

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Amir Faizi a prisoner at HMP Pentonville on 27 April 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Faizi died on 27 April 2017, having been found hanged in his cell at HMP Pentonville. He was 31 years old. We offer our condolences to Mr Faizi's family and friends.

Mr Faizi was a troubled man and the uncertainties created by his immigration status and his sentence of imprisonment for public protection were important factors in his risk of suicide and self-harm. Staff at HMP Pentonville appropriately opened Prison Service suicide and self-harm prevention procedures when Mr Faizi arrived at the prison, but did not comply with some basic aspects of these procedures and we are not satisfied that they supported him as they should have. Mr Faizi's case reviews, which should have considered his current risk of suicide and self-harm and sought ways to reduce that risk, were not multidisciplinary and did not put in place suitable plans to reduce his risk. We are concerned that staff did not consider all of the information available to them about Mr Faizi's risk and, therefore, underestimated his risk of suicide.

It is of particular concern that these findings reflect those we have made in a number of recent investigations at Pentonville. In our report into the most recent self-inflicted death at Pentonville, we recommended that the Prisons Group Director for London and Thames Valley commission a review on the operation and management of the ACCT process at Pentonville. Our findings in this investigation should also contribute to this review.

Mr Faizi also had a long history of mental ill health. We are concerned that the support he received from the mental health team at Pentonville was very poor and did not meet his needs.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

June 2018

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Summary

Events

1. In May 2007, Mr Amir Faizi was remanded in custody, and later sentenced to an indeterminate sentence for public protection. He was diagnosed with post-traumatic stress disorder and, in 2008, admitted to a psychiatric hospital for a short time. Mr Faizi spent most of his time in custody at HMP Bure, where staff sometimes managed him under Prison Service suicide and self-harm prevention procedures (known as ACCT). He was liable for deportation from the United Kingdom under the terms of the Tariff Expired Removal Scheme, which Mr Faizi appealed against.
2. On 7 February 2017, Mr Faizi was transferred to HMP Pentonville for a deportation hearing scheduled for 10 February. (The hearing was cancelled and rescheduled for 26 April.) On arrival at Pentonville, Mr Faizi said he had no reason to be alive and was looking for a means to kill himself. Staff began ACCT procedures. A supervising officer led the first ACCT case review, but no healthcare representative attended and no one was named case manager, both of which are mandatory requirements.
3. Over the following weeks, Mr Faizi frequently said he wished to die, spoke about flashbacks to his life in Afghanistan and expressed fears about returning to the country. A mental health nurse assessed Mr Faizi as at immediate risk of suicide, meaning he should be reviewed every day, but there were often periods of over a week in which no one from the mental health team saw him. There was a period of several weeks in which Mr Faizi had no allocated keyworker, and when a keyworker was appointed, he was a newly appointed occupational therapist rather than a mental health nurse. Healthcare staff also did not attend more than half of the ACCT case reviews.
4. On 24 April, Mr Faizi told an officer that he wanted to die and intended to hang himself. At an ACCT case review on 26 April (held after his deportation hearing was again postponed), he said that he had tried to suffocate himself the previous night. The supervising officer who led the case review did not change Mr Faizi's level of risk or frequency of observations.
5. At around 3.53am on 27 April, the night patrol officer found Mr Faizi had hanged himself. The officer radioed for assistance and, when colleagues arrived, they opened the cell and began cardiopulmonary resuscitation. The control room operator did not call for an ambulance immediately, as national policy requires. When paramedics arrived, they took over the resuscitation but, at 4.41am, confirmed Mr Faizi had died.

Findings

Management of risk of suicide and self-harm

6. Mr Faizi appeared isolated at Pentonville, and frequently spoke of his wish to end his life and his fears of deportation. We are concerned that the ACCT procedures did little to address his risk of suicide and self-harm. A number of key aspects of ACCT procedures aimed at reducing risk, including holding

multidisciplinary case reviews and setting meaningful caremap actions, were not completed. Mr Faizi's case manager was self-appointed several weeks after the ACCT procedures. We are concerned that he did not fully consider information that might have indicated Mr Faizi was at increased risk, and we are not satisfied he made appropriate decisions about the level of Mr Faizi's risk and frequency of his observations. These findings reflect those we have made in a number of recent investigations at Pentonville.

Clinical care

7. The clinical reviewer highlighted numerous failings in Mr Faizi's clinical management at Pentonville, and concluded that he did not receive care equivalent to that which he could have expected to receive in the community. Mr Faizi was reviewed very infrequently by mental health professionals, despite being judged at the highest level of risk, and there was very poor communication between practitioners and the service manager. We are not satisfied that Mr Faizi's history and risk was fully considered when a keyworker was appointed, or that the appointment reflected his needs.

Response to complaint form

8. Around two weeks before he died, Mr Faizi submitted a complaint that he had been assaulted by an officer. We are not satisfied that the wing manager who replied fully considered and addressed the serious issues Mr Faizi raised in line with national guidelines.

