

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jason Payne a prisoner at HMP Winchester on 17 August 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

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

Mr Payne was found unresponsive in his cell at HMP Winchester on 17 August 2015. His cause of death was the toxic effects of methadone. Mr Payne was 40 years old. I offer my condolences to Mr Payne's family and friends. The investigation was suspended while the police carried out a related investigation.

We are concerned about the management of Mr Payne's withdrawal from drugs. Staff failed to monitor him appropriately and missed opportunities to follow up serious indications that he was unwell.

We are also concerned that staff should have found Mr Payne much earlier on 17 August and used an appropriate emergency code. Staff then tried to resuscitate Mr Payne, despite clear signs that it was too late.

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

**Richard Pickering**  
**Deputy Prisons and Probation Ombudsman**

**December 2017**

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# Summary

## Events

1. On 12 August 2015, Mr Jason Payne was remanded to HMP Winchester. Mr Payne said he was dependent on drugs and alcohol and a reception nurse referred him to the Integrated Substance Misuse Service. A nurse started him on a substance withdrawal stabilisation programme, so prescribed him methadone and instructed healthcare staff to check him twice daily for five days.
2. Mr Payne was located on the induction wing. Some cells in the prison have modified hatches to allow unhindered observations of prisoners on a withdrawal programme. Mr Payne was not located in one of these cells.
3. On 13 and 14 August, the consultant psychiatrist in the substance misuse team increased Mr Payne's methadone after he reported that the amount was not managing his withdrawal symptoms.
4. During the weekend of 15 and 16 August, Mr Payne did not have his observations taken as required by the stabilisation programme. On 16 August, a nurse took Mr Payne's basic observations at 4.09pm, recorded that his pulse rate was significantly high, but took no further action.
5. At 9.22pm, a nurse and three officers went into Mr Payne's cell to give his medication. He was snoring very loudly, did not respond to officers calling his name or switching the light on. The nurse moved Mr Payne onto his side, into the recovery position. The nurse did not wake him to give him his prescribed medication for alcohol withdrawal, yet signed to say he had.
6. On 17 August, officers recorded that Mr Payne was asleep during morning roll checks. His cell was unlocked at 9.21am, but no one spoke to him. His cell was locked at 11.15am. At 11.55am, an officer unlocked his cell for lunch and noticed he had been in the same position since her earlier roll check, so called another officer for help. When they went into Mr Payne's cell, they found him cold to touch. One of the officers pressed the cell bell for assistance and when others arrived at the scene, a manager radioed an emergency code blue (indicating that a prisoner is unconscious or having difficulty breathing) and the prison called an ambulance. Despite clear signs of rigor mortis, staff attempted to resuscitate Mr Payne. At 12.25pm, paramedics confirmed that he had died.

## Findings

7. We have a number of concerns about the management of Mr Payne's substance withdrawal including his location, observations and missed opportunities to follow up on serious symptoms. Mr Payne's well being was not checked when his cell was unlocked and various further opportunities were missed. When Mr Payne was found unresponsive, staff did not use the appropriate medical emergency code straight away. We are also concerned that resuscitation was attempted when Mr Payne had clearly died.

## Recommendations

- The Governor and the Head of Healthcare should review the Integrated Substance Misuse Service policy and ensure that:
  - All prisoners are located appropriately during the stabilisation process;
  - Observations of prisoners are taken in line with the policy;
  - Any abnormal observation findings are recorded and followed up;
  - Staff working with prisoners receiving drug treatment are trained to recognise the common symptoms of drug induced unconsciousness and methadone toxicity and know how to respond; and
  - Staff should communicate effectively, maintain accurate records and hand over appropriately after their shift.
- The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of prisoners and that there are no immediate issues that need attention.
- The Governor and the Head of Healthcare should ensure that all prison staff understand their responsibilities during medical emergencies and in particular that staff:
  - communicate the nature of a medical emergency, using the appropriate emergency code; and
  - are given clear guidance about the circumstances in which resuscitation is inappropriate in line with established professional guidelines.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Payne's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Payne's clinical care at the prison.
11. The investigator interviewed six members of staff jointly with the clinical reviewer on 28 September and two further members of staff 26 October. Three telephone interviews with nurses took place on 26 October, 10 November and 19 January 2016.
12. We informed HM Coroner for Winchester of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Payne's wife to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not have any specific issues that she wanted the investigation to consider.
14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

# Background Information

## HM Prison Winchester

15. HMP Winchester is an adult male local prison which can hold 685 men. Central and North West London Foundation Trust provide all healthcare services, including primary care, substance misuse services, and mental health services. There is 24-hour nursing cover.

