Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Braben, a prisoner at HMP Wormwood Scrubs, on 16 August 2021

A report by the Prisons and Probation Ombudsman

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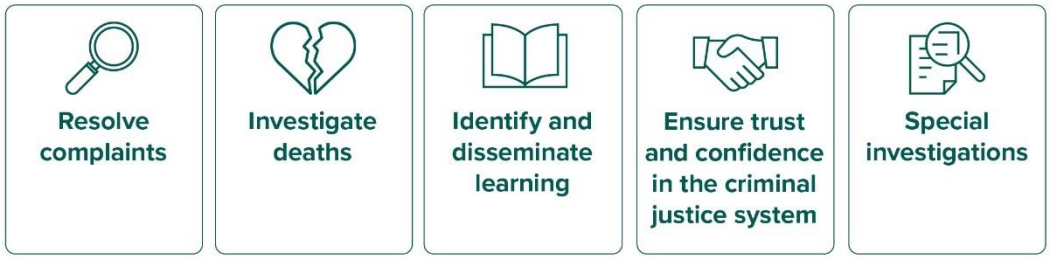
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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

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 Matthew Braben died on 16 August 2021, having been found unresponsive in his cell, with a plastic bag over his head, at HMP Wormwood Scrubs. He died from asphyxia. Mr Braben was 30 years old. I offer my condolences to Mr Braben's family and friends.

Mr Braben was in prison for the first time. He felt paranoid, struggled to settle and guilty that he could not be with his pregnant partner, who gave birth around two weeks before he died. During the last weeks of Mr Braben's life, opportunities were missed to adequately assess his risk of harm to himself and appropriately support him. Long waiting lists for mental health services and a lack of communication between different providers also meant that sometimes his mental health care was inadequate.

I also have concerns about the emergency response when Mr Braben was found. There were delays in summoning healthcare staff and requesting an ambulance. These delays would not have made a difference for Mr Braben, but could do in other emergency situations. Lastly, I am concerned that staff attempted to resuscitate Mr Braben, despite the fact that he was clearly dead. This was both undignified for Mr Braben and distressing for staff.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2022**

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Summary

Events

1. On 13 January 2021, Mr Matthew Braben was remanded to custody having been charged with offences of drug supply. It was his first time in prison. His partner was ten weeks pregnant at the time. He told staff that he had no thoughts of suicide or self-harm.

2. In February, Mr Braben was subject to Prison Service suicide and self-harm support measures, known as ACCT, for ten days. The ACCT was closed when Mr Braben said he felt more confident and had no thoughts of suicide.

3. In March, mental health staff assessed Mr Braben and he was referred to Improving Access to Psychological Therapies (IAPT) but their waiting lists were such that he was not seen by them before he died. In April, Mr Braben was again assessed by a mental health nurse who referred him to Atrium, a counselling service in the prison. On 24 June, Mr Braben was again referred to the mental health team as he was experiencing paranoia and hallucinations. No one actioned this referral.

4. On 5 July, following an altercation with another prisoner, Mr Braben resigned from his job as a wing cleaner. Staff and prisoners said that he became increasingly withdrawn after this. On 8 July, a mental health practitioner spoke to Mr Braben who said that he felt paranoid. On 27 July, Mr Braben's partner gave birth to their child. The next day, Mr Braben's family rang the prison as they were concerned about him. Staff spoke to him the next day and he said that he felt better. Mental health staff agreed that Atrium should urgently assess him. On 30 July, Atrium staff spoke to Mr Braben and said that they would return to assess him on 2 August.

5. On 31 July, Mr Braben presented himself to a nurse having made self-inflicted cuts on his wrists. He said he felt guilty about being in prison and the nurse noted he seemed low in mood, stressed, anxious and irritable. The nurse assumed Mr Braben was already subject to ACCT support so did not open an ACCT herself. This was not the case. On 2 August, an Atrium counsellor assessed Mr Braben. He was unaware that Mr Braben had cut his wrists two days earlier and recorded that he had no concerns about Mr Braben's risk to himself.

6. On 10 August, Mr Braben met his baby for the first time. Staff and prisoners said that he seemed happy but also overwhelmed and guilty that he was not there to support his partner and baby. On 11 August, an Atrium counsellor spoke to Mr Braben. He said that he felt better and no longer wanted counselling. The counsellor discharged him. On 15 August, during a call to his partner, Mr Braben said that he was finding it hard in prison and had not been going out of his cell. Mr Braben was locked in his cell that evening at 4.19pm after collecting his medication. An Operational Support Grade (OSG) checked him at 8.23pm and said he was standing up.

7. The next morning at 5.44am, the same OSG checked Mr Braben again. He was lying on the cell floor and he could not see his head. Mr Braben did not respond to his calls so he radioed for staff to do a welfare check. Three minutes later, officers arrived and could see that Mr Braben had a plastic bag over his head. They radioed a code blue (an emergency code indicating that a prisoner is not breathing

or is having difficulty breathing), requested permission to enter the cell and went into Mr Braben's cell.

8. Officers removed the bag from Mr Braben's head and cut the ligatures which were tying his arms behind his back and his ankles together. They noted that Mr Braben was cold and stiff and began chest compressions. Healthcare staff arrived and continued CPR. Paramedics attended and told staff to stop since Mr Braben had been dead for some time. At 6.06am, they pronounced that he had died.

Findings

9. During the weeks leading up to Mr Braben's death, we are concerned that staff did not adequately assess his risk to himself and opportunities to open an ACCT and support him were missed. Most notable of these was the nurse's failure to open an ACCT when Mr Braben came to her with self-inflicted cuts on his wrists. Staff were aware that Mr Braben was a new father and became more withdrawn during his time. We are not satisfied that they adequately engaged with him and considered his potential risk to himself.

10. The clinical reviewer concluded that until 24 June Mr Braben's mental healthcare was adequate but after this it became less responsive. They note that he was not seen by a GP as he should have been, he was discharged from counselling services without any discussion with the wider team and there were serious gaps in record keeping.

11. When Mr Braben was found unresponsive, the OSG did not adequately assess the situation, radio a code blue or consider going into his cell immediately. When other staff did arrive, they requested permission to enter the cell before going in. Staff started CPR despite Mr Braben having clearly already died. This is both undignified for the deceased and distressing for staff.

Recommendations

The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- staff understand that they need to take a prisoner's risk factors for suicide and self-harm into account, and not just what they say or how they present;
- staff start ACCT monitoring procedures when a prisoner self-harms or expresses suicidal thoughts; and
- staff share all information that affects risk.

