

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

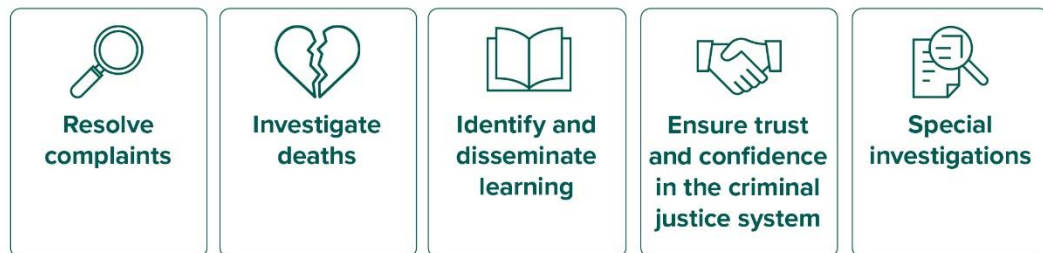
# **Independent investigation into the death of Mr Thomas Brotherton, a prisoner at HMP Preston, on 22 September 2021**

**A report by the Prisons and Probation Ombudsman**

## 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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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 reduce the number of self-inflicted deaths that occur every year in prison then our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Thomas Brotherton died in hospital on 22 September 2021 after being found hanging in his cell, in the segregation unit at HMP Preston, on 21 September. He was 21 years old. I offer my condolences to Mr Brotherton's family and friends.

In the three years prior to his death there had been no other self-inflicted deaths at Preston.

This investigation has noted a number of pro-active interventions by staff and volunteers that overall give the impression that there was a positive approach to safeguarding. Mr Brotherton was a sometimes difficult prisoner who had personal challenges in controlling his temper that had led to violent incidents. Despite this, there is good evidence that staff were engaged in caring for Mr Brotherton and attempting to assist him in making positive change. The most recent reports from Her Majesty's Chief Inspector of Prisons and from the Independent Monitoring Board indicate that HMP Preston took the care of prisoners' mental health seriously and had some good processes to support that endeavour.

The clinical reviewer concluded that the mental health care Mr Brotherton received at Preston was not equivalent to that he could have expected in the community and has made some recommendations for the Head of Healthcare.

Whilst, overall, events indicate that Preston takes safeguarding seriously there are legitimate questions raised over record keeping within some aspects of the ACCT process.

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**

**January 2024**

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# Summary

## Events

1. On 31 May 2021, Mr Brotherton was remanded to HMP Preston charged with criminal damage and affray. This was not his first time at Preston. Mr Brotherton said he had self-harmed years ago, but staff recorded no current concerns about his risk on his arrival.
2. On 3 June, staff began suicide and self-harm monitoring procedures (known as ACCT) when Mr Brotherton said he had overdosed on paracetamol. He was taken to hospital for treatment and was discharged two days later. Staff recorded that his actions had been impulsive and very dangerous. Mr Brotherton refused to accept support that was offered to him. On 12 June, staff assessed that Mr Brotherton was no longer at a raised risk and ended ACCT monitoring.
3. Mr Brotherton began a course at Preston which dealt with some traumatic aspects of his childhood. Mr Brotherton received good support from the course staff and prisoner mentors.
4. On 17 August, Mr Brotherton made superficial cuts to his arm and staff started ACCT procedures. Mr Brotherton said he had cut himself because he had been frustrated.
5. On 29 August, Mr Brotherton pulled down the pants of a fellow prisoner while on the exercise yard. Due to the potentially serious nature of the incident, the prison referred the matter to the police.
6. On 31 August, during a phone call to his father, Mr Brotherton said that he would hang himself if he was charged with additional offences. Staff spoke to Mr Brotherton who denied having talked about suicide and said he was fine. Staff took no further action.
7. On 18 September, Mr Brotherton seriously assaulted another prisoner with a bladed weapon and was moved to the prison's segregation unit. The incident was referred to the police to consider criminal charges.
8. On the morning of 21 September, Mr Brotherton was found guilty of assault under prison rules for the incident on the exercise yard. The punishment was 14 days cellular confinement in the segregation unit.
9. At 2.48pm that day, an officer went to Mr Brotherton's cell and saw him suspended from the light fitting by a sheet tied around his neck. Staff went into the cell and began CPR. Paramedics arrived and transferred Mr Brotherton to hospital. In the early hours of 22 September, Mr Brotherton died.

## Findings

### Management of Mr Brotherton's risk of suicide and self-harm

10. Mr Brotherton received good, personalised support from prison staff at Preston, particularly those involved with the Time4Change programme. He was twice monitored under suicide and self-harm prevention procedures (known as ACCT) at Preston but was not under ACCT procedures when he died. ACCT documents were managed appropriately, and staff made appropriate referrals for other types of support when it was needed.
11. However, we consider that staff should have recorded why they did not consider beginning ACCT procedures on 1 September, when Mr Brotherton told his father he would kill himself if he was charged with further offences. This information was not recorded in Mr Brotherton's prison file or shared more widely with relevant staff and so, when he assaulted another prisoner and was likely to face further charges, staff did not consider that his risk to self might have increased and did not consider beginning ACCT procedures.