Emergency response

9. It is unclear how quickly staff opened Mr Faizi's cell when the night patrol officer found him hanged. We found that she should have opened the cell promptly. We also found there was a delay to calling an ambulance.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff, where relevant.
 - ACCT caremap actions are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.
 - Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm and frequency of observations whenever an event occurs which indicates an increase in risk.
 - Conversations are carried out as directed and documented in the ongoing record.
 - All staff in contact with prisoners are trained in ACCT procedures.
- The Head of Healthcare should ensure that the mental health team is adequately resourced to provide a level of service equivalent to that which prisoners could expect to receive in the community, including that:

- Staff understand the zoning system and its requirements, including that they review prisoners in the red zone daily, share decisions to move prisoners into or out of the red zone with the service manager, and obtain psychiatric input, when necessary.
- Staff from different clinical backgrounds are competent to deliver a basic level of service.
- The allocation of keyworkers reflects the needs of the prisoner and the skills and experience of the member of staff.
- The Governor should ensure that staff respond to complaints in line with national guidelines, including that they address all of the issues raised in the complaint.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
 - Night staff enter cells as quickly as possible in a life-threatening situation.
 - Control room staff request an ambulance as soon as an emergency is called.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Pentonville on 2 May 2017. He obtained copies of relevant extracts from Mr Faizi's prison and medical records, and interviewed three prisoners who knew Mr Faizi.
12. The investigator interviewed 17 members of staff at Pentonville in June and July.
13. NHS England commissioned a clinical reviewer to review Mr Faizi's clinical care at the prison. She joined the investigator for interviews with clinical staff.
14. We informed HM Coroner for Inner North London of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Pentonville

16. HMP Pentonville is a local prison that holds over 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.
17. Healthcare services are provided by Care UK in partnership with Barnet, Enfield and Haringey Mental Health Trust. There is a large purpose-built healthcare centre, which has 22 inpatient beds and a daycare facility for patients with mental health problems who are managed on the wings.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Pentonville was in January 2017. Inspectors reported that the quality of ACCT documents was generally poor with very limited caremaps, inconsistent case management, and observations completed at predictable intervals. They reported that prison staff and immigration officials in the prison were unaware of each other's roles and lacked collaborative working. They also reported that mental health services had improved and were sufficient.

Independent Monitoring Board

19. 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 March 2017, the IMB reported that the quality of ACCT documents was "patchy". They also reported that Pentonville held many mentally ill men who received little or no help due to insufficient staff and resources.

Previous deaths at HMP Pentonville

20. Mr Faizi was the twelfth prisoner to die at Pentonville since August 2015, and the seventh to take his own life. Our report into the death of a prisoner in June 2016 found that ACCT case reviews were not multidisciplinary, the caremap did not fully reflect the man's issues, and staff did not consider all of the man's risk factors when determining his level of risk. Our report into the death of a prisoner in March 2017 found that ACCT case reviews were not multidisciplinary, a case manager was not assigned, caremap actions were not aimed at reducing risk, and information indicating increased risk was not always considered.

Assessment, Care in Custody and Teamwork (ACCT)

21. 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.
22. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. 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.

23. 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.

Tariff Expired Removal Scheme

24. The Tariff Expired Removal Scheme was introduced in 2012 and applies to all foreign national prisoners serving a life sentence or indeterminate sentence for public protection. The scheme allows foreign national prisoners who are liable for removal from the United Kingdom and who receive an indeterminate sentence to be removed from the country on or after the expiry of their tariff without reference to the Parole Board. It is a mandatory scheme and all such foreign national prisoners who are liable will be considered by the Public Protection Casework Section.

Zoning

25. Zoning is a system widely used in community and prison mental health teams to help effectively manage casework and target resources. Mental health professionals can place patients in green, amber or red zones, based on their clinical judgement following assessment. At Pentonville, healthcare professionals should record each patient's zone in their electronic medical record and on a board in the mental health team's office.
26. Local guidance at Pentonville states that patients in the red zone include those at immediate risk of suicide, those displaying new psychotic symptoms, or where there is a sudden change in behaviour that is concerning. The guidance states that red zone patients should be seen every day by a member of the mental health team.
27. Patients in the amber zone include those at potential risk of suicide and self-harm (including those on open ACCT documents) with possible risks identified. The guidance states that they should be seen weekly.
28. Patients in the green zone include those with no evidence of any risk of suicide and self-harm and who are not subject to ACCT procedures. These patients should be seen fortnightly.

Key Events

Background

29. Mr Faizi was born in Afghanistan and said that he left the country when he was 12 years old. He lived in Pakistan and Iran before travelling to the United Kingdom, arriving in 2003. Mr Faizi applied for asylum on arrival, but the Home Office refused his application.
30. In 2004, Mr Faizi was diagnosed with post-traumatic stress disorder (PTSD), related to events he had witnessed in Afghanistan. He was twice admitted to psychiatric units, for several weeks at a time. In 2005 and 2006, Mr Faizi served short prison sentences for breaching an antisocial behaviour order.
31. In May 2007, Mr Faizi was remanded in custody to HMP Woodhill charged with the rape of a male. He moved to HMP Wormwood Scrubs in September. Mr Faizi was convicted later in the year and, in May 2008, sentenced to an indeterminate sentence for public protection (IPP) with a tariff (the minimum time to be served before release can be considered) of two years and 173 days.
32. In August 2008, Mr Faizi was admitted to a psychiatric hospital. (It is not recorded how long he stayed there before he returned to prison.) He reportedly harmed himself while in hospital, although the method used was not recorded. Mr Faizi was diagnosed with a personality disorder (a condition that means the individual may find coping with demanding situations difficult or may struggle to interact with other people).

