, all confirmed that they had never been

[57] PDF 6. Core record page 4.
[58] NOMS PSI 15/2014
[59] SSHI Questionnaire PDF
[60] Testimony of Governor E.
[61] Testimony of Governing Governor A.

asked for these accounts or been formally interviewed for a fact-finding report. The failure to conduct the fact-finding report had a number of serious consequences.

Communication with the next of kin

It was clear that Ms X and other members of AR's family were not provided with a comprehensive account of the hours leading up to the incident.

Nearly two weeks after the incident FLO G recorded[62] that the family was:

'waiting for a Governor report to find out what actually happened that night and to confirm the lock up time and when he was found. I stated that I do not know what the lock up time was but he was found on roll check around 19:30….There are also concerns regarding the telephone conversation between AR and Ms Z as they know that one took place but are trying to piece together a reason why he attempted to take his life.'

This entry indicated that information which could reasonably have been made available to the family had not been collated or shared. The fact that this information was not accessible to the FLO should have led to a more questioning approach about why it was not available and when it would be; however, in their testimony, Governor D[63] the head of the offender management unit argued that it would not have been normal practice to look to the simple investigation report to answer these questions, this seemed illogical.

It is also clear that an insufficiently investigative approach had been taken regarding the contents of ARs cell. HMP Norwich could not provide the investigation with information regarding the clearing of the cell. Either no log of the contents of the cell had been prepared or it had been lost over time. No one from the prison appeared to have knowledge of the letters which were subsequently returned to Ms X.

The investigation was not told by HMP Norwich how the letters were returned to Ms X, although it was clearly not in a timely manner. This is particularly concerning, given the extremely sensitive and important nature of the contents. This is a significant failing.

It is also significant failing that no recording or transcript of the call between Ms Z and AR could be located by HMP Norwich at the request of the investigation. Without the benefit of the transcript, the investigation cannot reasonably judge whether all or part of the contents should have been disclosed to Ms X, although in the interest of transparency, there should be a presumption of disclosure.

[62] FLO log AR (2) redacted page 6
[63] Gov D testimony. Page 8

The ability to learn from the incident

The primary purpose of PSI 15-2014 as identified on the front-page summary of the instruction is[64]:

'to ensure that all telephone reportable incidents of serious self-harm and serious assaults are correctly followed up so that learning is identified and disseminated.'

The fact that HMP Norwich did not conduct a simple investigation meant this purpose was not met. It also meant that none of the professionals involved in the incident were able to promptly explain their actions and regard the matter as formally concluded.

Had there been a simple investigation that concluded their actions had been appropriate, with no blame being attributed to them, some staff may have experienced considerably less anxiety.

PSI 15/2014 mandated governors to:

'Ensure that a copy of the investigation report is submitted… not later than one week after the investigation has been completed.'

The PSI made no comment on the time scales within which the investigation should be completed. Although it may not be appropriate to require all reports to be written to the same time scales, it would be reasonable to expect a quarterly update on the progress of reports after an initial period.

Safer custody meetings around the time of the incident

The investigation was provided with the minutes of six safer custody meetings held between September 2018 and February 2019. These were all chaired by the Head of Safer Custody, Governor E, apart from one which was chaired by the Head of Offender Management, Governor D. The Governing Governor, Mr A attended one of these meetings in November 2018. He identified that he had two priorities[65].

One was to reduce self-inflicted deaths and we can only do that by absolute adherence to the ACCT process. We need to get better. He fully supports the ACCT process and supporting the people who need the support. Nothing comes more important than stopping death in custody. The second priority he came with was to stop violence against staff.

At this meeting it was noted that:

'We had 1 ligature, which was AR who still remains at hospital.'

Of the remaining safer custody minutes, there is one further mention of AR in February 2019 under any other business when Father K[66]:

[64] NOMS PSI 15/2014. Cover page
[65] PDF Minutes November 2018 redacted
[66] PDF Minutes Feb 19 redacted

'stated that AR is doing exceptionally well, but still has a long way to go'.

