Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Esam Dawood, a prisoner at HMP Bristol, on 4 March 2020

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Esam Dawood died on 4 March 2020, after he was found hanging in his cell at HMP Bristol. He was 27 years old. I offer my condolences to Mr Dawood's family and friends.

Mr Dawood was monitored under Prison Service suicide and self-harm procedures (known as ACCT) on four occasions at Bristol. Staff started the last period of ACCT monitoring on 26 February, but stopped it less than two days later, five days before Mr Dawood was found hanging.

I am concerned that the decision to stop ACCT monitoring was premature. Mr Dawood was self-isolating; his trial was ongoing and he was facing a long prison sentence; he was displaying erratic and paranoid behaviour and had sacked his legal team; and he was about to have a psychiatric assessment to check if he was fit to stand trial. The mental health team disagreed with the decision to stop ACCT monitoring, but no one restarted it and Mr Dawood was not being monitored when he died.

Prisoners should have weekly key worker sessions but during his 22 weeks at Bristol, Mr Dawood had only four. This is unacceptable. Mr Dawood had periods when he was low in mood, self-isolating and complaining that staff were not helping him. It is possible that a supportive key worker relationship could have made a difference for Mr Dawood.

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

Sue McAllister CB
Prisons and Probation Ombudsman **April 2021**

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Summary

Events

1. On 29 August 2019, Mr Esam Dawood was remanded in prison custody, charged with attempted murder, and sent to HMP Hewell. On 27 September, Mr Dawood was charged with murder and was moved to HMP Bristol.

2. Mr Dawood complained that he was not able to call his family in Sudan because he did not have the money to make international calls, and he often self-isolated and stopped eating. He was monitored under suicide and self-harm procedures (known as ACCT) on three occasions between October 2019 and January 2020.

3. A mental health nurse started a further period of ACCT monitoring on 26 February, as Mr Dawood was self-isolating and refusing to attend court. On 27 February, Mr Dawood did attend court but sacked his legal team and asked the judge to find him guilty. The judge ordered a psychiatric assessment to check Mr Dawood was fit to stand trial. On 28 February, a supervising officer (SO) decided to stop ACCT monitoring. The mental health nurse who started ACCT monitoring disagreed with the decision, but monitoring was not restarted.

4. On 4 March, at around 5.30am during the morning roll check, an operational support grade (OSG) saw Mr Dawood hanging in his cell. He called out to his colleague, who called a medical emergency code. Other officers arrived and entered the cell, cut Mr Dawood down and started resuscitation attempts. Healthcare staff and ambulance paramedics continued resuscitation attempts but they were unsuccessful, and paramedics declared Mr Dawood's death at 6.22am.

Findings

5. The clinical reviewer found that the standard of mental health care Mr Dawood received at Bristol was good, and equivalent to that he could have expected to receive in the community.

6. We are concerned that the SO who stopped ACCT monitoring on 28 February (himself an ACCT trainer) made the decision on his own, without any input from the mental health team. We consider the decision to stop ACCT monitoring was premature: Mr Dawood's trial was still ongoing, his behaviour continued to be concerning, he was awaiting a psychiatric assessment and the actions identified to support him had not been progressed.

7. There were other failings with ACCT management. Healthcare staff were not always invited to the first case review, caremaps were not always completed at the first case review and ACCT documentation was often incomplete.

8. Mr Dawood had only four key worker sessions during his 22 weeks at Bristol and there was a lack of meaningful interaction with staff, possibly because of a language barrier. The prison told us that they had not fully implemented key working at that time.

9. Although the OSG who found Mr Dawood did not call a medical emergency code as he should have done because he was in shock, another OSG called the code almost immediately. However, this OSG did not enter the cell and he told the investigator that he would never enter a cell alone. Staff should be reminded that they can enter a cell alone if a prisoner's life is in danger, where it is safe to do so.

10. A new family liaison officer (FLO) was appointed after the original FLO took sick leave. The new FLO did not have access to the original FLO log because it had been lost.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:
    - identify the prisoner's risk factors for suicide and self-harm rather than focussing solely on how he presents or what he says;
    - hold multidisciplinary case reviews where possible and ensure healthcare staff attend the first case review;
    - set meaningful, tailored caremap actions at the first case review, aimed at reducing the prisoner's risk of suicide and self-harm, and complete all caremap actions before closing an ACCT; and
    - complete ACCT paperwork fully and accurately.
- The Governor and Head of Healthcare should ensure that staff understand the escalation procedures to be followed when healthcare staff disagree with a decision to close an ACCT.
- The Governor and Head of Healthcare should ensure that staff consider using an interpretation service for prisoners whose first language is not English, particularly for in depth conversations such as ACCT reviews, mental health assessments and key worker sessions, and where they decide not to do so, record the reasons.
- The Governor should ensure that:
    - staff are allocated adequate time to perform the key worker role; and
    - key worker sessions take place in line with the national policy framework.
- The Governor should ensure that staff are aware that they may enter a cell alone, subject to an immediate risk assessment, where there is immediate danger to life.
- The Governor should ensure that establishment clocks are accurate.
- The Governor should ensure that the family liaison officer (FLO) opens a FLO log as soon as they are appointed and stores it securely.
- The Governor should share this report with SO A, OSG A and OSG B, and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Governor should ensure that SO A receives further ACCT training before he chairs another ACCT review or delivers any ACCT training himself.

The Investigation Process

11. 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.