HMP Bure

33. In January 2010, Mr Faizi was transferred to HMP Bure. His prescribed medication at the time included citalopram (an antidepressant) and quetiapine (an antipsychotic used to treat PTSD). Prison doctors continued to prescribe these medications for the remainder of his life. At Bure, Mr Faizi often spoke of experiencing flashbacks to his life in Afghanistan. Prison psychiatrists and other mental health professionals provided frequent input and support.
34. Prison staff explained the Tariff Expired Removal Scheme to Mr Faizi when it was introduced in 2012. Home Office staff issued deportation paperwork later in the year, after which Mr Faizi reportedly became more withdrawn and said he felt stressed about the thought of deportation. Mr Faizi applied for asylum again and appealed his deportation order.
35. Over time, Mr Faizi became more settled at Bure. He became a gym rep, worked on the servery and attended education sessions. In September 2014, Home Office staff served Mr Faizi with a 'notice of liability for deportation', after which he said he wanted to be dead. No-one began ACCT procedures.
36. In August 2015, Mr Faizi told prison staff that his application for asylum had failed, but he would rather return to Afghanistan than remain in prison in the United Kingdom. Mr Faizi said that he was frustrated that he had not made any progress in his sentence plan. He told his solicitor that he did not wish to appeal

his deportation further. Mr Faizi seemingly changed his mind on an unknown date, and continued with his appeal against deportation.

37. In November, prison staff opened ACCT procedures for 12 days, when Mr Faizi asked for medication to end his life. They opened ACCT procedures again on 1 March 2016, when Mr Faizi was transferred to Wormwood Scrubs for an immigration hearing. When he returned to Bure on 7 March, Mr Faizi spoke of his anxiety at awaiting the outcome of the hearing. Healthcare staff recorded that he said he would kill himself if his deportation order was upheld.
38. On 7 June, Mr Faizi said his solicitor had told him his appeal had failed. Prison staff began ACCT procedures and, a week later, they constantly supervised Mr Faizi for a few days when he said he had taken an overdose. Mr Faizi's solicitor lodged a further appeal against his deportation and prison staff closed ACCT procedures at the end of June.

HMP Pentonville

39. On 7 February 2017, Mr Faizi was transferred to HMP Pentonville for an immigration hearing scheduled on 10 February. Mr Faizi's offence meant that his risk of sharing a cell with another prisoner was automatically high, and staff therefore allocated him a single cell. An officer interviewed him on arrival and recorded that Mr Faizi said he had no reason to be alive and was looking for a painless means to kill himself. She began ACCT procedures.
40. On 8 February, an interventions worker with Phoenix Futures (who provide help for prisoners with substance misuse issues) assessed Mr Faizi as part of ACCT procedures. Mr Faizi said he felt stressed about his immigration hearing and hated himself because of his offence. Mr Faizi also said he felt stuck in his IPP sentence as he could not get parole because of his immigration status. Mr Faizi said he wanted to die and would find a way for this to happen.
41. A member of the prison's mental health team then completed a triage assessment. She recorded Mr Faizi's history of PTSD, personality disorder and anxiety, and that he said he wanted to end his life and would do so if he had the means. She noted that the mental health team would discuss Mr Faizi at their next multidisciplinary team meeting.
42. A Supervising Officer (SO) then led the first ACCT case review, with the interventions worker and Mr Faizi. No healthcare representative attended. The SO recorded that Mr Faizi said he hated his life and did not wish to be alive. He concluded that Mr Faizi's risk of suicide and self-harm was high (on a scale of low, raised and high) and set ACCT observations at a minimum of one per hour. He also recorded that prison staff should hold at least one good quality conversation with Mr Faizi each day.
43. The SO entered two actions on the ACCT caremap: for Mr Faizi to move to the vulnerable prisoners' unit; and for him to receive support and monitoring from the mental health team.
44. Mr Faizi's immigration hearing, due on 10 February, was postponed and rescheduled for 1 April.

