

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Brooke Marsden, a prisoner at HMP Lincoln, on 14 January 2022**

**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



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We are:

**Impartial:** we do not take sides

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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.

If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Brooke Marsden died of heart disease on 14 January 2022, at HMP Lincoln. Brooke was 33 years old. I offer my condolences to Brooke's family and friends.

Brooke identified as non-binary, meaning that they did not identify as male or female or subscribe to the pronouns associated with these genders. Therefore, throughout this report Brooke will be referred to by the pronouns they, them, or their.

Brooke died four days after arriving at Lincoln. This investigation found no obvious signs that Brooke was in poor health, or that they had any significant problems with their heart when they arrived at Lincoln.

The investigation found that information relevant to Brooke's physical and mental health collated at court was not shared with prison staff at Lincoln. Overall, however, the clinical reviewer concluded that the care Brooke received at Lincoln was equivalent to that which they could have expected to receive in the community.

The inquest into Brooke's death concluded on 18 July 2023, and concluded that the death was natural causes.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**May 2023**

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# Summary

## Events

1. On 10 January 2022, Brooke Marsden was remanded to HMP Lincoln, charged with sexual and common assault. This was their first time in prison.
2. On the way to the prison, the vehicle transporting Brooke was involved in a minor road traffic accident. Brooke suffered a small cut above their eyebrow. They were provided with some gauze to place on the cut, and the incident was recorded on the Person Escort Record (PER) form. They arrived at Lincoln at 7.36pm.
3. On their arrival at Lincoln, a reception officer completed some initial paperwork. The officer recorded that Brooke was displaying bizarre behaviour and described them as being 'flamboyant'. The officer considered that Brooke was not at risk of harm to themselves and had no immediate concerns about their ability to cope.
4. A reception nurse completed an initial health screen. The nurse also noted that Brooke was displaying strange behaviour. As a result, the nurse referred Brooke to the prison's mental health team. Brooke denied any thoughts or intent to harm themselves. Although Brooke's blood pressure was quite high, there was no reason for healthcare staff to be overly concerned about their physical health over the following few days.
5. At 4.18am on 14 January, during a routine check of prisoners, an officer noticed 'exaggerated' snoring coming from Brooke's cell. When he completed the roll count, he returned to Brooke's cell and opened the observation panel of the cell door and saw that Brooke had moved the mattress from the bed and had placed it on the floor. Brooke was lying on their front, snoring loudly. The officer remained at the door for around 20 seconds and tried to get a response from Brooke, but they did not respond. The officer returned to the wing office and checked Brooke's record to get more information about them.
6. At 4.20am, the officer returned to check on Brooke. Brooke was still snoring loudly. The officer tried, again, to get a response from them but they did not respond. The officer said that he noted movement so was not overly concerned.
7. At 4.31am, the officer went back to check on Brooke. He saw Brooke kneeling on their mattress, adjusting the blanket around their waist. The officer said that he did not try and speak to Brooke because he could see that they were awake.
8. At 7.57am, another officer carried out a routine check. He looked through Brooke's observation panel and saw them lying face down on top of their mattress. The officer called to Brooke and asked them if they were okay, but Brooke did not respond. The officer went into the cell and continued to try and get a response. The officer checked Brooke for a pulse but could not detect one. At 7.58am, the officer radioed a medical emergency code.
9. Nursing staff arrived at the cell within a minute. Control room staff called for an ambulance immediately.

10. Nursing staff noted that there were signs that Brooke had been dead for some time but began cardiopulmonary resuscitation (CPR). At 8.17am, paramedics arrived and took over Brooke's care and treatment. At 8.25am, the paramedics confirmed that Brooke had died.
11. The coroner gave Brooke's cause of death as heart disease.

## Findings

### Clinical care

12. The clinical review concluded that the care Brooke received at Lincoln was equivalent to that which they could have expected to receive in the community.
13. She did however identify some areas of concern.
14. The clinical reviewer was concerned about the quality and standard of record keeping. She was also concerned that healthcare staff failed to assess Brooke appropriately when records indicated that Brooke had been involved in a road traffic accident on the way to the prison. Had they been aware of the road traffic accident, they would have completed further clinical examinations, including assessing for a potential head injury. The clinical reviewer considered that although this was not directly linked to Brooke's death, it could be important for future cases.
15. We found that the resuscitation attempt on Brooke was not in accordance with prison policy or health guidelines. However, the clinical reviewer considered that it was not appropriate to be too critical of healthcare staff's decision to attempt CPR because of the unusual circumstances they found themselves in.