12. The investigator visited Bristol on 12 March 2020. She obtained copies of relevant extracts from Mr Dawood's prison and medical records.

13. NHS England commissioned an independent clinical reviewer to review Mr Dawood's clinical care at the prison.

14. The investigator interviewed 16 members of staff by telephone during July 2020. She and the clinical reviewer jointly interviewed healthcare staff.

15. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Dawood's nominated next of kin, his cousin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any concerns but asked to see a copy of the report.

17. Mr Dawood's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS provided some extra information and this report has been amended accordingly.

Background Information

HMP Bristol

19. HMP Bristol serves the local courts and holds up to 614 adult men over the age of 18 years old. HM Prison and Probation Service (HMPPS) placed Bristol under special measures in 2018 as they considered the prison needed additional specialist support to improve performance.

20. Healthcare services at Bristol are managed by Inspire Better Health, a partnership of eight health providers led by Bristol Community Health. GP services are subcontracted to Hanham Health Services, and Avon and Wiltshire Partnership provides mental health and substance misuse services.

HM Inspectorate of Prisons

21. The most recent inspection of Bristol was in May and June 2019. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification process informing the Secretary of State for Justice that there were numerous significant concerns about the treatment and conditions of prisoners. Inspectors reported that there was no effective strategy to reduce levels of self-harm and that Bristol had failed to keep prisoners safe.

22. Specific criticisms were made of how self-isolating prisoners were supported and monitored. Safer custody procedures (including family access to the hotline and prisoners' access to Listeners and the Samaritans) were not considered adequate.

Independent Monitoring Board

23. 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 July 2019, the IMB reported that the delayed key worker training was being rolled out and training had commenced.

24. The Board noted that some coping strategies were offered at Bristol but little else. Given the very high number of ACCTs that were open at the prison at the time (as many as 10% of the total prison population) they found this disappointing. They reported frequent encounters with prisoners expressing concern about the lack of trained support to assist with their mental health needs.

Previous deaths at HMP Bristol

25. Mr Dawood was the third prisoner at Bristol to die since March 2018. One of the previous deaths was self-inflicted and the other was from natural causes. We have previously made recommendations about ACCT management and about staff entering cells where a prisoner's life is at risk.

Assessment, Care in Custody and Teamwork

26. 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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

27. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

The key worker system

28. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS' Manage the Custodial Sentence Policy Framework. This says:

    - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
    - Key workers must have completed the required training.
    - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
    - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

29. On 29 August 2019, Mr Esam Dawood, a Sudanese national, was remanded in prison custody charged with attempted murder and sent to HMP Hewell. The charge was changed to murder on 27 September.

30. When Mr Dawood arrived at Hewell, staff started suicide and self-harm procedures (known as ACCT) as it was his first time in custody, he had been charged with a serious violent offence and the police custody mental health team thought he was displaying delusional and paranoid beliefs.

31. On 4 September, a mental health nurse assessed Mr Dawood. She noted that he had not displayed any delusional behaviour and he said he did not need any support from the mental health team. She discussed him with a psychiatrist, who referred him for assessment by Fromeside (a medium secure psychiatric hospital) because of the nature of his offence.

32. On 9 September, staff stopped ACCT monitoring because Mr Dawood said he had no thoughts of suicide or self-harm and they considered he was engaging well. Mr Dawood's only remaining issue was that he could not phone his family in Sudan as often as he wanted because of the cost of calls. (Prisoners must input a PIN before they can make a phone call and the cost of the call is deducted from their PIN account. Foreign national prisoners must be permitted a free five-minute call once in a four-week period if they have had no social visits during the preceding four-weeks.)

33. On 12 September, two nurses from Fromeside visited Hewell to assess Mr Dawood, but were unable to because of an incident on his wing.

34. On 17 September, a mental health nurse saw Mr Dawood. He said he did not want to be seen by the mental health team and signed a disclaimer. He said that when he called Sudan, his phone credit ran out quickly.

HMP Bristol

35. On 27 September, Mr Dawood was moved to HMP Bristol.

36. On 3 October, two nurses from Fromeside assessed Mr Dawood at Bristol. They concluded that he showed no evidence of a severe mental illness.

37. On 8 October, an officer introduced herself to Mr Dawood as his key worker. He said he wanted to work and that he had not yet received his phone PIN. She noted that she emailed the work allocations staff about finding him a job and that she told him she was trying to sort out his PIN.

First ACCT: 11 - 16 October

38. On 11 October, staff started ACCT procedures after they found a noose tied to Mr Dawood's bed and he said he was sad and wanted to speak to his family in Sudan.

39. That day, a mental health nurse saw Mr Dawood in his cell. She noted that his mood was flat, and he did not really engage apart from talking about his problems

with his international phone PIN. She thought he did not seem to understand his situation and kept asking why he could not go 'out' to work.

40. At the ACCT assessment interview. Mr Dawood said he was missing his family and the noose was not his, he had found it. He said he had never self-harmed and was fine and happy, as he had now been given his PIN.

41. A supervising officer (SO) chaired the first ACCT case review. A member of healthcare staff was present. He noted that Mr Dawood seemed to engage but there were some concerns that he did not fully understand what was being said. Mr Dawood said he had no financial support, so it was difficult for him to pay for calls to his family.

42. The SO completed a caremap with three actions: speaking to Safer Custody about using Language Line (the telephone interpretation service); finding Mr Dawood work (so he could pay for more phone calls); and sorting out his international PIN.