45. On 10 February, Nurse A reviewed Mr Faizi. When asked if he felt suicidal, Mr Faizi said he wanted to wait for the outcome of his immigration hearing. She placed Mr Faizi in the red zone.
46. On 12 February, a SO led an ACCT case review, with an interventions worker with Phoenix Futures. Mr Faizi said that he had nothing to live for and wanted to die. The SO concluded that Mr Faizi was at low risk of suicide and self-harm, and reduced ACCT observations to a minimum of one every two hours. She increased the frequency of quality conversations to a minimum of two per day. She added one action to the ACCT caremap: for Mr Faizi to complete applications for a job and to attend the prison gymnasium.
47. The mental health multidisciplinary team met on 14 February, and allocated Nurse A as Mr Faizi's keyworker. She assessed Mr Faizi later in the day. She recorded that his risk of self-harm was high and he said he was struggling and needed help.
48. On 15 February, Nurse A assessed Mr Faizi again. She noted that Mr Faizi said he was worried that he might face death if he was deported to Afghanistan, because he was gay and this was not accepted in the country. Mr Faizi also said he had thoughts of suicide. She reduced Mr Faizi's zone from red to amber. She told us that this was because his moods fluctuated and he did not present as suicidal that day.
49. On 20 February, a SO led an ACCT case review, with Nurse A and an interventions worker with Phoenix Futures. The SO recorded that Mr Faizi said he hated himself, had flashbacks to childhood events and was fearful of returning to Afghanistan. The nurse recorded that Mr Faizi said he heard voices telling him to kill himself. The SO made no change to the level of risk or observations.
50. The next day, a consultant psychiatrist discussed Mr Faizi's history, diagnosis and medication with Nurse A. The psychiatrist recorded that they would consider the frequency of reviews when Mr Faizi had begun purposeful activity.
51. On 22 February, Mr Faizi moved to a cell on the vulnerable prisoners' unit.
52. Prison staff held weekly ACCT case reviews over the next three weeks. A different supervising officer led each review. Two reviews had no one else present and none included a healthcare representative. The supervising officers each recorded similar themes: that Mr Faizi had no activities to keep him occupied and wanted something to do, and that he was struggling with his mental health. No one from the mental health team reviewed Mr Faizi during this period.
53. On 15 March, another prisoner stole some items from Mr Faizi's cell. Mr Faizi submitted a complaint form, requesting compensation for the theft of over 100 items. The wing manager replied that only two of these items were listed on Mr Faizi's property card. He offered £40 compensation to Mr Faizi (as an officer had mistakenly unlocked Mr Faizi's cell, allowing the prisoner the opportunity to enter it and take the items). Mr Faizi rejected the offer.
54. On 16 March, Nurse A reviewed Mr Faizi. She noted that he appeared calm and was socialising with other prisoners. She concluded that Mr Faizi was not at imminent risk.

55. The next day, Mr Faizi telephoned his solicitor and said he would kill himself. Mr Faizi's solicitor contacted Officer A, the prison's suicide prevention officer. A SO then led an ACCT case review, with Officer A, Officer B, and a mental health nurse. The SO recorded that Mr Faizi appeared very distressed and would not engage with the review. Officer B suggested that Mr Faizi was being bullied, and Mr Faizi said he felt scared. The SO increased Mr Faizi's risk to high, and increased observations to a minimum of one every 30 minutes.
56. Officer A told us that Officer B's comment about Mr Faizi being bullied related to the theft from his cell and comments the perpetrator had made to Mr Faizi. He said that no formal disciplinary action was taken against this prisoner, although he challenged the prisoner and warned him about his actions. The SO also said that he challenged the prisoner, and that there were no further incidents afterwards.
57. Nurse A then assessed Mr Faizi. She recorded that he appeared nervous and anxious and would not communicate with her. She increased Mr Faizi's zone from amber to red. All future entries in the medical record by members of the mental health team recorded that Mr Faizi was in the red zone. It does not appear that she updated Mr Faizi's zone on the board in the mental health team's office. The interim mental health team manager told us that Mr Faizi was listed as in the amber zone on the board.
58. On 18 March, a SO led an ACCT case review, with a wing officer also present. He recorded that Mr Faizi appeared better than the previous day, but said he was struggling with the voices he heard and hated his life due to the offence he had committed. The SO did not record Mr Faizi's level of risk and reduced the observations to a minimum of one every hour.
59. The SO told us that no one had been appointed as case manager until now and, because he had now led case reviews in successive days, he decided that he should take the role.
60. On 20 March, Mr Faizi's solicitor telephoned Pentonville and spoke to the duty manager. She recorded that Mr Faizi's solicitor said she was concerned about his mental health and did not think he was getting the support he needed. She noted that she had asked the mental health team to assess Mr Faizi.
61. On 21 March, Mr Faizi told wing staff that he had tried to hang himself overnight. He also made several cuts to his left forearm and chest. A SO led an ACCT case review, with Officer B, a nurse and an interventions worker with Phoenix Futures. Mr Faizi said that he was having flashbacks to his past, especially when he saw a particular officer who looked like a member of the Taliban who he said had murdered and raped members of his family. Mr Faizi also said he was upset about the theft from his cell. He said he hated his life and did not want to live. The nurse recorded in the medical record that Mr Faizi also related his distress to his upcoming immigration hearing. The SO recorded that Mr Faizi was at raised risk of suicide and self-harm and placed him on constant supervision (the highest level of monitoring, which means the prisoner must be watched at all times).
62. Later that day, Mr Faizi told a nurse that he felt overwhelmed by voices telling him to kill himself and wanted to end his life. Mr Faizi said he could manage the

voices better when engaged in activities but found it much more difficult when locked in his cell.