## HM Inspectorate of Prisons

16. The most recent inspection of Winchester was in July 2016. Inspectors reported that the prison had operated a restricted daily routine for many months due to inadequate staffing levels. They found that the prison's drug and alcohol strategy was well managed and that prisoners started drug treatment promptly. They found that only half of prisoners undergoing stabilisation or detoxification were located on the prison's designated stabilisation unit, which limited their access to support.

## Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent published report for the year to May 2016 the IMB noted that new psychoactive substances (NPS) were a challenge for the prison. They found that procedures had been strengthened to prevent the abuse of medication.

## Previous deaths at HMP Winchester

18. Before Mr Payne's death, there had been five self-inflicted deaths and seven deaths at Winchester since 2014. We have made recommendations about the emergency response in three of these previous deaths.

## Key Events

19. On 12 August 2015, Mr Payne was remanded to HMP Winchester, charged with burglary. He had previously been in prison in 2013. At his initial health screen, Mr Payne told a nurse that he spent £200 to £300 on drugs a day including crack cocaine, benzodiazepines, amphetamine and heroin. He also said he drank a lot of alcohol. She could not remember meeting Mr Payne. She recorded in his medical records that he had an irregular heartbeat and that he had previously fidgeted when withdrawing from drugs.
20. Mr Payne was given a single cell on the induction wing. The wing has four cells with modified hatches to allow for closer monitoring of prisoners withdrawing from drugs, but Mr Payne was not located in one of these cells. C Wing is a designated drug treatment wing and has 28 cells with modified hatches. The prison could not explain why Mr Payne was not located in a cell with a modified hatch for observation.
21. Later that day, a nurse from the substance misuse team saw Mr Payne to assess his substance misuse history. He recorded that Mr Payne was dependent on cocaine, heroin and benzodiazepines and prescribed him 20ml of methadone (a synthetic opioid used to treat heroin addiction) daily and started a substance withdrawal stabilisation programme. He assessed Mr Payne using the Clinical Opiate Withdrawal Scale (COWS - an assessment of drug withdrawal), which indicated symptoms of mild withdrawal. He assessed that Mr Payne was also experiencing mild alcohol withdrawal. He recorded that Mr Payne should be monitored twice daily for five days, in line with the prison's protocol for managing substance misuse withdrawal.
22. On 13 August, Mr Payne told a consultant psychiatrist in the substance misuse team that the 20ml of methadone only managed his symptoms for three or four hours and he was frightened of getting withdrawal fits. The psychiatrist increased his methadone to 30ml and also prescribed 10mg of diazepam to help with Mr Payne's benzodiazepine and alcohol withdrawal. He did not record a COWS assessment of Mr Payne's presentation.
23. On the morning of Friday 14 August, a nurse recorded that Mr Payne's pulse rate was 92 beats per minute (a normal rate is between 60 to 100 bpm) and later a nurse recorded a pulse rate of 71bpm. The consultant psychiatrist saw Mr Payne again that afternoon. Mr Payne said that he felt hot and cold, had tremors and was retching. He felt that his current dose of methadone may not be sufficient over the weekend. The psychiatrist recorded his pulse at 80bpm and assessed him using COWS, which still indicated mild withdrawal. He increased Mr Payne's methadone to 40ml per day.
24. On Saturday 15 August, a nurse saw Mr Payne and recorded his pulse at 96bpm and his blood pressure as normal. He assessed Mr Payne using the COWS scale and there was no change. No further monitoring of Mr Payne was recorded during the day.
25. On Sunday 16 August, a nurse recorded Mr Payne's pulse rate at 125bpm (significantly increased) at 4.09pm in his medical record. This was his first observation of the day. He told the investigator that he gave Mr Payne his daily

dose of methadone and he had no complaints. He took no further action. The senior nurse on duty told the investigator that he would expect to be told about Mr Payne's high pulse rate, but there was no evidence that this was done. The nurse told the investigator that he did not check Mr Payne again.