43. On 14 October, a mental health nurse saw Mr Dawood in his cell and noted he was happy he had spoken to his family and that he said he wanted to work. Wing staff told her that Mr Dawood was coming out of his cell and engaging with people.

44. On 16 October, a SO chaired the second case review. He told the investigator that although he had previously found communication with Mr Dawood difficult, he found it easier this time and decided not to use Language Line. Mr Dawood now had his PIN and had managed to make a couple of calls to his family. The SO noted he had again spoken to the allocations team about finding Mr Dawood work. Mr Dawood said he had no thoughts of self-harm. The SO noted that all the caremap actions had been completed and stopped ACCT monitoring.

17 October – 26 November

45. On 17 October, a healthcare assistant (HCA) saw Mr Dawood, who told him that he wanted to work and learn English. The HCA emailed prison staff on both issues. (Mr Dawood was allocated to a workshop on 18 October.)

46. The same day, Mr Dawood's key worker noted that she had missed her key worker session with Mr Dawood, as she was busy with other things on the wing and that she would try and see him that afternoon. There is no evidence she did.

47. On 31 October, Mr Dawood's key worker had a key worker session with Mr Dawood. She sorted out some new kit for him and he said he was happy on the wing. He shook his head when she asked if he was in contact with his family and again when she asked him if she could help with anything else.

48. On 4 November, Mr Dawood lost his workshop placement for non-attendance.

49. On 25 November, staff became aware that Mr Dawood was refusing food. In line with prison policy, they started a food chart and daily weighing. The following day, Mr Dawood said that he was not going to eat until he could call his family in Sudan. He was also refusing to work as he was unsentenced. Staff arranged for money to be transferred to his international PIN account. They also arranged for him to be seen by a nurse.

Second ACCT: 27 – 28 November

50. On 27 November, a nurse started ACCT procedures because Mr Dawood had not been out of his cell for five days and said he had not eaten for six.

51. A mental health nurse visited Mr Dawood on the wing because of concerns about his eating, self-isolation and refusal to comply with physical monitoring. Mr Dawood told her he had collected his breakfast that morning. He said he was refusing to eat because he was frustrated his needs were not being met. He said he had asked staff to help him contact his family in Sudan over three weeks ago but had got nowhere. He said wing staff were unhelpful and he had asked several times to be moved to B Wing.

52. The nurse noted that Mr Dawood had no thoughts of harming himself or others. She noted some disorientation but thought this was normal because he was spending long periods on his own. Mr Dawood said he would like to work, and she encouraged him to attend English sessions. She concluded that there was no role for the mental health crisis team and that she would refer Mr Dawood for support with education and work allocation.

53. On 28 November, an officer carried out the ACCT assessment interview. He noted that Mr Dawood seemed tired and depressed, did not engage much and that he needed to eat, although his cellmate was giving him water.

54. A SO chaired the first case review the same day. An officer and a mental health nurse attended. Mr Dawood said he had been struggling because he had not been able to contact his mother in Sudan, but his international credit had cleared, and he had now spoken to his mother and started eating. He asked for a move to B Wing and said he wanted to start work as quickly as possible.

55. The SO told the investigator that there was another Sudanese prisoner on B Wing, and they thought Mr Dawood might benefit from some social interaction with someone from his own country. The caremap had two actions: a move to B Wing and making a work referral. Both were marked as completed. Mr Dawood said that he was not thinking about harming himself and the SO recorded that mental health staff saw him regularly and had no concerns. He stopped ACCT monitoring.

56. Mr Dawood was subsequently moved to B Wing.

6 – 24 December

57. On 6 December, Mr Dawood's key worker saw him for a key worker session. She noted a marked improvement in his health and outlook. She told the investigator that after Mr Dawood moved to B Wing, he was fairly communicative with her and less reserved. He said that he was usually in contact with his family, although not right at that time as he did not have enough credit. She told him to make an application for more credit and checked he knew how to do this. He told her he wanted to work, and she recorded that she sent an email to the allocations team about this. Mr Dawood also told her that he had started studying English and was enjoying it. (The education department told the investigator that Mr Dawood was not in fact taking English lessons.)

58. On 16 December, staff arranged for money to be transferred to Mr Dawood's international PIN.

59. On 24 December, a SO recorded that a total of £7 had been added to Mr Dawood's international PIN in December, but that Mr Dawood had used it all. The SO told the investigator that an application is needed each time to transfer funds to an international PIN. He said he tried to help Mr Dawood by part-completing the application forms for him, but Mr Dawood waved him away, said he was not interested and told him to hold onto the paperwork.

Third ACCT: 27 December – 7 January 2020

60. On 27 December, officers found Mr Dawood unconscious. They called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and healthcare staff attended. Mr Dawood recovered quickly so the ambulance was cancelled. Staff thought the incident was due to Mr Dawood not having eaten much for the past seven days. ACCT procedures and a food/fluid monitoring chart were started.

61. On 28 December, an officer carried out the ACCT assessment interview. He noted that Mr Dawood was confused about why he had not been taken to court on 23 December. Although Mr Dawood did not engage much, the officer recorded that it was evident he had been eating as there were food packages in the cell. (The officer told the investigator there were also dirty bowls, utensils, packets of noodles and a baguette in the cell and that Mr Dawood had just finished a packet of crisps when he went to see him.)