The Head of Healthcare should ensure that:

- prisoners are assessed by a GP when primary mental health services are required;
- if a patient stops engaging with any mental health provider in the prison, this is discussed with the wider team;

- waiting lists for mental health services are managed appropriately in accordance with needs and risk; and
- all healthcare staff ensure their recording keeping is in line with guidelines.

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

- understand and use the appropriate emergency code when they discover a medical emergency; and
- staff enter cells as quickly as possible in life-threatening situations where it is safe to do so.

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

The Governor and Head of Healthcare should ensure that this report is shared with all staff named in it and that they are given the opportunity to reflect on the learning involved.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact her.

13. The investigator obtained copies of relevant extracts from Mr Braben's prison and medical records via post and email.

14. The investigator interviewed 16 members of staff and four prisoners at Wormwood Scrubs in October 2021. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Braben's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

15. We informed HM Coroner for West London of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Braben's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked the following questions:

    - Why were the family sent Mr Braben's clothing, which had blood on it, without any warning?
    - Was Mr Braben wearing blood-strained clothing? If he was, what action was taken?
    - Why was Mr Braben not on a wing solely for remand prisoners?
    - What action did staff take as a result of warning signs that Mr Braben was a risk to himself, including: his resignation from prison jobs, cut marks on his wrist, a mark on his neck, a decline in physical appearance in the four weeks before he died (a gaunt appearance, dark eyes, strange haircut and beard and poor personal hygiene), his lack of socialising with other people, his resistance to come out of his cell for a visit with his family and his resistance to meet with his solicitor on at least one occasion?
    - Did Mr Braben receive any medical treatment for the injuries on his wrist and neck?
    - Why was Mr Braben not on an ACCT when he died?
    - On a visit around 2 July, an officer suggested to Mr Braben's mother that she should call the safety team as he thought Mr Braben needed help. Who was the officer and was this recorded anywhere?
    - Mr Braben's sister called the prison raising concerns about Mr Braben dozens of times. What action was taken as a result of these calls?
    - Did Mr Braben talk to a Listener? If so, could they be interviewed?
    - Were there any incidents recorded between Mr Braben and officers or other prisoners?

- Did anyone else have access to Mr Braben's prison account?
- What did Mr Braben do on 15 August and how did he seem?
- Who was the last person to see Mr Braben alive? Who found him unresponsive? Can this person be interviewed?
- Did staff do CPR on Mr Braben?
- How was Mr Braben found? How did he manage to tie his hands and legs and put a bag over his head?
- Where did the plastic bag Mr Braben have on his head come from? Did it have holes in it?
- What investigative action took place after Mr Braben died, including any photos or videos of his cell and body?

17. Some of these questions are answered below and the rest of the family's questions are answered later within this report.

18. There is not a wing solely for remand prisoners at Wormwood Scrubs, sentenced and unsentenced prisoners are located together. There was no information recorded from around 2 July about an officer advising Mr Braben's mother that she should call the safer custody team. It was not possible for the prison to identify any officer in this regard. The prison confirmed that no one else apart from Mr Braben was able to access his prisoner account.

19. Staff said that they thought the bag that Mr Braben had used was likely to have been one that prisoners' food is delivered in. They do not have holes in for food hygiene reasons. Prisoners have frequent access to plastic bags from a variety of sources.

20. As with all deaths in custody, the police attended Wormwood Scrubs after Mr Braben died and carried out their own investigation. We do not seek access to their photos or video footage of the cell. With regards to how Mr Braben tied his hands and legs and put the bag over his head, this will be a matter for the police and coroner to consider.

21. Mr Braben's family received a copy of the initial report. The solicitor representing Mr Braben's family wrote to us pointing out two factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wormwood Scrubs

23. HMP Wormwood Scrubs is a local prison in West London holding up to 1,200 men. The prison holds men on remand from West London courts or prisoners serving short sentences or coming to the end of long sentences. Practice Plus Group provide physical health services, and Barnet, Enfield and Haringey Mental Health Trust provide mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Wormwood Scrubs was in June 2021. Inspectors reported that the prison felt calm and well-ordered and previous progress made had continued. Assaults on staff and the use of force had continued to fall while the rate of prisoner-on-prisoner assaults was one of the lowest of all local prisons. However, reductions in violence were at least partly due to most prisoners having been locked in their cells for 23 hours a day.

25. Inspectors noted that it had always been difficult to recruit and retain staff at Wormwood Scrubs and at the time of the inspection there was a large proportion of newly recruited officers. Staff training had been reduced due to the COVID-19 pandemic and they noted work would be needed to ensure officers were fully prepared once the regime opened up.

26. Leaders had been trying to improve the quality of key work in the prison and, although more vulnerable prisoners were being seen regularly, inspectors found that there was much more to do to ensure that every prisoner had meaningful contact. They noted the Listener scheme was particularly impressive. Self-harm had substantially reduced even before the COVID-19 pandemic. However, the implementation of ACCT was inconsistent and they found that PPO recommendations in relation to previous deaths had not all been implemented effectively.

27. Inspectors found that health services were led by a strong management team, including a new Head of Healthcare. There were several vacancies but strategic recruitment was taking place and staff accessed appropriate training. They noted that there was a comprehensive range of mental health services but routine appointments took place outside of the agreed timescales because of a doubling in referrals over the last year. Inspectors noted that Atrium ran counselling services and had recently increased their provision to three counsellors. An improving access to psychological therapies (IAPT) practitioner from Forward Trust supported 20 prisoners with mild to moderate psychological problems.

Independent Monitoring Board

28. 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 May 2021, the IMB reported that there had been a reduction in violence and improvements to ACCT documentation but that many of the prison's facilities remained in poor condition.

29. During the pandemic, they noted that the key worker scheme had been unable to function as intended. They also noted that prisoners' mental health had deteriorated during this time leading to a significant increase in mental health referrals.

Previous deaths at HMP Wormwood Scrubs

30. Mr Braben was the fifth prisoner to die at Wormwood Scrubs since August 2019. Three of these previous deaths were self-inflicted and one was due to natural causes. In all three self-inflicted investigations, we identified the need for improvements in risk assessment and ACCT management. One investigation also found improvements in mental health services were needed and staff should be given guidance about when resuscitation is inappropriate. Six prisoners have died since Mr Braben, four of natural causes and two were self-inflicted deaths.

