Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Brazier, a prisoner at HMP Cookham Wood, on 17 June 2025

A report by the Prisons and Probation Ombudsman

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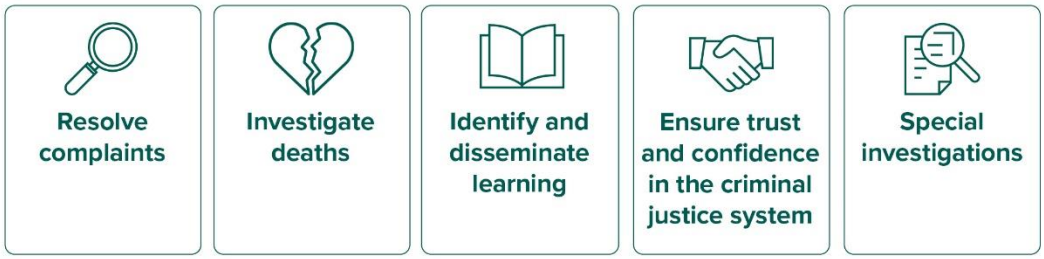
OUR VISION

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

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1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In May 2019, Mr Trevor Brazier was sentenced to life for murder. He died of cardiomegaly (enlarged heart) on 17 June 2025, at HMP Cookham Wood. He was 55 years old. We offer our condolences to Mr Brazier's family and friends.

4. The Ombudsman's office wrote to Mr Brazier's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Brazier's clinical care at Cookham Wood.

6. The PPO investigator investigated the non-clinical issues relating to Mr Brazier's care.

7. The PPO investigator and independent clinical reviewer interviewed seven members of staff between 30 July and 6 August.

8. The clinical reviewer concluded that overall, the clinical care Mr Brazier received in prison was of a good standard and equivalent to that which he could have expected to receive in the community. However, he found that some aspects of Mr Brazier's care, unrelated to his death, were not of the required standard. He made four recommendations that the Head of Healthcare will wish to address.

9. We did not find any non-clinical issues of concern. We make no recommendations.

10. We shared the initial report with HMPPS and the prison's healthcare provider, Oxleas NHS Foundation Trust. HMPPS and Oxleas NHS Foundation Trust pointed out some factual inaccuracies in the clinical review. These have been corrected.

11. At the inquest, held on 22 January 2026, the Coroner concluded that Mr Brazier died from natural causes.

Adrian Usher **January 2026**
Prisons and Probation Ombudsman

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