62. A SO chaired the first case review later that day. An officer attended. (There is no record on the ACCT document that healthcare staff were invited or asked to contribute, although a HCA noted on Mr Dawood's medical record that the SO had told him that ACCT procedures had been started but that healthcare staff were not needed at the ACCT review.) Mr Dawood refused to speak and called the SO a liar. The SO asked the officer to carry out the review and Mr Dawood engaged well, said he had eaten and had something to drink, had no thoughts of self-harm as he wished to see his family again and that he had been in contact with his family regularly. The SO and officer assessed his risk as low and closed the ACCT.

63. On 30 December, a SO contacted a mental health nurse to say he was concerned that Mr Dawood was not eating, and he might be having paranoid thoughts because he was isolating himself in his cell. A nurse assessed Mr Dawood later that day. She noted he was very reluctant to engage but he told her that he did not trust his solicitor and he felt he was being looked at strangely by officers, and that they were not helping him speak to his family in Sudan. Mr Dawood told her he had no current thoughts of suicide or self-harm, but she noted that he had lost just over 10% of his body mass since 2 December. She restarted ACCT procedures.

64. A SO chaired an ACCT case review that day. Another SO attended and a mental health nurse gave a verbal report. Mr Dawood said he did not have the funds to contact his family and believed the prison were trying to kill them. Staff noted that staff at Hewell had previously flagged Mr Dawood up for an urgent referral to Fromeside, but that he had not been assessed. (In fact, he had been assessed on 3 October and no evidence of a severe mental illness had been found.)

65. An unknown individual completed a caremap on an unknown date. Actions included a food/fluid monitoring chart and assessment by the mental health team. A food and fluids chart was completed for five days and Mr Dawood ate and drank something each day.

66. On 2 January 2020, a SO chaired another ACCT review and a HCA from the mental health crisis team attended. Mr Dawood was eventually persuaded to engage, after initially refusing. He said that he was eating proper food again, that he had no intention of self-harming or of taking his own life, and that his only concern was having contact with his father in Sudan.

67. On 7 January, a SO chaired another ACCT review. A mental health nurse also attended. Mr Dawood presented well. The SO noted that all the caremap actions had been completed and he stopped ACCT monitoring.

68. On 14 January, a SO carried out the post-closure review. He recorded that Mr Dawood was still concerned about not being able to contact his family and was still awaiting employment, but said he had support from family, prison staff and other prisoners and was going to the gym.

14 January – 24 February

69. On 16 January, Mr Dawood tried to stab another prisoner with a home-made weapon because he said two prisoners had been laughing at him. Staff made a Challenge Support and Intervention Plan (CSIP) referral. (CSIPs provide support to those who pose a risk of violent behaviour with the aim of encouraging more positive behaviour.)

70. A prison manager triaged the CSIP referral and decided further investigation was needed. A SO investigated and, on 18 January, concluded that this was a one-off incident but that Mr Dawood's key worker should work through his challenging behaviour with him. He sent Mr Dawood an anger-related support pack.

71. On 30 January, Mr Dawood's new key worker noted that she had tried to speak to Mr Dawood, but he was sleeping and did not respond to her.

72. On 21 February, the key worker recorded that she had tried to speak to Mr Dawood, but the interaction had been difficult because of the language barrier. She asked him if he needed help with anything, but he did not seem to and did not seem to want to engage. She told the investigator that Mr Dawood did not speak to her much, kept himself to himself and, if he came down for food, he came out last, seemingly to avoid crowds of other prisoners.

Fourth ACCT: 26 - 28 February

73. On 26 February, at 5.25pm, a mental health nurse started ACCT procedures because when she visited Mr Dawood on the wing he was self-isolating, low in mood, not speaking to staff or his legal team and was refusing to attend court. Mr Dawood's legal team had told the prison they were concerned that Mr Dawood might be paranoid as he had told them that his television was bugged and that the police were monitoring him in his cell.

74. A SO completed the Immediate Action Plan and set observations at one an hour. He noted that Mr Dawood could be facing a long sentence, that he should be seen by the mental health team and advised about phone access. All the actions were marked as completed. The SO also made a CSIP referral on the grounds that Mr Dawood was self-isolating. (CSIPs can be used to address isolation issues as well as violence reduction.)

75. On 27 February, Mr Dawood attended court but sacked his legal team and questions were raised about his fitness to stand trial. The Judge ordered a mental health assessment which was carried out by a social worker. The social worker said he was concerned that Mr Dawood had a mental illness and may not be fit to stand trial. The judge ordered an assessment by a psychiatrist and communicated this to Mr Dawood who said he would not see a psychiatrist, that he wanted the trial to finish, and that he had committed murder and wished to be punished by Allah. The social worker contacted a HCA at Bristol to tell them what was happening. She noted they would discuss Mr Dawood in the multidisciplinary team (MDT) meeting the next day.

76. When Mr Dawood returned to Bristol that evening, an officer carried out an ACCT assessment interview. Mr Dawood said he did not know what an ACCT was and seemed quiet and withdrawn, although he said he did not wish to harm himself. The officer contacted a nurse to ask what had happened at court. He noted that Mr Dawood had dismissed his legal team in court that day and said he had killed someone in an 'Act of God'. He also noted that court staff were concerned about his mental state and the judge had ordered him to see a psychiatrist, but Mr Dawood said he did not need to. Mr Dawood did not seem to be engaging fully with the officer and did not think anything was wrong. The officer and the nurse agreed observations should be increased to three an hour given Mr Dawood's apparent unpredictability.