Assessment, Care in Custody and Teamwork

31. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

32. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

33. On 13 January 2021, Mr Matthew Braben appeared at court, charged with offences of drug supply. Mr Braben was remanded to custody and taken to HMP Wormwood Scrubs. It was his first time in prison. Mr Braben told a nurse that he had no history or current thoughts of suicide or self-harm. Mr Braben was epileptic and told an Advanced Nurse Practitioner (ANP) that he had last had a seizure seven years ago. He also said that his partner was ten weeks pregnant. Mr Braben was assessed as suitable to share a cell. On 19 January, the ANP continued Mr Braben's prescription of his anti-epileptic medication, sodium valproate.

34. On 2 February, staff started Prison Service suicide and self-harm support measures, known as ACCT. Mr Braben said that he wanted to kill himself and he was under threat from prisoners on the landing. An officer referred Mr Braben to the mental health team. She noted that his mental health was deteriorating, he was having auditory hallucinations and was extremely paranoid.

35. On 8 February, a nurse from the mental health team assessed Mr Braben. He said that he had no thoughts of suicide or self-harm. There was no evidence he was experiencing hallucinations or paranoia. She noted that Mr Braben would be discussed at the mental health triage meeting on 10 February but he did not meet the criteria for allocation to the team and should be managed via the ACCT process. Mr Braben said he did not want support from the mental health team and felt better.

36. On 10 February, Mr Braben moved to E wing. Staff discussed Mr Braben at the mental health triage meeting and confirmed that he was not suitable for allocation to the mental health team but could be re-referred if there were any further concerns. On 12 February, staff closed Mr Braben's ACCT as he said he felt more confident and was hoping to move wings again to be with his friends.

37. On 18 March, a nurse did Mr Braben's secondary healthscreen. She had no concerns about him. Between 23 March and 6 April, Mr Braben was employed as a roof cleaner.

38. On 29 March, a nurse assessed Mr Braben. He said that he had fainted twice in the last ten days. He said his anxiety had worsened since coming to prison and he was expecting a long sentence next month. Mr Braben said that he had no feelings of suicide or self-harm but asked for an ACCT to be opened. He also asked to be re-referred to the mental health team and the nurse sent them an electronic task requesting they see him. The mental health team discussed Mr Braben at their triage meeting and it was agreed that he should be assessed by the Improving Access to Psychological Therapies (IAPT) team (run by Forward Trust) due to his anxiety.

39. A nurse told the investigator that all mental health referrals initially go to the mental health team. They have a triage meeting three times a week which is also attended by the IAPT team, Atrium counselling service and the primary care mental health team who work with prisoners with less severe mental health issues. Atrium is a counselling service at the prison four days a week. They provide six individual counselling sessions for prisoners to support their psychological and emotional well-being. On 31 March, Mr Braben was added to the IAPT waiting list.

40. On 1 April, staff noted that there had been an altercation between Mr Braben and another prisoner the week before and Mr Braben had not come out of his cell since. Staff spoke to him and offered him a move to another landing on the same wing but Mr Braben said he wanted to move to another wing. On 4 April, Mr Braben told staff that he was scared to leave his cell in case other prisoners thought he was a "grass". He refused to provide any further details. Mr Braben said that he was feeling depressed but had no thoughts of suicide or self-harm.

41. A prisoner first met Mr Braben around this time. He said that Mr Braben did not really interact with other prisoners but during association he would bring his chair to the door of his cell and read his newspaper there. After a while, they started exercising together. He told the prisoner that he was paranoid and heard voices. The prisoner tried to reassure him but after around six weeks, Mr Braben stopped exercising.

42. Between 7 April and 13 June, Mr Braben was not employed in the prison. It is not documented why he stopped working on 6 April but it seems likely it was related to him not wanting to leave his cell. On 9 April, Mr Braben asked a nurse to refer him to the mental health team as he was feeling depressed. He said he had no thoughts of suicide or self-harm. The nurse sent the mental health team an electronic task and the team responded that he was on the waiting list for IAPT.

43. On 10 April, a member of the chaplaincy team went to see Mr Braben at the request of an officer. He said that he wanted to see someone from the mental health team urgently as he felt paranoid that he would be forgotten. They emailed the healthcare administrator.

44. On 15 April, a health and wellbeing practitioner in the substance misuse team, began working with Mr Braben. She told the investigator that initially he was reluctant to engage with her but they built up a rapport over time and he became more responsive. She said that Mr Braben sometimes stayed in his cell a lot and was quite introverted. However, she said that he was positive about his family support and partner. They talked about his plans for release.

45. Throughout February, March and April, Mr Braben's family rang the prison safer custody team on over ten occasions when they were concerned about Mr Braben. As a result, prison staff checked on him or asked the mental health team to see him.

46. On 20 April, an officer spoke to Mr Braben who said that he was doing "okay" but was struggling with his mental health as his anxiety was worsening. The officer contacted the mental health team who said he would be seen that week.

47. On 21 April, Mr Braben went to court and pleaded guilty to the charges. On 22 April, a nurse assessed Mr Braben. She spoke to the wing officers who said that he had improved that week. Mr Braben told the nurse that he still felt paranoid but was aware that his thoughts were not true. She reassured him that it was normal to feel paranoid during his first time in prison. He said he was associating with other prisoners. He said that he suffered from sleep paralysis and the nurse referred him to the GP. Mr Braben said he had no thoughts of suicide or self-harm. The nurse provided him with some in-cell activities and reminded him of the other support available. She referred Mr Braben to Atrium. He also remained on the IAPT

waiting list. On 28 April, mental health staff discussed Mr Braben and noted that he was still not suitable for allocation to their team but was on the waiting list for IAPT.

48. On 29 April, an atrium senior therapist, processed Mr Braben's referral and added him to the waiting list. He was not an urgent referral, who would be seen within a week, so the expected waiting time was around three to six months.

49. On 30 April, a nurse assessed Mr Braben's sleep paralysis. Mr Braben said that he did not want to see a GP. Mr Braben also mentioned his epilepsy. On 14 June, Mr Braben began working as a wing cleaner. On 24 June, Mr Braben was referred to the mental health team as he was experiencing paranoia and hallucinations. It is unclear who made the referral.

50. On 5 July, an officer went to the prison storeroom with Mr Braben and, when they returned to the wing, asked him to look after the trolley of goods. The officer was then aware of an alarm bell sounding on the wing to which he responded. Other staff told him that Mr Braben had been involved in an altercation. He went to see Mr Braben, who was already in his cell and he told him that he had challenged another prisoner who had tried to take something from the trolley. He also said he had an altercation with another prisoner but the officer did not know if this was the same prisoner. Mr Braben would not name any of the prisoners involved. This is not documented in Mr Braben's record.

