Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Paine, a prisoner at HMP Liverpool, on 19 February 2018

A report by the Prisons and Probation Ombudsman

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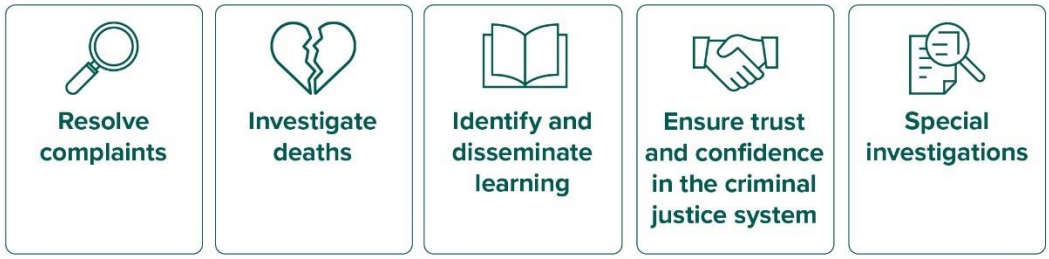
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony Paine died in hospital on 19 February 2018 after being found hanging in his cell at HMP Liverpool earlier that day. He was 35 years old. I offer my condolences to Mr Paine's family and friends.

Mr Paine had a history of serious mental health problems and a diagnosis of schizophrenia. Despite being allocated a mental health key worker after arriving at Liverpool, he was not seen by her in the 20 weeks he was at the prison. The key worker said she had been unable to see him due to her heavy workload. This is unacceptable, especially as Mr Paine was supposed to be on a Care Programme Approach (an enhanced package of measures for those with mental health problems).

Staff were monitoring Mr Paine under suicide and self-harm prevention procedures when he was found hanging and had failed to increase the frequency of observations when his risk escalated in the preceding hours. He had been left alone in his cell after his cellmate was moved out and had been found tying a noose to the light fitting. Clearly Mr Paine was at high risk of suicide at that time.

I am appalled at the condition of the cell that Mr Paine was moved to three days before he died. The walls and ceiling were painted a dark colour, almost black, the light was not working and the windows were broken. These were not acceptable living conditions for any prisoner, let alone one who had been assessed as at increased risk of suicide and self-harm.

Mr Paine was a regular user of psychoactive substances (PS) and his use escalated in the days before his death. I am unable to say what influence Mr Paine's PS use might have had on his decision to hang himself. I am concerned that the prison failed to follow its own substance misuse policy on the numerous occasions when Mr Paine was found under the influence of PS.

This is a deeply disturbing case. In addition to the clear failings in the management of Mr Paine's risks, it also raises issues about the adequacy of Liverpool's response to the concerns raised last year by Her Majesty's Chief Inspector of Prisons and subsequently echoed by the Justice Select Committee. In light of these concerns I am taking the unusual step of sending copies of this report to the Prisons Minister, the Chair of the Justice Select Committee and the Chief Inspector for their information.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **April 2024**

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Summary

Events

1. Mr Anthony Paine was remanded into custody at HMP Liverpool on 2 October 2017 after pleading guilty to criminal damage and affray. He had a history of self-harm, substance misuse and mental health problems, including a diagnosis of schizophrenia.

2. Mr Paine was on a Care Programme Approach (CPA), an enhanced package of care for those with mental health problems, and on 11 October, he was allocated a mental health keyworker. She made several entries in Mr Paine's record that she was unable to see him because of her heavy workload and did not see him in his four and a half months at Liverpool.

3. On 1 February, Mr Paine made superficial cuts to his arms. Staff started suicide and self-harm prevention procedures (known as ACCT). Mr Paine said that he was being bullied on G Wing, including being forced to use psychoactive substances (PS). (He was found under the influence of PS frequently while at Liverpool.) Staff moved him to B Wing on 3 February.

4. On 16 February, Mr Paine was downgraded to basic regime for using PS and for telling staff that he intended to keep using it. He was moved to a different cell on B Wing with a new cellmate who was also on basic regime. The cell's walls and ceiling had been painted a dark colour, almost black, there was no working light and the windows were broken.

5. Due to being on basic regime, Mr Paine and his cellmate remained in their cell throughout the weekend. Staff noted that Mr Paine was displaying bizarre behaviour. He made cuts to his arms and was suspected of being under the influence of PS. However, healthcare staff were unable to attend to him because the cell was in darkness. During this time, Mr Paine's ACCT monitoring remained at three observations during the day and three observations during the night.

6. On the morning of 19 February, staff increased Mr Paine's observations to one an hour and made a request for an urgent mental health assessment. The mental health triage nurse decided to assess Mr Paine that afternoon as part of a multidisciplinary ACCT review. Staff moved Mr Paine's cellmate out of the cell around midday. Staff observed Mr Paine at 12.45pm and 1.25pm when he said he was fine.

7. An officer found Mr Paine distressed and tying a noose (a sheet) to the light fitting at around 2.00pm. He told the investigator that he managed to calm Mr Paine down but the officer did not take the ligature away from him. The officer saw Mr Paine in his cell at around 2.45pm and asked him to pass him the ligature, but Mr Paine said he had already got rid of it through the window. When the officer returned to collect Mr Paine for his ACCT review approximately 15 minutes later, he found him hanging by a sheet from the light fitting. The officer called an emergency radio code and staff responded quickly. They cut Mr Paine down and started cardiopulmonary resuscitation (CPR) until healthcare staff arrived. Ambulance staff arrived promptly and resuscitated Mr Paine. He was taken to hospital where he did not regain consciousness and died later that day.