77. Later that evening, a SO chaired the first ACCT case review. An officer and HCA attended. The SO noted that Mr Dawood was very distant, showed no emotion and gave short answers, although he said he did not have any current thoughts of self-harm. Staff assessed Mr Dawood's risk of suicide or self-harm as high and set observations at four an hour. They scheduled a case review for the next day because Mr Dawood was due back in court that day and they felt his risk could increase as a result.

78. Also on 27 February, a prison manager recorded on the CSIP paperwork that investigations were needed to check if Mr Dawood attended visits, used his phone, was engaged in activities, said why he was isolating and if translation services had been used to find out if he was isolating. A SO filled in the investigation portion of the CSIP form stating that Mr Dawood had refused to attend court, refused to engage with staff or solicitors, rarely came out of his cell and that court appearances were a trigger for him. The CSIP report concluded, 'Needs extra support. Will support outside of CSIP with keyworker. Staff to try and get Mr Dawood to mix with other prisoner that speaks the same language.'

79. On 28 February, SO A was due to chair another ACCT case review. The paperwork shows that an officer attended the review and that there was a verbal contribution from 'Crisis'. However, the SO said at interview that the review did not take place because Mr Dawood refused to engage and just grunted at him when he went to speak to him.

80. SO A told the investigator that he asked a mental health nurse for pre-review input on behalf of the mental health team and that she said she had no concerns about Mr Dawood. He wrote in the case review log that mental health intended to visit Mr Dawood regularly. The nurse told the investigator that as far as she was concerned, she was due to attend the ACCT review and that although SO A called her, he did not invite her to it. She said she discussed the frequency of Mr Dawood's ACCT observations with him and said she would be visiting Mr Dawood every day as he was on the mental health caseload for daily visits.

81. SO A completed a caremap and noted the issues were self-isolation and motivation. He added the following caremap actions: engage with regime, go back to work, support with mental health and CSIP referral. He noted on the CSIP referral that Mr Dawood was self-isolating, that mental health was a factor and that the mental health team had started ACCT procedures. He marked the caremap actions as complete and stopped ACCT monitoring. He noted that, as Mr Dawood was not self-harming or threatening to do so, ACCT monitoring was not needed but that he had made a CSIP referral and that Mr Dawood would be put on Behaviour Support Monitoring (BSM). (Where appropriate a prisoner being monitored under CSIP can be placed on BSM which requires staff to make a daily entry on NOMIS about the prisoner's behaviour, engagement with staff, family, showering, collecting food, generally coming out of their cell, etc.)

82. SO A told the investigator that he noted in the wing observations book that he had stopped ACCT monitoring and said staff should ensure food was taken to Mr Dawood's cell. However, the prison's liaison officer for this case told us there was nothing in the wing book about Mr Dawood after 17 February.

83. Later that day, the mental health nurse went to assess Mr Dawood in his cell, but he was reluctant to engage. He told her that he had spoken to his family recently, although staff told her that he had not and that he had made no requests to speak to them. They said he had collected his food and been to prayers that day.

84. Wing staff also told the nurse that ACCT monitoring had stopped. She spoke to SO A to express her concerns about this, but he did not share them and told her that Mr Dawood would be monitored under BSM. She remained concerned about the decision, so she and another nurse went to speak to prison staff in Safer Custody. SO A joined the discussion. The nurse said she did not agree that ACCT monitoring should have been stopped, but SO A said that ACCT procedures were not to manage mental health issues – they were to manage self-harm and suicide attempts. SO A told the investigator that he informally checked his decision with other staff who were present (another SO and a prison manager).

85. Mr Dawood was not monitored under BSM. The investigator was told that CSIP referrals are triaged on the next working day (which would have been Monday 2 March in this case). However, it was not until 3 March that a SO triaged Mr Dawood's referral and recorded that further investigation was needed. The SO could not recall what had prevented him from triaging the referral on 2 March.

29 February – 3 March

86. On 29 February, the mental health nurse saw Mr Dawood and noted that his engagement was slightly better, he continued to pray and was eating and drinking,

though he continued to self-isolate. She noted there was 'no overt evidence of responding to external disturbance'.

87. On 1 March, the mental health nurse visited Mr Dawood and noted that he continued to spend his time in bed and declined to engage with wing staff and the mental health team. On 2 March, two HCAs visited Mr Dawood and discovered he had not attended court that day. Mr Dawood did not acknowledge their attempts to engage with them and appeared to be asleep. They planned to visit again the next day.

88. On 3 March, Mr Dawood refused to attend court and the Judge ordered that prison officers use reasonable force to bring him to court. (Prison records suggest force was not used.) A psychiatrist assessed Mr Dawood and concluded that he was fit to stand trial. He said he believed that Mr Dawood had mental health issues but that he would need more time to provide a specific diagnosis.

89. The Judge told Mr Dawood that he would adjourn the trial once more to give Mr Dawood time to speak to a solicitor. Mr Dawood said that he had committed murder and wanted to plead guilty, that he wanted the trial to be over, and that it was his destiny to be punished by Allah. The Judge urged Mr Dawood to think about his position overnight and return the next day. Mr Dawood insisted that he would refuse, but the judge adjourned proceedings until the following day.

90. An officer received Mr Dawood back from court. He said in his police statement that he could see from Mr Dawood's paperwork that he was still remanded. He said he asked the GEO Amey escort officer if he had any concerns about Mr Dawood's wellbeing, and he said he did not. The Person Escort Record makes no reference to Mr Dawood changing his plea to guilty.