51. After this, Mr Braben resigned from work as he said he was not in the right headspace to work. Staff tried to encourage him to get an off-wing job but he did not work again after this. A prisoner said that this incident affected Mr Braben's behaviour and after this he became more withdrawn and stopped responding to him when he tried to talk to him.

52. Mr Braben's sister rang the prison as she was concerned about Mr Braben's mental health. She said that he seemed very low and had been reluctant to attend their visit which was unusual. The health and wellbeing practitioner saw him and noted that Mr Braben seemed unwell and distant and was waiting for the mental health team to see him.

53. The next day, an officer checked on Mr Braben. He said he was not doing well but did not currently require any help. He said that he needed to see the mental health team but knew that he was currently on their waiting list so was happy to wait for them to assess him. (It is assumed that he meant the waiting lists for Atrium and IAPT). They discussed him asking for his job back to keep himself busy but he said he got anxious when there were lots of people around.

54. A prisoner said that around June or July, Mr Braben stopped showering, his cell was untidy and he seemed depressed. Mr Braben was often upset and in tears when they spoke and said that he was his only friend on the landing. Mr Braben said that he felt paranoid. He also made some bizarre repetitive statements throughout the day and night and sat on his chair looking through the crack in his cell door. The prisoner said he was unsure whether the behaviour was genuine or Mr Braben was trying to get some attention. He said that Mr Braben seemed genuinely concerned whenever he tried to encourage him out of his cell but he did not specify why. He assumed he was worried about a risk from other prisoners. He said several staff persevered in trying to get Mr Braben to come out of his cell.

55. On 7 July, Mr Braben's sister left a voicemail with the safer custody department that she was concerned about him. On 8 July, a primary mental health practitioner spoke to Mr Braben at his cell door at the request of a wing officer. Mr Braben said he felt paranoid and had had a panic attack the day before as found it difficult to be in crowds. Mr Braben said that he did not want to talk anymore and had no thoughts of suicide or self-harm. The practitioner noted that Mr Braben was on the waiting list to be assessed by the mental health team. Again, this was not the case but he was on the IAPT and Atrium waiting lists.

56. A SO told the investigator that Mr Braben was "quite anxious" and "twitchy". The SO said that Mr Braben seemed paranoid that people were talking about him. She spoke to Mr Braben about this but he could not identify anybody specific he felt at risk from. The SO said that she emailed the mental health team several times asking them to assess him as she was concerned he had mental health issues. She said that he seemed open with staff and would approach them if he had an issue. The SO said that Mr Braben often did not come out of his cell but staff and his friends encouraged him to do so or would stand at his cell door chatting to him. She said that he felt bad he was in prison and could not support his pregnant partner.

57. Other staff and prisoners told the investigator that Mr Braben's mood fluctuated. Some days he would be very anxious and concerned about other prisoners, while at other times he was more positive, engaged and looking towards the future. Some prisoners said that he became increasingly withdrawn towards the end of July and early August. No prisoners or staff we spoke to were aware of any genuine threats against Mr Braben. A prisoner said that Mr Braben was finding it hard not knowing how long he would be sentenced to. The prisoner also saw Mr Braben three times in his Listener's capacity. Although the content of these conversations remains confidential as per the Samaritan's policy, the prisoner said that he was never concerned that Mr Braben was a risk to himself and if he had been, he would have told the safer custody department.

58. On 28 July, Mr Braben's sister rang safer custody and said she was very concerned about his mental health. She said that his partner had recently given birth to their daughter and Mr Braben was distressed that he could not be with them and was not coping with the shame of being in prison. She said that she was concerned that Mr Braben might harm himself. Mr Braben had stopped attending his visits or video calls which was unusual. She said that he also had an upcoming court appearance. Safer custody staff emailed the mental health team and wing staff with this information. An officer did a welfare check. Mr Braben said that he had refused to attend his video visit that afternoon but was okay. He said that his partner had given birth to their child the night before and he felt emotional but was feeling better today. The officer had no serious concerns and spoke to Mr Braben's sister.

59. On 29 July, the SO replied to safer custody's email to say that she had been concerned about Mr Braben for a "little while", believed he suffered from paranoia and had been trying to get him seen by mental health services for several weeks. Due to COVID-19, the SO told the investigator that the prison was short staffed and prisoners were only getting around 30 minutes to one hour out of their cell each day. Due to the information from Mr Braben's sister and the email from safer custody, staff discussed Mr Braben at the triage meeting and noted that Atrium should urgently assess him.

60. On 30 July, a senior therapist from Atrium spoke to Mr Braben through the observation panel in his cell door. She told Mr Braben that her colleague would speak to him on Monday. Mr Braben was pleased about this and said he had no thoughts of suicide or self-harm. He said he did not think he needed to be on an ACCT at present but would tell staff if this changed. She told the investigator that she spoke to two officers before she left the wing and explained there were some concerns about Mr Braben and could they "keep an eye on him" which they agreed to do.

61. That afternoon, an officer checked on Mr Braben and noted that he appeared to have trouble deciding what to do. During association he had closed his door so she went back to him and convinced him to go into the exercise yard and have a shower. He said he was okay and needed time to "think and sort out his head".

62. On 31 July, a nurse was giving prisoners their medication in the treatment room. She told the investigator that one or two officers had brought Mr Braben to the room with self-inflicted cuts on both wrists. He told the nurse that he had made the cuts 24 hours ago. Mr Braben said he was having auditory hallucinations and felt guilty about being in prison, leaving his family and friends behind. The nurse noted that Mr Braben seemed low in mood, stressed, anxious and irritable. He said he had cut himself as he hated himself.

63. The nurse had met Mr Braben frequently when she administered his medication and reflected that on this day he seemed different. The nurse cleaned and dressed his wounds. The nurse told the investigator that she could not steristrip them as she was concerned they were old wounds and might have been infected. The nurse asked Mr Braben if he wanted to die, which he denied and the nurse asked him to let staff know if he had any thoughts of suicide. The nurse noted that he was to be monitored as he was already under the care of the mental health team. This was not correct but he was waiting to be seen by Atrium and IAPT.

64. The nurse administered Mr Braben's medication over the following days. There is no evidence that she checked his dressings or asked how he was feeling.

65. A prisoner said that he noticed that Mr Braben had cut his wrists and had a mark on his neck that looked like it had been made by a rope. The prisoner said that Mr Braben tried to cover it up. He said that Mr Braben disengaged from him, did not want to talk to him and did not leave his cell. He was concerned that Mr Braben might be a risk to himself. He tried to motivate him and wrote him a schedule for his day which Mr Braben attached to his wall. He also said that Mr Braben looked like he had lost weight and was neglecting his appearance.