Despite the acknowledgement that a very serious incident had taken place, there was no indication from the three most senior attendees of the safer custody meeting thought that it was a suitable place to consider the incident in detail or disseminate any learning. The investigation considered this to be a significant failing.

Background information on self-harm incidents in HMI Prisons reports

As part of the inspection regime, HM Inspectorate of Prisons regularly assess the performance of prisons regarding the management of incidents of self-harm.

An HM Inspectorate of Prisons report during the year following the incident involving AR found that:[67]

'Investigations into serious acts of self-harm were not carried out promptly and lessons to be learned were not identified'.

It was unfortunate that this finding did not cause HMP Norwich to audit if there were any outstanding cases to consider and indicated that at the time of the incident and for a period thereafter, insufficient attention was paid to investigations concerning self-harm.

A further, more recent HMI Prisons report[68] found that this issue seemed to have been resolved:

'Investigations following serious acts of self-harm were comprehensive and lessons identified were shared appropriately'.

[67] Report of an unannounced inspection into HMP/YOI Norwich October 2019. Page 28
[68] Report of an unannounced inspection into HMP/YOI Norwich August 2022. Page 23

Summary of Part 3

It was immediately clear that AR had suffered a serious injury. A decision was made to allocate a FLO to AR's family. The FLO's task was made more complicated by tensions between AR's partner and other members of his family.

Mandatory actions that follow an incident of serious self-harm were commenced but not concluded. Governing Governor A was responsible for commissioning a simple investigation report, which was not completed. This was a significant failing that had considerable consequences. AR's family were not provided with information which they could reasonably have been. Staff were also left without an opportunity to account for their actions and feel that the matter was closed. Any potential learning was not considered.

It was a further significant failing that the contents of AR's cell did not appear to have been the subject of any review. HMP Norwich had no record of the letters which would have assisted in the simple investigation, meaning they had not been considered at all. The existence of the letters, which throw considerable light on AR's frame of mind at the time of the incident were not given to Ms X in a timely or sensitive manner.

A transcript of a telephone call between AR and his partner, which was significant to the understanding his actions was produced and read by some members of staff, although HMP Norwich could not locate the transcript, which was a significant failing.

No member of the management team of HMP Norwich took responsibility for the required investigation or made any enquiry as to why it had not been produced. It would be reasonable to expect an incident of this type to be considered in the Safer Custody meetings attended by the relevant managers; however, it was barely mentioned, despite Governing Governor A's contribution to those meetings that 'self-inflicted deaths' were his priority. This finding is consistent with an HMI Prisons report from the same period. This was a significant failing.

Part 4

Conclusions

AR was a clearly troubled individual who experienced significant trauma in his early life. Despite some periods of stability, he often relapsed into offending behaviour and had received several lengthy custodial sentences.

During earlier sentences, he had displayed some disruptive behaviour. As he grew older, he was still liable to relapse into this behaviour at times of stress, such as when being arrested or sentenced. Despite this, the staff who knew him spoke of him in positive terms and thought that he was reasonably content in prison.

AR sometimes declined to participate in medical assessments and had periodically suggested that he had experienced thoughts of suicide or self-harm. On each occasion he expressed such thoughts, he denied any intention to actually carry them out. Whilst in custody on a previous sentence he had received help from the 'wellbeing service'. He had been given information about how to obtain a similar service in the community, although he did not pursue this.

His behaviour and treatment during the most recent sentence at HMP Norwich until the incident of self-harm was consistent with his previous custodial experiences. There were no indications that he was contemplating an act of serious self-harm which could have been anticipated by staff. The investigation has not identified any significant failings in the management of AR prior to the incident.

It is highly likely that the catalyst for the act of self-harm was the telephone call between AR and his partner, although HMP Norwich had no knowledge of this call until after the event. The degree of monitoring that would be required to alert prison staff of the contents of such a call would not be practical or desirable.

With regard to the incident, the immediate actions of staff were prompt, professional and effective in saving AR's life. The investigation has not identified any failings in the immediate response to the incident.

The investigation found four significant failings in the response of HMP Norwich to the incident.

