

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Cartwright, a prisoner at HMP Onley, on 12 June 2023

A report by the Prisons and Probation Ombudsman

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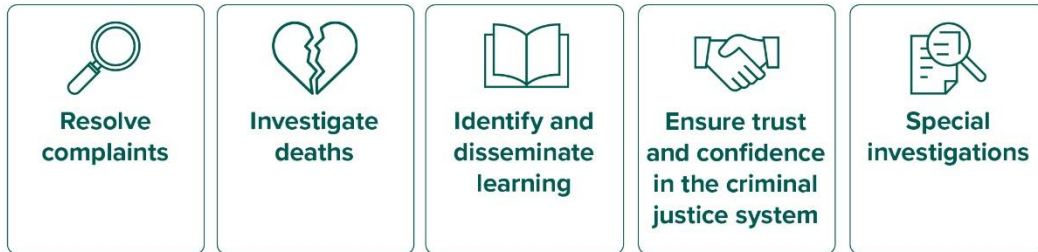
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OUR VISION

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

WHAT WE DO



WHAT WE VALUE



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

Mr Paul Cartwright was found hanged in his cell at HMP Onley on 12 June 2023. He was 42 years old. I offer my condolences to Mr Cartwright's family and friends.

Mr Cartwright's death was the first self-inflicted death at Onley in almost five years.

Mr Cartwright had a history of self-harm but appeared settled in the weeks before his death. I am satisfied that staff could not have foreseen his actions.

I make no recommendations.

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

March 2024

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	12

Summary

Events

1. In January 2023, Mr Paul Cartwright was recalled to prison because of his drug use. He was sent to HMP Dovegate on 23 January.
2. Mr Cartwright had a long history of substance misuse and mental health issues. He heard voices and self-harmed by cutting. On 16 February, he told staff that he had taken an overdose of paracetamol. Staff monitored him and assessed that he had no symptoms of overdose. Blood tests initially showed a borderline result for paracetamol and then a normal result. Mr Cartwright told staff he had done it to get his antipsychotic medication which he had still not been prescribed.
3. On 8 March, Mr Cartwright was moved to HMP Onley. He engaged with the mental health team and was prescribed antipsychotic and antidepressant medication. His mood improved and he seemed to settle.
4. On the evening of 5 May, Mr Cartwright made cuts to his arm. He told staff that he was locked up 20 hours a day, was not getting any help and would “be hanging by the morning”. Staff started suicide and self-harm prevention procedures (known as ACCT) but stopped them the next morning, satisfied that Mr Cartwright was no longer at risk.
5. Staff gave Mr Cartwright a job in the kitchens. His behaviour on the wing was good, and he got on well with staff and peers. However, on 7 June, he told staff that he was anxious about his impending release (in six weeks’ time) because he had fallen out with his family.
6. On 11 June, Mr Cartwright refused to go to his job in the kitchens as he said he did not feel like it. Staff issued him with a warning but said they had no concerns about him. He left his cell and interacted with other prisoners. However, during telephone calls to his mother that afternoon and evening, Mr Cartwright was distressed and said he planned to take his own life.
7. An officer carried out a routine check at 8.00pm that evening and said that he saw Mr Cartwright sitting on his bed and had no concerns. Mr Cartwright made a phone call to a community mental health team shortly after 9.00pm, and left a voicemail message. That was the last call he made.
8. During a routine check at around 5.25am the next morning, an officer found Mr Cartwright hanging. He called a medical emergency code and staff responded. When they went into the cell, they found that Mr Cartwright was clearly dead and so did not start CPR. The Head of Healthcare from a nearby prison verified his death.

Findings

9. We consider that staff stopped ACCT procedures prematurely on 6 May, less than 15 hours after they had started them. We note that it was another month before Mr Cartwright took his own life, but this could have been an opportunity to properly identify his risks and triggers and put more support in place.

10. Mr Cartwright appeared settled in the weeks leading to his death. Staff would have been unaware of the content of the calls he made to his mother on 11 June. We are satisfied that staff could not have foreseen Mr Cartwright's actions.
11. The clinical reviewer found that Mr Cartwright's healthcare was only partially equivalent to that which he could have expected in the community. She made several recommendations, none of which were directly linked to Mr Cartwright's death, which the Heads of Healthcare at Onley and Dovegate will wish to address.
12. We make no recommendations.