### Welfare checks and roll checks

16. Roll checks are primarily a security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoners' safety to be identified and managed.
17. Officer A checked on Brooke three times between 4.18am and 4.31am. He told us that he had initially looked in on Brooke while he was conducting a morning roll check on the wing. He said at that time Brooke was snoring very loudly and described it as 'exaggerated'. He attempted to wake Brooke but was unable to gain a response. He then returned to the wing office and after reading Brooke's notes returned and checked them again, as he said that they were snoring more loudly. Again, he attempted to get a response from Brooke, but was unsuccessful. When he checked again at 4.31am, Brooke was awake, but he did not speak with them to check on their well-being.
18. Officer A accepted that in hindsight it would have been advisable to check with Brooke that they were all right and document this on their record. He said that he recognised the need for him to ensure that whenever he has concern about a prisoner's wellbeing, he should speak with them to satisfy himself that they are fit and well and should record these interactions.

## Recommendations

- The Governor and Head of Healthcare should ensure that there is a formal process in place to report incidents and accidents that occur during prisoner transports to the healthcare staff in reception.
- The Mental Health Clinical Matron should work with the local Liaison and Diversion Teams to ensure that their assessments are included in the prisoners PER.
- The Head of Healthcare and Mental Health Clinical Matron should remind staff of the importance of good quality record keeping in accordance with the NMC Code, General Medical Council (GMC) Practice Guidelines and Health Care Professional Council (HCPC) Standards of conduct, performance and ethics.
- The Governor should ensure that staff obtain a response from prisoners if they are concerned about a prisoner's welfare.

## The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
20. The investigator obtained copies of relevant extracts from Brooke's prison and medical records.
21. The investigator interviewed five members of staff at Lincoln and by telephone on 28 February and 25 to 26 March.
22. NHS England commissioned a clinical reviewer to review Brooke's clinical care at the prison. The clinical reviewer attended interviews with the investigator on 25 and 26 March.
23. We informed HM Coroner for Lincolnshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
24. The Ombudsman's family liaison officer contacted Brooke's family to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. Brooke's family asked the following questions:
  - Why was Brooke taken to HMP Lincoln when HMP Nottingham was the closest local prison?
  - What date did they enter custody?

We have answered the family's questions in this report and in separate correspondence.
25. The family received a copy of the initial report and indicated that they had no comments to make in regard to our findings.

## **Background Information**

### **HMP Lincoln**

26. HMP Lincoln holds up to 729 remanded and convicted men. It serves the courts of Lincolnshire, Nottinghamshire, and Humberside. It has four residential wings, including a Vulnerable Prisoners Unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover.

### **HM Inspectorate of Prisons**

27. The most recent inspection of HMP Lincoln was in January 2020. Inspectors reported that Lincoln was a much safer prison since their last inspection in 2017. Inspectors said that the prison's approach to prisoners in crisis was good, and they had implemented previous PPO recommendations.
28. The inspectors found that prisoners and staff had good relationships, which was a real strength.

### **Independent Monitoring Board**

29. 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 31 January 2021, the IMB reported the prison was being run well given the limitations of its Victorian buildings and the COVID-19 restrictions, and staff had delivered a humane regime. There had been a significant reduction in violence and self-harm.

### **Previous deaths at HMP Lincoln**

30. Brooke was the eighth prisoner to die at Lincoln since March 2020. Of the previous deaths, four were self-inflicted and three were from natural causes. We found no similarities between the findings from our investigation into Brooke's death and the findings from our investigations into the previous deaths.