Findings

8. Staff failed to respond appropriately when Mr Paine's risk of suicide and self-harm escalated in the hours before he was found hanging. After Mr Paine had self-harmed by cutting himself, staff moved his cellmate out, leaving him alone in the cell. Around two hours later, Mr Paine was found tying a noose to the light fitting. Staff failed to remove the noose from him. Despite clear indications that Mr Paine's risk was escalating, his ACCT was not reviewed and his observations remained at one an hour. At the very least, the frequency of observations should have been increased, and given that Mr Paine had been seen making preparations for suicide, the possibility of constant supervision should have been considered. It also appears no proper consideration was given to the impact of removing Mr Paine's cellmate, the presence of whom would generally be regarded as a protective factor.

9. The conditions of Mr Paine's cell were unacceptable, particularly for someone at risk of suicide or self-harm, and not in accordance with Prison Service Instruction (PSI) 17/2012: Certified Prisoner Accommodation. The walls and ceiling were painted in a non-standard dark colour, there were no lights and the windows were broken. We found little evidence that staff attempted to arrange repairs to the cell or to alert senior managers to the cell conditions. Due to the lack of light in the cell, healthcare staff were unable to go into the cell to treat Mr Paine. Mr Paine was kept in this cell for three days and we consider that the inappropriate cell conditions may have negatively impacted on his mental health.

10. We consider it unacceptable that Mr Paine, who was on a CPA and was supposed to be receiving an enhanced package of mental health care, did not meet his keyworker at all during the 20 weeks he was at Liverpool. Nor did he have a mental health assessment or see a psychiatrist. There was limited input from the mental health team at Mr Paine's ACCT reviews.

11. We found that staff did not adhere to their own substance misuse policy in relation to Mr Paine's use of PS. Mr Paine was not always assessed by healthcare when he was under the influence and we found no evidence that staff submitted intelligence reports about his use of PS.

12. We found that some members of staff did not feel supported after Mr Paine's death and that members of healthcare staff involved in the emergency response were not invited to attend a debrief.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that they:
    - remove ligatures from prisoners at the earliest opportunity;
    - hold multidisciplinary case reviews with relevant healthcare staff and other keyworkers providing detailed input if they are unable to attend;
    - set a frequency of observations that is appropriate to the level of risk; and

- review the level of risk and frequency of observations immediately if the prisoner's circumstances and/or presentation change, rather than waiting for the next ACCT review.

- The Governor should ensure that:
  - cell conditions are properly checked and documented, especially in circumstances where prisoners have alerted staff to faults that may require repair;
  - repairs are promptly reported and fully documented and that there is a clear audit trail showing when the fault has been reported and when it has been resolved; and
  - prisoners are not placed in cells that do not meet the minimum requirements, in accordance with PSI 17/2012 and the Governor's Notice to Staff 34-18: Cell Minimum Standards.
- The Head of Healthcare should ensure that mental health services meet the needs of prisoners by:
  - implementing a referral system that results in a timely, face-to-face assessment using all relevant information for appropriate continuity of care and follow-up;
  - ensuring that care plans are adhered to and adequate resources are available so that prisoners can have regular face-to-face contact with their keyworkers; and
  - ensuring prisoners have access to services equivalent to those in the community.
- The Governor should ensure that staff adhere to the requirements of Governor's Notice 107-17 when prisoners are suspected of using PS.
- The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all staff involved in the incident, including healthcare staff, are invited to attend.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Paine's prison and medical records.

15. NHS England commissioned an independent clinical reviewer to review Mr Paine's clinical care at the prison.

16. The investigator and clinical reviewer interviewed 11 members of staff at HMP Liverpool. The investigator interviewed one prisoner and two members of staff on her own. The interviews took place between March and September 2018.

17. We informed HM Coroner for Liverpool of the investigation who sent us the results of the post-mortem examination. We have given the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Paine's mother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Paine's mother wanted to know if Mr Paine was being bullied, whether he was being monitored; why he was in a cell on his own, and how quickly staff responded to the emergency when he was found hanging.

19. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

20. We sent a copy of our initial report to the legal representatives of Mr Paine's mother. They found no factual inaccuracies.

21. After we issued our initial report, we were notified that the police had resumed their investigation. Two members of prison staff at Liverpool were subsequently charged with gross negligence manslaughter and failing to take reasonable care for the health and safety of Mr Paine. They appeared in court in November 2023 and were found not guilty on both counts. We delayed issuing our final report until the criminal case had concluded.

Background Information

HMP Liverpool

22. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 1400 adult men. Lancashire Care NHS Foundation Trust provides health care services at the prison.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Liverpool by HM Inspectorate of Prisons (HMIP) was conducted in September 2017. Inspectors found that only 22 of the 89 recommendations made in the 2015 inspection had been achieved and that 'the bare statistics of the failure to respond to previous inspection findings do not adequately describe the abject failure of HMP Liverpool to offer a safe, decent and purposeful environment'.

24. The inspection found that living conditions for many prisoners were extremely poor. Many cells lacked the basic requirements for health, hygiene and safety and should not have accommodated prisoners. Thousands of maintenance jobs were outstanding.

25. Inspectors found that violence had increased significantly and drug availability and use were high. Levels of self-harm were increasing and the overall strategic response to reducing self-harm was underdeveloped. The prison had anywhere between 70 and 90 men on an ACCT at any one time. Inspectors found that ACCT documentation was variable and required improvement. Triggers were incorrectly recorded, caremaps lacked detail and some observational entries were poor.

26. Inpatients had a very poor regime and were offered little therapeutic activity. Mental health service provision had deteriorated. One registered mental health nurse was assigned each day to attend all ACCT case reviews which inspectors found to be disproportionate and to undermine the capacity of the mental health team which was stretched to unacceptable levels. It was recommended that a more proportionate and risk based approach be developed by the prison.