91. The officer said he asked Mr Dawood if court had gone okay and he said it had. He also asked if he had any thoughts of self-harm and Mr Dawood said he did not. He said that Mr Dawood's quiet demeanour was normal for him.

92. An officer searched Mr Dawood in reception. He said he asked Mr Dawood if he wanted something to eat, but he refused even though the officer tried to convince him that he should eat, and said he just wanted to go back to his cell. He declined a muffin that an orderly at the servery tried to give him. The officer took Mr Dawood back to his cell and locked him up for the night.

93. At approximately 7.10pm, an officer did an evening roll check. It was dark in the cell and she got no response when she called Mr Dawood. She checked that he had returned from court earlier and then entered the cell, calling Mr Dawood's name. He did not respond initially but then he removed the duvet over his head and said he was okay.

94. An officer and a colleague were asked to re-do the earlier roll count as the numbers did not reconcile with the wing record. CCTV footage shows that the officer spent over 30 seconds at Mr Dawood's cell. He told the investigator he could not make out if Mr Dawood was in there and, as they were re-doing the roll check, he was being extra careful to accurately record how many people were in each cell and taking his time. He could not recall if he had unlocked the cell and put his head in and it is not possible to tell from the film as the cell door is in a recess. He could not recall if he had any interaction with Mr Dawood that evening.

95. At approximately 9.00pm, two Operational Support Grades (OSG) did the last roll check. OSG A was looking into the cells and OSG B was operating the counter clicker. He does not recall seeing anything out of the ordinary.

4 March

96. At approximately 5.30am, OSG A and OSG B started the morning roll check. (There is no clock on the CCTV footage of Mr Dawood's landing, so it is not possible to give exact times.) When OSG B looked into Mr Dawood's cell, he saw him hanging from the privacy curtain rail. He shouted to OSG A that Mr Dawood was hanging and then collapsed to the floor in shock.

97. The landing was dark, and OSG A was not sure if he had heard correctly. He initially looked through the observation panel of the cell next to Mr Dawood's as he was not sure which one OSG B had meant. He looked into Mr Dawood's cell next and immediately called a code blue. The control room log says this happened at 5.40am but body-worn camera (BWVC) footage suggests it was earlier. Control room staff called an ambulance straightaway.

98. Two officers arrived within approximately 20 seconds of the code blue being called. One officer unlocked the cell, and both went in. One officer lifted Mr Dawood up whilst the other cut the ligature (a bedsheet). As he was released, Mr Dawood's body fell forward a little, glancing his head on the bedframe. The officers laid Mr Dawood on the floor and took turns to give chest compressions.

99. Two CMs arrived. They instructed the officers to move Mr Dawood onto the landing and asked OSG A to get a defibrillator. One CM left with an officer to meet the paramedics when they arrived, and the other CM joined the chest compression rotations.

100. Within approximately a minute of the code blue being called, two nurses arrived and helped custodial staff with compressions. The defibrillator advised that Mr Dawood did not have a pulse and shocks were not advised. Staff continued with CPR and administered oxygen.

101. At 5.48am (BWVC footage time), the first paramedics arrived at the scene, followed by two further teams of paramedics. Mr Dawood did not respond to resuscitation attempts and, at 6.22am, paramedics declared that he had died.

Contact with Mr Dawood's family

102. The prison appointed a prison chaplain as the family liaison officer (FLO), but he took sick leave shortly after being appointed. We have been told that his FLO log was lost in an office move. The investigator was instead provided with a brief summary of events which says that on 4 March, the FLO contacted the Sudanese Embassy about Mr Dawood's death and was asked to call back the next day. There were several more conversations with the Sudanese Embassy, but it is not clear when Mr Dawood's family were told of his death.

103. On 13 March, an officer was appointed as the replacement FLO for Mr Dawood's next of kin and she kept a log of events from then on. It is not clear when the first

FLO started his sick leave or how long there was no contact point for Mr Dawood's family.

104. Mr Dawood's funeral was on 28 March. No one from the prison attended because of COVID-19 restrictions. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

105. After Mr Dawood's death, a prison manager 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.

106. The prison posted notices informing other prisoners of Mr Dawood's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Dawood's death.

Post-mortem report

107. The post-mortem concluded that Mr Dawood died as a result of ligature suspension (hanging). The pathologist said there was nothing to suggest Mr Dawood had been the victim of assault or restraint against his will prior to his death.

Findings

Clinical care

108. The clinical reviewer concluded that the clinical care Mr Dawood received was equivalent to that he could have expected to receive in the community. She praised the ongoing care and support Mr Dawood received from the mental health crisis support team throughout his time at Bristol.

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

109. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.

110. Mr Dawood was monitored under ACCT on four occasions at Bristol between October 2019 and February 2020. We are particularly concerned about the management of the final period of ACCT monitoring, which was stopped five days before Mr Dawood died.

111. A mental health nurse appropriately opened an ACCT on 26 February, because Mr Dawood was self-isolating, low in mood, not speaking to staff or his legal team and refusing to attend court. His legal team had also reported concerns that Mr Dawood might be paranoid as he had told them his television was bugged and his cell was being monitored by the police. On 27 February, Mr Dawood did attend court, but he sacked his legal team. Concerns were raised about whether he was fit to stand trial and the judge ordered a psychiatric assessment (scheduled for 3 March). At the first case review that evening, staff assessed Mr Dawood's risk of suicide or self-harm as high and increased observations to four an hour. We consider that was appropriate.