## Key Events

31. On 6 January 2022, Brooke was arrested and taken into police custody after they were found naked in the street holding a large kitchen knife to their throat. It was alleged that they had damaged a vehicle and threatened a member of the public. While in police custody, the Liaison and Diversion team (L&D) assessed Brooke. L&D services identify people who have mental health, learning disabilities, substance misuse or other vulnerabilities when they first enter the criminal justice system.
32. The L&D team noted that Brooke was not known to the community mental health services but said that they had previously received counselling for sexual abuse. The L&D team noted that Brooke identified as non-binary. Non-binary is the term used to describe someone who does not identify as either male or female or in some cases might identify as both genders.
33. Brooke was taken from police custody to court. Their Person Escort Record (PER) did not indicate that the L&D team's assessment from police custody was attached. The front cover of the PER provides a box to indicate whether it has been attached, but the box on Brooke's PER was blank.
34. Derby Magistrates Court remanded Brooke to prison charged with sexual assault and common assault and they were taken to HMP Lincoln. Usually, Derby MC would take newly remanded/sentenced prisoners to HMP Nottingham as the closest local prison. However, Nottingham had no spaces left and therefore Brooke was taken to Lincoln, the next nearest local prison served by the court. This was Brooke's first time in prison. Brooke was due to appear at Derby Crown Court again on 7 February.
35. On the way to the prison, the cellular vehicle transporting Brooke was involved in a minor road traffic accident. Brooke sustained a small cut above their eyebrow. Escort staff provided them with some gauze to place on the cut, and staff recorded the incident on the PER. They arrived at Lincoln at 7.36pm.
36. The L&D report was not attached to the PER when Brooke arrived at Lincoln. The L&D Team sent copies of the assessment report to the mental health team at Lincoln on 11 January. However, healthcare staff did not add them to Brooke's medical record until 14 January.
37. An officer met Brooke in Lincoln's reception area. She completed Brooke's cell sharing risk assessment (CSRA), which indicated that due to the sexual offence charge they were not suitable to share a cell.
38. The officer told the investigator that Brooke displayed bizarre behaviour. She said that Brooke spoke openly, but when other staff or prisoners were around, they would not make eye contact and whispered the answers to questions. She said that Brooke did not mention at any point during the reception process that they identified as non-binary. She used the pronoun Mr, and Brooke did not correct her. She said that Brooke gave no indication that they were at risk of harm to themselves, and although she was aware that it was their first time in prison, she had no immediate concerns about their ability to cope.

39. The officer said that the only information she had available to her was the PER. She was aware that there had been a minor road traffic accident on the way to the prison. She did not recall if Brooke had an injury and said that had if it had been significant, she would have remembered. She said that Brooke made no reference to any injury during the assessment.
40. A nurse completed Brooke's initial health screen. He took Brooke's clinical observations and recorded that they were all within a normal range except for their blood pressure, which was slightly raised at 139/83mmHg. (An ideal blood pressure reading is considered to be between 90/60 mmHg and 120/80mmHg. A high blood pressure reading is considered to be 140/90mmHg.) The nurse noted no physical concerns.
41. Brooke told the nurse that they had depression, an undiagnosed personality disorder, and may have been assessed for autism in the past. However, there was no confirmation of this in their medical records. Brooke also said that they had no drug or alcohol issues. The nurse noted that Brooke was displaying strange behaviour. They were smiling and grinning in an inappropriate manner and walking on tiptoes. The nurse also noted that Brooke was very animated. As a result, the nurse completed a routine referral for Brooke to be seen by the prison's mental health team. Brooke denied any thoughts of suicide or self-harm. In interview, the nurse said that he had not seen the assessment completed by the L&D team or the PER. The nurse did not assess Brooke's head injury and did not record details of this in their medical record.
42. At 2.22pm the following day, a chaplain visited Brooke as part of the induction process for new receptions. He recorded that it was difficult to engage with Brooke. He described them as very softly spoken and using hand gestures. Brooke raised no concerns, but the chaplain noted that their presentation was unusual. He sent an email to the Safer Custody team and mental health team. The mental health team responded to the chaplain and said that they had already received a referral for Brooke and that their assessment was arranged for 13 January.
43. On 13 January, Brooke was moved from the first night wing (C wing) to the vulnerable prisoner wing (E wing). Later that day, a Probation Service Officer (PSO) completed a basic custody screening (BCS) with Brooke. The BCS assesses any needs to be addressed prior to a prisoner's release from prison and identifies support available in prison. Brooke said they would not be in contact with their family and friends while they were in prison. They said that they had no physical health concerns, had a personality disorder, but had not been prescribed any medication for this. The PSO confirmed that an appointment with the mental health team was scheduled for later that day. Brooke also said that they had no issues with illicit drug use.
44. A nurse completed an initial mental health assessment. (The nurse was not available for interview.) She recorded that Brooke engaged with the assessment and that they presented with no obvious psychotic symptoms or thoughts of suicide or self-harm. She recorded that Brooke had a close family and that they appeared to be planning for the future.
45. Brooke told the nurse that they did not know why they were having a mental health assessment. They described their mood as 5 out of 10 and said that they