63. On 22 March, a manager led an ACCT case review, with a SO and Officer A. He recorded that Mr Faizi was very distressed and had punched himself in the head and butted his cell door. Mr Faizi said he was distressed because he had seen the constant supervision nurse rearranging his ACCT document and was concerned that sensitive information about his past might be mislaid.
64. Later that day, Nurse A assessed Mr Faizi. She recorded that he would not communicate with her other than shouting in his first language. She recorded that the SO told her that Mr Faizi had said he disliked her and did not want her to continue as his keyworker. She said she told the interim mental health team manager that Mr Faizi should be reallocated, but the manager said that she did not remember her speaking to her about this. No one from the mental health team reviewed Mr Faizi in the next three weeks.
65. In the evening, Mr Faizi cut his arm with a razor blade he had secreted. He also banged his head on the wall.
66. On 23 March, a manager led an ACCT case review, with a SO, Officer A and two nurses. Mr Faizi's solicitor also attended. Mr Faizi said he hated his life and wanted to die if he had the opportunity. He said he was stressed and struggling to cope with the flashbacks and voices he experienced.
67. On 26 March, Mr Faizi cut his arm. Afterwards, he handed a razor blade and broken pieces of plastic to an officer. A SO led an ACCT case review shortly afterwards with an officer. He recorded that Mr Faizi said he did not know why he had harmed himself.
68. The next day, the safer custody manager led an ACCT case review with a SO. She recorded that she had also received a verbal contribution from a prison nurse. She concluded that constant supervision was no longer required, as Mr Faizi had not made a serious attempt to harm himself in the previous days. She reduced ACCT observations to a minimum of one per hour. There was no further change to Mr Faizi's level of risk or observations for the remainder of his life.
69. Mr Faizi's immigration hearing, scheduled for 1 April, was postponed and rescheduled for 26 April.
70. On 3 April, a SO led an ACCT case review, with Officer A. Mr Faizi said he was still struggling with his past and would not give up trying to end his life. He said he had banged his head on the wall overnight and had cut his arm a few days earlier. Mr Faizi said he wanted something to do and asked about working off the wing. The SO recorded that Mr Faizi had recently not attended his education classes, as he said he did not like being in large groups of people. He told us that Mr Faizi did not like coming out of his cell or going to education because he did not like the noise made by groups of prisoners. He said he advised Mr Faizi to try coming out of his cell for short periods at a time or to go to education classes in order to build up his confidence. Despite this, he said that Mr Faizi mostly isolated himself in his cell.

71. On 5 April, the interim mental health team manager appointed an occupational therapist as Mr Faizi's new keyworker. She said she made the new appointment because Nurse A no longer worked at the prison, rather than in response to Mr Faizi's request for a new keyworker. She told us that she introduced the keyworker to Mr Faizi on 7 April, although there is no entry in the medical record or the ACCT to confirm this and the keyworker told us (and recorded contemporaneously) that his first meeting with Mr Faizi was on 12 April.
72. On 10 April, a SO led an ACCT case review, with a nurse. The nurse said she had started working at Pentonville a week earlier and this was the first ACCT case review she had attended. The SO recorded that Mr Faizi appeared a lot calmer and his personal appearance had improved, although he said he still heard voices telling him to harm himself. Mr Faizi also said he was scared to mix with other prisoners, as he did not like large groups.
73. The SO added three actions to the caremap: for Mr Faizi to engage with staff when he felt like talking, in order to help him begin to mix with others; to continue to work with the mental health team; and for the SO to contact the offender management unit about a transfer. He told us that he did not think Pentonville was a suitable prison for Mr Faizi, as his vulnerable prisoner status meant he was restricted in what he could do, which appeared to affect his state of mind. He thought a transfer to a prison with better facilities for vulnerable prisoners would be beneficial. He recorded that he had emailed the offender management unit and was awaiting a response. (Any prospective transfer would not be able to take place until after Mr Faizi's immigration hearing.)
74. On 12 April, Mr Faizi submitted a complaint form about a wing search the previous day. Every cell on the wing was searched, and Mr Faizi wrote that the officer who searched his cell had pushed him three times while doing so. Mr Faizi wrote that this made him feel stressed and nervous to the extent that he tried to suffocate himself overnight.
75. On the same day, the keyworker introduced himself to Mr Faizi. He recorded that Mr Faizi was in a low mood and expressed hopelessness, and that he was at high risk of suicide and self-harm.
76. The next week was quieter for Mr Faizi. On 17 April, he told an officer that he felt a lot better than previously. There was little other evidence of staff holding quality conversations with Mr Faizi.
77. On 19 April, a SO led an ACCT case review, with a nurse. Mr Faizi said he had banged his head on the wall recently, and he still wanted to die because of the voices and flashbacks he experienced. He again said he had not attended education or spent time with other prisoners recently because of his fear of large groups. The SO encouraged him to come out of his cell and to approach wing staff if he required help. He arranged the next ACCT case review for 26 April, so that it coincided with Mr Faizi's immigration hearing.
78. On the same day, a manager replied to Mr Faizi's complaint of a week earlier. He wrote that staff searched the whole wing and so everyone was affected equally. He did not mention Mr Faizi's complaint about the officer's actions. He told us that the officer did not normally work on F Wing and he did not therefore

pursue the matter further. He also said he did not remember seeing the line in the complaint form in which Mr Faizi said he had tried to suffocate himself.