### Clinical care

1. The clinical reviewer concluded that the care Mr Brotherton received at Preston in relation to his mental health care was not equivalent to that which he could have expected in the community.

### Allegation against segregation unit staff

2. At interview, a staff member said that a prisoner had told them that an officer working on the segregation unit had refused to give Mr Brotherton his food. The prisoner said that when Mr Brotherton told the officer that if he didn't get his meal, he would harm himself, the officer said, 'Well, go on then'. The investigator found no evidence to support these allegations.

## Recommendations

- The Governor should remind staff of the importance of:
  - considering all of a prisoner's current risk factors when assessing risk and that they should not rely solely on what a prisoner says, how they present or their past behaviour in the establishment;
  - where potential risk has been highlighted and a decision is taken to not open an ACCT, they should record their reasons for not doing so; and
  - recording potential triggers for suicide and self-harm to help inform future decisions.
- The Head of Healthcare should ensure there is a process in place in the event prisoner requests to have a fellow prisoner/third party in attendance at a counselling session, to ensure that the care needs of the prisoner are taken into account.

- The Head of Healthcare should ensure that, where the Mental Health Team is aware of any Independent Psychiatric Reports, they request sight of and consider the contents of them as appropriate.
- The Head of Healthcare and the Mental Health Team Manager should review the process of follow up from the Mental Health Team and how this is completed and monitored. If further input is not required, clear rationale for this decision should be documented. Failed follow up should also be monitored to ensure it takes place promptly.
- The Head of Healthcare should review waiting times for seeing the GP in relation to reviews of antidepressant medication and ensure that there is a triage system in place to ensure prisoners requiring a review of mental health medication are seen within recommended time scales.

## The Investigation Process

3. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
4. The investigator obtained copies of relevant extracts from Mr Brotherton's prison and medical records. He interviewed 14 members of staff at Preston between 24 and 26 November 2021.
5. NHS England commissioned a clinical reviewer to review Mr Brotherton's clinical care at the prison.
6. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
7. The Ombudsman's family liaison officer contacted Mr Brotherton's family to explain the investigation and to ask if they had any matters that they wanted the investigation to consider. Mr Brotherton's family wanted to know:
  - When was Mr Brotherton diagnosed with psychosis?
  - What medication and support did Mr Brotherton receive after the diagnosis?
  - Why was Mr Brotherton not being monitored under suicide prevention procedures, given the diagnosis?

We have addressed these concerns in this report or in separate correspondence.

8. Mr Brotherton's family were sent a copy of the initial report, but no response to the findings or factual inaccuracy of the report has been made by them.
9. An inquest held on 6 December 2023, returned a verdict of Misadventure in respect of Mr Brotherton's death.

## Background Information

### HMP Preston

10. HMP Preston is a category B male local and resettlement prison, servicing courts across northwest England. The prison holds males aged 18 and over remanded in custody awaiting trial, serving sentences of 12 months or less, or awaiting transfer to another prison after sentencing.
11. Spectrum Community Health CIC run the healthcare and drug and alcohol recovery services at the prison. Spectrum, in partnership with Tees, Esk and Wear Valleys NHS Foundation Trust provide mental health services. The integrated mental health team (IMHT) offers prisoners a full mental health assessment, and support from first reception through to discharge.

### HM Inspectorate of Prisons

12. The most recent inspection of HMP Preston was in March 2017. Inspectors found that there had been four self-inflicted deaths since their last inspection. The prison had developed comprehensive action plans in response to the Prisons and Probation Ombudsman (PPO) reports on the three deaths in 2014, which addressed some key weaknesses, including better risk assessment of new arrivals. The inspection noted that the bimonthly strategic Safer Preston meeting monitored self-harm issues well, with more detailed discussion of this area than of violence reduction. Mental health staff attended the weekly operational Safer Preston meeting, which contributed to good case management of the prisoners of most concern.

### Independent Monitoring Board

13. 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 March 2022, the IMB reported that care was taken to ensure that any prisoner who expressed thoughts of suicide or self-harm was placed on an ACCT and helped accordingly. Prisoners on ACCT plans met with their support team at least once a week to discuss the support and supervision they needed, and they were monitored at least once an hour. The IMB reported that dedicated key workers attended each ACCT review.

### Previous deaths at HMP Preston

14. Mr Brotherton was the second prisoner to die at Preston since August 2019. The previous death was due to natural causes. Since his death there have been a further five deaths at HMP Preston, one of which was self-inflicted. There are no similarities between the findings in the previous deaths and this investigation.

