Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ezra Tamiem, a prisoner at HMP Bedford, on 15 July 2020

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.

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 Ezra Tamiem was found hanged in his cell at HMP Bedford on 15 July 2020. He was 39 years old. I offer my condolences to his family and friends.

Mr Tamiem was a troubled man who appeared to be in crisis when he arrived at Bedford. Prison staff appropriately started Prison Service suicide and self-harm prevention procedures and several aspects of his management were positive. However, there was no consistent case management and the assigned case manager only attended a third of Mr Tamiem's case reviews. I am also concerned that prison staff did not identify the potential triggers for suicide and self-harm which Mr Tamiem presented in the last two weeks of his life.

On the night of his death, prison nurses did not complete the required number of observations, and the prison officer who observed Mr Tamiem in the morning (when it is possible that Mr Tamiem was already hanging in the cell) did not take sufficient time to satisfy himself that Mr Tamiem was alive and well.

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 **March 2021**

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Summary

Events

1. On 4 May 2020, Mr Ezra Tamiem was remanded in custody to HMP Bedford, charged with the attempted murder of his wife. Prison staff recorded that he was disoriented, confused, and struggled to answer basic questions. They started Prison Service suicide and self-harm prevention procedures (known as ACCT) and placed Mr Tamiem under constant supervision (meaning that he was placed in a special cell and a member of staff watched him constantly). The ACCT procedures remained open throughout the rest of Mr Tamiem's life.

2. On 6 May, Mr Tamiem was moved into a cell in the healthcare inpatient unit. He said he heard voices and experienced hallucinations. A psychiatrist prescribed antipsychotic medication. By 14 May, Mr Tamiem had begun to engage more and prison staff stopped the constant supervision. Over the following weeks, they recorded that he continued to settle and engage well.

3. On 12 June, an operational manager reinstated constant supervision after staff identified an apparent ligature mark around Mr Tamiem's neck. He was reportedly confused and did not engage much. Three days later, prison staff stopped the constant supervision as Mr Tamiem's wellbeing and engagement had improved.

4. By 1 July, the ACCT observations had reduced to a minimum of four per night, and staff recorded that Mr Tamiem had improved slowly but noticeably and had settled into a daily routine. Over the following two weeks, staff recorded that he struggled to pass the time and spent much of the day sitting in the dark staring at his cupboard.

5. On the night of 14-15 July, the night nurses did not complete the required four ACCT observations and recorded some observations that did not happen. At around 7.30am, an officer completed an ACCT observation but did not appropriately satisfy himself that Mr Tamiem was alive and well. Around 20 minutes later, staff found Mr Tamiem hanged. Shortly afterwards, paramedics confirmed that he had died.

Findings

6. Prison staff took some positive, supportive actions to help Mr Tamiem. Constant supervision was used appropriately in times of crisis. The ACCT case reviews were multidisciplinary and had good input from the mental health team, as well as senior managers and clinicians, when appropriate.

7. However, there was no consistent case management. The ACCT case manager attended only a third of all case reviews and just one of the last six.

8. In addition, no one considered whether Mr Tamiem's more withdrawn behaviour in the last two weeks of his life might indicate that his risk of suicide or self-harm had increased, particularly as this was recorded in the ACCT document as a potential trigger.

9. ACCT observations were not properly completed on the night of Mr Tamiem's death, and seemingly false entries were made in his ongoing record.

Recommendations

- 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:
    - 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.
- 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.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Bedford informing them of the investigation and asking anyone with relevant information to contact him. No one responded. The investigator obtained copies of relevant extracts from Mr Tamiem's prison and medical records.

11. The investigator interviewed nine members of staff in September 2020. (We were unable to interview the Head of Safety, who chaired most of the ACCT case reviews when Mr Tamiem was constantly supervised, as he was absent from work on sick leave during our investigation.)

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

13. All the interviews were conducted by Microsoft Teams or by telephone because of the restrictions in place in response to the COVID-19 pandemic.