considered themselves a positive person. Brooke talked about having an undiagnosed personality disorder and said that they felt like they were living two lives. Brooke told the nurse that they were confused about their sexuality and had previously considered gender reassignment and that this had lowered their self-esteem. Brooke told the nurse that they planned to plead guilty to the offences that they had been charged with when they next appeared at court. The nurse recorded that Brooke did not need continued support from the mental health team at that time and discharged them from the mental health services.

46. At 5.07pm, Brooke was unlocked to collect their evening meal. They were barefoot and a Supervising Officer (SO) told them to go back and put shoes on. CCTV shows at 5.13pm, Brooke collected their meal and returned to their cell. An officer looked their cell door.
47. At 7.03pm, an officer completed a roll check (a routine security check to account for all prisoners). No issues were raised at that time.
48. That evening, Officer A had agreed to complete an extra night shift because of staff shortages. He said that because he arrived late, he did not complete the first roll check, which was completed by a colleague, and no issues were passed on to him when he arrived.

#### **14 January**

49. At 4.18am, Officer A began a morning roll check. Once he had finished checking the prisoners on the landing, CCTV shows that he returned to Brooke's cell at 4.20am, and he stayed there for two minutes, until 4.22am. He told us that before he had even got to the cell, he heard 'exaggerated snoring'. He said that Brooke was snoring very loudly. When he opened the observation panel on the door, he could see that Brooke had moved the mattress from the bed and placed it on the floor, which he said was not unusual for prisoners to do, as the mattresses are quite thin and uncomfortable.
50. Officer A said that Brooke was lying on their front, with their boxer shorts around their ankles, and a blanket over themselves, and was snoring quite loudly. He said that he thought that this was a little strange. He stayed outside the door for around 20 seconds and tried to get a response from Brooke, but they did not respond. Brooke continued to snore. He considered that perhaps this was just how Brooke slept, so he moved on.
51. Officer A went back to the office and checked Brooke's record, as he knew nothing about them. He noted the chaplain's comment about Brooke displaying bizarre behaviour, and he said that he just put Brooke's snoring down to the same thing. He said that when he checked on Brooke, he had not seen anything in the cell that caused him concern.
52. At 4.31am, Officer A went onto the landing again to complete another routine check. He checked on Brooke and the loud snoring had stopped. He looked into the cell and saw that Brooke was kneeling on their mattress, adjusting the blanket around their waist. He did not speak to Brooke as he could see that Brooke was awake. He told the investigator that he had no concerns about Brooke at this time and therefore did not consider discussing Brooke with other prison staff on duty.