## **Assessment, Care in Custody and Teamwork**

15. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
16. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

## Key Events

17. On 31 May 2021, Mr Brotherton was remanded to HMP Preston charged with criminal damage and affray. This was not his first time at Preston.
18. When he arrived, a nurse completed an initial health screen. She recorded that Mr Brotherton appeared settled, pleasant, and polite. Mr Brotherton said that he had no current mental health issues, was not on any medication and that he smoked cannabis occasionally. Mr Brotherton said that he had cut himself 'years ago' but had no current thoughts of harming himself.
19. Staff completed a first night interview with Mr Brotherton. He said that he would have support from his family while in prison and that he had no immediate concerns. Although he had self-harmed in the past, he again said he had no current thoughts of suicide or self-harm.
20. On 1 June, an officer completed a keyworker session and the final part of the induction with Mr Brotherton. Mr Brotherton raised no concerns with the officer.
21. At 6.30pm on 3 June, Mr Brotherton rang his emergency cell bell. When staff attended, he pointed to five empty boxes of paracetamol on the ground outside his cell. Mr Brotherton told staff that he had taken them all because he had not been given a pillow since arriving onto the wing. Mr Brotherton became threatening toward staff and said that he had a weapon. As a result, nursing staff were unable to go into his cell and assess him.
22. Mr Brotherton smashed the observation panel of his cell door. A duty manager calmed Mr Brotherton down and healthcare staff then assessed him. Staff started suicide and self-harm prevention procedures, known as ACCT, and set observations at four per hour. Nursing staff took a blood sample from Mr Brotherton, and the results indicated that he needed hospital treatment. At 1.00am on 4 June, Mr Brotherton was taken to hospital and was admitted as an inpatient. On 5 June, he was discharged from hospital and returned to prison.
23. On his return, staff completed an ACCT review, which was attended by a member of the prison's Integrated Mental Health Team (IMHT). They recorded that Mr Brotherton engaged well and appeared to be in good spirits. The review meeting staff asked him about his recent overdose. Mr Brotherton said he had been stressed by the way staff had treated him (by not providing a pillow). He said that he regretted his rash actions. Mr Brotherton said that he would like to work with the mental health team to address his anger management. He told the review meeting staff that he had no further thoughts of suicide or self-harm. Due to his actions being so impulsive (and potentially life threatening) the review meeting agreed that ACCT procedures would remain in place for a further period of assessment and support.
24. Staff held three further ACCT case reviews with Mr Brotherton. At each of the reviews the trigger for Mr Brotherton's impulsive actions was recorded as stress. On 12 June, the review meeting decided to end ACCT procedures. A post-closure review took place on 18 June, during which Mr Brotherton said that he had no

further thoughts of suicide or self-harm. Mr Brotherton was on the waiting list for support interventions to address his impulsive behaviour.

25. On 16 June, Mr Brotherton submitted a self-referral to IMHT. On the referral it was stated that Mr Brotherton wanted a mental health screening and to be prescribed medication. The IMHT triaged the referral the next day and recorded on Mr Brotherton's medical record that he had been added to the GP list to consider whether he needed any medication.
26. On 24 and 29 June, Mr Brotherton's was seen as part of keyworker sessions by an officer. On both occasions, she noted that Mr Brotherton was coping well and had no immediate issues, although he had a lot of impulsive angry outbursts. Mr Brotherton told her that he had yet to find any way of managing them. Mr Brotherton said that he had completed a mental health self-referral form but was still waiting for a response. Following the keyworker session on 29 June, she telephoned the IMHT who confirmed that they had arranged an appointment for Mr Brotherton to see the GP to help with any medication.
27. Mr Brotherton's behaviour was sometimes poor. As a result, staff gave him several warnings. On 8 July, prison staff moved him to the segregation unit after he refused to return to his room and then became rude toward staff. He remained in the segregation unit for 24 hours. Staff noted that he was fully compliant the next day.
28. On 12 July, a prison GP saw Mr Brotherton. He noted that Mr Brotherton recorded on his mental health self-referral form that he had been suffering with anxiety and depression for a while, and that in the past, he had been prescribed mirtazapine and sertraline. Mr Brotherton told him that his mood was 'up and down,' he was struggling to sleep, and his appetite was poor. He recorded that Mr Brotherton made good eye contact, had good body language and there was no evidence of psychosis or thought disorder. He prescribed Mr Brotherton paroxetine (an antidepressant) and advised Mr Brotherton that it could take around two weeks for the medication to take effect.
29. On 22 July, Mr Brotherton attended the first session of the Time4Change course. Time4Change is a 12-week course aimed at young adults aged 18-25, covering a range of topics including gang life, young fatherhood, forgiveness, and conflict resolution, as well as job opportunities, starting businesses and life skills.
30. On 24 July, an officer held a keyworker session with Mr Brotherton. During the session, she told Mr Brotherton that because he had spent time in care as a child, he might be able to access support from a personal adviser allocated to work with him after his release from prison and until he was 25. She explained the role of the adviser, but Mr Brotherton declined the offer.
31. Despite attending and engaging well with the Time4Change course, Mr Brotherton continued to display poor behaviour on the wing. Prison staff issued several warnings for breaches of the prison rules.
32. The Custodial Manager (CM) who leads the Time4Change programme at Preston told the investigator that Mr Brotherton was initially quiet when the course began, but as the weeks went by, he was more open and engaged well. Both the CM and other staff involved in the course, told the investigator that there was a noticeable