27. In February 2018, the Justice Select Committee published a report finding that HM Prison and Probation Service (HMPPS) had failed to respond properly to HMIP recommendations to improve safety, conditions and other outcomes for prisoners at Liverpool.

Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 December 2016, the IMB stated that there was a gap in services at Liverpool for prisoners with personality disorders and serious mental health issues. The sectioning of prisoners and their transfer to mental health facilities were taking an unacceptable amount of time. The IMB also reported that some prisoners had been put in cells with no electricity and

no water and blocked toilets. Although prisoners had been moved from these as quickly as possible, it was still unacceptable.

Previous deaths at HMP Liverpool

29. Mr Paine was the 17th prisoner to die at Liverpool since February 2015. Seven of the previous deaths were self-inflicted, eight were from natural causes and one was unascertained. In previous investigations, we identified deficiencies with the operation of suicide and self-harm prevention procedures as well as issues in assessing and monitoring risk. In our report on a self-inflicted death at Liverpool in October 2016, we found that the prisoner was held in a dark and dirty cell with broken windows that at times lacked working light fittings and other facilities and which we described as 'wholly unacceptable'.

Assessment, Care in Custody and Teamwork

30. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

31. 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 (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

32. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Psychoactive Substances (PS)

33. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

34. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction

strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

35. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

36. Mr Anthony Paine was remanded into custody at HMP Liverpool on 2 October 2017 after pleading guilty to criminal damage and affray. Reception screening staff noted that he had a history of self-harm, substance misuse and mental health problems as well as some physical health problems (including a stroke two years earlier, heart disease, high blood pressure and an aneurysm). A nurse carried out Mr Paine's initial healthcare screening. She noted that he had a diagnosis of schizophrenia and that he required a psychiatric report, but she did not refer him to the mental health team. Mr Paine disclosed disabilities in relation to reduced physical capacity and mental illness and said he had no thoughts of suicide or self-harm.

37. A GP prescribed amisulpride and olanzapine (to treat schizophrenia), atenolol (for heart condition), mirtazapine (antidepressant), atenolol (for heart condition), perindopril erbumine (for high blood pressure), simvastatin (to reduce cholesterol) and folic acid. The GP also noted that Mr Paine required a blood test so that he could prescribe warfarin (blood thinning medication).

38. On 3 October, Mr Paine attended a substance misuse induction session. He was allocated a substance misuse keyworker and referred for counselling.

39. On 6 October, a nurse recorded that Mr Paine refused his amisulpride medication, saying that he would not take it again until he saw the doctor as it was causing him difficulties sleeping. Mr Paine took the rest of his prescribed medication.

40. On 9 October, Mr Paine was allocated a mental health caseworker, a mental health nurse, following a multidisciplinary team meeting. The meeting had been held following a mental health alert from the Criminal Justice Liaison Team (CJLT) which identified Mr Paine's mental health and substance misuse risks as well as concerns raised by his mother about risks of self-harm. On the same day, Mr Paine had an initial assessment with his substance misuse keyworker and agreed to do group work and one-to-one work to address his substance misuse issues. He also asked for his mother to be involved.

41. On 13 October, Mr Paine had a secondary reception health screening with a nurse. She noted that he had a diagnosis of schizophrenia and that he was under the care of the mental health team in the community, subject to the CPA, and complying with his medication. Mr Paine told her that he had no current thoughts of suicide or self-harm but had self-harmed a year ago.

42. Mr Paine's mental health records were requested from his community GP on 16 October. On 17 October, his mental health caseworker wrote in his records that he was 174th on the waiting list to see the GP for a review of his medication. She also made a Datix entry (the NHS Trust's incident reporting system) to say that she had been unable to see him that day due to workload pressures.

43. On 27 October, Mr Paine was found to be under the influence of psychoactive substances (PS). Healthcare staff saw him and gave him his usual evening medication. Staff did not submit an intelligence report.

44. On 31 October, Mr Paine had an appointment with his substance misuse keyworker who noted that he presented well and showed a good awareness about his use of PS.

45. On 3 November, his mental health caseworker wrote in Mr Paine's records that he was 78th on the waiting list to see the GP for a review of his medication and that his community mental health notes were still awaited. She made a Datix entry to say that she was unable to see him due to workload pressures. Mr Paine was still refusing to take his amisulpride but he was taking his other prescribed medication, including antipsychotics and antidepressants.

46. On 11 November, his mental health caseworker made a Datix entry to say she was still unable to see Mr Paine due to workload pressures. She noted that he was not taking amisulpride but that his medication review with the GP was pending.

47. On 15 November, Mr Paine had a medication review with a GP. At Mr Paine's request, the GP stopped his amisulpride, prescription. He increased the dosage of his antidepressants. The GP noted no concerns about Mr Paine's mental health and no concerns about suicide or self-harm.

48. On 16 November, his mental health caseworker made a request to the mental health administrative team for a routine psychiatrist appointment for Mr Paine. She noted that he had not been seen by a psychiatrist since his arrival at Liverpool.

49. On 20 November, his mental health caseworker made a Datix entry to say that she had still been unable to meet with Mr Paine due to workload pressures.

50. On 27 November, Mr Paine was suspected of being under the influence of PS and was seen by healthcare staff. Staff did not submit an intelligence report.

51. On 10 December, his mental health caseworker made a Datix entry to say she was still unable to see Mr Paine due to workload pressures. She noted that Mr Paine was working with substance misuse keyworker and had recently been suspected of using PS.