53. At 7.57am, Officer B began carrying out welfare checks of prisoners on the landing. He looked into Brooke's cell via the observation panel and saw them lying face down on top of their mattress. He called to Brooke and asked if they were okay, but Brooke did not respond. He unlocked the door and tried to get a response by calling to Brooke. He said that he had noted that Brooke's underwear was by their ankles, they had a blanket covering their midriff area and they were wearing a sweatshirt. He also noted that there was water on the cell floor and an unplugged kettle was on the floor next to Brooke.
54. Officer B turned Brooke over and continued to try to get a response from Brooke. In his written statement, he said that initially, he was unsure if they were a heavy sleeper or playing a joke. When he got no response, he reached down to Brooke and their head felt 'warm and moist'. He attempted to find a pulse but was unsure if he had detected one. At 7.58am, he radioed a medical emergency 'code blue' (indicating that a prisoner is unconscious or is having breathing difficulties). At 8.00am, control room staff called an ambulance.
55. Within seconds, staff arrived at Brooke's cell. Officer B told them that he was unsure whether he could feel a pulse. A nurse, the Matron along with a Healthcare Support Worker (HCSW) attended. They noted that Brooke was on their back on the floor, unresponsive and appeared stiff and cold to the touch, and the skin on their legs appeared mottled. The Matron recorded that the floor was wet. Brooke's top half was also wet, and their lips appeared blistered, red and they had water all over their face and mouth. They also noted that there was a small cut to Brooke's forehead. Nursing staff attempted to insert a suction tube to clear Brooke's airway, but they were unable to do so because their jaw was rigid. Nursing staff began CPR and removed Brooke's wet clothing from their top half and dried them with towels to attach defibrillator pads. The nurse recorded that the HCSW was unable to move Brooke's head due to the presence of possible rigor mortis. Nursing staff continued with CPR.
56. At 8.17am, the paramedics arrived and took over Brooke's treatment. At 8.25am, the paramedics confirmed that Brooke had died.

## **Contact with Brooke's family**

57. The prison appointed a family liaison officer (FLO). Brooke had not given any next of kin details when they arrived at HMP Lincoln. The FLO contacted Brooke's solicitor, the local police station, the magistrates court and healthcare department to try and obtain contact details for their next of kin. At 2.30pm, they obtained details for Brooke's mother and stepfather. They called Brooke's mother three times, but there was no answer, so they called Brooke's stepfather and informed him of Brooke's death. They offered their condolences and support. Brooke's stepfather said that he would inform Brooke's mother. The FLO said they would call the following week, which they did, and spoke to Brooke's mother. They offered continued support.
58. The prison offered a contribution to the funeral costs in line with Prison Service policy.

## **Support for prisoners and staff**

59. After Brooke's death, the Head of Safety and Equality 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.
60. The prison posted notices informing other prisoners of Brooke'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 Brooke's death.

## **Post-mortem report**

61. The coroner gave Brooke's cause of death as coronary artery atheroma (heart disease). No illicit drugs or unprescribed medications were found in Brooke's system.

# Findings

## Clinical care

62. The clinical reviewer concluded that the care Brooke received at HMP Lincoln was equivalent to that which they would have expected to receive in the community.
63. She did, however, identify some areas of concern.
64. She was concerned about the quality and standard of record keeping. Prison staff uploaded assessments completed by the Liaison and Diversion (L&D) team at court three days after they received them. The mental health nurse assessed Brooke on 13 January but did not update Brooke's record until the following day. Also, not all healthcare staff involved in the emergency response on 14 January correctly recorded their involvement on Brooke's medical record.
65. The clinical reviewer was also concerned that although it was recorded on the PER that the vehicle that took Brooke to Lincoln was involved in a minor traffic accident and Brooke had sustained a cut to their forehead, a nurse failed to assess and record their injury in their medical record, which is not in line with guidance. We asked the nurse whether he had noted the cut to Brooke's head. He said that he could not recall this. He said that he had not been aware of the road traffic accident, but after the interview, he told the interviewer that he did recall that something had been mentioned, but not specific to Brooke. He said that the reception area was very busy in the evening at that time and there was one nurse on duty, with assistance from one healthcare assistant, which had put pressure on the nurses and gave them limited time to assess new prisoners.
66. The clinical reviewer considered that if the nurse was aware of the road traffic accident, he would have completed further clinical examinations, including assessing for a potential head injury. The clinical reviewer said that although this was not, according to the post-mortem report, linked to Brooke's death, it could be important for future cases. We recommend:

**The Governor and Head of Healthcare should ensure that there is a formal process in place for incident and accidents to be reported that may occur during prisoner transports to the healthcare staff in reception.**

In response to the recommendation the prison have said:

***The Head of Operations will ensure that a clear line of reporting incidents and accidents is in place between the Prisoner Escorting Contractors and HMP Lincoln Reception, and that this information is available to healthcare staff to ensure a comprehensive medical assessment can take place upon reception.***