improvement in Mr Brotherton's behaviour. During a Time4Change group on 12 August, Mr Brotherton was invited to tell the group the story of his upbringing and family relationships at the next session. Mr Brotherton struggled to read and write, and staff agreed that one of the mentors, with whom he had a close bond, would help him to write his story and share it with the group.

33. On 17 August, Mr Brotherton made superficial cuts to his forearm. Staff started ACCT procedures and, following an assessment, conducted an ACCT case review on 18 August. Mr Brotherton told the review meeting that he had self-harmed in frustration at not being unlocked to complete his story for the group session. Mr Brotherton accepted that wing staff were sometimes busy, and that he had since been able to complete his story. Mr Brotherton said that he felt the course was having a positive impact on his general outlook.
34. Caremap actions for Mr Brotherton included for him to continue to engage with the Time4Change programme and maintain contact with family and friends. A mental health nurse attended the ACCT case review, and Mr Brotherton spoke to him about his medication. Mr Brotherton told him that he did not feel that his medication was working. The nurse said that he would arrange a medication review. He recorded that Mr Brotherton had a well-kempt appearance, a laid-back presentation and engaged well with the review.
35. Mr Brotherton also told the ACCT case review meeting that cutting his arm had been an impulsive act, and that he occasionally used self-harm to regulate his emotions. He said that he did not have any suicidal intent or any further thoughts of self-harm. He said that he had regular contact with his family by telephone and was expecting a visit from his brother and stepmother the following week, and that he was looking forward to it.
36. During the review, Mr Brotherton told the nurse that he had recently had an independent psychiatric report completed for court and was not sure of the outcome. The nurse told Mr Brotherton that he would speak to the psychiatrist at her next clinic. The review meeting agreed that the ACCT would be closed with a post-closure review planned for 25 August.
37. The nurse told the investigator that a psychiatrist working at Preston had been asked to complete a court-ordered psychiatric assessment of Mr Brotherton. The psychiatrist told the nurse that she would ask the judge if a copy of the report could be made available to the IMHT. However, the nurse said that the report was never provided. On 10 August, healthcare staff asked the psychiatrist whether she intended to prescribe Mr Brotherton quetiapine, (prescribed for mental health conditions, including schizophrenia and bi-polar disorder) but there is no record of her response. Mr Brotherton had no formal diagnosis of any mental health condition.
38. On 19 August, Mr Brotherton attended the Time4Change discussion group, and his mentor read his story to the group. The CM told the investigator that Mr Brotherton's story was very upsetting and while it was being read out Mr Brotherton sat with his back to the group and found the process difficult. He said that Mr Brotherton was supported throughout the group session. He said that he had advised the safer custody team so that they could follow up and see if Mr

Brotherton needed any further support. He also felt that Mr Brotherton would benefit from one-to-one counselling and submitted a referral to the IMHT.