66. On 2 August, an atrium counsellor assessed Mr Braben. He noted that Mr Braben had engaged well and was "no current risk issue". He said that he had not read Mr Braben's medical record and was unaware that he had self-harmed two days earlier. He said that Mr Braben was ashamed that he was in prison and they spoke about his history and aspirations. Mr Braben said that he was paranoid and wary of other prisoners. Since Mr Braben had been referred as a priority, he booked their first session for 11 August.

67. On 9 August, Mr Braben's sister left a voicemail with the safer custody department that she was concerned about Mr Braben and asked staff to do a welfare check.

68. On 10 August, Mr Braben had a visit from his partner and newborn baby. There is no reference to this in his record. Another prisoner said that Mr Braben seemed happy about his baby but had to be persuaded to go to the visit to meet her. He thought this might have been because he was so low in himself. A prisoner said that Mr Braben seemed happy and slightly overwhelmed that he had a daughter when he returned from the visit. Other prisoners also said that Mr Braben was happy about his baby but felt sad that he could not be with her and his partner. The SO said Mr Braben was very happy and "cried tears of joy" but still felt guilty that he was not there to support his baby and partner. The SO never had any concerns that Mr Braben was a risk to himself, particularly as he was in a happy relationship and now had a baby.

69. A prisoner said that other prisoners said that Mr Braben was feeling suicidal. He said that Mr Braben was withdrawn and did not make eye contact when they had a conversation. The prisoner said that he saw an officer speaking to Mr Braben through his observation panel. He said that he heard the officer say to Mr Braben, "you can go and kill yourself then" and then slammed his observation panel shut. The prisoner said that he and another prisoner submitted a complaint about this. Prison staff checked the prisoner's records and he did not submit a complaint. The officer told the investigator that she had never said this to Mr Braben.

70. A prisoner told the investigator that he noticed what looked like about four or five superficial cuts on the side of his neck around this time. He thought they were a "cry for help".

71. On 11 August, a therapist went to see Mr Braben for his first counselling session. Mr Braben told him that he was feeling better and did not want to engage in counselling. The therapist thought this was unusual and therefore asked Mr Braben if he was sure, to which he replied that he was okay and had no concerns. He explained that he could change his mind at any time and be re-referred to the service. The therapist spoke to an officer on the wing, explaining what had happened and the officer said that his engagement with staff fluctuated. He asked the officer to "keep an eye" on him. The therapist told the investigator that he had no concerns that Mr Braben was a risk to himself. He was more concerned about Mr Braben's paranoia and that he might be vulnerable to being bullied by other prisoners. The therapist then discharged Mr Braben from Atrium.

72. Mr Braben spoke to his partner on the telephone about her visit with their newborn baby the day before and how their daughter had been doing. His partner said that he had lost a lot of weight and he had marks on his neck and arms which Mr Braben said was where he had hit a door. He said that he still loved her and it was hard being in prison.

73. On 13 August, Mr Braben spoke to his partner. They discussed their daughter and what his partner had been doing. Mr Braben said he could not wait until they next visited. He also spoke to his sister about his daughter and future visits. He said that his court appearance on 16 August had been cancelled and they talked about him getting sentenced in September and having more certainty then about his plans.

74. The health and wellbeing practitioner went to see Mr Braben. He did not want to come out of his cell to meet with her in a private room. She told the investigator that she had no concerns about him and thought he wanted some "space". When

asked, she said that Mr Braben looked quite pale and unwell. She said that he appeared more distant. She started her entry on his medical record but said she must have forgotten to save it so no details apart from her name appear.

75. On 14 August, Mr Braben applied to be enrolled in a business management course. He spoke to his mother about meeting his daughter for the first time.

76. An officer said around this time, she did not see Mr Braben out of his cell as much as usual but thought that he was in a positive space so was not concerned. He told the officer that he had stopped working with mental health as he did not feel he needed their input and the officer had no concerns.

77. On 15 August at 8.27am, Mr Braben called his partner. He sounded upset and despondent. He said that he had not been going out of his cell and was finding it "hard". His partner tried to motivate him by talking about their daughter, the future and to try and get some exercise which he agreed to do.

78. Around 9.00am, a prisoner said that he saw Mr Braben running on his own in the exercise yard. He did not speak to him but was surprised that he was out of his cell. A prisoner saw Mr Braben again during the same association period, sitting in the door of his cell and he gave him his newspaper.

79. From CCTV footage, Mr Braben collected his medication around 4.00pm. He was locked back into his cell at 4.04pm. At 4.19pm, an officer checked Mr Braben's cell was locked and that he was okay and in his cell. The officer cannot specifically remember doing this check but accepts that he did so. At 8.23pm, an Operational Support Grade (OSG) checked Mr Braben, along with all the other prisoners on the wing. He said that he recalled Mr Braben was standing up.

Events of 16 August

80. Around 5.30am, the OSG began his morning roll count of the wing. At 5.44am, he got to Mr Braben's cell and looked through the observation panel. He saw Mr Braben lying on the floor. He could see his legs but not his head which he said was under the bed. He turned on the cell light and called to Mr Braben but he did not respond. The OSG radioed Oscar 5 requesting that they come and do a welfare check. While waiting for other staff to arrive, the OSG continued his roll count of other prisoners and waited in the middle of the landing away from Mr Braben's cell door.

81. Oscar 5 that night was an officer. She was responsible for oversight of three wings, including E wing. At the time she heard the request for assistance, she was with two other officers. All three officers went to E wing in case they needed to unlock Mr Braben's cell. They arrived three minutes after the OSG had requested assistance.

82. Oscar 5 looked into Mr Braben's cell and could see him lying on the floor with what she thought was a plastic bag over his head. She asked an officer to confirm it was a bag over his head, which she did. Oscar 5 immediately radioed a code blue and requested permission to enter the cell which was granted. The control room requested an ambulance. The three officers went into the cell just over a minute after they had got there. Mr Braben was lying on his back with his feet near the cell

door and his head near the window. Oscar 5 said he was lying parallel to the bed but his head was not underneath it.

83. Mr Braben's ankles were tied together with ripped bed sheets, his arms were tied behind his back and to the bed with ripped clothing and he had a plastic bag over his head tied up with a shoelace. Oscar 5 cut the lace securing the bag and took it off his head. She noted that Mr Braben's lips were blue and his body was "ice cold". Oscar 5 cut the ties from Mr Braben's wrists and noticed that his arms were stiff. An officer cut the ties from Mr Braben's ankles. She also noted that Mr Braben was cold and stiff.