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

15. The Ombudsman's family liaison officer contacted Mr Tamiem's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not ask any specific questions.

16. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies. Their action plan is annexed to this report.

17. We also shared the initial report with Mr Tamiem's mother. She did not make any comments.

Background Information

HMP Bedford

18. HMP Bedford is a local prison holding around 500 men. Northants Healthcare NHS Foundation Trust provides all healthcare services. There is an inpatient unit with nine single cells and a four-bed dormitory.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Bedford was in August to September 2018. Inspectors reported that the number of incidents of self-harm had increased substantially since their last inspection (in 2016) and was higher than in comparable prisons. There had also been five self-inflicted deaths since the last inspection in 2016. Inspectors also reported that ACCT processes were weak, including that some care plans failed to address issues of concern.

20. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State on 12 September 2018, setting out his significant concerns about the treatment of prisoners, including the management of prisoners at risk of suicide or self-harm.

21. In August 2019, HMIP carried out an Independent Review of Progress which followed up 13 of the 61 recommendations they had made after their 2018 inspection. Inspectors found that there had been no meaningful progress in the support of prisoners at risk of suicide or self-harm, and that the number of incidents of self-harm had increased dramatically. They found that ACCT caremaps were not used effectively and there were not enough ACCT case managers.

Independent Monitoring Board

22. 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 June 2019, the IMB reported that levels of self-harm were among the highest in the country.

Previous deaths at HMP Bedford

23. Mr Tamiem is the fourth prisoner to die at Bedford since July 2018, and the second to take his own life. We have not yet issued our report into the previous self-inflicted death.

Assessment, Care in Custody and Teamwork

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

25. 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. 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

26. On 4 May 2020, Mr Ezra Tamiem was remanded in custody to HMP Bedford, charged with the attempted murder of his wife.

27. A nurse started ACCT procedures when Mr Tamiem arrived at Bedford. She recorded that Mr Tamiem's behaviour was unusual and that he said he believed he was "full of poison". Mr Tamiem struggled to answer basic questions about his address and date of birth and the nurse recorded that he was disoriented and confused. Mr Tamiem said that he had previously thought of suicide and self-harm but had no current plans to act on these thoughts and that he had not harmed himself in the past. The duty manager authorised that staff should constantly supervise Mr Tamiem (meaning he was placed in a special cell with a barred gate instead of a door and a member of staff sat outside observing him for 24 hours a day to ensure he did not self-harm). The nurse also referred him to the mental health team.

28. An officer then interviewed Mr Tamiem for the ACCT procedures. He recorded that Mr Tamiem said that his wife had been "drugging him". The officer noted that there were "widespread concerns" about Mr Tamiem's mental state and that Mr Tamiem was convinced that he would die in the next 48 hours, even though he said he had no thoughts of suicide.

29. On 5 May, the Head of Safety chaired the first ACCT case review. Others present included the visiting psychiatrist and a nurse of the mental health team. The Head of Safety recorded that Mr Tamiem behaved bizarrely throughout the review. He recorded that Mr Tamiem had had little sleep and agreed to take medication to help. The Head of Safety added two items to the caremap: firstly, for sleeping tablets to be prescribed and, secondly, for the mental health team to provide ongoing support.

30. The psychiatrist recorded that Mr Tamiem said he had not slept for 12 days, and that he appeared paranoid and blamed his wife for all of his problems, believing that she was listening to him all the time and had given him tablets to prevent him from sleeping. The visiting psychiatrist told us that Mr Tamiem presented with symptoms of a lack of sleep and extreme distress due to trauma. He prescribed a short course of diazepam to help Mr Tamiem sleep.

31. On 6 May, an operational manager chaired an ACCT case review. A prison psychologist was also present. The prison psychologist recorded that Mr Tamiem reported hearing voices, appeared to be in crisis and was very vulnerable. She concluded that he was still at high risk and that constant supervision should continue.

32. The prison psychologist recorded that Mr Tamiem was responding to unseen stimuli and appeared acutely unwell. Managers and healthcare staff agreed that Mr Tamiem should move to a cell in the healthcare inpatient unit for further assessment and monitoring. He moved cells later that day.