79. Mr Faizi completed a form to appeal against the outcome, because the reply did not consider his complaint against the individual officer. It does not appear that he submitted this form and staff found it in his cell after his death.
80. On 24 April, a prison chaplain visited Mr Faizi. She recorded that Mr Faizi told her his life was not worth living and he “should not be on this earth”. Mr Faizi said he was terrified of being deported to Afghanistan as he thought his life would be ended there.
81. Later that day, an officer spoke to Mr Faizi, who said that he hated himself and wanted to die. He asked Mr Faizi how he intended to take his life, to which he answered “hanging”. Mr Faizi said he had banged his head 120 times the previous night (the officer said there was no sign of any injury) and he felt isolated and a risk to himself. The officer said that it was unusual for Mr Faizi to say so much and he thought that Mr Faizi seemed better by the end of the conversation for having “got some things off his chest”. He recorded Mr Faizi’s comments in the ACCT document.
82. On 25 April, the keyworker reviewed Mr Faizi, who said he had banged his head in his cell and that half his face now felt paralysed. The keyworker said there was no sign of any injury. Mr Faizi said his immigration hearing (scheduled for 26 April) had been postponed and he did not know when it would now be held. (It is not recorded when or by whom Mr Faizi was told that his hearing was postponed.)

26 April 2017

83. During the night of 25-26 April, Mr Faizi told the night officer that he heard voices telling him to bang his head on the walls. She said she spent around five minutes with Mr Faizi, during which time his mood improved.
84. At around 2.30pm, a SO led an ACCT case review, with the keyworker also present. The keyworker recorded that Mr Faizi spent a lot of time looking at the floor, and his speech was quiet and mumbled. Mr Faizi repeated his statement that he had banged his head 120 times, which he said he did to stop the voices. He said he had tried to kill himself the previous night by suffocating with a plastic bag, and that he hated himself and wanted to die. The SO recorded that Mr Faizi said he found it hard to deal with the stress of his immigration hearing. He said he was not aware of the conversation Mr Faizi had had with an officer and did not therefore discuss this. The SO removed all plastic bags from Mr Faizi’s cell. He made no change to the level of risk or observations. He told us that his understanding at the time was that if he felt observations should be more frequent than one per hour then the next step was constant supervision, which he did not think Mr Faizi required.

Emergency response

85. At around midnight, Mr Faizi told the night officer that he felt low and felt bad about his offence and his victim. She said that Mr Faizi had said similar things before and he did not say anything that was unusual for him.

86. At around 3.50am, the night officer went to Mr Faizi's cell to complete an ACCT observation. She saw Mr Faizi sitting at the back of the cell. She said she called to Mr Faizi and banged on the cell door, but Mr Faizi did not respond. She said she then saw a thin strip of material from Mr Faizi's neck to the window. She radioed a code blue medical emergency, indicating a life-threatening situation. The control room operator recorded this call at 3.53am.
87. At night, officers have a cell key in a sealed pouch for use in an emergency. The night officer said that Officer C arrived around 20 to 30 seconds after she made her radio call, and opened Mr Faizi's cell as she was about to break her pouch. Officer C also thought it took him around 30 seconds to reach Mr Faizi's cell, and that he opened the door immediately. A nurse, who was on F Wing at the time, said that she waited around two to three minutes outside the cell before an officer arrived to open it.
88. Officer C opened the cell and found Mr Faizi hanging from a ligature made from a bed sheet that he had tied to the mesh outside his window. He cut the ligature and the nurse began cardiopulmonary resuscitation, supported by a colleague who arrived shortly afterwards. The nurse asked for an ambulance. Ambulance service records show that they received a call at 3.56am.
89. The nurses attached a defibrillator, which found no shockable heart rhythm. They continued chest compressions until paramedics arrived at around 4.11am. At around 4.41am, the paramedics confirmed that Mr Faizi had died.

Contact with Mr Faizi's family

90. Mr Faizi did not name any next of kin and prison staff could not trace any of his family after his death. Pentonville contributed to the cost of Mr Faizi's funeral in line with Prison Service instructions.

Support for prisoners and staff

91. After Mr Faizi's death, a senior 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 Deputy Head of Healthcare debriefed the clinical staff. The staff care team also offered support.
92. The prison posted notices informing other prisoners of Mr Faizi'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 Faizi's death.

Post-mortem report

93. A post-mortem examination established the cause of death as suspension by ligature.

Findings

Management of risk of suicide and self-harm

94. Prison staff appropriately began ACCT procedures when Mr Faizi arrived at Pentonville. While some positive, supportive actions were taken, such as inviting his solicitor to a case review, we are concerned that the ACCT procedures were poorly managed and were not in line with Prison Service policy. While this might not have affected the eventual outcome, it would have given prison managers and staff a better chance of producing a co-ordinated and effective care plan, aimed at addressing his issues and reducing his risk.

