Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ahmed Alshbli, a prisoner at HMP Durham, on 10 November 2022

A report by the Prisons and Probation Ombudsman

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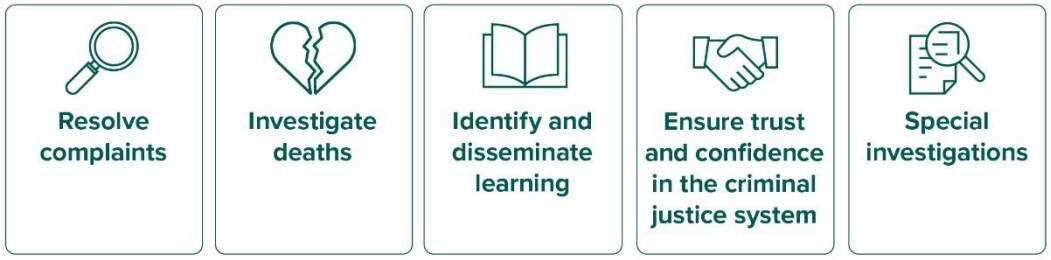
OUR VISION

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.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ahmed Alshbli died in University Hospital North Durham on 10 November 2022, after he was found hanging in his cell in HMP Durham on 2 November. He was 35 years old. I offer my condolences to Mr Alshbli's family and friends.

Mr Alshbli was found hanged on the day he was remanded to prison for the first time. He had harmed himself at court and arrived with his risk of suicide and self-harm clearly flagged.

Although he was subject to suicide and self-harm prevention procedures when he died, there were missed opportunities to identify the level of his risk.

This investigation identified issues with the reception process at Durham, similar to our findings in the investigation into the death of another prisoner at Durham who died three days before Mr Alshbli. I am concerned that, on more than one occasion during Mr Alshbli's short time at Durham, there seemed to be confusion about who was responsible for making key decisions.

Durham is receiving additional support from HMPPS headquarters as a result of the number of self-inflicted deaths there in the last 12 months. The learning from this investigation can usefully inform considerations about staff training and suicide and self-harm risk management.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

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Summary

Events

1. On 2 November 2022, Mr Alshbli was remanded to Durham for a range of offences, including harassment and assault of his partner. It was his first time in prison. Mr Alshbli had banged his head against a wall and tied a jumper around his neck at court. On the way to prison, Mr Alshbli wrapped his seatbelt around his neck. He arrived with a suicide and self-harm warning form.

2. When Mr Alshbli arrived at Durham, he said he had not intended to harm himself in court and was just trying to avoid being sent to prison. The prison officer Mr Alshbli spoke to assessed that he did not need the support of suicide and self-harm prevention procedures (known as ACCT) but asked the mental health team for their view.

3. A nurse completed Mr Alshbli's initial reception health screening. She was not aware of the suicide and self-harm warning form he arrived with, and Mr Alshbli said he had no history of self-harm or mental health issues but was tearful. The nurse did not have any serious concerns and did not start ACCT procedures.

4. A mental health nurse assessed Mr Alshbli later that day. He said he felt hopeless and suicidal, though he said he had no intention to act on those feelings. The mental health nurse began ACCT procedures with checks at least once every 30 minutes.

5. Just after 8.00pm, an officer completed an ACCT check on Mr Alshbli. He had obscured the view into his cell, was partially out of sight, and had tied something to the underside of the upper bunk bed. The officer requested emergency assistance and went into the cell. Mr Alshbli said that he had tied a loop in which to rest his legs and had no intention of harming himself. The obstruction was removed, and Mr Alshbli was told not to obscure the view and not to tie anything to the bed. His risk was not reassessed, and observations were not increased.

6. At a further check just before 10.00pm, Mr Alshbli was found hanging. Staff went into the cell and tried to resuscitate him. Ambulance paramedics were in the prison attending to another emergency, and they took over. Mr Alshbli was transferred to hospital, where he died on 10 November.

Findings

Assessment of risk

7. Mr Alshbli arrived at Durham with a suicide and self-harm warning form, clearly setting out his self-harm attempts at court and on the way to prison. However, not all of the prison and healthcare staff responsible for receiving Mr Alshbli into prison had access to all of the relevant information about him. The supervising officer who did have full access appeared not to fully understand his responsibilities in relation to ACCT and considered it to be primarily a mental health process.