33. A Custodial Manager (CM) was appointed as the ACCT case manager. On 7 May and on 8 May, he chaired case reviews and recorded each time that Mr Tamiem was not well enough to have a conversation or answer questions.

34. By 10 May, Mr Tamiem was able to engage more in case reviews. The prison psychologist recorded that he said he had trouble telling the difference between what was real and what was not. He did not report further hallucinations but believed that he had been tortured on a television game show and that his food and drink had been "spiked" in police custody.

35. Over the following days, staff recorded that Mr Tamiem was a little better after having some sleep, but still appeared distressed and confused.

36. On 12 May, the visiting psychiatrist, reviewed Mr Tamiem. He recorded that Mr Tamiem had improved since being prescribed diazepam, although there were signs of pseudo hallucinatory experiences (meaning hallucinations that the patient recognises are not real). The visiting psychiatrist stopped diazepam due to the risk of Mr Tamiem becoming dependent on it. He prescribed a small dose of quetiapine (antipsychotic medication), which he recorded was to help with anxiety, lack of sleep, and the psychotic features associated with Mr Tamiem's stress. The psychiatrist us that Mr Tamiem appeared much better and was able to hold a conversation. He said that he thought Mr Tamiem was experiencing an adjustment disorder because of the significant changes in his life at the time.

37. On 14 May, the Head of Safety chaired an ACCT case review, with a CM and a nurse. The nurse recorded that Mr Tamiem engaged with them and appeared more settled. The panel concluded that Mr Tamiem's risk of suicide and self-harm was now low. They reduced his observations to a minimum of four per hour, with quality conversations to be held in the morning and afternoon.

38. In the following weeks, prison and healthcare staff recorded that Mr Tamiem continued to settle and engage well. His ACCT observations were reduced to a minimum of one per hour.

39. On 12 June, staff saw a red mark around Mr Tamiem's neck and thought that he might have attempted to hang himself during the night. Mr Tamiem denied this. The Head of Safety chaired an ACCT case review the same day. He recorded that Mr Tamiem was confused and did not engage much. The panel concluded that Mr Tamiem was again at high risk of suicide or self-harm and reinstated constant supervision.

40. On 13 June, the Head of Safety chaired an ACCT case review, with the CM and the nurse. He recorded that Mr Tamiem appeared very low in mood and did not engage much. The nurse recorded that Mr Tamiem denied having tied a ligature or having any thoughts of ending his life but did not appear convincing. The panel concluded that he was still at high risk of suicide or self-harm and should remain constantly supervised.

41. On 15 June, the Head of Safety chaired an ACCT case review, with the prison psychologist and nurse. He recorded that Mr Tamiem's wellbeing and communication had improved, and that Mr Tamiem agreed that he felt better and no longer suicidal. The nurse recorded that Mr Tamiem said he had heard voices, including one that told him to tie a ligature and "do myself in". Mr Tamiem said he did not want to take his life but had been hallucinating. The prison psychologist told us that Mr Tamiem said he found things more difficult during the night.

42. The panel discussed potential triggers for suicide or self-harm, including sleep deprivation, hearing voices, and distanced and withdrawn behaviour, which the Head of Safety recorded in the relevant section of the ACCT document. He recorded that Mr Tamiem's risk of suicide and self-harm was now low. The panel reduced the level of observations to a minimum of four per hour during the day and constant supervision at night.

43. On 19 June, a CM chaired an ACCT case review, with another CM and the prison psychologist. He recorded that Mr Tamiem engaged very well and spoke at length about how he was feeling. The prison psychologist recorded that Mr Tamiem was more lucid than she had seen him before. He told her that he had not meant to tie a ligature on 12 June but was using the blanket to try to block out the voices he heard. The panel reduced the level of observations to a minimum of four per hour throughout the day and night.

44. Over the following week, staff recorded at ACCT case reviews and in general conversation that Mr Tamiem was more engaged and was participating in activities to keep himself occupied.