Attendance at ACCT case reviews

95. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It requires ACCT case reviews to be multidisciplinary where possible and says that, for the first case review, a healthcare representative must attend. No one from the healthcare team attended the first case review. We are concerned that there was no healthcare representative at more than half of Mr Faizi's case reviews (including some when he was constantly supervised, when healthcare attendance is mandatory at case reviews held within the first 72 hours), particularly in light of his mental health issues and apparent isolation.
96. Both the keyworker and a mental health nurse, who between them attended Mr Faizi's final three ACCT case reviews, were new to the prison and neither had received formal training in ACCT procedures. PSI 64/2011 requires that all staff in contact with prisoners receive this training.

Caremap

97. A caremap must be completed at the first case review for all prisoners subject to ACCT monitoring. PSI 64/2011 says that the caremap should reflect the prisoner's needs, the triggers of their distress, and must aim to address the issues identified at the assessment interview. The caremap should set time bounded actions and be aimed at reducing the risk the prisoner presents to themselves. Mr Faizi's caremap contained no effective plan to support him through what appeared to be the most significant aspect of his distress – his potential deportation to Afghanistan – and no one referred him to the Home Office immigration staff embedded in Pentonville
98. While staff recognised that Mr Faizi largely isolated himself and did not engage with activities, no one we spoke to recognised how different this was to his behaviour at Bure. We appreciate that staff encouraged Mr Faizi to engage, but there was little involvement from multidisciplinary agencies to address the reasons for his isolation and create an effective plan to address them. We are not satisfied that this was properly addressed through the ACCT plan and caremap.

Appointment of case manager

99. PSI 64/2011 instructs that a case manager be appointed at the first case review. A SO was named as case manager on the front cover of the ACCT plan, but did not have any contact with Mr Faizi until nearly three weeks after ACCT monitoring began. He told us he was never formally given the role of case manager and appointed himself to the role when he led case reviews on consecutive days. This was over a month after ACCT procedures were opened. The lack of case manager is likely to have contributed to the lack of care planning, particularly in the first weeks after ACCT procedures were opened.

Completing and recording observations and conversations

100. PSI 64/2011 states that staff must follow the level of observations and conversations stated on the ACCT document and must record these immediately or as soon as is practical. It also states that staff must actively engage with the prisoner, encouraging them to talk and participate in activities where appropriate.
101. There is no evidence that wing staff held good quality conversations with Mr Faizi at the required frequency, and most of their interaction with him was brief. Mr Faizi spent much of his time at Pentonville isolated in his cell, and he did not have any visits or telephone calls to family or friends. In these circumstances, it is particularly important that staff try to engage with a vulnerable and suicidal man.

Assessing risk of suicide and self-harm

102. At an ACCT case review on 26 April, around 12 hours before his death, Mr Faizi said he had tried to kill himself the night before and that he wanted to die. The SO said he was not aware of Mr Faizi's recent conversation with an officer – in which he said he intended to hang himself – despite this being recorded in the ACCT document. He made no change to the level of risk or observations (meaning that he judged the risk to be raised and set a minimum of one observation per hour).
103. Guidance in the ACCT document is that risk is high when a prisoner has frequent suicidal ideas that are not easily dismissed, there is a specific plan with likely access to lethal means, there is evidence of acute or ongoing mental illness and there is an escalating pattern of self-harm. Mr Faizi had other risk factors for suicide and self-harm. He was evidently concerned by the uncertainty surrounding his immigration status and the hearing cancelled that day, as well as his lack of progress in his indeterminate sentence for public protection. We consider that the SO should have assessed Mr Faizi's risk of suicide and self-harm as high at the case review on 26 April, and increased the frequency of observations.
104. The SO told us that one reason he did not increase the frequency of observations was because he understood at the time that he should initiate constant supervision if he thought one observation per hour was insufficient. He said he did not think Mr Faizi required constant supervision. Officer A, the suicide prevention coordinator, also said that this was his understanding of local procedures for setting ACCT observations. The Head of Safer Prisons told us

that there is no prohibition on setting ACCT observations, and both the SO and Officer A told us that they now understand that options more frequent than one observation per hour are available.

105. In a PPO Learning Lessons Bulletin, published in March 2015, about the self-inflicted deaths of prisoners in 2013-14, we found that staff should ensure that prisoners at risk of suicide and self-harm are managed in line with national instructions and guidance. We found that this should include holding multidisciplinary case reviews, completing relevant caremap objectives, ensuring observations follow the prescribed level, and ensuring that all staff receive training and are confident in the ACCT procedures.
106. Our findings echo those of previous investigations at Pentonville, notably that following the death of a prisoner in March 2017 in which we found that ACCT case reviews were not multidisciplinary, a case manager was not assigned, caremap actions were not aimed at reducing risk, and information indicating increased risk was not always considered. In our report following this death, we highlighted our concern at repeatedly making similar recommendations about the ACCT process. We recommended that the Prisons Group Director for London and Thames Valley should commission a review of the operation and management of the ACCT process at Pentonville. As we very recently issued this report, and await the response, we do not repeat the recommendation. We make the following recommendation to reflect our findings in our investigation into Mr Faizi's death:

