

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Payne, a prisoner at HMP Channings Wood, on 13 December 2020

A report by the Prisons and Probation Ombudsman

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.

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 Stephen Payne died at HMP Channings Wood of heart disease. He was 62 years old. I offer my condolences to Mr Payne's family and friends.

The clinical reviewer considered that the care Mr Payne received was of a good standard and equivalent to that he could have expected to receive in the community.

I am concerned that an officer did not check Mr Payne's wellbeing when she opened his cell door that morning, a concern that I have brought to the Governor's attention in a previous investigation. This did not affect the outcome for Mr Payne as he had been dead for some time, but it could make a critical difference in other medical emergencies.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

September 2021

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Summary

Events

1. In March 2019, Mr Stephen Payne was sentenced to four years imprisonment for burglary. On 19 March, he was transferred to HMP Channings Wood and remained there until his death.
2. When he arrived at Channings Wood, Mr Payne had an initial health screen and a secondary health screen. He had several long-term medical conditions, including high blood pressure, type 2 diabetes, gout, arthritis and kidney disease. Mr Payne's long-term conditions were regularly reviewed by healthcare staff.
3. On 13 December 2020, an officer unlocked Mr Payne's cell door at about 8.10am but did not speak to him because she thought he was asleep. Around 45 minutes later, another officer noticed that Mr Payne had not moved, so went into his cell and found that he was not breathing. She radioed an emergency code.
4. Healthcare staff attended but assessed that Mr Payne had rigor mortis, so did not try to resuscitate him. Paramedics arrived, assessed him and confirmed Mr Payne's death.
5. The post-mortem examination found that Mr Payne died of heart disease. A blocked artery in the heart was found to be a contributory factor.

Findings

6. The clinical reviewer found that the care Mr Payne received during his time at Channings Wood was equivalent to that he could have expected in the community.
7. The officer who unlocked Mr Payne's cell did not check on his welfare as she should have done. Although this made no difference to the outcome for Mr Payne, it could be critical in other cases and it is important that prison staff carry out unlock procedures correctly so that any welfare needs are identified. We have brought this to the Governor's attention in a previous investigation and repeat the recommendation in this report.

Recommendation

- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner, in line with PSI 75/2011.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Channings Wood informing them of the investigation and asking anyone with relevant information to contact her. Another investigator interviewed an officer by video in August 2021.
9. NHS England commissioned an independent clinical reviewer to review Mr Payne's clinical care at Channings Wood.
10. We informed HM Coroner for Plymouth, Torbay and South Devon of the investigation. The coroner confirmed Mr Payne's cause of death. We have sent the coroner a copy of this report.
11. The Ombudsman's family liaison officer contacted Mr Payne's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a response.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Channings Wood

13. HMP Channings Wood is a medium security prison near Newton Abbot in Devon. It holds approximately 700 men. Care UK provides healthcare and substance misuse services. There is nursing cover from 7.30am to 6.00pm on weekdays and from 8.30am to 5.30pm on weekends. Devon Doctors provide an out of hours GP service.

HM Inspectorate of Prisons (HMIP)

14. The most recent full inspection of HMP Channings Wood was in September 2018. Inspectors reported that some efforts had been made to improve standards since their last inspection in October 2016, but they were not co-ordinated, and previous HMIP recommendations had not been implemented. Inspectors assessed the prison outcomes as not sufficiently good in all four areas of their healthy prisons' tests – safety, respect, purposeful activity, and rehabilitation and release planning.
15. In relation to healthcare, inspectors reported that local clinical governance systems were not driving improved outcomes for patients. Primary care staffing was stretched and not always able to meet demand. An independent health complaints system had been introduced but many complaints had not been responded to and a backlog had developed. Responses were not always adequate.
16. In July 2019, HMIP conducted an Independent Review of Progress (IRP) at Channings Wood. Inspectors found that the establishment and its leaders had taken their cue very positively from the 2018 findings and recommendations, and within nine months had moved ahead in the great majority of the areas where they had identified weaknesses. Reasonable or good progress had been made in carrying out 11 of the 13 recommendations which were reviewed in the IRP.
17. Inspectors reported that the overall governance of healthcare had improved. Partnership, contracts and local delivery board meetings were robust and well supported by the NHS England commissioner. There was a much-improved process for raising concerns or complaining about health services; more recent changes to the process needed more time to embed.

Independent Monitoring Board

18. 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 August 2020, the IMB reported that healthcare provision at Channings Wood was generally of an equivalent standard to that received in the wider community. They reported that staff responded effectively to COVID-19 infections in the prison and had put appropriate measures in place to cope with the restricted regime.

Previous deaths at HMP Channings Wood

19. Mr Payne was the sixth prisoner to die at Channings Wood since December 2018. Two of the previous deaths were from natural causes, one was drug-related and two were self-inflicted. There has been one death from natural causes since Mr Payne died.
20. Following a death in February 2019, we raised concerns about officers not checking prisoners' wellbeing when they unlock their cells. We repeat these concerns and the related recommendation in this report.