**The Mental Health Matron should work with the local Liaison and Diversion Teams to ensure that their assessments are included in the prisoners PER.**

In response to the recommendation the prison have said:

***Memorandum is to be issued to Reception Nurses and Mental Health Team regarding the following process. Any documentation /assessments that have***

***been completed on the patient by Liaison and Diversion Teams are to be reviewed by the Reception Nurse on arrival and the Duty Mental Health Worker notified. The documents to be embedded into the patients SystemOne records.***

**The Head of Healthcare and Mental Health Clinical Matron should remind staff on the importance of good quality record keeping in accordance with NMC Code, General Medical Council (GMC) Practice Guidelines and Health Care Professional Council (HCPC) Standards of conduct, performance and ethics.**

In response to the recommendation the prison have said:

***Memorandum is to be issued to Healthcare staff highlighting the need for good quality, accurate record keeping as stated by their Governing bodies:***

***Nurses and Midwifery Council Code Section 10 (10.3); Health and Care Professions Council Standards of Care, Proficiency and Ethics Section 10; General Medical Council Paragraph 50 & 51.***

67. The clinical reviewer made some other recommendations which we do not repeat in this report but which the Head of Healthcare will need to address.
68. This investigation found nothing to suggest that staff should have been concerned about Brooke's physical health or suspected that they had a serious heart condition.

### **Emergency response**

69. In September 2016, Professor Sir Bruce Keogh, National Medical Director at NHS England wrote to Heads of Healthcare for prisons and Immigration Removal Centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison, IRC or residential short-term holding facility, and was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".
70. The nursing staff who attended the emergency response noted that Brooke was unresponsive, appeared stiff and cold to the touch and the skin on their legs appeared mottled. We also note that they attempted to insert a suction tube to clear Brooke's airway, but they were unable to do so because their jaw was rigid, and that they were unable to move Brooke's head due to the presence of possible rigor mortis. Staff continued attempting CPR until ambulance paramedics arrived. It seems clear that attempting CPR for Brooke was inappropriate. However, the clinical reviewer considered that it was not appropriate to be too critical of healthcare staff's decision to attempt CPR because the circumstances they found themselves in were unusual, given the amount of water in the cell, that Brooke was also wet, and which caused one member of staff to think that Brooke had still felt warm.
71. The Head of Healthcare told us that following an internal learning review, which identified inappropriate resuscitation as an issue, the prison had already taken steps to address this. All healthcare staff undertook further training to increase their awareness of the Royal College of Nursing (RCN) guidance. The Head of

Healthcare also said that he was working with the Governor to develop their own local guidance for staff to follow, in conjunction with the RCN guidance. In light of the steps taken to address this area of concern, we make no recommendation.

## Checks during the night

72. Roll checks are primarily a security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoner's safety to be identified and managed.
73. Officer A checked on Brooke three times between 4.18am and 4.31am. He told us that he had initially looked in on Brooke while he was conducting a morning roll check on the wing. He said at that time Brooke was snoring very loudly and described it as 'exaggerated'. He attempted to wake Brooke but was unable to gain a response. He then returned to the wing office and after reading Brooke's notes returned and checked them again, as he said that the snoring was louder. Again, he attempted to get a response from Brooke but was unsuccessful.
74. When Officer A checked again at 4.31am, he said that Brooke was knelt on their mattress readjusting the bedding, but he did not attempt to speak with them or ask if they were all right, despite previous concerns. We asked him, given that he had gone to Brooke's cell three times in a relatively short period because he was concerned, whether he had recorded his concerns about Brooke anywhere or passed the information onto anyone else, he said that he had not.
75. The investigator discussed this with Officer A at interview, and he accepted that, in hindsight, it would have been advisable to check with Brooke that they were all right and document this on their record. He appreciated the need for him to ensure that he satisfied himself of a prisoner's wellbeing if he had any concerns. We make the following recommendation:

**The Governor should ensure that staff obtain a response from prisoners if they are concerned about a prisoner's welfare.**

In response to the recommendation the prison have said:

***The Head of Safety will issue a Notice to Staff reminding them of the importance of gaining a response from the prisoner when conducting welfare checks***

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