26. At 9.22pm, Nurse A, accompanied by three officers went into Mr Payne's cell to give him his night medication (diazepam). One officer told the investigator that when they entered the cell Mr Payne looked to be asleep, but did not look comfortable. His head was slightly hanging off the bed and he was snoring very loudly. He said that he called Mr Payne's name twice but he did not respond.
27. Nurse A told the investigator that when he went into Mr Payne's cell, officers turned the light on and called out his name. He noticed his loud snoring but said that he checked his pulse and his colour was fine. He decided to move him into the recovery position in case he vomited and said that Mr Payne did not react at all. He said that he was not concerned about Mr Payne because he was asleep. He did not give Mr Payne any diazepam and left the cell with the officers. He said that he told an operational support grade on the landing below that Mr Payne had not had his medication and to keep an eye on him.
28. Nurse A signed Mr Payne's medication chart to reflect that he had given him diazepam and told the investigator this was accidental because he was working in darkness. He said that he did not mention at the morning handover that Mr Payne had not had his diazepam.
29. On 17 August, an operational support grade completed the first roll check at 6.06am and noted that Mr Payne was asleep on his bed. An officer completed another roll check at 7.31am and also recalled that Mr Payne was asleep. At 9.21am, Officer A unlocked Mr Payne's cell for association. He told the investigator that when he unlocked Mr Payne's door he was lying on his bed asleep and he did not get any response from Mr Payne. He said that he does not speak to prisoners when unlocking their cells, because he does not have time.
30. An officer arrived on Mr Payne's wing at around 9.30am to take prisoners to collect their medication. Mr Payne did not attend for his medication. At 9.51am, a substance misuse worker went to Mr Payne's cell and called his name. She did not get a response and left.
31. At 11.15am Officer A locked Mr Payne's cell. At 11.55am, another Officer B unlocked Mr Payne's cell and found him in the same position that he was when she completed the roll check. She called out to Mr Payne that it was lunchtime and continued unlocking other cells. She noticed that Mr Payne had not come out of his cell and went back to check on him. She saw that his chest was not moving and left the cell to call for Officer A who was on the same landing.
32. Officer A told the investigator that when he entered the cell he touched Mr Payne and immediately thought he was dead because he felt very cold. Officer B pressed the cell bell for assistance and Officer A said that he used his radio to call for help but could not remember what he had said. A custodial manager said in a statement that he responded to the alarm and when he arrived on the scene he called a code blue (an emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties) and asked for an

ambulance to be called. Control room records show that an ambulance was called at 12.00pm.

33. A Supervising Officer (SO) was on the landing below and responded to the call for help. She told the investigator that when she arrived at the cell it was clear that Mr Payne had died because he had signs of rigor mortis. A nurse was working on the wing and arrived at the cell at the same time as the SO. Despite signs of rigor mortis, staff moved Mr Payne onto the floor and attempted to resuscitate him.
34. Another nurse responded to the code blue and arrived at the cell with the appropriate medical bag. He applied a defibrillator machine, which advised for no shock to be given but to continue resuscitation. He said that rigor mortis had set in and he thought that Mr Payne had died. The first paramedic reached Mr Payne's cell at 12.12pm and a paramedic pronounced him dead at 12.25pm.

### **Contact with the family**

35. Mr Payne's next of kin was his wife, who was notified of Mr Payne's death by staff at HMP Bronzefield. The prison's family liaison officer contacted Mr Payne's mother and stepfather to tell them of their son's death. The prison contributed to the cost of Mr Payne's funeral, in line with national instructions.

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

36. After Mr Payne's death, the Governor debriefed all the staff involved in the emergency response (apart from some who had gone home) to ensure that staff had the opportunity to discuss any issues arising and to offer support. The staff care team offered support.
37. The Governor issued notices to staff and prisoners informing them of Mr Payne's death. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Payne's death.

