REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Ministry of Justice** **2. His Majesty's Prison and Probation Service**
1	**CORONER** I am Dr Anton van Dellen, HM Assistant Coroner, for the coroner area of West London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** An investigation was commenced into the death of Matthew Paul Braben, aged 30. The investigation concluded on 26 April 2024. The conclusion of the jury in the inquest was: *Suicide. Matthew's death was probably the result of systemic failures across multiple agencies including the Prison services. A contributing factor to these failures may have been Covid. There was inadequate communication between agencies and a lack of information sharing. This probably led to a failure to identify his deteriorating mental health and increasing suicide risk. This is evidenced by repeated failures to open ACCTs post February. Despite concerns raised by a highly engaged, caring and supportive family, it is probable insufficient weight was given to their attempts to raise the alarm.* The medical cause of death was 1a Aspyhxia 1b Suffocation [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Matthew died on 16th August 2021 at HMP Wormwood Scrubs, Du Cane Road, Hammersmith. Matthew was remanded in custody in January 2021. It was his first time in prison. He was on an ACCT in early February 2021 but not thereafter. He was referred to be seen by a counselling service. His first-born child was born on 27th July 2021. The birth of a child is not listed a risk factor in PSI 64/2011. He was awaiting sentencing. He was seen by a nurse in prison on 31st July 2021 with cut wrists. His family repeatedly raised concerns about his mental health. He was first assessed by the counselling service on 2nd August 2021, declined counselling on 11th August 2021 and was consequently discharged from that service. No action was taken by the prison when repeated concerns were raised by his family on Saturday 14th August 2021. He was last seen alive on Sunday 15th August 2021. He was found in his cell on 16th August 2021 after he had tied [redacted] around his neck and tied his wrists and ankles to the bed. He died due to asphyxia. At the time that he did the act that caused his death, he probably did so with the intention of ending his life. On the balance of probabilities, there were numerous failings by the prison service that cumulatively contributed to Matthew's death, including: a failure to record and keep complete records on NOMIS or otherwise; a failure to communicate between colleagues and shifts; and a failure to follow up closure

	of his ACCT and resignation of wing cleaner role. It was unacceptable that multiple opportunities, that would constitute opening an ACCT, were missed (April, July, August 2021). The prison failed to act on repeated serious concerns raised by Matthew's family on Saturday 14th August through the Safer Custody Helpline. It is possible that multiple opportunities were missed to identify concerns with Matthew's mental health due to the Key Worker System not being fully implemented throughout HMP Wormwood Scrubs. Covid may have been a significant contributor to some of these failings due to increased work pressures and regime changes. On the balance of probabilities, the implementation of the policy in relation to the opening of ACCTs was inadequate. It was noted by a Supervising Officer that there was an implied pressure not to open an ACCT due to associated workload pressures. Post closure period processes for ACCTs were not adhered to after Matthew arrived in E wing. If these were effectively followed, then risks could have been more readily identified. This failure probably contributed to Matthew's death. Post Matthew's arrival to E wing, there were numerous red flags over an extended period across all services (e.g. prison Services, PPG, secondary mental healthcare, Forward Trust and Atrium) that should have resulted in an ACCT being opened – failure to do so probably contributed to Matthew's death. On the balance of probabilities, Matthew's risk of suicide was not adequately identified. Post move to E wing and closure of the ACCT, there were numerous failures to identify suicide risks. Not enough weight was given to known risk factors such as the birth of Matthew's daughter, approaching court dates, first time in prison and feelings of guilt, shame and paranoia. These were not given due credence in comparison to Matthew's assurances that he was not suicidal. As Matthew's mental health deteriorated towards the end of July, a series of escalating risk indicators arose. Family concerns were raised to Safer Custody and escalated to the Supervising Officer and secondary mental health services. No action was taken by the prison when repeated concerns were raised by his family on Saturday 14th August. These inadequacies in the identification of suicide risk cumulatively probably contributed to Matthew's death. The Court heard evidence that prisoners were locked in their cells for up to 23 hours a day, with a negative effect on their mental health. The Court heard evidence that one of the ways that prisoners could leave their cells is to attend gym, but that there is a shortage of gym instructors due to the manner of training of gym instructors which entails potential trainees having to attend training at a distant location for significant period of times rather than locally as well as the length of the course, both of which serve as significant disincentives for staff to be trained as gym instructors.
5	**<u>CORONER'S CONCERNS</u>** During the inquest, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. The birth of a child is not recognised as a specific risk factor in PSI 64/2011 which means that staff may under-estimate its significance on mental health. 2. The robustness of the process for ensuring that the ACCT post-closure process is followed, particularly following a move to another location. 3. Training of staff in the ACCT process. 4. Prisoners being kept in their cells for up to 23 hours a day, with a negative effect on their mental health. 5. The manner of training of gym instructors which entails potential trainees having to attend training at a distant location for significant period of times rather than locally as well as the length of the course, both of which serve as significant disincentives for staff to be trained as gym instructors. The shortage of gym instructors leads directly to more prisoners being kept in their cells for up to 23 hours a day, with a negative effect on their mental health.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th September 2024. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.

8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. [redacted] 2. [redacted] 3. [redacted] 4. [redacted] 5. [redacted] 6. Ministry of Justice 7. His Majesty's Prison and Probation Service 8. Practice Plus Group 9. Barnet, Enfield and Haringey Mental Health NHS Trust 10. Forward Trust 11. Atrium I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**1st August 2024**