45. On 23 June, the psychiatrist reviewed Mr Tamiem. He recorded that Mr Tamiem said that he was sleeping better and felt "okay" with his medication. Mr Tamiem described hearing voices all the time and said that they were more intense on the day he had tied a ligature around his neck. The psychiatrist told us that Mr Tamiem was very coherent and stable and that he said that the voices were vague and "in the background". He recorded his conclusion that there was no evidence to suggest psychosis and that Mr Tamiem's initial presentation was mostly due to sleep deprivation. The psychiatrist told us that there was no indication that Mr Tamiem had a mental illness (including severe depression, psychosis or paranoia) that might cause him to harm himself. However, he recorded that Mr Tamiem remained at high risk. He told us that this related to his social circumstances (meaning his imprisonment and associated significant life changes) and that this might increase when his case went to trial. (No date had yet been set for Mr Tamiem's trial.)

46. On 1 July, the case manager chaired an ACCT case review, with a nurse. This was the only case review (out of six in total) in the last month of Mr Tamiem's life that the case manager attended. He told us that he could not remember the specific reasons why he did not attend more of these case reviews and thought it might have been because he was assigned other operational duties or they were held on days he was not working. The case manager also said that as Mr Tamiem became more settled and his needs less complex, it was more likely that his case reviews would be assigned to whichever custodial manager or supervising officer was available.

47. At the case review, the case manager recorded that there had been a slow but noticeable improvement in the last two weeks. Mr Tamiem said that he felt better and was able to think more clearly, although he was missing his family. He said that he no longer had any issues sleeping. The case manager told us that Mr Tamiem now gave a "consistent impression that he was doing all right" and had settled into a daily routine, including telephoning his family and going out for exercise. He recorded that Mr Tamiem was at low risk of suicide or self-harm.

He reduced the level of observations to four during the night (none during the day) and that staff should hold quality conversations with Mr Tamiem in the morning, afternoon and evening.

48. On 3 July, an officer spoke to Mr Tamiem and recorded that he said he was bored and struggled to pass the time. Mr Tamiem said that he did not feel that he wanted to harm himself.

49. On 6 July, a prison GP reviewed Mr Tamiem. She recorded that he said he was “up and down” but the quetiapine prescription had helped with the voices and hallucinations. The prison GP recorded that Mr Tamiem had no thoughts of suicide or self-harm.

50. On 7 July, an officer recorded that Mr Tamiem said that he was lacking energy and that he did not appear to want to make conversation. He recorded that Mr Tamiem kept his curtains closed all day and just stared at his cupboard.

51. On 8 July, a CM chaired an ACCT case review, with a nurse. Neither had attended any of Mr Tamiem’s previous case reviews, and the CM told us that she had never met Mr Tamiem before the review. The CM recorded that Mr Tamiem was very quiet and subdued and said he still had thoughts of self-harm but was “managing” them. Mr Tamiem said it was “overwhelming” to think of what came after his remand. The CM recorded that he required purposeful activity. She made no change to the level of risk or observations.

52. On 11 July, a nurse reviewed Mr Tamiem. He recorded that Mr Tamiem said he had no new issues, but said his sleep was still “erratic”. Mr Tamiem said that he was still seeing and hearing things, which was worse with poor sleep. Mr Tamiem said that he was distressed when he hallucinated. The nurse recorded that Mr Tamiem appeared settled at the time and that there was no indication of increased risk of suicide or self-harm.

53. The nurse told us that there was some discussion among his colleagues about Mr Tamiem’s motivation when he spoke about hearing voices at this stage. He said that, while there was indication that Mr Tamiem had heard voices or experienced hallucinations, he might have had other motives when he spoke about such events as he was keen to ensure that his solicitor was made aware of his experiences.