52. On 13 December, a nurse sent a referral to the mental health team as Mr Paine told her he would not be taking any more medication for his physical health. He said this was because he was upset that, when he had seen a nurse previously about dental pain, he had only been given codeine. The nurse wrote in his notes that she was worried his refusal of medication could be linked to a decline in his mental health. On the same day, Mr Paine attended a counselling session with his substance misuse keyworker where they reviewed his substance misuse recovery plan and he agreed to attend a new group session.

53. On 14 December, Mr Paine was suspected of being under the influence of PS and was assessed by healthcare staff. Staff did not submit an intelligence report. Mr Paine met with his substance misuse keyworker again on 19 December and she noted that he still seemed motivated to address his substance misuse and attend the group sessions.

54. On 30 December, staff suspected Mr Paine was under the influence of PS and healthcare staff withheld some non-critical medication. Staff did not submit an intelligence report.

55. On 31 December, his mental health caseworker made a Datix entry stating that she was still unable to see Mr Paine due to workload pressures. She noted that he had a pending appointment with the psychiatrist on 15 January and that he was continuing to misuse substances.

56. On 4 January 2018, Mr Paine failed to attend a substance misuse group. He met with his substance misuse keyworker the following day who told him that she was concerned by his lack of motivation, but she arranged to see him again on 29 January. The following day, staff suspected Mr Paine was under the influence of PS again. He refused his medication later in the evening. Staff did not submit an intelligence report about Mr Paine's use of PS but an intelligence report was submitted the following day when Mr Paine became angry about his medication and made a threat to healthcare staff.

57. On 7 January 2018, Mr Paine damaged his cell on G Wing which he shared with three others, stripped naked and covered himself in soap. He also flooded the cell which resulted in his personal belongings being damaged. He was taken to the segregation unit under restraint, where he was seen by healthcare staff and no concerns were noted. Mr Paine initially said he had done this as he was angry that he had not received his medication. However, he later told staff that he was being bullied but was not prepared to say who was bullying him.

58. On 13 January, while still in the segregation unit, Mr Paine was seen by his mental health caseworker as the duty mental health nurse. His mental health caseworker had no concerns about him and noted that he declined to see the mental health team. She noted that he had a pending psychiatrist appointment on 22 January and that he was on the mental health team caseload. The following day, his mental health caseworker made a Datix entry stating that she was still unable to see Mr Paine as his allocated worker due to workload pressures.

59. On 15 January, Mr Paine attended court for sentencing. He was seen by the CJLT and he had a psychiatric report prepared by his defence team. The CJLT did not have any concerns about Mr Paine's mental health and the psychiatric report did not contain anything that would affect his sentencing. He was sentenced to 18 months imprisonment for criminal damage and affray. Mr Paine had an appointment scheduled with the prison psychiatrist for the same day, but this was rearranged to 22 January.

60. On 16 January, Mr Paine met with his offender supervisor to discuss his sentence plan. He told her that he wanted to address his substance misuse and that he was taking medication for schizophrenia.

61. On 22 January, Mr Paine was due to see the psychiatrist for the first time, but the appointment was cancelled. The reason for the cancellation is not recorded. His mental health caseworker requested that the appointment should be rearranged as a priority but she did not see him. An appointment was rearranged for Mr Paine to see the psychiatrist on 29 January but Mr Paine did not attend. It is not clear if Mr Paine was aware of the rearranged appointment.

62. On 28 January, his mental health caseworker completed a mental health care plan based on information from Mr Paine's medical record. She still had not had a face-to-face appointment with him. She told the investigator and the clinical reviewer that she had been told by a manager that the care plan needed to be completed, even though she had not seen Mr Paine. She said she knew that she would be unable to carry out the work within the care plan but said she felt she had to do it as instructed.

63. On 31 January, Mr Paine climbed over the railings on G Wing and fell onto the netting, hurting his back. His substance misuse keyworker was on her way to see him when she saw this happen. Healthcare staff assessed him and noted that he was under the influence of PS. Mr Paine said that he had pain in his lower back and that he needed an X-ray. He was examined but not given any pain relief. He was told to contact healthcare if he had any further problems. His substance misuse keyworker said that she tried to see Mr Paine later in the day but was told by staff that they would not be able to unlock him as he had been under the influence of PS earlier in the day.

64. On 1 February, Mr Paine made superficial cuts to his arms. He said he did this because he was still waiting for pain relief for his back injury. He threatened to jump from the landing and said that he would refuse all medication. Staff started suicide and self-harm prevention monitoring (ACCT procedures). By the time of the ACCT assessment interview, Mr Paine had also attempted to tie a ligature around his neck but staff had intervened to stop him. At the ACCT assessment interview, Mr Paine told a supervising officer (SO) that he was being threatened on G Wing, that he had had a knife held to his throat and that he had been made to fight with his cellmate. He said he did not know the reason for the bullying and thought it was a case of mistaken identity as he was being called “a nonce”. Mr Paine said he didn’t want to die, but he wanted the problems to end.

65. The first ACCT review was held later in the afternoon and was chaired by an SO. It was also attended by another SO and a mental health nurse. Mr Paine said that other prisoners had also been forcing him to take PS. He said the bullying had been going on for about a week and he wanted to move from G Wing. Staff assessed Mr Paine’s risk as raised and set hourly observations. Violence reduction staff spoke to Mr Paine immediately after the ACCT review and started an investigation into his bullying allegations. Mr Paine was moved to B Wing on 3 February.

66. Mr Paine had his second ACCT review on 3 February which was chaired by an SO and attended by another SO. No one from healthcare attended. He told staff he was happy to have moved to B Wing and said he had previously self-harmed as a cry for help as he was being bullied on G Wing. The SOs reduced Mr Paine’s risk to low and also reduced the frequency of monitoring to three daily observations and three nightly observations.