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

- **ACCT case reviews are multidisciplinary and include all relevant people involved in the prisoner's care, including healthcare staff, where relevant.**
- **ACCT caremap actions are specific and meaningful, and identify all of the issues identified at assessment interviews and case reviews.**
- **Case reviews consider all relevant information that affects risk, and staff review the risk of suicide and self-harm and frequency of observations whenever an event occurs which indicates an increase in risk.**
- **Conversations are carried out as directed and documented in the ongoing record.**
- **All staff in contact with prisoners are trained in ACCT procedures.**

Clinical care

107. The clinical reviewer highlighted numerous failings in Mr Faizi's clinical management at Pentonville. She found serious omissions to observe Mr Faizi and raise concerns, and to comply with accepted standards. She concluded that the care Mr Faizi received was not equivalent to that which he could have expected to receive in the community. We urge the Head of Healthcare at Pentonville and the Clinical Director at Barnet, Enfield and Haringey Mental Health Trust to review her report and act on her numerous recommendations.

Allocation of appropriate keyworker and zoning

108. Mr Faizi was allocated a keyworker, Nurse A, on 14 February. She concluded that Mr Faizi was in the amber zone, meaning he should be reviewed weekly, but no one from the mental health team saw him from 15 February until 16 March.
109. Nurse A then appropriately increased Mr Faizi's zone to red, meaning he was at immediate risk of suicide and should be reviewed every day. However, she did not update the board in the mental health team's office of this important change and no one else, including the manager, seemingly knew of the change at the time. There was no recognition of Mr Faizi's increased risk and no one discussed Mr Faizi with a psychiatrist. The clinical reviewer concluded there was no effective clinical escalation of Mr Faizi's increased risk and changing behaviour.
110. Despite his being in the red zone, mental health professionals continued to review Mr Faizi very infrequently. As well as the confusion about his zone, this was partly due to Nurse A's apparent failure to inform the manager that Mr Faizi no longer wished to work with her. This meant that she stopped seeing Mr Faizi on 22 March, but no one else reviewed him until 12 April, three weeks later.
111. A new keyworker was appointed on 5 April because Nurse A no longer worked at the prison. He acknowledged that Mr Faizi was in the red zone, but reviewed him once per week. He is an occupational therapist rather than a mental health nurse. He had very recently started working at Pentonville and had not received some significant training, including in ACCT procedures. The clinical reviewer considered that managers incorrectly assumed that his experience as an occupational therapist meant he had competence in other areas of mental health care. At the same time, Mr Faizi's allocation to him was made on the assumption that he was in the amber zone and without reviewing his records, so his risk was underestimated. The clinical reviewer concluded that the manager did not take sufficient steps to evaluate Mr Faizi's situation at the time. While we appreciate that the mental health team was significantly understaffed at the time, we are not satisfied that the allocation to the keyworker was appropriate. We make the following recommendation:

The Head of Healthcare should ensure that the mental health team is adequately resourced to provide a level of service equivalent to that which prisoners could expect to receive in the community, including that:

- **Staff understand the zoning system and its requirements, including that they review prisoners in the red zone daily, share decisions to move prisoners into or out of the red zone with the service manager, and obtain psychiatric input, when necessary.**
- **Staff from different clinical backgrounds are competent to deliver a basic level of service.**
- **The allocation of keyworkers reflects the needs of the prisoner and the skills and experience of the member of staff.**

Response to complaint form

112. Mr Faizi submitted a complaint form on 22 April, which said that an officer who had searched his cell the previous day had pushed him three times. A manager replied to the complaint a week later, but did not address Mr Faizi's specific complaint about the officer and did not speak to the officer in question or any of the other staff who conducted the search. He also said he did not see the line on the form in which Mr Faizi said he had tried to suffocate himself in the aftermath of the cell search.
113. PSI 02/2012 on prisoner complaints, says that complaint responses must address the issues raised and must be answered by someone capable of providing an adequate and meaningful reply. We are not satisfied that the manager properly addressed the serious issues that Mr Faizi raised. We make the following recommendation:

The Governor should ensure that staff respond to complaints in line with national guidelines, including that they address all of the issues raised in the complaint.

Emergency response

Opening Mr Faizi's cell

114. At night, officers have a key in a sealed pouch for use in an emergency. Prison Service Instruction 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then 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. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.
115. It is unclear how quickly staff opened Mr Faizi's cell when they found him hanging. Two officers thought it was within 30 seconds of the night officer's call for assistance. The nurse (who does not carry a cell key) said that she waited for two to three minutes before someone came to open the cell. Without the benefit of CCTV, we cannot be certain about what happened.
116. We recognise that it can be difficult for staff in such situations to make instant decisions, but when there is a potentially life-threatening situation, it is essential to act quickly. The night officer could see that Mr Faizi was hanging by a ligature and, in the circumstances, we would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life.

Calling an ambulance

117. PSI 03/2013 on Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the

relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.

118. The night officer radioed a code blue medical emergency at 3.53am, but the control room did not call an ambulance until 3.56am.
119. We cannot say whether any of these delays affected on the outcome for Mr Faizi. Nevertheless, it is important that prison staff understand their roles in a medical emergency as early intervention when someone is found hanging might save their life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **Night staff enter cells as quickly as possible in a life-threatening situation.**
- **Control room staff request an ambulance as soon as an emergency code is called.**

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