54. On 13 July, the prison GP reviewed Mr Tamiem. She recorded that he said he had not slept well and said he was “up and down”. The prison GP recorded that there was no evidence that Mr Tamiem was responding to hallucinations or voices and that he had no thoughts of suicide or self-harm. She recorded that she encouraged Mr Tamiem to take part in activities and interact with others. The prison GP prescribed medication to help Mr Tamiem sleep.

14 to 15 July 2020

55. On the morning of 14 July, an officer recorded that Mr Tamiem said that he felt good and had no concerns to raise. A member of the chaplaincy team visited Mr Tamiem and recorded that he sounded “a lot more positive”.

56. During the day, Mr Tamiem made a telephone call, had a shower and socialised outdoors with other prisoners.

57. Two nurses were on duty overnight. At 9.11pm, CCTV footage shows that one of the nurses completed an ACCT observation. She recorded that Mr Tamiem was lying on his bed and did not raise any issues.

58. At 11.00pm, the nurse recorded in the ACCT document that Mr Tamiem appeared asleep. CCTV shows that no one visited his cell at this time.

59. At 12.16am, the second nurse pressed the cell call bell at Mr Tamiem’s cell, but did not look in. (This was for a process known as ‘pegging’, whereby the staff record an electronic footprint around the unit to show that they have patrolled a number of times.)

60. At 2.05am, the second nurse recorded that Mr Tamiem appeared asleep. CCTV shows that no one visited his cell at this time.

61. At 2.45am, the second nurse looked in Mr Tamiem’s cell for around 19 seconds. She did not make an entry in the ACCT document. The second nurse told us that she accidentally woke Mr Tamiem and he responded to her.

62. At 3.33am and at 4.39am, the first nurse pressed the cell call bell at Mr Tamiem’s cell but did not look into the cell.

63. At 5.43am, the first nurse conducted an ACCT observation (and pressed the cell call button). She recorded that Mr Tamiem appeared asleep.

64. At 7.25am, the first nurse recorded in the ACCT record that Mr Tamiem appeared asleep. CCTV shows that no one went to his cell at this time.

65. At 7.28am, an officer (who had just started his shift) completed a count of prisoners. He looked in Mr Tamiem’s cell for around four seconds. The officer recorded that Mr Tamiem was lying on his right-hand side and appeared asleep. He wrote that it was “difficult to note movement due to bed covers covering whole body”. The officer told us that he did not see Mr Tamiem move and could not see any part of his body because of the covers. He said that he believed that Mr Tamiem was asleep.

Emergency response

66. At 7.52am, a nurse went to Mr Tamiem’s cell to administer his medication. In a statement, the nurse recorded that Mr Tamiem appeared to be lying on his bed under a blanket. She called to him and knocked on the door, but there was no response. The nurse therefore asked the officer to unlock the door.

67. At 7.53am, the officer unlocked and tried to open the door but found that Mr Tamiem had created a barricade. When the door was ajar, the nurse saw Mr

Tamiem hanging from a ligature in the corner of the cell. She radioed a medical emergency code blue. The control room operator telephoned for an ambulance immediately. The officer continued trying to push the door open.

68. At 7.54am, the officer arrived with an anti-barricade key (a key that allows a cell door to be quickly removed from its hinges) and opened the cell. He cut the ligature from Mr Tamiem's neck and a nurse began cardiopulmonary resuscitation. The nurse attached a defibrillator, which indicated he should continue with chest compressions. Paramedics arrived shortly afterwards. At 8.06am, they confirmed that Mr Tamiem had died.

Contact with Mr Tamiem's family

69. A prison family liaison officer (FLO), telephoned Mr Tamiem's mother and informed her of his death. (Family liaison officers would normally break the news of a death in person but were instructed to do so by telephone during the COVID-19 pandemic.)