Key Events

21. On 7 March 2019, Mr Stephen Payne was sentenced to four years imprisonment for burglary. On 19 March, he was transferred to HMP Channings Wood and remained there until his death.
22. When he arrived at Channings Wood, Mr Payne had an initial health screen and a secondary health screen. He had several long-term medical conditions, including high blood pressure, type 2 diabetes, gout, arthritis and kidney disease.
23. On 4 April 2019, Mr Payne was reviewed by the prison GP and was referred for chronic disease management. He was also referred for an occupational therapist assessment for his arthritis.
24. Prison healthcare staff regularly reviewed his long-term conditions and care plans were put in place to monitor his health.
25. In 2020, in line with national guidance on protecting those at most risk of complications from COVID-19, Mr Payne was advised to shield because of his complex health conditions. Mr Payne refused to shield, so healthcare staff advised him to maintain social distancing and use a face covering and encouraged frequent hand washing. Staff regularly explained the risks of not shielding to Mr Payne, but he still chose not to do so.
26. On 26 September 2020, Mr Payne was admitted to hospital after he told healthcare staff that he was short of breath. In hospital, he was tested for COVID-19, but it was negative. Mr Payne was treated for a chest infection and discharged three days later with a diagnosis of heart failure and appropriate medication was prescribed promptly.

Events of 13 December

27. At around 7.30am on 13 December, Officer A completed a roll check on Mr Payne's wing. She said Mr Payne was asleep in his bed, but thought she remembered seeing his arm move.
28. At around 8.10am, Officers A and B unlocked prisoners for 45 minutes association. Officer B unlocked Mr Payne's cell. She told the investigator that, as it was a Sunday morning, they spoke to prisoners who were 'up and about', but left those who were still asleep to have a bit of a lie in. When she unlocked Mr Payne's door, Mr Payne was in bed and she thought he was asleep, so she did not speak to him or try to get a response from him but left him to sleep.
29. At about 8.25am, Officer A checked all cell bells on the wing, including Mr Payne's. She did not go into his cell but reached around his door to press the cell bell.
30. At 8.55am, prisoners were locked back in their cells after morning association. When Officer A got to Mr Payne's cell, she realised he had not changed position since her roll count earlier that morning. She called his name, but he did not reply, so she went into his cell and realised that he was cold and not breathing.

31. Officer A radioed a code blue (indicating a medical emergency related to breathing difficulties) and the control room called an ambulance. Other officers got to the cell and tried to move Mr Payne but could not. Healthcare staff arrived and assessed that Mr Payne had rigor mortis, so did not try to resuscitate him.
32. The ambulance arrived and at 9.30am paramedics confirmed that Mr Payne had died.

Contact with Mr Payne's family

33. After Mr Payne's death, the prison's family liaison officer tried to contact Mr Payne's next of kin but there was no response. The prison asked Hampshire Police to find Mr Payne's next of kin and they eventually notified them of his death on the prison's behalf. The next of kin telephoned the prison on 21 December but did not want any further contact.
34. Mr Payne's funeral took place on 13 January 2021. The prison offered to pay funeral costs, in line with national guidelines.

Support for prisoners and staff

35. The prison posted notices informing other prisoners of Mr Payne'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 Payne's death.

Post-mortem report

36. A post-mortem examination concluded that Mr Payne died of heart disease. The pathologist recorded that a blocked artery in the heart was a contributory factor.

Findings

Clinical care

37. The clinical reviewer concluded that the clinical care Mr Payne received was equivalent to that which he could have expected to receive in the community. His long-term conditions were regularly reviewed and well-managed and he received prompt and appropriate care for his physical health needs.

Roll checks and unlock procedures

38. The primary purpose of a roll check is to confirm that all prisoners are present in their cells. It also provides an opportunity to check on prisoners' welfare. However, staff are not required to obtain a response from prisoners when they carry out roll checks so they would only be expected to notice if a prisoner is lying on the floor or is obviously unwell.

39. On unlock procedures, Prison Service Instruction (PSI) 75/2011, *Residential Services*, states:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...”

“[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”

40. We are concerned that Officer B incorrectly told the investigator that the roll check, not unlock, is the opportunity to check on prisoners' welfare. She said:

“The unlock is just to unlock them. We don't do any welfare checks at unlock; they're all done during the roll checks ... If we knocked on everybody's door and woke everybody up, every morning there would be riots.”

She said that this was accepted practice at Channings Wood.

41. We consider that Officer B should have tried to get a response from Mr Payne when she opened his cell door that morning, in line with PSI 75/2011.
42. Following our investigation into the death of a prisoner at Channings Wood in February 2019, we raised concerns about differing unlock practice across the prison, contrary to national requirements. The Governor accepted our recommendation in that case, issued a notice to staff reminding them of the requirements of PSI 75/2011 and introduced management checks to ensure staff were checking prisoners' wellbeing when unlocking their cells.

43. Although it is unlikely to have made a difference in this case as Mr Payne had clearly been dead for some time when he was found, we are concerned that officers are still not aware of the requirement to check a prisoner's wellbeing when unlocking a cell door. We repeat the recommendation:

The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner, in line with PSI 75/2011.

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