84. An officer had also entered the cell by this stage, noted that Mr Braben's body was "fully rigid" and started chest compressions. The officer told the investigator that he could not administer breaths as Mr Braben's jaw was stiff and clenched.

85. Two nurses heard the code blue and went to E wing immediately. They arrived two minutes after the officers had gone into Mr Braben's cell. Staff were already doing chest compressions. A nurse checked for signs of life, administered oxygen using a facemask and attached the defibrillator. They attempted to insert an airway but were unable to do so as Mr Braben's jaw was stiff and they were unable to open it. More healthcare staff arrived and the nurse took over chest compressions from officers. The nurse told the investigator that Mr Braben was stiff and she knew that he was dead.

86. Paramedics attended and assessed Mr Braben. They told staff to stop chest compressions as Mr Braben had been dead for some time. He was cold to the touch, had signs of rigor mortis and hypostasis (blood pooling in the body according to gravity). At 6.06am, paramedics pronounced that Mr Braben had died. Nurses and prison staff involved in the emergency response told the investigator that they did not notice any marks on Mr Braben's wrists or neck.

87. After Mr Braben had died, police noted that there was writing on his wall which included statements about not giving in to paranoia or voices. It also said, "try not to talk to any officers whatsoever now cos you're overthinking what you've said and drive yourself mad". It also included reference to him speaking to the drug team about taking someone else's anti-anxiety medication in prison before and that tradesmen had bugged his cell.

Contact with Braben's family

88. The Governor and Head of Safety went to Mr Braben's mother's address at 9.40am but there was no response. The Governor telephoned Mr Braben's mother and said he needed to speak to her in person. She was at Mr Braben's sister's address so they went to that address and informed them of Mr Braben's death and offered their condolences. The Head of Safety remained the point of contact with Mr Braben's family. She had not had the family liaison officer (FLO) training but there were no trained FLOs available in the prison at the time. In line with Prison Service policy, she offered Mr Braben's family a contribution to his funeral expenses.

89. We have seen evidence of emails between the family liaison officer and Mr Braben's mother indicating exactly when his belongings had been sent to her.

90. The Safety Hub Manager packaged Mr Braben's clothes and said that there was no blood on any of them. The Head of Safety said that Mr Braben's family confirmed that they did not want to come to the prison to collect Mr Braben's belongings but that they could be posted. Due to COVID-19 restrictions at the time, they were not allowed to go into the prison but were offered this opportunity once restrictions were lifted.

Support for prisoners and staff

91. After Mr Braben's death, the Deputy 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.

92. The prison posted notices informing other prisoners of Mr Braben'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 Braben's death.

Post-mortem report

93. The pathologist concluded that the cause of Mr Braben's death was asphyxia caused by suffocation by the plastic bag tied over Mr Braben's head. No drugs or alcohol were detected in his system. The pathologist noted that there were self-harm marks on both wrists but did not note any marks on Mr Braben's neck.

Findings

Identifying and managing Mr Braben's risk of suicide and self-harm

94. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

95. Mr Braben was subject to ACCT support for ten days in February 2021 when he said he wanted to kill himself. He was not assessed as a risk to himself after this time.

96. As the clinical reviewer notes, it was Mr Braben's first time in prison and he found it difficult to settle and feel safe. He withdrew from activities and appeared to minimise his distress. He was also separated from his pregnant partner who gave birth to their daughter around two weeks before he took his own life. It is clear he felt considerable shame and inadequacy about not being able to support his partner.

97. We recognise that staff and prisoners made considerable efforts to engage with Mr Braben, alleviate his concerns and get him assessed by mental health services. The adequacy of his mental health care is discussed further below. We also recognise that, most of the time, Mr Braben said he had no thoughts of suicide or self-harm and staff followed up his family's concerns appropriately by checking on him or asking mental health staff to do so.

98. However, during the last few weeks of Mr Braben's life, there are some stark deficiencies in the care he received. The most serious of these was a nurse's assessment of Mr Braben on 31 July and her actions thereafter. The nurse said that one or two officers brought Mr Braben to the treatment room after he had cut his wrists. There is no evidence to support this assertion that officers were with Mr Braben, nor has it been possible to identify them. Even if officers were with Mr Braben, the nurse should not have assumed they had already opened an ACCT. She should have asked to see the ACCT herself and documented her interaction with Mr Braben in it. If there was no ACCT open, as there was not, she should have opened an ACCT herself.

99. The nurse said that she was in the middle of administering medication to the prisoners on the wing when Mr Braben was brought in and that this affected how well she documented the event. However, the nurse saw Mr Braben to administer his medication over the following days but did not check his wounds or ask how he was feeling. The nurse told the investigator that, in future, she would never assume a prisoner was on an ACCT but would always check with staff. She also reflected that she could have finished medicating the other prisoners before speaking to Mr Braben so that her consultation with him was not so rushed.

100. The Deputy Governor told the investigator that the nurse's employer, Practice Plus Group, had completed an internal investigation into her actions, which the prison had also contributed to. He confirmed that no formal proceedings would be taken against her and that she had reflected on the issue and how she would act differently in the future.

101. On 2 August, the therapist assessed Mr Braben and was unaware that he had self-harmed two days earlier. It was in line with Atrium's policy at the time that the therapist was not expected to read any of a prisoner's medical record before assessing them. However, this meant that the therapists' assessment that Mr Braben was "no risk issue" was based on what he told him during their meeting rather than a holistic consideration of his risk factors, behaviour and circumstances.

102. Two of the prisoners we spoke to said that Mr Braben had marks on his neck. These have not been verified either by staff or the post-mortem. However, it is evident that Mr Braben had self-harm wounds on his wrists which staff did not notice, although prisoners did. Mr Braben's family also said that they saw marks on Mr Braben's neck and wrists. We accept that Mr Braben may have deliberately hidden these wounds from staff but if these marks were visible during visits and to prisoners it seems likely that they could also have been visible to staff and appropriate action should have been taken.

103. Some staff noted that Mr Braben appeared more distant, withdrawn, pale and unwell in the days before his death. During the conversation with his partner the day before he died, he sounded upset and despondent. Staff would not have been aware of the content of this call as Mr Braben's calls were not being monitored. However, it seems likely that this level of despondency would also have been apparent to staff.