112. SO A chaired the second case review on 28 February. However, Mr Dawood did not engage, and SO A closed the ACCT. We are concerned that the SO took this decision on his own without input from anyone else. PSI 64/2011 says that case reviews should be multidisciplinary where possible, and as a member of the mental health team had started the ACCT procedures on 26 February, and Mr Dawood's mental health was an issue of concern, we consider someone from the mental health team should have been invited to attend the review.

113. SO A told the investigator that he had asked a mental health nurse for input on behalf of the mental health team and that she said she had no concerns. This is disputed by the nurse, who told the investigator that although SO A called her, he did not invite her to the case review which she had expected to attend. When she heard later that day that the ACCT had been closed, she made it clear that she disagreed with the decision and she felt sufficiently strongly to raise her concerns with the Safer Custody team.

114. SO A said ACCT procedures were not appropriate in Mr Dawood's case because ACCT procedures were designed to manage the risk of suicide and self-harm rather

than mental health issues. He also said that the mental health team would be visiting Mr Dawood every day.

115. We agree that ACCT procedures are designed to manage the risk of suicide and self-harm rather than mental health issues. However, Mr Dawood had a number of risk factors for suicide and self-harm that had led the mental health nurse to open the ACCT and we are concerned that SO A, himself an ACCT trainer, failed to consider these risk factors before he closed the ACCT.

116. Mr Dawood's mental health was a key risk factor because it appeared to lead him to have paranoid thoughts and to behave unpredictably and irrationally and had led the judge to question his fitness to stand trial. He was about to have a full psychiatric assessment. The other significant risk factors were the stress of the ongoing trial; the fact that Mr Dawood was facing a long prison sentence; and his social isolation and lack of social support, including his concerns about not being able to phone his family as often as he wanted. In the light of these risk factors, Mr Dawood's ACCT observations had been increased to four an hour the previous day. Nothing had changed since then, and we consider that SO A's decision to end the ACCT was premature.

117. SO A said that he had made a CSIP referral instead to address Mr Dawood's self-isolation and that Mr Dawood was going to be managed under the BSM procedures. However, this appears to reflect a basic misunderstanding about ACCT. CSIP is not designed to be an alternative to ACCT and is no substitute for regular ACCT observations. In addition, even though a CSIP referral had been made, it had not been triaged so there was no guarantee that Mr Dawood was going to be monitored under CSIP when SO A closed the ACCT.

118. SO A said he informally checked his decision to close the ACCT with another SO and a prison manager. If so, we are concerned that they shared his misunderstanding about the assessment of risk.

119. The Head of Healthcare at the time told the investigator that there had been other instances at Bristol where prison staff had stopped ACCT monitoring against the advice of healthcare staff. She had raised the issue at the Local Quality Delivery Board (a bimonthly meeting between healthcare staff and the Governor) and, since Mr Dawood's death, the Governor had agreed a new escalation process where healthcare staff should raise concerns with the duty governor if they disagree with a decision to stop ACCT monitoring. If the issues remained unresolved, healthcare staff should escalate their concerns to the Head of Healthcare who will raise them directly with the Governor.

120. We identified some other failings in the management of the ACCT procedures. PSI 64/2011 says that healthcare staff must attend the first case review and a caremap should be completed. No-one from healthcare was invited to the first case review when ACCT monitoring began in December, and a caremap was not completed at the first case review on 27 February.

121. In addition, ACCT documents were often unsigned, or signatures were indecipherable. Examples of this can be found across the ACCT documentation: the concern and keep safe form of 11 October, the post-closure interview of 2 December and a caremap dated 7 January. On 28 February, SO A noted on the

case review that he had had a verbal contribution from 'Crisis' but no name was recorded, which is insufficient.

122. We also note that SO A and some other prison staff referred to Mr Dawood as 'refusing' to engage, suggesting they saw this as a conscious decision on his part and therefore a behavioural issue. We are concerned that some staff did not appear to recognise that this could be a symptom of mental health issues and therefore a risk factor for suicide and self-harm.

Return from court: 3 March

123. There was an opportunity to have re-opened the ACCT when Mr Dawood returned to the prison from court on the evening of 3 March. Mr Dawood had been taken to court against his will that day, had been assessed by a psychiatrist who had concluded he had mental health problems, had changed his plea to guilty, and, when told by the judge to think about his plea overnight, had said that he would be judged by Allah. However, we recognise that this was not well recorded on the Prisoner Escort Record that accompanied Mr Dawood when he returned, and that Mr Dawood was not on an ACCT.

124. We make the following recommendations:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that staff:

- **identify the prisoner's risk factors for suicide and self-harm rather than focussing solely on how he presents or what he says;**
- **hold multidisciplinary case reviews where possible and ensure healthcare staff attend the first case review;**
- **set meaningful, tailored caremap actions at the first case review, aimed at reducing the prisoner's risk of suicide and self-harm, and complete all caremap actions before closing an ACCT; and**
- **complete ACCT paperwork fully and accurately.**

The Governor and Head of Healthcare should ensure that staff understand the escalation procedures to be followed when healthcare staff disagree with a decision to close an ACCT.

Communication

125. Mr Dawood's first language was Arabic. All the staff who interacted with Mr Dawood said he spoke English, but it has been difficult to establish exactly how fluent he was. Most staff said that Mr Dawood's understanding of English was good, including the mental health nurse, who said that Mr Dawood 'seemed to understand what we were talking about or what we were exploring at the time, and he was able to give us clear rationale into what he wanted us to do and how he wanted his care'.