70. Bedford contributed to the costs of Mr Tamiem's funeral in line with Prison Service instructions.

Support for prisoners and staff

71. After Mr Tamiem's death, the Governor 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.

72. The prison posted notices informing other prisoners of Mr Tamiem's death and offering support.

Post-mortem report

73. A post-mortem examination established that the cause of death was asphyxiation due to hanging.

Findings

Management of risk of suicide and self-harm

74. Prison staff appropriately started ACCT procedures when Mr Tamiem was remanded to Bedford. It is apparent that many staff knew him well and some positive, supportive actions were taken. Constant supervision was used appropriately in times of crisis. The ACCT case reviews were multidisciplinary and had good input from the mental health team. Senior managers and clinicians were involved in ACCT case management, particularly when constant supervision was in place.

75. However, while there is much that was positive about Mr Tamiem's management, some of the ACCT procedures were poorly managed and not in line with Prison Service policy.

Case management

76. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It instructs that a case manager must be appointed at the first case review. The case manager should lead all case reviews, where possible, to promote consistency in managing the ACCT plan, assessing risk and care planning.

77. No one was named as case manager on the front cover of the ACCT document. A CM told us that he was the case manager, but he only chaired five case reviews out of the 21 held and only one of the six case reviews held in the last month of Mr Tamiem's life. (He also attended two other case reviews chaired by senior managers.) The final case review was chaired by a custodial manager who had never previously met Mr Tamiem and attended by a nurse who had no previous recorded contact with him.

78. The case manager said that he was unsure why he did not attend more case reviews in the latter stages of Mr Tamiem's life. He thought it was a combination of being assigned other duties, reviews being held on days he was not working and assigning case reviews to other staff as Mr Tamiem's needs appeared to settle.

Identification of triggers

79. Prison staff are required to record any potential triggers for suicide or self-harm on the inside cover of the ACCT document. The document instructs that these triggers should be considered at each case review. PSI 64/2011 also instructs that when an ACCT trigger is activated, a case review must be held.

80. Prison staff recorded six triggers in the ACCT document. This included sleep deprivation, hearing voices, and distanced and withdrawn behaviour.

81. In the last two weeks of his life, staff made several entries indicating that Mr Tamiem was becoming more withdrawn. An officer, for example, recorded that Mr Tamiem kept his curtains closed all day and just stared at his cabinet. Mr Tamiem also said that his sleep was erratic and that his hallucinations were worse with poor sleep. All of these factors match the triggers for suicide or self-

harm recorded in the ACCT document, yet there is no evidence that anyone recognised that Mr Tamiem's risk might have increased.

Completing and recording observations

82. PSI 64/2011 states that staff must follow the level of observations stated on the ACCT document and must record these immediately or as soon as is practical. Mr Tamiem should have been observed a minimum of four times during the night of 14-15 July, but the night staff only completed three observations. A nurse made five entries in the ACCT ongoing record, at least two of which related to ACCT observations that did not happen. Failure to provide the required monitoring of prisoners at risk of suicide and self-harm will increase their risk and completing these observations should be a priority.

83. Since Mr Tamiem's death, two nurses have been suspended from work subject to an internal investigation.

84. An officer completed a count of prisoners at 7.28am and recorded an ACCT observation at the same time. He noted that Mr Tamiem was completely covered in bed and it was therefore difficult to see movement. The officer spent four seconds looking in the cell. He told us that he did not see Mr Tamiem move.

85. Mr Tamiem had in fact made a 'dummy' in his bed, which appears to have been convincingly constructed. (An emergency response officer told us that he initially thought there were two prisoners in the cell when he first saw the dummy.) It is possible that Mr Tamiem was already hanging when the officer looked in the cell at 7.28am.

86. It is vital that staff satisfy themselves that a prisoner is alive and well when they complete ACCT observations. There will be times – such as when the prisoner is asleep in bed – when this will be more difficult. In such circumstances, staff should take as much time as is necessary to satisfy themselves about the prisoner's welfare, and take action if they cannot be certain. We make the following recommendations:

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:

- **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.**

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.

Mental health care

87. The clinical reviewer noted that the mental health team frequently reviewed Mr Tamiem from reception into custody until his death. He was supported by healthcare staff from a variety of disciplines in this time. The clinical reviewer concluded that Mr Tamiem received mental health care of a good standard and equivalent to that which he could have expected to receive in the community.

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