The Investigation Process

13. HMPPS informed us of Mr Cartwright's death on 12 June 2023. The investigator issued notices to staff and prisoners at HMP Onley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator visited Onley and obtained copies of relevant extracts from Mr Cartwright's prison and medical records. He interviewed 12 members of staff at Onley.
15. NHS England commissioned an independent clinical reviewer to review Mr Cartwright's clinical care at the prison. The investigator and the clinical reviewer conducted joint interviews of healthcare staff.
16. We informed HM Coroner for Northamptonshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. The Ombudsman's family liaison officer contacted Mr Cartwright's brother-in-law, who was acting as the contact point for Mr Cartwright's mother and the rest of his family, to explain the investigation and to ask if the family had any matters they wanted us to consider. He did not respond.
18. We shared our initial report with HMPPS. They pointed out a factual inaccuracy which has been amended in this report.

Background Information

HMP Onley

19. HMP Onley is an adult male category C prison (the lowest security prisons that are not open prisons) in Northamptonshire. It holds approximately 740 adult male prisoners.
20. Practice Plus Group provides healthcare services, including mental health services. Phoenix Futures provides substance misuse services. A wide range of primary care services are available each day, including weekends. A GP is on duty during normal working hours. There is no 24-hour healthcare cover, and out-of-hours support has to go through the NHS 111 telephone line.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Onley was in May and June 2022. Inspectors reported that there were serious staffing problems. Despite this, staff and management had worked to reduce the supply of drugs and reduce the levels of violence, making a significant improvement in safety. The level of self-harm was 25% lower than the average for similar jails and had continued on a downward trend throughout the previous 12 months. Prisoners who were under ACCT management at the time of the inspection told inspectors that they were generally satisfied with the level of care and support they received.

Independent Monitoring Board

22. 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 28 February 2023, the IMB reported that the health and wellbeing requirements of prisoners were generally being met. Staff shortages had an impact on the regime.

Previous deaths at HMP Onley

23. Mr Cartwright's death was the first death at HMP Onley since August 2018.

Assessment, Care in Custody and Teamwork (ACCT)

24. 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.
25. 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 multidisciplinary 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.

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

Key Events

27. On 18 November 2022, Mr Paul Cartwright was released on licence after serving half of his 16-month sentence for arson. On 18 January 2023, probation staff decided to recall Mr Cartwright because he was using drugs (heroin, cocaine, and psychoactive substances (PS)) and alcohol. He had failed to engage with drug treatment services and had been evicted from his accommodation for drug misuse. On 23 January, he was arrested and taken to HMP Dovegate.

HMP Dovegate

28. At his initial health screen, Mr Cartwright told the nurse that he heard voices, which worsened when he used drugs. He said that he normally took quetiapine (an antipsychotic). The nurse noted that Mr Cartwright had a history of self-harm but had no current thoughts of harming himself. She referred him to the mental health and substance misuse teams.
29. Mr Cartwright was subsequently prescribed medication to treat drug and alcohol withdrawal symptoms, along with medication for some of his physical health conditions.
30. On 31 January, Mr Cartwright had a mental health assessment. He said that he was feeling well and had no thoughts of harming himself, but was concerned that if he did not take his medication he could deteriorate. He said that he heard voices and had done for many years. He asked for quetiapine or another stronger medication as he said he had been struggling mentally since returning to prison and had not been sleeping. The mental health nurse noted that Mr Cartwright needed a psychiatry appointment.
31. On 13 February, a mental health nurse saw Mr Cartwright for a review. The nurse noted that Mr Cartwright was fixated on seeing a psychiatrist so that he could be prescribed quetiapine. The nurse noted that Mr Cartwright showed no symptoms of psychosis but had a diagnosis of mixed personality disorder. She noted that Mr Cartwright was making veiled threats to try to expedite a psychiatrist appointment and reported this to the security and safer custody departments.
32. A GP at Dovegate saw Mr Cartwright and noted that he was on quetiapine and mirtazapine during his last prison sentence but not since then. The GP noted that he had been caught concealing mirtazapine in a previous prison and that she would need to discuss this prescription with the psychiatrist when Mr Cartwright was assessed for quetiapine.
33. On 16 February, Mr Cartwright asked the pharmacist if he could have some paracetamol to take when he needed them. He said that he had headaches each day but did not want to constantly bother staff. The pharmacist told him that he could buy paracetamol from the canteen but if he had frequent headaches then he should book an appointment to have this investigated.
34. That afternoon, healthcare staff discussed Mr Cartwright at a multidisciplinary team meeting (MDT). They noted that he wanted quetiapine and was threatening to “kettle someone” if he was not seen soon. They made a routine psychiatry referral.