126. However, Mr Dawood's first key worker said Mr Dawood was 'hard to understand but I could get the gist of what he was saying'. She also noted that he told her he

was enjoying English lessons, even though he never had lessons at Bristol, which suggests she may have misunderstood what Mr Dawood told her.

127. Mr Dawood's second key worker noted on 24 February, 'Mr Dawood doesn't appear to speak good English which has made our interactions very difficult'. When interviewed she said, 'It would seem that he didn't understand what I was saying when I spoke to him. Whether he did and was choosing to pretend not to understand me, so he didn't have to speak to me, I don't know. But when I did have that one conversation with him it took a little while for him to explain what he meant and then for him to understand my answers. So, I would say that there was a language barrier there'.

128. A SO told the investigator that Mr Dawood 'did speak perfect English but I wasn't really sure whether the English was all there. But whenever I asked him questions, he answered it fully', and an officer said there was a language barrier but he could find out what Mr Dawood's issues were, although 'there were certain words that [Mr Dawood] struggled with'.

129. We consider that where there is any doubt over a prisoner's ability to understand or express themselves in English, staff should consider using an interpretation service for important interactions such as ACCT reviews, mental health assessments and key worker sessions. If they decide not to use an interpretation service, they should record reasons for their decision, including details of any discussion they have had with the prisoner about their need for an interpreter. We recommend:

The Governor and Head of Healthcare should ensure that staff consider using an interpretation service for prisoners whose first language is not English, particularly for in depth conversations such as ACCT reviews, mental health assessments and key worker sessions, and where they decide not to do so, record the reasons.

Key workers

130. All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them. Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

131. Mr Dawood was at Bristol for over 22 weeks, and he had only four key worker sessions. Mr Dawood's key worker saw him twice in October, not at all in November, only once in December, not at all in January and once in February. The prison told us that at the time of Mr Dawood's death, they had not fully implemented the key worker scheme and the prison had not received HMPPS 'sign off' (as the prison had not achieved a level of delivery in line with the requirements of the national policy framework - 80% of key worker sessions delivered for a period of four weeks consecutively).

132. In January, the CSIP investigation concluded that Mr Dawood's key worker should work through his challenging behaviour with him. However, Mr Dawood's key worker at the time did not meet him at all in January, and when they met on 21 February, there is no record of any discussion about his challenging behaviour. She told the investigator that she sometimes missed key worker sessions with Mr

Dawood because she would be asked to do other urgent things instead. We recommend:

The Governor should ensure that:

- **staff are allocated adequate time to perform the keyworker role; and**
- **keyworker sessions take place in line with the national policy framework.**

Emergency response

Medical emergency code

133. When OSG B saw Mr Dawood hanging while he was carrying out the morning roll check, he called out to his colleague, OSG A, and then collapsed. He told the investigator that he knew he should have called a medical emergency code, but it was only his fifth week in the job, and he was in shock. We are satisfied that OSG A called a code almost immediately and, in the circumstances, we do not consider a recommendation is necessary.

Entering the cell

134. PSI 24/2011, Management and Security of Nights says that under normal circumstances prisoners' cells can only be opened on the authority of the Night Orderly Officer and with at least two staff present. However, it goes on to say that the preservation of life must take precedence over the usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer and an individual member of staff can enter the cell on their own. It says that any lone member of staff's decision to enter a cell, should be informed by a 'dynamic risk assessment' – informed by attempts to gain a response, what they can see through the observation panel and any other knowledge of the prisoner. Bristol's local policy follows the PSI.

135. OSG A told the investigator that when he saw Mr Dawood hanging, he did a dynamic risk assessment and decided not to go in. He said OSG B was in no fit state to help him if Mr Dawood was faking it. (OSG B told the investigator that Mr Dawood was approximately two feet in the air and that the situation was clearly genuine.) When the investigator asked OSG A if he would ever enter a cell alone, he said he did not think he would.

136. Although once OSG A called the code blue, other officers arrived very quickly and went straight into Mr Dawood's cell, we are concerned that he said he would never enter a cell alone, regardless of the circumstances. We recommend:

The Governor should ensure that all staff are aware they may enter a cell alone, subject to an immediate risk assessment, where there is an immediate danger to life.

Timings

137. The investigator noticed that the times on the body-worn camera, the CCTV and the control room log do not tally. For example, the control room log states that the code blue was called at 5.40am but body-worn camera footage shows Mr Dawood being removed from his cell at 5.37am. Some CCTV discs did not contain any timing information. We recommend:

The Governor should ensure that establishment clocks are accurate.

Family liaison

138. We were told that the log kept by the original prison FLO was lost in an office move. This would have made it more difficult for the second FLO to take over the role. In addition, we have been unable to establish exactly what happened in the period immediately after Mr Dawood's death and when his family was told. We recommend:

The Governor should ensure that the family liaison officer (FLO) opens a FLO log as soon as they are appointed and stores it securely.

Learning lessons

139. We consider it essential that staff learn the lessons from our reports. We therefore recommend:

The Governor should share this report with SO A, OSG A and OSG B, and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Governor should ensure that SO A receives further ACCT training before he chairs another ACCT review or delivers any ACCT training himself.

Inquest

140. At the inquest, held from 11 to 27 September 2023, the jury concluded that Mr Dawood died by suicide.

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