39. On 25 August, staff completed the ACCT post-closure interview with Mr Brotherton and no further concerns were recorded.
40. On 29 August, while on the exercise yard, Mr Brotherton pulled down the pants of a fellow prisoner, exposing him to the rest of the prisoners. Staff placed him on report. The following day, Mr Brotherton attended an adjudication for his actions. Because the incident could be considered sexual assault, it was referred to the police and the adjudication was adjourned.
41. On 1 September, staff completed routine monitoring checks of Mr Brotherton's telephone calls from the previous day. During a telephone conversation with his father, Mr Brotherton said that if he was charged with a further offence, he would be found hanging from the light fitting. It is not clear what Mr Brotherton was referring to, possibly the alleged sexual assault that had been referred to the police. The nature of the call was immediately reported to prison staff on D wing who spoke to Mr Brotherton. Mr Brotherton told staff that he had not made any comments about harming himself. He said that he was all right and that he had no issues. Staff recorded that Mr Brotherton was aware that if he needed any support, he could either talk to staff or wing Listeners (prisoners trained to offer support to other prisoners) or use the Samaritans telephone. Staff did not consider starting ACCT procedures and they did not record the information in his prison file.
42. On 7 September, in response to the referral submitted to the IMHT by the CM, a psychological wellbeing practitioner assessed Mr Brotherton for counselling. Mr Brotherton told her that he had received support from community mental health services when he was around 15-16 years old, but he could not remember why. He said that he had previously self-harmed, and his last act of self-harm was about a month ago. Mr Brotherton also said that he only got the urge to self-harm when he was angry as the sight of blood calmed him down. He said that he had no such thoughts at that time and denied any previous suicide attempts.
43. The psychological wellbeing practitioner completed a Patient Health Questionnaire 9 (PHQ9, to assess levels of depression) with Mr Brotherton and he scored 15, which indicated moderately severe depression. She also completed a generalised anxiety disorder questionnaire and Mr Brotherton scored 7, which indicated that he had mild anxiety. Mr Brotherton told her that he considered himself to be a risk to others because he was unpredictable and said that his mood changed quickly and randomly. He said that he could sometimes stay in a hostile mood for days.
44. The psychological wellbeing practitioner recorded that Mr Brotherton presented with symptoms of moderate anxiety and moderate-severe low mood. He was unable to relax, was always restless and fidgety and easily angered. He had reported hardly sleeping and having difficulty concentrating. Mr Brotherton said that he felt his anxiety and depression were under control and that he hoped if or when he received the quetiapine medication, it would help him further. He also said that he would quite like to engage in counselling. Mr Brotherton talked about previous traumatic events from his childhood, which he said that he had only ever shared with mental health professionals and his peers on the Time4Change course.

45. Mr Brotherton was worried that if he became upset during a counselling session he might lash out and hurt the counsellor. He asked the psychological wellbeing practitioner whether his mentor could attend with him, because he had a close relationship with him and he was able to calm him down. She told Mr Brotherton that there were confidentiality rules and that it would be unusual to have another prisoner present. She said that she reassured Mr Brotherton that he would not be forced to talk about anything. The next day, Mr Brotherton was added to the counselling/talking therapy waiting list.
46. On 9 September, the psychological wellbeing practitioner and the counsellor went to see Mr Brotherton on the wing, but he was not there. They recorded that they would re-arrange to see Mr Brotherton but there is no evidence that any further attempts were made to see him.
47. On 10 September, an officer went to check on Mr Brotherton following a knife crime discussion during the Time4Change session. Mr Brotherton told him that the presentation had been about a friend, so it had affected him, but that he was fine. Another officer also saw Mr Brotherton for a keyworker session on 14 September, and they spoke about the session. Again, Mr Brotherton said it had been about someone he knew, and the incident had taken place outside his grandmother's house, but he was doing all right and was fed up with people coming to see him about it. No further concerns were reported.
48. On 18 September, Mr Brotherton cut another prisoner's face with a bladed weapon. Staff moved him, without force, to the segregation unit.
49. Staff completed the Segregation Safety Algorithm when Mr Brotherton arrived in segregation unit. The safety algorithm must be completed by a nurse to indicate any medical reasons why an individual should not be held on the unit and is countersigned by a senior prison manager. A nurse completed the algorithm and indicated that there were no medical reasons why Mr Brotherton should not be held in the segregation unit. She told the investigator that she was aware that Mr Brotherton had engaged with the IMHT at some stage, but as he was not being prescribed antipsychotic medication and was not under their care, there was no need for them to be informed. Another nurse countersigned the document.
50. On 19 September, segregation unit Officer A recorded that Mr Brotherton had been polite and respectful towards staff. He had been offered a shower and exercise and he raised no concerns. Mr Brotherton was also seen as part of the daily segregation rounds by a nurse. The nurse recorded that Mr Brotherton engaged well and asked about being restarted on quetiapine. She told him that she would highlight his request on his medical notes. During his contact with her, Mr Brotherton denied any thoughts of suicide or self-harm.
51. That day, a Supervising Officer (SO) went to the segregation unit along with Officer A to speak to Mr Brotherton about the incident the previous day. Mr Brotherton told them that the prisoner he had assaulted had previously assaulted Mr Brotherton's cousin while at another establishment. The SO said that Mr Brotherton was very matter of fact about his actions but then accepted that he had gone too far. Mr Brotherton told her that he did not want to be moved from D wing and was keen to remain on the Time4Change course. They discussed the fact that he would likely be subject to a Challenge Support and Intervention Plan (CSIP, the Prison Service

system for managing violence in prisons). Mr Brotherton said that he understood the reasons for this.