(We understand that at that time, the waiting time to see a psychiatrist was 76 days.)

35. On Monday 27 February, Mr Cartwright told a member of the substance misuse team that on the previous Friday, 24 February, he had taken six boxes of paracetamol. He told a nurse that he had taken an overdose because he had not got his quetiapine. Healthcare staff monitored him and noted no symptoms of paracetamol overdose. Staff sent off blood tests and the results showed a borderline result for paracetamol. The blood tests were repeated, and the results were normal. Staff did not begin ACCT procedures.
36. On 3 March, Mr Cartwright underwent an ECG (a test to check the heart's rhythm) with a view to starting him on quetiapine. (It is standard procedure to carry out an ECG before commencing antipsychotic medication. The GP reviewed the ECG result on 8 March but noted that no further action was needed as Mr Cartwright had been moved to another prison.)
37. Mr Cartwright told his key worker that he took the paracetamol because he did not feel mentally stable. When the key worker saw him again on 6 March, he said that he felt much better. He was settled on his wing, had no thoughts of harming himself, and was taking courses to help him move forward.

HMP Onley

38. On 8 March, Mr Cartwright was moved to HMP Onley. At his initial health screen, he told the nurse that he heard voices and had psychosis. He was concerned that his mirtazapine and quetiapine had been stopped. He also mentioned his paracetamol overdose. The nurse referred him to the mental health team.
39. On 9 March, a GP at Onley prescribed Mr Cartwright's medication for his physical health conditions. On the same day, he was sent an invitation letter to engage with the Forward Trust (a drug and alcohol recovery service). We understand that he did not respond.
40. On 23 March, a mental health nurse saw Mr Cartwright. The nurse noted that Mr Cartwright appeared low and was tearful. Mr Cartwright asked for quetiapine and mirtazapine to be re-prescribed to him. The nurse noted that Mr Cartwright should be added to the mental health caseload and that he needed a GP and psychiatry referral.
41. On 28 March, a GP at Onley saw Mr Cartwright. Mr Cartwright said that he had recurring thoughts of self-harm. He said that his mental health improved when he took quetiapine. The GP agreed to prescribe quetiapine and mirtazapine.
42. On 6 April, an officer held a key work session with Mr Cartwright. He said that he did not have any pressing problems. His conduct on the wing was good, and he interacted well with both staff and peers. He was awaiting spaces on the courses he wanted to attend, but did not want any support while not working in the meantime. He was in touch with friends and family through his in-cell telephone.
43. On 8 April, the mental health nurse saw Mr Cartwright. The nurse noted that he engaged well. He said that he still heard voices. He was fairly positive, looking to

and planning for the future. He regularly spoke to his family and his partner. He was trying to organise his remaining time in prison to complete courses to help him on release. He had been engaging with the Chaplaincy Department, who had put him in contact with organisations to support him after release. He was keen to work with the substance misuse team, who had helped him in the past. The nurse formulated a care plan.

ACCT – 5 to 6 May

44. At 8.00pm on 5 May, Mr Cartwright pressed his cell bell. An officer responded and found that Mr Cartwright was very agitated. He complained about being locked in his cell for 20 hours a day (because he was not employed or engaged in education) and said he could not do it anymore. He showed her that he had made cuts to his arm. He said he was hearing voices, that he was sitting in his cell cutting himself and nobody was doing anything to help him. He said he would “be hanging by the morning”.
45. The officer contacted a custodial manager (CM) who attended with another CM. Mr Cartwright said that he had received some documentation relating to his release that day but said that he had fallen out with his sister and was having family issues and problems with his partner. He was concerned that prisoners thought he was a sex offender who shared the same name (there are no sex offenders in Onley). He did not want to engage with the mental health team anymore, and just wanted an increase in his medication to stop the voices. During the conversation he calmed down and handed over a razor blade and assured staff that he had no plans to harm himself further.
46. Staff started suicide and self-harm procedures (known as ACCT) and immediately carried out the assessment interview followed by the first case review. A CM chaired the review, which was attended by another CM, an officer and Mr Cartwright. Mr Cartwright was initially distressed but calmed down during the review. He talked about problems with his family relationships, his fears about other prisoners, and the voices he could hear. He said that he had recently tied a ligature (a belt) to his light to try to electrocute himself. He said that he had no further feelings of wanting to harm himself. Staff removed his belt and set observations at one an hour.
47. At 11.00am the next morning, a CM chaired another ACCT review. Mr Cartwright and the mental health nurse attended. In interview, the nurse said that she had not had the opportunity to read the ACCT document before the review. Mr Cartwright said that he felt in a better place and had no intention of harming himself again. He said that he had only used drugs once since arriving in Onley and he would not do so again. He talked about the support he would need after his release, and said he was considering moving in with his mother but disengaging from people who had a negative impact on him. Mr Cartwright said that he did not need ACCT support and had no intention of harming himself. The case review team agreed to close the ACCT.

