Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 HMP Bedford, Governor, [redacted]** **2 Director General of the Prison Service, [redacted]**
1	**CORONER** I am Dr Séan Cummings, Assistant Coroner for the coroner area of Bedfordshire and Luton
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 04 August 2020 I commenced an investigation into the death of Ezra Mathew TAMIEM aged 39. The investigation concluded at the end of the inquest on 16 December 2021. The conclusion of the inquest was that: On the 4th May 2020 Mr Ezra Tamiem was detained at HMP Bedford after stabbing his wife. On the 15th July 2020 Mr Tamiem was found in cell 3 in the healthcare wing of the prison at 0754 am hanging from a ligature he made. At 0806am he was confirmed to be deceased by the attending paramedics. The jury believes that with the evidence it has been presented that Mr Tamiem intended to take his life. We the jury believe that the authorities at HMP Bedford were aware of the risk of suicide. On the night of his death Mr Tamiem was to have four observations performed at random intervals. Of the 5 observations recorded only 2 were actually performed. Overall there was a serious failure of the observation procedure resulting in Mr Tamiem's death occurring between 21:11 and 07:54.
4	**CIRCUMSTANCES OF THE DEATH** Mr Ezra Mathew Tamiem was detained at HMP Bedford on the 4th May 2020 after being remanded following the stabbing of his wife. Because of concerns about his mental state and his risk of suicide, he was held in the healthcare wing. On the 15th July 2020 he was found in his cell [redacted]
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern)

	Mr Tamiem was housed in a cell on the healthcare wing. [redacted] Head of Safety at HMP Bedford told the court that was for both security [redacted] gave evidence that this device was in operation throughout the prison except in refurbished cells and except in the "safer cell". The safer cell did not have this ligature point. Safer cells are cells with injury and ligature points designed out. [redacted] hanged himself and died as a result. [redacted] told the court there were no plans to remedy this and so the risk remains.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13th September 2022. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons I have also sent it to [redacted] **– PPO Inspector** [redacted] who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated 19/07/2022** Dr Séan Cummings Assistant Coroner