104. On 10 August, Mr Braben met his newborn baby for the first time. This was not documented in his record, nor was there any specific support offered to Mr Braben in relation to becoming a new father and separated from his child. The deputy governor told the investigator that Wormwood Scrubs had no specific policy or support relating to new fathers. This is something which we would suggest the Prison Service gives some consideration to. At the very least, the fact that Mr Braben had recently become a father should have been noted in his record.

105. Following the three previous self-inflicted deaths that occurred at Wormwood Scrubs in the two years before Mr Braben's, we recommended that ACCT processes and risk assessment are improved. Following the last self-inflicted death in March 2021, we also requested that the Prison Group Director write to the Ombudsman to outline the steps he was taking to address the concerns identified in our investigations into these deaths. The Director wrote to the Ombudsman in November 2021 and also acknowledged the two further self-inflicted deaths which had occurred, including that of Mr Braben. We understand that the prison has been identified as a cluster site for self-inflicted deaths and as such, a formal multi-disciplinary team has been convened to work on further steps to improve prisoner safety. Despite this, given the shortcomings in Mr Braben's care, we make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **staff understand that they need to take a prisoner's risk factors for suicide and self-harm into account, and not just what they say or how they present;**
- **staff start ACCT monitoring procedures when a prisoner self-harms or expresses suicidal thoughts; and**
- **staff share all information that affects risk.**

Clinical care

106. The clinical reviewer recognised that during the time Mr Braben was at Wormwood Scrubs, all healthcare services were under significant pressure due to the COVID-19 pandemic, along with the mental health team and IAPT services having staff vacancies. The Mental Health Team Leader told the investigator that referrals to their service had increased by around 200% over the previous 18 months. The clinical reviewer concluded that there was significant variation in the level of Mr Braben's care and they were unable to reach an overall conclusion about whether his care was equivalent to that which he could have expected to receive in the community.

Physical health

107. Mr Braben disclosed that he was epileptic when he arrived at Wormwood Scrubs. There was a delay of six days between Mr Braben arriving at the prison and being prescribed anti-epileptic drugs. This did not appear to cause a problem for Mr Braben but should not have occurred given the critical nature of the medication. He was prescribed sodium valproate in his possession and was last given 56 tablets in June which would have finished by early August. He made no further request for medication. The clinical reviewer notes that this suggested that Mr Braben did not take his medication as directed and should have been followed up by healthcare staff.

108. Mr Braben's secondary healthcare screening was not undertaken until 18 March. This should have taken place within 72 hours of him arriving at Wormwood Scrubs. The clinical reviewer also notes that it made no further exploration of his epilepsy.

109. The clinical reviewer notes that information about Mr Braben's condition should have been shared with the prison to inform a risk assessment. Although we recognise that it did not impact on his death, the Head of Healthcare will want to note the clinical reviewer's recommendations with regards to Mr Braben's epilepsy.

Mental Health

110. The clinical reviewer concluded that Mr Braben's mental healthcare until the 24 June was equivalent to that he could have expected to receive in the community but after this it was less responsive.

111. Mr Braben was first assessed by the mental health team on 8 February. He did not meet the criteria for allocation to their caseload. Mr Braben was referred for IAPT support provided by Forward Trust on 31 March. He was never seen by Forward Trust and access to groups and support had reduced around this time. The health

and wellbeing practitioner said that there was a waiting list of five months for a prisoner to see the IAPT service, partly due to staffing vacancies.

112. The clinical reviewer concluded that up until 24 June, the mental health team's approach was clear and all requests for assessment by the team were either followed up by reviewing Mr Braben's records, by advice or by assessing Mr Braben. Mr Braben was referred to the team again on 24 June but there is no evidence that anyone assessed or reviewed him.

113. On 8 July, a member of the mental health team saw Mr Braben, whose presentation was different and he was less forthcoming than he had been in the past. This conversation was not discussed at the mental health team meeting. After another referral, on 29 July, staff discussed Mr Braben at the triage meeting and decided that Atrium needed to assess him. They were aware of the concerns raised by Mr Braben's sister and the birth of his baby but they did not see him or reassess him themselves. The clinical reviewer concluded that they should have done so.

114. On 31 July, Mr Braben presented himself to the nurse with self-inflicted cuts on his wrists. The clinical reviewer noted that the nurse did not complete a record of exactly where Mr Braben's cuts were or what he had used to inflict the wounds. There was no follow up plan or action regarding the care of his wounds. As we have already detailed in the section above, she should have opened an ACCT to enable a multi-disciplinary approach to Mr Braben's risk to himself.

115. On 22 April, Mr Braben had been referred to Atrium and added to their waiting list. The referral was not marked as urgent and the waiting list was three to six months long. On 30 July, following concerns from staff, this referral was marked as urgent and prioritised. Atrium assessed Mr Braben on 2 August. The therapist had not checked Mr Braben's medical record which contained reference to him cutting his wrists two days earlier. The therapist assessed that there were no risk issues. At the time, Atrium staff only reviewed records before seeing a prisoner if they were deemed to be high risk, such as those on an ACCT. This policy has since changed and counsellors are expected to check all prisoners' healthcare records before meeting them.

116. On 11 August, the therapist had his first counselling session with Mr Braben. However, on this date Mr Braben said that he no longer wanted counselling. The therapist did not discuss Mr Braben's withdrawal from engagement with the mental health team or anyone else in healthcare. The clinical reviewer concluded that, in general, the communication between Atrium and IAPT and the wider mental health team was very limited. Since Mr Braben's death, Atrium counsellors are expected to discuss any prisoners they are considering discharging with the mental health team. As Mr Braben did not meet the criteria for allocation to the mental health team, no oversight of his care remained with them.

117. The Mental Health Team Manager said that she was aware that the mental health providers in the prison often worked in isolation from each other. She has tried to encourage communication between them and has re-invited Atrium to attend the mental health triage meetings following Mr Braben's death.

118. The clinical reviewer concluded that although Mr Braben did not meet the criteria for allocation to the mental health team, he had several vulnerabilities. It was his first time in prison and he was an expectant father. The stress of separation from his

family was therefore greater. Healthcare staff did not explore this with Mr Braben and groups relating to family issues and relationships were not operating at the time.

119. The clinical reviewer noted that although Mr Braben showed signs associated with depression, he was never seen by a GP to consider if medication may have been beneficial. There was only one referral to a GP which resulted in him being seen by a nurse who did not fully consider the reasons for his referral. This was not appropriate.

120. Although there were many referrals to the mental health team and it is clear that prison staff had clear concerns about Mr Braben, this never led to a specific multi-disciplinary meeting between healthcare and prison staff. Healthcare staff were unaware that Mr Braben had resigned from his job or met his newborn baby for the first time.