52. The SO arranged for one of the D wing mentors to visit Mr Brotherton in the segregation unit. It is unusual for prisoners to be allowed visits from other prisoners while in the segregation unit, but following a discussion with the duty governor, she arranged this. She said that when the mentor came down to the segregation unit, they discussed with Mr Brotherton his actions and how he could have dealt with things differently, which she said he had accepted.
53. The SO considered starting ACCT procedures as she was aware that Mr Brotherton had been subject to monitoring previously, but ultimately decided it was not necessary. She said that she considered the conversations she had with him, his location in the segregation unit (which is known to increase the risk of suicide), his disclosure of past childhood trauma and previous history of self-harm. She said that Mr Brotherton denied any thoughts to harm himself, spoke about moving back to D wing and re-engaging with the Time4Change course, and accepted the need to segregate him and begin CSIP procedures following the assault.
54. The next day, Mr Brotherton attended the adjudication hearing for his assault of the prisoner on 18 September, which was chaired by a senior manager. Mr Brotherton pleaded guilty to the charges, but due to the serious nature of the assault, the adjudication was adjourned while the police decided whether to charge Mr Brotherton with a criminal offence. Healthcare staff updated the segregation safety algorithm, and again indicated that there were no medical reasons against segregation.
55. The senior manager said that he had explained to Mr Brotherton that he would remain in the segregation unit and would have a review in a couple of days, and they might know then whether the police were going to proceed with any charges. Mr Brotherton accepted this and appeared all right.
56. Later that day, staff recorded on the segregation paperwork that Mr Brotherton continued to engage with the unit regime and staff allowed him to exercise, shower, and use the telephone. A prison GP saw Mr Brotherton briefly while carrying out a routine segregation visit and recorded that he appeared fit and well with no evidence of acute mental illness.

### **Events of 21 September**

57. On the morning of 21 September, Mr Brotherton attended another adjudication hearing for the incident in the exercise yard. The police had decided not to charge Mr Brotherton so the adjudication hearing could go ahead. Mr Brotherton was found guilty and as received 14 days cellular confinement in the segregation unit. A nurse updated the safety algorithm and confirmed that there were no medical reasons against segregation.
58. At around 11.00am, a member of the prison's Independent Monitoring Board made a routine visit to the unit. He asked Mr Brotherton if he had any problems and Mr Brotherton said he was fine.

59. In the afternoon, two officers were on duty in the segregation unit. Officer B was completing paperwork in the office and Officer C was allowing prisoners out of their cells one at a time to use the showers and telephone.
60. In his written statement, Officer C said Mr Brotherton was well behaved and chatty while in the unit. When he came on duty that day, he checked the unit observation book to see if there were any issues that he needed to be aware of and there was nothing recorded. Just after 1.30pm, he went to each of the cells to collect the lunch trays. Officer C said that when he opened Mr Brotherton's cell, he was lying on his bed and got up and passed the tray to him. He asked him if he was all right and Mr Brotherton replied 'Yeah'.
61. At 2.00pm, Officer C completed a welfare check on all the prisoners. He looked in on Mr Brotherton who was sat up on his bed and raised no concerns.
62. At 2.48pm, it was Mr Brotherton's turn to use the telephone. Officer C went to his cell to collect him and looked through the observation panel before unlocking the door. When he looked into the cell, he saw Mr Brotherton suspended from the light fitting by a sheet tied around his neck. He said that he immediately shouted to Officer B, who was in the office, and then he entered the cell at 2.49pm. He lifted Mr Brotherton by his waist.
63. A Supervising Officer (SO) responded to Officer C's call for assistance. Officer B and the SO both went to the cell and Officer B radioed an emergency code blue, (indicating a prisoner is unconscious or is having breathing difficulties). Control room staff called an ambulance at 2.53pm.
64. The SO cut the ligature from around Mr Brotherton's neck, allowing Officer C to take his weight and lower him to the floor. The officer checked for a pulse but could not find one and there were no signs of breathing. He immediately began CPR. Within minutes, nursing staff arrived with medical equipment including a defibrillator, followed by prison staff from other areas. Staff continued with resuscitation attempts.
65. At 3.09pm, a doctor arrived in a rapid response car, followed by an ambulance at 3.16pm. Nursing staff continued to assist paramedics in attempts to resuscitate Mr Brotherton, and they detected a pulse, but Mr Brotherton could not breathe without support. He was taken to hospital at 3.42pm and arrived at around 3.55pm. He was taken straight into the emergency department, where efforts continued to resuscitate him.
66. At 4.15pm, the prison telephoned Mr Brotherton's father and told him what had happened. The family arrived at the hospital at 9.35pm. At 11.10pm, a hospital doctor told them that medical treatment was to be withdrawn. At 12.03am, it was confirmed that Mr Brotherton had died.
67. After Mr Brotherton had been taken to hospital, prison staff searched his cell for any signs that would indicate reasons for his actions. Staff found a sealed note Mr Brotherton had written. The police provided the investigator with a copy of the note, in which Mr Brotherton said that he wanted to be prescribed medication to stop the voices in his head. He said it was getting harder to blank them out and they were stopping him from sleeping. He wrote that he could not take much more, and he

feared he might do something silly to stop the voices. He asked for help before it was too late. Nursing staff had last seen Mr Brotherton on 21 September, and he had not asked to see the prison's mental health team at that time.