67. On 8 February, Mr Paine had his third ACCT review which was chaired by an SO and attended by a nurse from the mental health team. Mr Paine said he no longer needed to be monitored on an ACCT as he was happy that he had moved to B Wing. He said he had no thoughts of suicide or self-harm. The SO and the nurse were concerned that he had made a noose a few days earlier, so decided to keep the ACCT open and monitor him for a further week. Staff assessed his risk as low and his observations remained the same.

68. On 9 February, Mr Paine’s mother called the prison’s Safer Custody Careline to say she was concerned about her son. Staff told Mr Paine’s mother that her son had been moved to B Wing and that he was settled and happy with his new cellmate. Mr Paine’s mother visited him at the prison the following day.

69. On 14 February, Mr Paine was found to be under the influence of PS twice during the day. Healthcare attended but he declined to have a full assessment and later denied using any drugs.

70. On 15 February, Mr Paine was due to have his fourth ACCT review at 9.20am but this had to be rearranged as he was under the influence of PS. Later that morning, he met with his offender supervisor and told her that his back was still hurting after falling onto the netting. He told her that he had no intention of giving up PS and she was worried about the impact this might have on his mental health. She told the investigator and the clinical reviewer that there had been previous occasions when she had tried to see Mr Paine and he had been under the influence of PS. She said that, after she met with Mr Paine on 15 February, she sent an email to his substance misuse keyworker expressing her concerns about his motivation, suggesting they have a meeting to discuss how to support him.

71. On 16 February, an SO downgraded Mr Paine to basic regime for using PS and for telling staff that he intended to keep using it. On the same day, he had his rescheduled ACCT review which was chaired by an SO and attended by another SO. No one from healthcare attended. Due to Mr Paine's behaviour and ongoing use of PS, the SOs decided to continue to monitor him on an ACCT for a further week. Mr Paine's risk was assessed as low. The SO did not change his level of observations so these remained at three times during the day and three times during the night. Mr Paine was moved to a different cell on B Wing, B4-16, with a new cellmate who was also on basic regime. The cell walls and ceiling were painted a dark colour, almost black.

72. The SO told the investigator that she had not seen cell B4-16 before Mr Paine moved into it. She said that it is the job of a Movements Officer to allocate cells and she had not been made aware that there were any problems with the cell. The SO said she was on duty that weekend and no one had reported any problems to her about the cell. She said that it was unusual for a cell to be painted black as they are usually a magnolia colour, but prisoners sometimes got hold of paint and painted the cells themselves.

73. At 11.55pm on 16 February, a night support officer carried out an ACCT check on Mr Paine and noted that he was asleep. She recorded in the wing observation book that Mr Paine's cellmate appeared to be under the influence of PS. She said his speech was slurred, he moved slowly and he used offensive language towards her. She said she had noticed the poor condition of cell B4-16 but she did not report it as she assumed it would have been reported by day staff.

74. On 17 February, Mr Paine and his cellmate were suspected to be under the influence and, at 10.05am, they were seen by a nurse. While the nurse was assessing them, an officer found a table leg in the cell which staff thought could be used as a weapon. Staff removed the table leg and submitted an intelligence report. The same morning, an officer noted that Mr Paine said he needed to move to another cell because he was not getting on with his cellmate. (His cellmate told the investigator that there had been no problems between him and Mr Paine.) The ACCT observation record for that day showed that Mr Paine was suspected of being under the influence of PS at 11.45am, 4.30pm and 11.30pm but there is nothing in his medical record to show that he was assessed by healthcare.

75. At 11.30pm on 17 February, Mr Paine told the night support officer, that he had lost his toes. She said that Mr Paine was very distressed and she was concerned that his cellmate was enjoying seeing Mr Paine under the influence. She believed that his cellmate had told Mr Paine that he had lost his toes and said that he was laughing when she tried to reassure Mr Paine that he was fine. She said that,

although it was dark in the cell, she was able to see that there were no injuries to Mr Paine's toes so she told him to get back into bed. She said that, although he was distressed, he was compliant and did not display any aggression towards her.

76. A prison officer attended the cell around 11.45pm after Mr Paine rang his cell bell again. He told her that his toes had been cut off. The officer wrote in the wing observation book that both Mr Paine and his cellmate were under the influence and were acting bizarrely. She also assured Mr Paine that his toes were fine, but healthcare were not called to assess either prisoner. The officer also noted that the light fitting in the cell was broken and logged that a repair was required.

77. The cellmate told the investigator that Mr Paine was distressed as he had cut his toe and it was bleeding. He said staff spoke to Mr Paine through the door but no one came into the cell to see what had happened to him. He said he had been in the cell a few days before Mr Paine joined him. He said the cell was full of rubbish, it was painted black, the windows were broken and there was no light. He said that he was worried about Mr Paine's mental health, that they had both complained about the state of the cell, and that staff were not taking it seriously. He also said Mr Paine kept asking for his medication and saying that he needed to see the nurse but no one from healthcare came to see him.

Events of 18 and 19 February

78. On the morning of 18 February, an officer wrote in the wing observation book that Mr Paine was under the influence of PS. The officer did not call healthcare or submit an intelligence report.

79. At 11.45am, the ACCT observation record shows that Mr Paine collected his lunch, he said he was fine, and no concerns were noted. Mr Paine had a further ACCT observation carried out at 2.20pm and again at 4.30pm when he received his evening meal. No concerns were noted about Mr Paine at these times.

80. At 6.00pm, an officer wrote in the wing observation book that the fire alarm had gone off in Mr Paine's cell. The officer wrote that Mr Paine and his cellmate said they had lit a wick in the cell as they had no electricity.