### **Post-mortem report**

38. The post-mortem investigation concluded that Mr Payne died of the toxic effects of methadone.

# Findings

## Substance Misuse Management

39. The clinical reviewer considered that Mr Payne was appropriately referred for the substance misuse stabilisation programme. He concluded that the prescription of methadone and diazepam were appropriate to meet his needs and within clinical guidelines.
40. There are 36 cells at Winchester prison with modified hatches to allow for additional monitoring for prisoners withdrawing from drugs, most of which are on C Wing. The Integrated Substance Misuse Service policy states that all patients that require stabilisation for detoxification “will need to be located [in cells with modified hatches on C Wing] as they will need to be monitored”. The consultant psychiatrist described the process for locating prisoners onto C Wing from reception as ‘hit and miss every time’. The prison could provide no explanation why Mr Payne was not located on C Wing. In their most recent inspection, HM Inspectorate of Prisons was concerned about prisoners going through drug and alcohol withdrawal not being located on the stabilisation wing. We consider that Mr Payne should either have been located on that wing for substance misuse support or, had this not been possible, placed in a cell with a modified hatch in the induction wing to assist observation.
41. Winchester’s substance misuse policy requires a minimum of twice daily observations for five days of prisoners going through withdrawal from opiates and the same observations for seven days for those going through alcohol withdrawal. We are concerned that over the weekend of 15 and 16 August only one set of observations was taken on each day.
42. On 16 August, a nurse recorded Mr Payne’s pulse rate at 125bpm, which was significantly higher than the previous day. Both the senior nurse and consultant psychiatrist told the investigator that they would have expected this finding to prompt a response from the member of staff. No further action was taken following this abnormal finding.
43. During the evening of 16 August, Nurse A went into Mr Payne’s cell with officers to administer medication. Mr Payne did not respond to his cell light being switched on, his name being called, or being moved into the recovery position. He was also snoring loudly. We are concerned that staff were not alert to the risk that Mr Payne could have been displaying the effects of drug intoxication. Typically, people who die from the effects of methadone become deeply unconscious, unrousable and are often heard to be snoring heavily before they stop breathing. These warning signs have been evident in a number of deaths we have investigated. We would have expected staff to have recognised symptoms of potential methadone toxicity and sought further medical assistance promptly.
44. Nurse A told the investigator that he accidentally recorded that Mr Payne had received his evening dose of diazepam for alcohol withdrawal, but did not rectify this mistake when handing over to the next shift. Had others been made aware he had not received his medication, he may have been followed up earlier.

45. The clinical reviewer concluded that the care that Mr Payne received in relation to substance withdrawal was below equivalent to what would be expected in the community. We make the following recommendation:

**The Governor and the Head of Healthcare should review the Integrated Substance Misuse Service policy and ensure that:**

- **All prisoners are located appropriately during the stabilisation process;**
  - **Observations of prisoners are taken in line with the policy;**
  - **Any abnormal observation findings are recorded and followed up on;**
  - **Staff working with prisoners receiving drug treatment are trained to recognise the common symptoms of drug induced unconsciousness and methadone toxicity and know how to respond; and**
  - **Staff should communicate effectively, maintain accurate records and hand over appropriately after their shift.**
46. The clinical reviewer makes a number of other recommendations that the Head of Healthcare will want to consider.

**Unlocking cells**

47. Officer A unlocked Mr Payne's cell for association at 9.21am. He told the investigator that Mr Payne was asleep on his bed and he did not check his well being. He said that he does not speak to prisoners when opening their cells because this would take too long.

48. When unlocking cells, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

"Prior to unlock staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

49. When the investigator met the Deputy Governor, he told her that he would expect staff to check on the well being of prisoners when unlocking their cells. After this first opportunity to check Mr Payne there were three further times when a member of staff could have discovered that Mr Payne was unwell. Although we do not know when Mr Payne died, it is possible that earlier intervention may have saved his life. We make the following recommendation:

**The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of prisoners and that there are no immediate issues that need attention.**

## Emergency response

50. Officer B pressed the cell bell and Officer A may have radioed when they discovered Mr Payne. During interview, Officer A was not clear on the difference between a code blue (prisoner is unconscious or having breathing difficulties) and a code red (prisoner is bleeding) emergency call. This is not the first time we have commented on the failure to use an appropriate medical emergency code at Winchester.
51. Winchester issued an instruction to staff on 19 June 2014 on the codes to be used in an emergency. Prison Service Instruction (PSI) 3/2013 sets out how a prison should respond to a medical emergency. It requires that every prison should develop a protocol to ensure that officers use emergency radio codes immediately and an ambulance should be called automatically when a medical emergency code is used. There was a delay in an ambulance arriving because the ambulance service questioned whether a paramedic was required based on the information given to them.
52. All staff interviewed that saw Mr Payne after he was found not to be breathing described him as looking as though he had already died. He was described as cold to touch and that rigor mortis had set in. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. European Resuscitation Council Guidelines 2010 say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...", such as the presence of rigor mortis. In October 2014, The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance about making appropriate resuscitation decisions. It said that every decision should be made on the basis of a careful assessment of each individual's situation and was in place when Mr Payne died in 2015. Revised guidance was issued in 2016 which the Head of Healthcare will be familiar with. We make the following recommendation:

**The Governor and the Head of Healthcare should ensure that all prison staff understand their responsibilities during medical emergencies and in particular that staff:**

- **should efficiently communicate the nature of a medical emergency, using the appropriate emergency code; and**
- **that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with established professional guidelines.**

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