### **Contact with Mr Brotherton's family**

68. The prison appointed a chaplaincy manager as the family liaison officer. He telephoned Mr Brotherton's father to tell him what had happened and that his son had been taken to hospital. He met the family at hospital later that evening.
69. On 27 September, Mr Brotherton's father visited HMP Preston and met with the chaplaincy manager and the Deputy Governor. Mr Brotherton's father also spoke with staff who had worked closely with his son on the Time4Change programme. Mr Brotherton's father was told that prisoners who had known Mr Brotherton had raised just over £400 for a local mental health charity in his memory.
70. The prison contributed towards the cost of Mr Brotherton's funeral, in line with national guidance.

### **Support for prisoners and staff**

71. The duty manager 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.
72. The prison posted notices informing other prisoners of Mr Brotherton's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case the death had adversely affected them.

### **Post-mortem report**

73. The post-mortem report gave Mr Brotherton's cause of death as hypoxic brain injury. Toxicology tests showed that Mr Brotherton had not used any illicit drugs or unprescribed medication prior to his death.

# Findings

## Assessment of risk

74. There is evidence that Mr Brotherton received good, personalised support from prison staff at Preston, particularly from staff and mentors involved in the Time4Change programme.
75. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when a prisoner is assessed as being at risk of suicide and self-harm.
76. When Mr Brotherton arrived at Preston, staff completed a reception screening, health screening and first night interview, all of which appropriately considered his risk to himself. Staff noted that he had self-harmed sometime in the past but had no current thoughts or intentions of suicide or self-harm. Staff recorded no recent indications that he posed a risk to himself, and he denied any mental health issues.
77. On 3 June, Mr Brotherton told staff that he had taken an overdose of paracetamol and staff appropriately began ACCT procedures which remained open until 12 June, when staff assessed Mr Brotherton's risk to himself had sufficiently reduced.
78. On 17 August, staff began ACCT procedures again after Mr Brotherton made superficial cuts to his arm. The ACCT was closed the same day when staff were reassured Mr Brotherton had no thoughts of suicide or self-harm.
79. On 31 August, during a phone call to his father, Mr Brotherton talked about killing himself if he was charged with further offences. When staff talked to him about this, Mr Brotherton denied having made the comments and told staff that he had no issues. Staff did not start ACCT procedures, record how they reached this decision or record this information in his prison file as a potential trigger for suicide or self-harm.
80. On 18 September, Mr Brotherton seriously assaulted another prisoner and was moved to the segregation unit. He must have known that it was quite likely that this assault would result in criminal charges. Had staff been aware of the nature of his conversation with his father a few weeks earlier, they might have considered beginning ACCT procedures to offer additional support and monitoring. We make the following recommendations:

### **The Governor should remind staff of the importance of:**

- **considering all of a prisoner's current risk factors when assessing risk and that they should not rely solely on what a prisoner says, how they present or their past behaviour in the establishment;**
- **where potential risk has been highlighted and a decision is taken to not open an ACCT, they should record their reasons for not doing so; and**

- **recording potential triggers for suicide and self-harm to help inform future decisions.**

81. The recommendation was accepted and in response the Governor said:

A notice to staff was published in July 2023 reminding staff that when assessing a prisoner's current risk factors in relation to self-harm and suicide, they must take into account all available information from relevant paper and electronic sources including the digital PER, SASH form, Probation and OMU information. In addition, the member of staff must talk to the prisoner and consider their previous and current presentation, although they must not rely solely on this information when making decisions about risk.

The notice also reminded staff of the importance of documenting the reasons for the decision not to open an ACCT and that an entry on NOMIS case notes must be made. This must make clear the nature of the potential risk and why a decision not to open an ACCT has been made.

Staff will also be reminded to consider potential triggers for suicide and self-harm and, if appropriate, open an ACCT. If a decision is made to open an ACCT, information in relation to risks, triggers and protective factors must be entered in the appropriate section. If a decision is made not to open an ACCT, this must be noted on NOMIS and details about potential triggers and protective factors should be recorded.