81. At around 7.00pm, the first responder nurse was called to attend Mr Paine's cell as he and his cellmate were suspected to be under the influence of PS. The nurse said that one of her colleagues had told her that the cell was in darkness and that the occupants had been making threats towards staff, so she did not think it was safe to go into the cell. She said that she spoke to a prison manager who told her that the cell was in darkness and this was not likely to change. She submitted a Datix entry to say that she was unable to assess the occupants of cell B4-16 due to environmental issues and personal safety. She went off duty at around 9.00pm.

82. When the night support officer carried out an ACCT check on Mr Paine at 8.45pm, she complained that there were no lights in the cell. She also noted in the wing observation book that the fire alarm was set off in cell B4-16 at 8.01pm, 8.18pm, 10.45pm and 10.50pm.

83. At around 10.00pm, Mr Paine rang his cell bell and the night support officer attended the cell. Mr Paine told her that he had not had his medication. She said that she arranged for a nurse to speak to Mr Paine and the nurse told him he would

not be getting any medication that evening. There is no mention in Mr Paine's medical record that he spoke to a nurse that evening. The night support officer could not remember which nurse attended and she was also unsure of the reason why Mr Paine's medication was refused, although she suspected it was due to his use of PS. She said Mr Paine then became aggressive and threatening towards healthcare staff. She said he was not abusive towards her but he threatened to cut himself, smash the observation panel, and flick excrement at staff.

84. At 10.20pm, Mr Paine pressed his cell bell again and the night support officer attended. Mr Paine had made cuts to his arms which he showed her through the observation panel. She called healthcare to attend. However, Mr Paine later got into bed and said he did not want to see healthcare as he had only scratched his arms. A nurse wrote in Mr Paine's medical record that she had attended to see him at 11.18pm but she was told by officers that he no longer wanted to see her. Further ACCT observation checks were carried out on Mr Paine at 2.00am, 5.00am and 6.45am and staff noted that he was asleep.

85. At 7.05am on 19 February, Mr Paine rang his cell bell and an officer attended his cell. She said that Mr Paine was being aggressive and making racist comments about healthcare staff. She said that Mr Paine swore at her and he was upset that he was being kept in his cell all weekend due to his use of PS. A Custodial Manager (CM) instructed the officer to place Mr Paine on report for using racist language.

86. At 9.00am, a pharmacy technician went to Mr Paine's cell to give him his medication. Staff were unable to open the cell door as Mr Paine was being verbally abusive and threatening. He said he would throw excrement over anyone who opened the door and he refused to have his medication.

87. At 9.40am, Mr Paine said that he was hearing voices and had made cuts to his arms. An officer said that she attended the cell and opened the door for a nurse to assess him but Mr Paine was being verbally aggressive towards staff. The nurse said that four officers accompanied her to the cell due to Mr Paine's aggressive behaviour. She said she was willing to assess him but, for her own safety, she required officers to be present. She said that Mr Paine objected to the presence of the officers and he swore at her when she refused to treat him in the cell on her own.

88. The nurse said that Mr Paine was very angry towards prison staff and he was complaining about his cell being in darkness. He also told her he had been waiting to see a nurse since the night before and no one had come. The nurse told him that she was unable to see him the night before because the cell was too dark. She told the investigator and the clinical reviewer that the cell was in a poor state of repair and, even at that time of the morning, it was still in complete darkness. She described it as the worst cell she had ever seen. She said she told Mr Paine that she could not treat him as he had refused, but she told him she would return later if he calmed down and consented to treatment.

89. At 11.05am, Mr Paine made cuts to his arms again. Healthcare were called and a nurse attended his cell. Mr Paine was aggressive but allowed the nurse to treat his wounds in the presence of an officer. He told the nurse that he would be refusing any further medical treatment as he had been asking to see mental health and no one had seen him. The nurse made an urgent referral to the mental health team. Mr Paine also said that he had a blade and would continue to self-harm. The officer

searched the cell but was unable to find a blade. She submitted an intelligence report to say that Mr Paine said he had a blade in his possession. The CM told the investigator that Mr Paine's observations were increased to once an hour, although the time this decision was made was not recorded in the ACCT document, and that an ACCT review was arranged to take place that afternoon.

90. The mental health clinical lead wrote in Mr Paine's medical record at 11.38am that a request had been received from wing staff for Mr Paine to have an urgent mental health assessment due to refusal of medication and a hostile manner. The mental health triage nurse said that he checked an icon on the front screen of Mr Paine's medical records but he could not see anything to indicate he was known to the mental health team.

91. The mental health triage nurse said he was about to open Mr Paine's medical record (which would have shown him that Mr Paine was in fact on a CPA and had an allocated keyworker) when he received a phone call from a prison manager telling him that an ACCT review had been arranged for Mr Paine later that afternoon and that the mental health team were required to attend. The nurse said that, due to Mr Paine's aggression and the fact that he was not aware that Mr Paine was known to the mental health team, he agreed with the prison manager that Mr Paine's mental health needs should be assessed at the ACCT review instead. The nurse therefore rejected the request for a separate mental health assessment but did not document the reason for his decision.

92. The CM said that Mr Paine's ACCT review was originally arranged for 2.00pm but it was put back to 3.00pm because the Safer Custody team had to attend an urgent review in the segregation unit. The CM said that just before lunchtime he made the decision to move the cellmate from the cell he shared with Mr Paine as he did not think it was acceptable that he should be eating in a cell that was covered in Mr Paine's blood. He did not increase Mr Paine's ACCT observations once the cellmate had been removed from the cell. An officer checked Mr Paine at 12.45pm and again at 1.25pm and Mr Paine said he was fine.