May to June

48. On 12 May, the mental health nurse saw Mr Cartwright. He was settled and after having some worries about his partner's health was pleased to have received good news from her. He told the nurse that the only occasion that he had used PS was approximately eight weeks previously. The nurse said that she appreciated Mr Cartwright's honesty and stressed the danger of using illicit substances while taking antipsychotic medication.
49. On 14 May, an officer held a key work session with Mr Cartwright. He said that he had no pressing concerns. The officer offered a wellbeing plan, but Mr Cartwright said he did not need one. His behaviour on the wing had been good, and he got on well with staff and peers. He had started working in the kitchen and was pleased to be doing so. He remained in telephone contact with friends and family. The officer noted that she had no concerns for his welfare.
50. In his ACCT post-closure interview that day, Mr Cartwright said that he was in a much better place, as the issues that had upset him had been resolved. He felt supported by wing staff and had learned to communicate when he felt low. He felt that he had family support and could talk to his key worker. Staff kept the ACCT closed.
51. On 18 May, an officer had a key work session with Mr Cartwright. He said that he had no issues to raise. When offered any further support he politely declined.
52. On 4 June, the mental health nurse saw Mr Cartwright. He presented as well and settled. He was stable in his mental health, was taking his medication, and reported no issues.
53. On 7 June, an officer had a key work session with Mr Cartwright. He was still working in the kitchens. He had applied for enhanced status under the Incentives and Earned Privileges scheme (IEP, designed to reward and encourage good behaviour). During the session, Mr Cartwright was upset, saying that he was due for release in six weeks, and he was anxious about it. He had fallen out with his family, with whom he was going to live. He said that he had no thoughts of harming himself, and while aware of how to access support did not need anything at that time. In interview, the officer said that by the end of the session Mr Cartwright's mood was back to normal and she had no concerns about him. The officer spoke to staff working on the wing and asked them to keep an eye on Mr Cartwright. Later that afternoon she noted that he had collected his meal and was socialising with other prisoners.
54. On 8 June, a pharmacy technician carried out a medication in-possession risk assessment and concluded that Mr Cartwright could hold 28 days' worth of medication in his own possession. The technician incorrectly recorded that Mr Cartwright had no history of self-harm and no issues with drugs or alcohol. (Mr Cartwright was not given any in-possession medication before he died and continued to collect it up to his death.)
55. On 11 June, Mr Cartwright refused to attend work. An officer asked him why, and he said that he did not feel like it. She told the kitchens and then told Mr Cartwright that she would have to give him an IEP warning. She asked him if there was

anything further behind his refusal, and he told her that he “could not be bothered”. The officer gave Mr Cartwright an IEP warning. She told us that he did not appear to be upset or frightened, and left his cell and interacted with other prisoners.

56. In the afternoon and evening of 11 June, Mr Cartwright made several telephone calls to his mother. He was distressed and told her that he planned to take his own life. His last call to his mother was at 7.35pm.
57. During a routine check at 8.00pm, an officer saw Mr Cartwright sitting on his bed and had no concerns. There was no reason to check on Mr Cartwright again during the night and he did not press his cell bell at any point.
58. Mr Cartwright made his final phone call shortly after 9.00pm. He called a community mental health team and left a message for three people who he said had previously counselled him. He said, “Thank you for nothing”.