## **Clinical and mental health care**

82. The clinical reviewer concluded that the mental health care Mr Brotherton received at Preston was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community, due to the following factors.
83. There was no healthcare follow up after Mr Brotherton took a significant overdose of paracetamol. There was a lack of planned follow up from the prison's mental health team and they had minimal input into Mr Brotherton's ACCT reviews, having decided that they were not needed at ACCT reviews.
84. Although Mr Brotherton was referred to the Mental Health Team on 19 August 2021, he was not seen until three weeks later. The psychological wellbeing practitioner and the counsellor attempted to see Mr Brotherton on 9 September, but he was away from the wing on exercise. There is no evidence that they attempted to follow up and arrange to see him again prior to his death.
85. Mr Brotherton had asked that his mentor attend his counselling appointment. This was refused due to confidentiality. Mr Brotherton consented to his mentor being present and staff did not raise any concern about his capacity to make this decision, therefore the clinical reviewer saw no reason why his request was refused and considered that staff should have taken account of Mr Brotherton's individual needs.
86. Mr Brotherton's Independent Psychiatric Report was not shared with healthcare staff. As a result, they were unable to action the psychiatrist's recommendations, including that Mr Brotherton's medication should be changed. The clinical reviewer

considered that although the report was independent and prepared for court, best practice would have been for the mental health team to have sought advice from the psychiatrist about whether a further assessment was needed.

87. Mr Brotherton was prescribed antidepressant medication after his initial health screen. Mr Brotherton had asked for his medication to be changed on 18 June 2021, but he was not seen by the GP until 12 July. The clinical reviewer concluded that Mr Brotherton should not have had to wait 24 days before his medication was reviewed. She considered that an acceptable waiting time was 14 days. We recommend:

**The Head of Healthcare should ensure there is a process in place in the event prisoner requests to have a fellow prisoner/third party in attendance at a counselling session, to ensure that the care needs of the prisoner are taken into account.**

88. The recommendation was accepted, and the Head of Healthcare said:

Chaperone posters are in place in healthcare. A discussion with the mental health service lead took place in March 2023 to ensure that any request for third party attendance is discussed and assessed in line with these recommendations and discussed as part of individualised care plan. Advocacy focus is available and utilised where appropriate.

**The Head of Healthcare should ensure that, where the Mental Health Team is aware of an Independent Psychiatric Report, they request sight of and consider the contents of them as appropriate.**

89. The recommendation was accepted, and the Head of Healthcare said:

The service lead from Tees Esk and Wyre Valley mental health team ensures that if there is information received from the patient or from a psychiatrist that would suggest the existence of a potential unmet care need, then the mental health team should refer this information to the Psychiatrist to actively seek further information to clarify and action the patient's needs.

Once information is received then the mental health caseworker will send an email to solicitor and the Psychiatrist to send a copy of the patients report.

Once received, the document will be scanned in and if required a conversation with the visiting Psychiatrist will take place. If report warrants mental health assessment, if not already completed, then the mental health team should assess appropriately. The Nurse/Professional must ensure this is accurately documented on SystemOne in line with NMC record keeping guidelines.

**The Head of Healthcare and the Mental Health Team Manager should review the process of follow up from the Mental Health Team and how this is completed and monitored.**

90. The recommendation was accepted, and the Head of Healthcare said:

A shared care pathway is now in place in relation to transition of care in-between tiers, including discharge from the mental health team.

The mental health team have admin allocated and will ensure that ledgers are coded correctly for failed to attend appointments to ensure the patient is placed back on the waiting list for follow up appointment.

**The Head of Healthcare should review waiting times for seeing the GP in relation to reviews of antidepressant medication and ensure that there is a triage system in place to ensure prisoners requiring a review of mental health medication are seen within recommended time scales.**

91. The recommendation was accepted, and the Head of Healthcare said:

Reviews are managed by the GP, training to be sourced to train a further clinician to ensure two weeks reviews are being met.

An audit of waiting list to be established. New mental health primary care nurse to hold reviews as part of her workplan.

### **Allegation against segregation unit staff**

92. During the course of the investigation, the investigator was told that a prisoner had claimed that Mr Brotherton had been refused food while in the segregation unit. The prisoner said that Mr Brotherton told a segregation officer that he would self-harm in response and the officer had responded 'Well, go on then'.

93. The prisoner that gave the information did not want to be named, but he said another prisoner in the neighbouring cell to Mr Brotherton, had overheard the conversation and that he had passed this on to Officer C.

94. The investigator asked Officer C about the claim. He said that he was not aware of any issues and no prisoners had raised any concerns about Mr Brotherton with him. He said that during the period that Mr Brotherton was in the unit, there had been no one located next door to him, and that Mr Brotherton had collected all the meals served. He said that along with all prisoners on the unit, Mr Brotherton was observed hourly and was offered the opportunity to shower, use the telephone and go out onto the exercise yard every morning.

95. There were no reports of any issues relating to Mr Brotherton from any other prisoners and the prisoner that provided the details of the alleged incident had himself not been held in the segregation unit. The investigator found no evidence to support these allegations.

### **Other learning**

There was a very small delay between Officer C finding Mr Brotherton hanging in his cell and the raising of the code blue emergency. Control room staff called an ambulance at 2.53pm, four minutes after staff entered the cell and three minutes after a code blue was called. Any delay in calling an ambulance could prove critical in emergency situations. We bring this to the Governor's attention.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100