Assessment Care in Custody and Teamwork (ACCT)

8. When it was suspected that Mr Alshbli had tied a ligature to his bed, no one member of staff took responsibility for considering the incident in light of Mr Alshbli's known risk factors and earlier behaviour at court. The frequency of checks was not reassessed, and no other measures were taken to manage the risks.

9. Staff checked Mr Alshbli at regular intervals, making it easy for Mr Alshbli to predict when he would next be checked.

Mr Alshbli's healthcare

10. The clinical reviewer concluded that the healthcare provided to Mr Alshbli in Durham was equivalent to that which he could have expected in the community.

11. She considered that reception nurses should have access to available risk information on prisoners to complete effective risk assessments.

12. The clinical reviewer makes several clinical recommendations to improve processes around risk management that the Head of Healthcare should address.

Recommendations

- The Governor and Head of Healthcare should review reception procedures to ensure that all staff supporting individuals and completing initial risk assessments have access to relevant information, including digital PERs, SASH forms and prison records.

- The Governor and Head of Healthcare should ensure that staff responsible for ACCT procedures comply with the following national policy requirements:

    - assessing a prisoner's risk based on their risk factors and not solely their presentation;

    - reassessing risk and observation levels after any indication of increased risk.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. There were no responses.

14. The investigator visited Durham and obtained copies of relevant extracts from Mr Alshbli's prison and medical records.

15. The investigator interviewed seven members of staff at Durham. He also interviewed a member of staff on detached duty to another prison.

16. NHS England commissioned a clinical reviewer to review Mr Alshbli's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

17. We informed HM Coroner for County Durham and Darlington of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's family liaison officer contacted a friend, whom Mr Alshbli had noted as his next of kin, as well as Mr Alshbli's brother, to explain the investigation and to ask if they had any matters they wanted us to consider. They did not have any specific questions.

Background Information

HMP Durham

19. HMP Durham is a local prison that receives men who are remanded or serving sentences from courts in Tyneside, Durham and Cumbria. It has a maximum capacity of 985 men. Spectrum Community Health provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Durham was in November 2021. Inspectors reported that serious staff shortages had affected all aspects of healthcare provision. Inspectors also found that new prisoners often arrived late in the day and a significant number did not receive an initial health screen before going to their cells. The quality of care provided via ACCT procedures varied.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 October 2022, the IMB reported that Durham was generally a safe environment. There were concerns about the lack of supervisors' checks on ACCT documents.

Previous deaths at HMP Durham

22. Mr Alshbli was the eighth prisoner of HMP Durham to die since the beginning of 2021. One prisoner apparently took his own life three days before Mr Alshbli and we have commented on the similarities in our learning in this report. The other deaths were all due to natural causes. There have since been two further apparently self-inflicted deaths.

23. Durham is currently receiving additional support from HMPPS headquarters due to the number of self-inflicted deaths there in the last 12 months.

Assessment, Care in Custody and Teamwork (ACCT)

24. 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.

25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (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.

26. 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.

Key Events

27. Mr Alshbli was a Syrian national who had been living in the UK since 2018. On 2 November 2022, he was remanded to HMP Durham charged with various offences including harassment, assault and coercive behaviour in his relationship. This was his first time in prison. Staff considered that Mr Alshbli spoke reasonable English, and while he was not fluent, it did not inhibit communication.

28. At court, Mr Alshbli tied a jumper around his neck, punched walls and banged his head against them. Custody officers put constant observation in place to prevent him from harming himself. In the escort van, Mr Alshbli wrapped his seatbelt around his neck. He arrived in Durham with a digital suicide and self-harm warning form (SASH) detailing these events and highlighting the risks.

29. An officer took Mr Alshbli from the escort vehicle into reception, where he handed over to colleagues who booked him in. Once Mr Alshbli had been booked in, the officer provided Mr Alshbli with guidance on search procedures. Mr Alshbli said that it was his first time in custody, and he had questions about how prison worked, which the officer answered. The officer said that Mr Alshbli's demeanour did not cause him to have any concerns that he presented a risk to himself. He knew Mr Alshbli had arrived with a SASH form, but as he was in a mobile role did not have access to the digital form and therefore had not seen the details. He recorded that Mr Alshbli was also advised of support available, including Listeners (prisoners trained by the Samaritans to provide peer support), Samaritans and talking to staff.