93. At 2.00pm, Mr Paine pressed his cell bell and an officer attended. The officer found Mr Paine in a very emotional state and tying a noose, made from a sheet, to the light fitting. Mr Paine told the officer that he had not had his medication and he had no lights in his cell. He also asked to speak to the prison chaplain.

94. The officer told the investigator that he spoke to Mr Paine through the cell door for around 30 minutes and managed to calm him down. He said that he persuaded Mr Paine to remove the noose, which Mr Paine threw on the floor. The officer said he did not want to leave Mr Paine's door until he was sure he had calmed down as he was concerned about him. While they were talking, Mr Paine told the officer that his cellmate had been beating him up but he did not give any further information. The officer told Mr Paine he would try to find out what was going on and he left him alone. He did not take the ligature away.

95. The officer said that he returned to Mr Paine's cell at around 2.30pm and found him to be calmer. He said that he told Mr Paine that an ACCT review was being arranged and that he would be seen by the mental health team and the chaplain. The officer said he asked Mr Paine to pass the ligature to him but Mr Paine said he had already discarded it through the window. The officer said he believed what Mr

Paine had said, so he left the cell door at around 2.45pm and Mr Paine thanked him for listening to him.

96. When the officer returned to the cell just before 3.00pm to collect Mr Paine for the ACCT review, he found Mr Paine hanging from the light fitting. He had used a sheet as a ligature. The officer called a code blue over the radio (an emergency code that indicates a prisoner is not breathing and an ambulance is required) at 2.59pm and an ambulance was called immediately. Staff cut Mr Paine down and began CPR. Healthcare staff arrived within two minutes and continued with CPR until paramedics arrived at approximately 3.10pm. The ambulance staff were successful in resuscitating Mr Paine and he was taken to hospital but he never regained consciousness and was pronounced dead at 5.31pm.

97. Mr Paine left a suicide note to his mother saying that he had been beaten up and had been left in his cell for the weekend. He also said that staff had been lying about him and that he had never used “spice” (PS).

Contact with Mr Paine’s family

98. Mr Paine’s mother was listed as his next of kin. The prison’s appointed family liaison officer accompanied by a senior manager and the prison chaplain visited Mr Paine’s mother at her home on 19 February at approximately 6.30pm to tell her about her son’s death. The prison contributed to the cost of Mr Paine’s funeral, in line with Prison Service instructions.

Support for prisoners and staff

99. Staff attended a debrief led by the Governor, but most of the staff directly involved in the emergency response did not attend. However, staff said that they were offered support by the prison’s care team and felt supported by managers and other colleagues.

100. The Governor posted a notice for prisoners informing them of Mr Paine’s death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Paine’s death.

Post-mortem report

101. The post-mortem report concluded that Mr Paine’s death was due to hanging. Toxicology results showed the presence of antipsychotic, antidepressant, anticoagulant and beta-blocker medication in doses consistent with those that were prescribed to Mr Paine. The presence of PS was also detected, but it was not possible to establish when the substances were taken or how they might have affected Mr Paine at the time of his death.

Findings

Management of Mr Paine's risk of suicide and self-harm

102. Staff failed to respond appropriately to Mr Paine's escalating risk in the hours before he was found hanging. Over the weekend of 17 and 18 February, Mr Paine was suspected of being under the influence of PS and on the evening of 18 February, he cut his arms. The next morning, staff increased his observations to one an hour. They also decided to move his cellmate out of the cell because they considered it was unfair to leave him in a cell covered in Mr Paine's blood. However, it appears that no consideration was given to the potential impact this might have on Mr Paine, given that having a cellmate is generally considered to be a protective factor against suicide and self-harm, and no consideration was given to increasing the level of Mr Paine's observations.

103. Around two hours after Mr Paine's cellmate was moved out, Mr Paine was found tying a noose to the light fitting. The officer told us that he spent some time talking to Mr Paine trying to calm him down, but he did not remove the noose from him. He returned a short time later and asked Mr Paine to pass him the noose but Mr Paine said he had disposed of it out of the window. No one checked his cell to see if this was indeed the case. We consider it highly likely that Mr Paine used the same noose to hang himself a few minutes later. The officer told us that Mr Paine was being aggressive and might have had a weapon. While we accept that it might not have been safe for him to enter Mr Paine's cell alone at that time, he should have sought assistance so that the noose could have been removed from Mr Paine.

104. Despite clear indications that Mr Paine's risk was escalating, his ACCT was not reviewed and his observations remained at one an hour. At the very least, the frequency of observations should have been increased, and as Mr Paine had been seen making preparations for suicide, constant supervision should have been considered.

105. We found that key members of staff, such as Mr Paine's substance misuse worker and mental health keyworker, did not attend ACCT reviews. Furthermore, given Mr Paine's complex needs, we were concerned to find that relevant healthcare staff did not attend all the ACCT reviews. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, in particular that they:

- **remove ligatures from prisoners at the earliest opportunity;**
- **hold multidisciplinary case reviews with relevant healthcare staff and other keyworkers providing detailed input if they are unable to attend;**
- **set a frequency of observations that is appropriate to the level of risk; and**
- **review the level of risk and frequency of observations immediately if the prisoner's circumstances and/or presentation change, rather than waiting for the next ACCT review.**

Cell conditions

106. Prison Service Instruction (PSI) 17/2012: Certified Prisoner Accommodation, sets out the minimum requirements for a cell to be occupied by prisoners. It includes cell capacity, heating, lighting, ventilation and the cell call system. Cell B4-16 was in a very poor state of repair. The walls and ceiling were painted in a non-standard dark colour, the lights were not working and the windows were broken.