121. The clinical reviewer concluded that there is considerable evidence of poor record keeping. For example, in the triage meeting on 24 June, the nurse's record on 31 July and health and wellbeing practitioner's meeting with Mr Braben on 13 August. We make the following recommendation:

The Head of Healthcare should ensure that:

- **prisoners are assessed by a GP when primary mental health services are required;**
- **if a patient stops engaging with any mental health provider in the prison, this is discussed with the wider team;**
- **waiting lists for mental health services are managed appropriately in accordance with needs and risk; and**
- **all healthcare staff ensure their recording keeping is in line with guidelines.**

Risk from others

122. According to staff and prisoners, Mr Braben spent an increasing amount of time in his cell in the weeks before he died and was reluctant to engage with other prisoners. Sometimes he said that he felt at threat from other prisoners. In March, he had an altercation with a prisoner and did not leave his cell for some time after this. In July, he had another altercation with a prisoner. This was not documented in his record but seems to have resulted in him giving up his employment. He did not work again after this which would have impacted on his mental health. Such altercations should be clearly noted in a prisoner's record and we urge the Governor to ensure that this occurs.

123. The SO said that she did not believe opening a Challenge Support and Intervention Plan (CSIP – used to support prisoners at risk from others) would have helped Mr Braben since she did not believe he was under threat from others. Mr Braben himself often acknowledged that he was probably being paranoid. Our investigation did not find any evidence that Mr Braben was at ongoing risk from others.

Emergency response

124. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, requires prisons to have a two-code medical emergency response system. Wormwood Scrubs' local policy instructs staff to use a code blue where a prisoner is unconscious or otherwise showing signs of breathing difficulties or a code red when a prisoner is bleeding or severely burned. Calling an emergency medical code should automatically trigger the control room to call an ambulance and for healthcare staff to attend with the appropriate medical equipment.

125. PSI 24/2011, *Management and Security of Nights*, states that under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two or three staff are present, one of whom should be the NOO. However, the PSI goes on to say:

> "Staff have a duty of care to prisoners, themselves and to other staff. The preservation of life must take precedence … Where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO … and an individual member of staff may enter the cell on their own."

126. The PSI also says that staff should not take action that they feel would put themselves in unnecessary danger, that staff must make every effort to first gain a verbal response from the prisoner, that they must make a rapid dynamic risk assessment on whether to enter the cell immediately or wait for assistance, and that they must inform the communications room before entering the cell.

127. When the OSG checked Mr Braben, he could see him lying on the floor and thought he might be in a "deep sleep" and did not believe it was an emergency situation. He told the investigator that he could not see Mr Braben's head which was under the bed. He radioed for staff to come and do a welfare check on Mr Braben. While he was waiting for the staff to arrive for three minutes, he did not continue to try to clarify the situation with Mr Braben or get a response but checked other prisoners and waited in the middle of the wing.

128. The OSG actions concern us. Firstly, as Mr Braben was unresponsive, he should have radioed a code blue. Since he did not do this, no ambulance was called, healthcare staff did not attend and prison staff did not know that Mr Braben was unresponsive. As it was, prison staff did go straight to Mr Braben's cell but did not hurry and arrived three minutes later. While this delay did not make a difference for the outcome for Mr Braben, it could do in other emergency situations.

129. Secondly, when other staff arrived, they immediately saw that Mr Braben had a plastic bag over his head. This suggests that the OSG did not look through Mr Braben's observation panel sufficiently carefully. The OSG told the investigator that he considered using the inundation key when he could not see Mr Braben's head. This is a key which would have allowed the OSG to get a lower view of Mr Braben through the inundation point in the door – usually used if there is a fire in the cell. However, he did not do so. The OSG also said that he had a sealed pouch containing a cell key which he can use in case of an emergency but as he did not think it was an emergency situation, he did not consider using it.

130. The Deputy Governor told the investigator that the prison intended to do an internal investigation regarding the OSG's actions. This had not taken place at the time of writing.

131. Oscar 5 responded to the OSG's radio call with two colleagues as they had all been in the same location when she heard the OSG's request. Once she had looked in the cell, she radioed a code blue, requested permission to enter the cell and went straight in. Oscar 5 told the investigator that she had to request permission to unlock a cell at night and there always had to be three staff present to open a cell door. As the PSI indicates, staff do not need to request permission in some circumstances and there does not need to be three members of staff present. Luckily, in this situation it did not lead to any delay in responding to the emergency but it may do in other situations.

132. Healthcare staff responded to the code blue and got to Mr Braben's cell three minutes after the officers. The failure by the OSG to call a code blue, therefore, contributed to a delay before an ambulance was called and before a nurse arrived with the emergency equipment. This did not affect the outcome for Mr Braben as it is clear that he had been dead for some time, but even a short delay may make a significant difference in other medical emergencies. 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 staff:

- **understand and use the appropriate emergency code when they discover a medical emergency; and**
- **enter cells as quickly as possible in life-threatening situations where it is safe to do so.**

133. European Resuscitation Council Guidelines for Resuscitation (2015), which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. The Guidelines say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." They define examples of futility as including the presence of rigor mortis.

134. When officers found Mr Braben, they noted that he was cold and stiff. Despite this, they began chest compressions. They could not administer breaths because Mr Braben's jaw was stiff and clenched. An officer, who started the chest compressions, said that his initial assessment of the situation was that Mr Braben had been in that position for several hours. However, all prison staff we asked, said that they would always start CPR and continue until a medical professional arrived.

135. Healthcare staff arrived and continued chest compressions. They attempted to insert an airway but were unable to do so due to Mr Braben's stiff jaw. A nurse told the investigator that she knew Mr Braben was dead. Despite this, staff continued until paramedics arrived and told them to stop.

136. The guidelines are clear that CPR should not be carried out where it would be futile. Although we understand that staff were doing what they thought was right, trying to resuscitate someone who is clearly dead is distressing for staff and

undignified for the deceased. Following a death at the prison in November 2020, we recommended that staff were given clear guidance about when resuscitation is appropriate. The prison accepted the recommendation and, in December 2021, noted that they had reissued guidance to all staff. This was after Mr Braben's death. However, we are concerned that again staff have attempted resuscitation when it was inappropriate and we therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

137. Finally, given the learning outlined in this report, we make the following recommendation:

The Governor and Head of Healthcare should ensure that this report is shared with all staff named in it and that they are given the opportunity to reflect on the learning involved.

Inquest

138. The inquest into Mr Braben's death ended on 26 April 2024 and concluded his death had been due to suicide.

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