30. A supervising officer (SO) interviewed Mr Alshbli to complete an initial risk assessment. He referenced Mr Alshbli's SASH and PER forms. Mr Alshbli told the SO that the events in court and in the escort vehicle were misunderstood and he had been wearing his jumper around his neck. The other actions had been to try to prevent staff from taking him to prison, but he regretted them. Mr Alshbli said that his alleged offence was committed against his ex-partner, and he was angry at her and pleased that they were now separated. The SO asked if he had any thoughts of harming himself, and Mr Alshbli said he did not. He mentioned protective factors including his friends and his business, which he planned to return to. Mr Alshbli said he had been nervous in the police station and in court but felt more comfortable in prison now that he had spoken to staff. The SO explained the support that was available, and Mr Alshbli said that he understood and knew how to ask if he needed help. The SO recorded that Mr Alshbli explained the issues raised in the SASH form and gave him no cause for concern during the interview. However, the SO asked a mental health nurse to assess Mr Alshbli. (The SO did not turn up for his scheduled interview, was then on long term sick leave and has now left the Prison Service. He was not interviewed as part of the investigation.)

31. Mr Alshbli saw general nurse for a reception health screening. He said he had no mental health issues or recent history of harming himself and had no plans to do so. The nurse noted that the SO had referred Mr Alshbli to the mental health team to assess whether he needed any support. Mr Alshbli said that he was angry at his situation, saying that he felt hopeless. The nurse noted that he talked of protective factors including his family and his children, but that his mood was low and that he was tearful. She did not see the digital PER and was not aware that there was a SASH form for Mr Alshbli. She said that she did not have any concerns that he

might harm himself. The investigator was told that not all healthcare staff had access to prisoners' digital information because they did not have Nomis (the prison record system) accounts.

32. Staff took Mr Alshbli to the First Night Centre. An officer gave Mr Alshbli his induction interview, explaining the support that was available. He noted on Mr Alshbli's electronic record that he signed all the necessary paperwork and was in a good mood with no thoughts of self-harm and no issues to raise.

33. Later in the day, a nurse from the mental health team met with Mr Alshbli. The nurse also did not have access to any of Mr Alshbli's records, including his PER and SASH forms. He engaged well but was in a low mood and tearful. He said that he had no mental health issues but felt suicidal. Mr Alshbli told the nurse he had no plans to harm himself. Mr Alshbli spoke of his son as a protective factor but said that he felt like he had lost everything: his family, his house, his car, his job. The nurse judged that Mr Alshbli needed further support and opened ACCT procedures with checks at least once every 30 minutes. She explained the support that was available, and that someone from the mental health team would see Mr Alshbli the following day.

34. A custodial manager (CM) was the wing manager on the First Night Centre. The nurse told him that she had opened ACCT procedures for Mr Alshbli. She explained her concerns and recorded them on the ACCT document. The CM said there were several issues on the wing that evening and he did not see Mr Alshbli in person. He completed the immediate action plan.

35. Mr Alshbli was taken to his allocated shared cell, but the occupant objected to sharing so Mr Alshbli was taken to a double cell as a single occupant.

36. At 8.01pm, an officer completed an ACCT check on Mr Alshbli. He looked through the observation panel and saw Mr Alshbli was sitting on the bottom bunk. He had put a bed sheet up at the end of his bed, attached to the frame of the top bunk. This obscured the view into the bottom bunk where he was sitting. He had tied his socks together to form a long strand and tied the end to the underside of the top bunk, forming a loop. He briefly saw Mr Alshbli's face but when he called to him, Mr Alshbli leaned back behind the sheet. He saw the tied socks go taut and felt concerned that Mr Alshbli might have the other end tied to his neck. He radioed a code blue emergency (meaning a prisoner is unconscious or having trouble breathing and seeking assistance). As his colleague arrived, he unlocked and entered the cell. Mr Alshbli had reclined on the bottom bunk and put his foot through the loop, suspending his leg in the air.

37. The officer told Mr Alshbli why he was concerned and had entered the cell. He said Mr Alshbli must be visible at all times. Mr Alshbli said that he had put his ankles into the loop to stretch his legs, something he did frequently at home. He found it funny that anyone would think he had tied something around his neck and said that it was not the case. The officers removed the screen Mr Alshbli had tied to the bed and told him that he should not tie anything to the bedframe. A CM went to the cell when he heard the emergency call. When he arrived, he could see Mr Alshbli sitting talking to the officers, so returned to his duties.