1. The failure to conduct a simple investigation

This meant that any learning that there may have been from the incident had not been identified. Without the simple investigation HMP Norwich had no way of formally concluding if there were any relevant lessons or not. It also meant that the information that should have been made available to AR's family was not. Had the simple investigation been conducted in a timely manner, with a reasonable degree of thoroughness, it is unlikely the following identified failings would have occurred. It was also of concern that HMPPS policy had set no deadlines for the completion of simple reports or process to follow if they were not received.

2. The handling of letters found in AR's cell

Evidence from AR's cell was not reviewed shortly after the incident, and the significance of the letters contained therein was not appreciated. HMP Norwich returned these letters to Ms X without realising their existence or importance.

3. The retention and management of records

The transcript of the telephone call between AR and his partner could not be located at all. Other important documents, including the serious self-harm questionnaire were not produced at the start of the investigation, although were subsequently provided by individual officers.

4. Safer Custody meetings

The safer custody meetings held after the incident should have reviewed the simple investigation as part of its remit to contribute to the safe management of the prison. The absence of the simple investigation should have been noted and a plan to rectify the problem should have been instigated in this forum. Failure to learn from such incidents was noted in an HMI Prisons report in 2019, suggesting that this may not have been an isolated incident.

The investigation's recommendations

The investigation has no recommendations concerning the management of AR prior to the incident of self-harm or concerning the immediate response to the incident.

Recommendation 1

HMPPS should update PSI 15/2014 (which has an expiry date of 02 April 2018). Consideration should be given to:

- requiring governors to complete any simple investigation within three months of the incident, or provide an update on the progress of the investigation at three monthly intervals
- facilitating the dating of all documents and annexes that require completion

Recommendation 2

HMP Norwich should ensure that there is an awareness of the contents of property returned to prisoners next of kin, and that such returns are handled sensitively

Recommendation 3

HMP Norwich should review its record keeping procedures to ensure documents are stored in a way that they can be retrieved and produced on request

Recommendation 4

HMP Norwich should formally include a standing item on the safer custody meeting agenda to review progress on outstanding simple investigations.

Glossary of Terminology

ACCT	Assessment Care in Custody and Teamwork
HMP	His Majesty's Prison
ROTL	Release on Temporary License
HDC	Home Detention Curfew
HMPPS	His Majesty's Prison and Probation Service
ECHR	European Court of Human Rights
MIR	Mercury Intelligence Record
SystmOne	Medical system for recording medical notes
NSFT	Norfolk and Suffolk Foundation Trust
HCRG	Healthcare provider at HMP Norwich
PPO	Prolific and Priority Offender
BCST	Basic Custody Screening Tool
CSRA	Cell Share Risk Assessment
PTSD	Post-Traumatic Stress Disorder
MH Teams	Mental Health Teams
PER	Person Escort Record
SSHIQ	Serious Self Harm Incident Questionnaire
CPR	Cardiac Pulmonary Resuscitation
Code Blue	Radio call sign, to alert assistance needed with breathing difficulties
IMDR	Incident Management Decision Record
FLO	Family Liaison Officer
PSI	Prison Service Instruction
HMIP	His Majesty's Inspectorate of Prisons
FME	Force Medical Examiner

Annexed Documents

Family Documents
Letter to family 1
Letter to family 2
Letter to family 3
HMPPS Documents
PDF 1. Core record Part 1
PDF 2. Core record Part 2 redacted
PDF 6. Core Record Part 6 page 4
PDF 7. Case note history
PDF 8. Page 17. NOMIS transfer report redacted
PDF 10. Early release on compassionate grounds
PDF 11. AR Mercury report redacted
PDF 16. AR CSRA Redacted
PDF 17. Escort log 18.09.2018
PDF 19. AR ACCT redacted
PDF 20. Visits information for Mr. AR redacted
PDF 21. Page 6. HMP Norwich 25.10.2021 full detail schedule
PDF 27. Security information
PDF Serious self-harm incident review annex A
PDF SSHI Questionnaire
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