Events of 12 June

59. During a routine check at around 5.25am, an officer found that Mr Cartwright had blocked the observation panel in his cell door. The officer looked through a small gap and thought he saw Mr Cartwright hanging. He called a code blue (a medical emergency code used when a prisoner is unconscious or having difficulty breathing). The control room called an ambulance.
60. Staff responded to the code blue. A CM tried to open Mr Cartwright’s door, but he had put some furniture behind it. The CM forced the door. She found that Mr Cartwright was hanging by a ligature attached to the ceiling light. The CM used an anti-ligature knife to cut the ligature and lowered Mr Cartwright to the floor. There was blood on the floor, which had come from cuts Mr Cartwright had made to his leg. (He had carved into his leg the words, “The jail has to pay. Don’t let truth be lies.”)
61. In interview, the CM said that Mr Cartwright’s body was cold and stiff, and it was clear to her that he had died. The CM went to the office to telephone the control room to update them. An officer had also responded to the code blue. In interview, he said that Mr Cartwright was not breathing, had no pulse, and was cold and stiff. He used his radio to tell the control room that Mr Cartwright was dead. An Operational Support Grade (OSG) was in the control room and passed this message onto the Ambulance Service who cancelled the ambulance.
62. A nurse arrived for work at 7.10am, and was asked to go to Mr Cartwright’s cell. She noted that Mr Cartwright had rigor mortis and was clearly dead, but she was not trained to verify death. She was unsure why she had been called to attend. None of the medical staff at Onley who are qualified to verify death were on duty that day. The Head of Healthcare at neighbouring HMP Rye Hill is a paramedic and qualified to verify death so staff asked him to attend. He did so, and at 9.55am, confirmed that Mr Cartwright had died.

Contact with Mr Cartwright's family

63. The prison appointed a family liaison officer. The family liaison officer and the Governor went to Mr Cartwright's mother's address and informed her of her son's death. In line with HMPPS guidance, Onley made a contribution to the cost of Mr Cartwright's funeral.

Support for prisoners and staff

64. After Mr Cartwright's death, managers and the staff care team spoke to staff involved in the emergency response to ensure that they had the opportunity to discuss any issues and to offer support. A senior manager later held a debrief session.
65. The prison posted notices informing other prisoners of Mr Cartwright's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Cartwright's death.

Post-mortem report

66. The post-mortem report concluded that Mr Cartwright died from hanging. There were no illicit substances found in his system.

Findings

Management of Mr Cartwright's risk of suicide

67. Staff at Onley correctly started ACCT procedures for Mr Cartwright on the evening of 5 May, when he cut his arm and said that he would "be hanging by the morning". However, they closed it less than 15 hours later, when Mr Cartwright said he felt better and no longer required the support of ACCT. We acknowledge that it was another month before Mr Cartwright took his own life but nevertheless, we consider that the closure of this ACCT was premature. In our view, too much emphasis was placed on what Mr Cartwright said, rather than his risk factors and recent behaviour.
68. The mental health nurse, who was a member of the case review team who closed the ACCT, said at interview that she had not read the ACCT document and was unaware that Mr Cartwright had recently said that he had attached a ligature to the light fitting to try to electrocute himself. It is important that staff attending case reviews know about the individual's recent behaviour, and particularly recent self-harm attempts, so that they can make well-informed judgements about the need for ongoing ACCT support and the level of observations required.
69. We bring these issues to the attention of the Governor and Head of Healthcare.
70. Mr Cartwright appeared to be more settled in the weeks before his death. On 11 June, he refused to attend work but continued to interact with other prisoners, so staff had no concerns. The contents of his telephone calls to his mother that afternoon were clearly concerning, but staff would have been unaware until after his death. We accept that staff could not have foreseen Mr Cartwright's actions.

Clinical care

71. The clinical reviewer concluded that Mr Cartwright's care was partially equivalent to that which he could have expected to receive in the community.
72. The clinical reviewer made recommendations to Onley about medication in-possession risk assessments, physical health monitoring following the prescription of antipsychotic medication, provision of substance misuse services, long-term condition monitoring and healthcare involvement in supporting those being monitored using ACCT. None of these issues were directly related to Mr Cartwright's death but the Head of Healthcare at Onley will wish to address them.
73. The clinical reviewer made recommendations to Dovegate about responding to paracetamol overdoses, handovers to other prisons and long-term condition monitoring. Again, none of these issues related to Mr Cartwright's death but the Head of Healthcare at Dovegate will wish to address them.

Head of Healthcare to note

Verification of death

74. Onley do not have 24-hour healthcare cover, so there were no medical staff present when Mr Cartwright was found hanged at 5.25am. When the nurse came on duty at 7.10am, she was asked to go to Mr Cartwright's cell. It is unclear why, as it was already clear that Mr Cartwright was dead, and the nurse was not able to verify death. Mr Cartwright's death was not verified until a qualified member of staff from a neighbouring prison attended, some hours after he had been found. The Head of Healthcare may wish to consider whether they need a clearer process for verifying death.

Inquest

75. At the inquest, held from 8 to 10 December 2025, the jury concluded that Mr Cartwright died by suicide.

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