38. A nurse also responded to the emergency call. As she approached Mr Alshbli's cell, prison officers told her that it was a false alarm. She decided to see Mr Alshbli anyway and went into the cell. Mr Alshbli told her that he had tied the loop so he could put his feet up and relax. She said that he was in a jovial mood and told her that he was not attempting to harm himself and that he had not put anything around his neck. She noted the torn bed sheet (which an officer confirmed that the officers removed from the cell) and asked the prison officers if Mr Alshbli was under ACCT management. They told her that he was. Staff left the cell. They did not make any changes to the frequency of checks or take any other action.

39. At approximately 9.00pm, an officer carried out an ACCT check on Mr Alshbli. In interview she said that Mr Alshbli was asleep. At approximately 9.30pm, she returned for a further check and spoke briefly to Mr Alshbli, who told her he could not get back to sleep. She had no concerns about him.

40. The officer returned for a further check at 9.58pm and saw Mr Alshbli hanging by a jumper attached to his shower rail. She called a code blue emergency and she and a fellow officer went into the cell. The emergency call prompted the control room to call an ambulance. She said that she had difficulty cutting the ligature because it was thick, but once she had managed to break it officers brought Mr Alshbli out of the cell onto the landing to provide space for cardiopulmonary resuscitation (CPR). CCTV footage showed that this was at 9.59pm. Other staff had responded to the emergency call, including a nurse, and together they began to perform CPR. Ambulance paramedics were already on the wing, having responded to another call from the prison, and within a minute they joined the staff in attempting to resuscitate Mr Alshbli. Further paramedics arrived and transferred Mr Alshbli to hospital.

Contact with Mr Alshbli's family

41. The prison appointed a family liaison officer soon after Mr Alshbli's transfer to hospital. Mr Alshbli had noted a friend as his next of kin, so the following morning prison staff contacted her. They also identified his brother and made contact to share the news. Mr Alshbli's family visited him in hospital.

42. Mr Alshbli remained on life support until 10 November. After discussion with his family, doctors withdrew Mr Alshbli's life support. Mr Alshbli died at 3.37pm that day.

43. Prison staff were at the hospital when Mr Alshbli died. They engaged with his family at the time and following his death. In line with Prison Service guidance, Durham offered a contribution to the cost of the funeral.

Support for prisoners and staff

44. When Mr Alshbli went to hospital, a senior member of staff debriefed 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.

45. When Mr Alshbli died, prison managers spoke to staff who were at the hospital with him. They offered support, but the staff declined a formal debrief.

46. The prison posted notices informing other prisoners of Mr Alshbli'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 Alshbli's death.

Post-mortem report

47. Post-mortem reports showed that Mr Alshbli died as a result of brain injury caused by lack of oxygen due to hanging. Because he had been in hospital for some days before he died, toxicology tests were not undertaken.

Findings

Assessment of suicide and self-harm risk

48. Prison Service Instruction (PSI) 64/2011, Safer Custody, lists risk factors and potential triggers for suicide and self-harm, including violent offences against a family member, first reception into custody and previous suicide attempts and self-harm. It says all staff should be alert to the increased risk posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures, for which there are mandatory requirements.

49. Person Escort Records (PERs) are electronic or hard copy documents used to share risk information when individuals move between police, court and prison custody. PERs are a key source of information for new receptions and should inform initial risk assessments completed by prison and healthcare staff. Suicide and self-harm (SASH) warning forms highlight the particular risks for individuals moving between police and prison custody.

50. Mr Alshbli presented several risk factors listed in PSI 64/2011. He arrived at Durham with a PER and SASH warning form completed by the police, court and escort staff, which noted head banging, wall punching and attempts to ligature at court and in the escort vehicle. Mr Alshbli had been charged with offences against his former partner, some of which were violent. He was a new arrival, and it was his first time in prison.

51. It is clear that Durham has put efforts into ensuring reception processes are comprehensive. Prisoners have a health check and are interviewed by at least one senior prison officer and two nurses. They are assessed by a mental health nurse if required. Mr Alshbli moved through each stage of the process. However, there were issues with some staff accessing his information and some poor decision making, particularly by the SO in reception.

