

Action Plan – Mr Ezra Tamiem at HMP Bedford – Self-Inflicted Death on 15/07/2020

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> • A case manager is appointed at the first case review, who should lead all subsequent case reviews whenever possible. • All triggers are considered when determining the level of risk of suicide and self-harm. • Observations are carried out as directed and documented in the ongoing record, and that staff satisfy themselves that the prisoner is alive and well at each observation. 	Accepted	<p>A single case management process was introduced in August 2020 to ensure a dedicated case manager leads the first and all subsequent case reviews. This is monitored by the Head of Safety for compliance. To further support this process, additional staff will be trained in the role to ensure that there are sufficient case managers available at all times. This training will commence when the current COVID-19 restrictions allow.</p> <p>A quality assurance (QA) process was introduced in February 2021 to ensure that all triggers are considered when determining the level of risk and progress will be monitored and discussed at the monthly Safety Committee and SMT meetings. Any actions will then be discussed with the case manager.</p> <p>Further QA checks of all ACCT documents were also introduced and are now completed daily by senior managers to ensure that observations have been carried out as required, all interactions are documented appropriately and staff have assured themselves that the resident is alive and well.</p> <p>A notice to staff was sent in February 2021 as a reminder of the requirements of conducting ACCT observations, including the need to ensure that both movement and breathing are seen and that this is correctly documented.</p> <p>Staff are also reminded of all ACCT requirements during the fortnightly Suicide and Self-harm (SASH) training which commenced in February 2021 and is accessible to both prison and healthcare staff. Staff are routinely reminded during the SASH training of the importance of considering all triggers when determining the level of risk and of the requirements for observations.</p>	Completed Head of Safety Head of Healthcare

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2	The Governor and Head of Healthcare should inform the Ombudsman of the findings of the internal investigation into the events of 14-15 July, and of any action taken as a result, by 31 March 2021.	Accepted	The Head of Healthcare will write to inform the Ombudsman of the findings following the internal investigation into the events of 14-15 July, and the actions that were taken as a result by the 31 March 2021.	31 March 2021 Head of Healthcare