107. We found it difficult to establish when the damage to the lights and the windows took place. Mr Paine's cellmate said that he found the cell like that when he went into it around 13 February. Mr Paine joined him there on 16 February. Staff have said that the damage was caused by Mr Paine and his cellmate over the weekend. The CM said that daily fabric checks are carried out on every cell and that this would have been done for cell B4-16 over the weekend. However, the prison has been unable to provide us with the records to show that these checks were carried out. We therefore found no evidence that staff carried out daily fabric checks on the cell or alerted senior managers to the cell conditions.

108. Regardless of how or when the damage occurred, it was clear that the walls and ceiling were painted in a dark colour, almost black, from the time that Mr Paine went into the cell on 16 February and that problems with the lights were evident from the evening of 17 February when an officer logged that a repair was needed.

109. We consider that the condition of the cell was unacceptable and not in accordance with PSI 17/2012. We do not consider that any prisoner should have been placed in a cell like this for a whole weekend, but it is particularly concerning that this cell was considered suitable for a prisoner with mental health problems, on basic regime, who was at risk of suicide and self-harm. We consider that the cell conditions may have had a negative impact on Mr Paine's mental health and that he should never have been placed in such an environment. Furthermore, we were concerned to find that healthcare staff were unable to access the cell of a vulnerable prisoner due to the appalling conditions and the lack of lighting. A nurse said that it was the worst cell she had ever seen.

110. We are aware that, since Mr Paine's death, a Governor's Notice has been issued to staff reminding them of the minimum standards required and when a cell should be taken out of use. Nevertheless, we make the following recommendation:

The Governor should ensure that:

- **cell conditions are properly checked and documented, especially in circumstances where prisoners have alerted staff to faults that may require repair;**
- **repairs are promptly reported and fully documented and that there is a clear audit trail showing when the fault has been reported and when it has been resolved; and**
- **prisoners are not placed in cells that do not meet the minimum requirements, in accordance with PSI 17/2012 and the Governor's Notice to Staff 34-18: Cell Minimum Standards.**

Mental health

111. Mr Paine had been receiving care under the Care Programme Approach (CPA) in the community and he was allocated a CPA keyworker, his mental health caseworker, in prison on 11 October. The CPA is designed to support those with mental health problems and his mental health caseworker's role should have included devising a plan of care and having regular meetings with Mr Paine to monitor his progress and provide support. However, his mental health caseworker did not see Mr Paine as his allocated keyworker in the four and a half months he was at Liverpool. His mental health caseworker devised a CPA plan based on SystmOne records rather than any direct knowledge of Mr Paine, and this was done nearly four months after he arrived at Liverpool.

112. Mr Paine did not have a mental health assessment in the time he was at Liverpool. Although three psychiatrist appointments were arranged, two of these were cancelled and Mr Paine failed to attend the other one. The mental health team had limited input into his ACCT reviews and, on the day that he died, the triage nurse failed to realise that Mr Paine was on the mental health team's caseload when an assessment was requested by staff.

113. We heard from staff, including his mental health caseworker and the triage nurse, that it was not possible for them to carry out their duties due to excessive caseloads and conflicting priorities. His mental health caseworker had submitted a number of Datix entries to say that Mr Paine was at risk as she had been unable to see him. Other members of the mental health team said that they had expressed similar concerns about their inability to support patients due to excessive workloads and they felt the prison's healthcare providers were ignoring these serious issues.

114. The clinical reviewer concluded that Mr Paine's mental health care was not equivalent to that which he would have received in the community and we agree with this conclusion. Whatever the reason, it was not acceptable that a vulnerable man like Mr Paine did not receive the mental health care and support he needed. We therefore make the following recommendation:

The Head of Healthcare should ensure that mental health services meet the needs of prisoners by:

- **implementing a referral system that results in a timely, face-to-face assessment using all relevant information for appropriate continuity of care and follow-up;**
- **ensuring that care plans are adhered to and adequate resources are available so that prisoners can have regular face-to-face contact with their keyworkers; and**
- **ensuring prisoners have access to services equivalent to those in the community.**

Substance misuse

115. Mr Paine was found to be under the influence of PS on a number of occasions during his time at Liverpool and this increased in the weeks leading up to his death. Governor's Notice to Staff 107-17: Staff Managing Prisoners Suspected of Using

NPS, dated May 2017, states that staff should contact healthcare to assess the prisoner and confirm if he has been using PS. The Notice also states that staff should submit an intelligence report every time someone is found to be under the influence of PS. We found some instances, particularly in the days before his death, where Mr Paine was suspected of being under the influence of PS but he was not assessed by healthcare. We also found no evidence that intelligence reports were submitted specifically for his PS use. We therefore make the following recommendation:

The Governor should ensure that staff adhere to the requirements in Governor's Notice 107-17 when prisoners are suspected of using PS.

Violence reduction

116. We found that staff took effective action to support Mr Paine when he said he was being bullied on G Wing. He was moved to B Wing on 3 February. We found no further evidence to suggest that Mr Paine was bullied or threatened until the day of his death when he told an officer that his cellmate had been bullying him. By this time, the cellmate was no longer in the cell with Mr Paine. The cellmate said that there were no problems between him and Mr Paine and that he was concerned about him. While we acknowledge that Mr Paine also mentioned in his suicide note that his cellmate had been bullying him, we do not consider that staff would have had sufficient time to investigate this allegation before Mr Paine took his life.

Support for staff

117. We found that some members of staff who were directly involved in the emergency response were not present at the debrief that was held in accordance with PSI 64/2011. Many of the prison staff were distressed and had gone home directly after the incident so they did not attend. However, we heard from some healthcare staff that they were available to attend but were not invited. We make the following recommendation:

The Governor should ensure that, in accordance with PSI 64/2011, a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend.

Inquest

118. The inquest, held on 19 February 2025, concluded that Mr Paine died by suicide contributed to by neglect.

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