52. Records suggest that the SO, the supervising officer responsible for interviewing new arrivals that day, had access to all of the relevant information about Mr Alshbli. However, he considered that ACCT monitoring was not necessary, largely it seems on the grounds that Mr Alshbli said he had not really intended to harm himself – despite the objective evidence saying something quite different. The SO asked the mental health nurse to review Mr Alshbli, but it is not clear why. One interpretation is that the SO considered ACCT to be a mental health process, which the guidance makes clear it is not. Overall, we consider that the SO's decision making was, at best, poor and, at worst, fell far below the standard expected of a supervising officer. Had the SO not already left the Prison Service, we might well have been recommending that the Governor consider a disciplinary investigation into his actions.

53. When the nurses in reception completed Mr Alshbli's initial healthcare interview they did not have access to his digital PER or SASH form, which they told us was not unusual. They were therefore unaware of events in police custody, court and during Mr Alshbli's escort to prison. They could see that he had been referred to the

mental health team by prison officers because this was recorded on the healthcare system but did not explore the reasons for this. Healthcare noted Mr Alshbli's low mood and hopelessness but assessed that he did not present an increased risk of harm to himself and did not require ACCT monitoring. Fortunately, despite also not having access to the digital PER or SASH form, the mental health nurse promptly began ACCT monitoring when Mr Alshbli mentioned low mood and thoughts of suicide.

54. Durham is currently receiving additional support from HMPPS headquarters because of the number of self-inflicted deaths there in the last 12 months. Risk identification in reception has been identified as a key issue and additional training has been provided to staff on risks, triggers and protective factors, with further training to follow. The prison's senior leadership team has implemented processes to improve first night interviews and initial health screens and to ensure that every prisoner is able to make a telephone call on their first night. These are welcome initiatives, but the issue of appropriate access to vital digital information remains a concern. We make the following recommendation:

The Governor and Head of Healthcare should review reception procedures to ensure that all staff supporting individuals and completing initial risk assessments have access to relevant information, including digital PERs, SASH forms and prison records.

Increase in risk

55. PSI 64/2011 requires an urgent ACCT case review if an event or disclosure suggests risk is likely to have increased.

56. An officer called a code blue emergency when he thought Mr Alshbli might have ligatured in his cell. Mr Alshbli persuaded staff that he had not tied a ligature but had been fashioning a support for his legs. He was right to be concerned about Mr Alshbli's behaviour, and his account of it should have continued to ring alarm bells for the staff and led to a review of Mr Alshbli's level of risk.

57. Following the incident, no one member of staff took responsibility for considering the implications. The CM did not discuss the event with the officer (who said he did not know about Mr Alshbli's earlier behaviour in court). A nurse told us that once she knew Mr Alshbli was already on an ACCT, she assumed prison staff would review the frequency of observations. In the event, no one increased the frequency of observations, which remained at once every thirty minutes.

58. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff responsible for ACCT procedures comply with the following national policy requirements:

- **assessing a prisoner's risk based on their risk factors and not solely their presentation;**
- **reassessing risk and observation levels after any indication of increased risk.**

Mr Alshbli's healthcare

59. The clinical reviewer concluded that the healthcare provided to Mr Alshbli in Durham was equivalent to that which he could have expected in the community. However, the clinical reviewer makes several recommendations to improve processes around risk management that the Head of Healthcare should address.

Governor to note

60. PSI 64/2011 requires specific actions to be completed by a wing manager once an ACCT has been opened. ACCT User Guidance advises staff to meet with the prisoner and complete the Immediate Action Plan (IAP) within an hour. ACCT managers must also open an alert on the prisoner's electronic record that ACCT procedures have begun. Prisoners should be provided with information on the ACCT process and how it works, to ensure they understand the process and can contribute to their risk management effectively.

61. Mr Alshbli's ACCT manager completed the IAP within guideline timescales. However, he did not seek any engagement with or input from Mr Alshbli. He was also unable to confirm that Mr Alshbli had been given written material explaining the ACCT process. We do not know how well Mr Alshbli understood the process, which was new to him and would have benefited from his input.

62. ACCT guidance says that observations should be made at irregular intervals so that they cannot be predicted by prisoners at risk of self-harm or suicide. The observations completed for Mr Alshbli were all made around the hour and half-hour.

63. PSI 58/2010 says that the PPO should have unfettered access to Prison Service data and information for the purposes of their investigations. Durham was unable to provide us with copies of the digital PER and SASH forms.

64. The Governor will wish to consider and address these issues.

Inquest

65. The inquest, held from 14 to 18 October 2024, concluded that Mr Alshbli died by suicide.

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