Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Payling, a prisoner at HMP Doncaster, on 10 December 2020

A report by the Prisons and Probation Ombudsman

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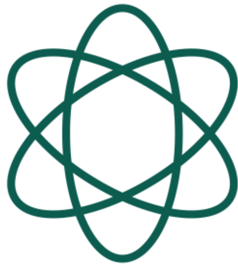
Our vision

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 Anthony Payling died of hypovolaemic shock (severe blood loss) as a result of making cuts to his wrists in his cell at HMP Doncaster on 10 December 2020. He was 36 years old. I offer my condolences to his family and friends.

Mr Payling was serving a long sentence for serious offences. He had little contact with his family and the contents of telephone calls he made before his death (which were not known to prison staff at the time) indicate that this caused him great distress. While he had these and other risk factors for suicide and self-harm, I consider that there was little to indicate to staff that he was at imminent risk of suicide at the time of his death.

I am, however, concerned about the quality of staff interaction through the key worker scheme, and that this would have limited their ability to identify any emerging risk factors and support Mr Payling.

I have expressed concerns about deficiencies in the key worker scheme and the assessment of risk of suicide and self-harm in previous investigations at Doncaster. In January 2021, I asked the Executive Director for Custodial Contracts to set out the actions he intended to take to address my concerns. He said in response that he had served an Improvement Notice against Serco Ltd (who are contracted to manage Doncaster). He told me that he was considering the findings and recommendations of a review of progress against the Improvement Notice and would write to me when he had done that. I have not received the promised update from the Executive Director and so do not know what measures he has taken to require an improvement in the assessment of risk and the operation of the key worker scheme.

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 **July 2021**

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Summary

Events

1. In September 2017, Mr Anthony Payling was remanded in custody to HMP Doncaster. He was later sentenced to 15 years in prison. Mr Payling had a history of anxiety and depression and on arrival in prison, he said he had thoughts of self-harm. Prison staff started suicide and self-harm prevention procedures, known as ACCT, and stopped monitoring him two weeks later.

2. Over the next three years, Mr Payling received mostly positive comments from prison staff. He trained to work as a safer custody buddy, a trusted role that involves intervening in disputes among prisoners to resolve issues and prevent violence. In July 2020, prison staff found illicit fermenting equipment for making 'hooch' in Mr Payling's cell. He lost his job as a safer custody buddy as a result but later found new employment as a laundry worker.

3. On 1 November, Mr Payling made several telephone calls. In voicemail messages, Mr Payling asked his brother to answer his calls and said that he could not live without contact with him. In a call to a friend, Mr Payling said that he had a "noose" in his cell, that he constantly thought of ending his life, and that only using illicit drugs and alcohol prevented these thoughts. (Mr Payling's telephone calls were not monitored at the time but prison staff listened to them after his death.)

4. On 1 December, Mr Payling reported symptoms of COVID-19 and subsequently tested positive for the virus. He began a period of isolation in his cell.

5. During the night of 9 to 10 December, Mr Payling made several telephone calls to his friend. He spoke about his lack of contact with his brother and his mother's death two years earlier. In later calls, Mr Payling spoke little and said that he just wanted to hear a voice.

6. At around 9.50am on 10 December, a prisoner found Mr Payling lying on the floor of his cell. He alerted wing staff, who unlocked the cell and found that Mr Payling had made cuts to his wrists. Prison and healthcare staff began cardiopulmonary resuscitation but paramedics later confirmed that Mr Payling had died.

Findings

7. Mr Payling had some risk factors for suicide and self-harm, although not all were known to prison staff at the time. We are satisfied that there was little to indicate to staff that he was at immediate risk of suicide and self-harm at the time of his death.

8. We are concerned that staff did not have meaningful contact with Mr Payling during his time at Doncaster. Key worker sessions were inconsistently led and rarely by his designated key worker, and entries were generic, with important information either not discussed or incorrectly recorded. We have highlighted this issue in several previous investigations at Doncaster.

Recommendation

The Executive Director of Custodial Contracts should write to the Ombudsman to update her on the outcome of the review about the Improvement Notice within one month of the date of this report.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with relevant information to contact him.

10. The investigator obtained copies of relevant extracts from Mr Payling's prison and medical records. As a result of technical issues caused by the COVID-19 restrictions, we have not been able to view CCTV footage of the events of 10 December 2020, and have relied on accounts of HMPPS staff who viewed the footage (as set out in Doncaster's Early Learning Review).

11. The investigator interviewed 11 members of staff and two prisoners at Doncaster in February 2021. NHS England commissioned a clinical reviewer to review Mr Payling's clinical care at the prison. They jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the COVID-19 restrictions.

12. We informed HM Coroner for South Yorkshire (East District) of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Payling's father and brother to explain the investigation and to ask if they had any matters which they wanted us to consider. Mr Payling's brother asked why Mr Payling's telephone calls were not monitored by prison staff.

14. We shared our initial report with Mr Payling's father and brother. They did not make any comments.

15. We also shared our initial report with HMPPS. They did not identify any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Doncaster

16. HMP Doncaster is a local prison, operated by Serco. It holds up to 1,145 prisoners who have been remanded in custody or sentenced. Care UK provides clinical services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Doncaster was in September 2019. Inspectors reported their concern about increased levels of self-harm, including five self-inflicted deaths since their previous inspection. Inspectors also reported that they were not assured that all staff understood how to identify and manage the risk of suicide and self-harm.

18. Inspectors also reported that most prisoners were positive about their relationships with staff. They found that the key worker scheme was promising, but contact was often too infrequent and formulaic and prisoners' key workers changed too often.

19. Inspectors reported that the staffing profile of the mental health team was not able to meet the high demand for services.

Independent Monitoring Board

20. 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 September 2019, the IMB reported that access to mental health care was not always as timely as expected and that ACCT processes were not always followed as required. The IMB also reported that the key worker scheme had been introduced to positive effect.

Previous deaths at HMP Doncaster

21. Mr Payling was the eighteenth prisoner to die at Doncaster since December 2018, and the ninth to take his life in this time. We have previously made recommendations about poor assessment of risk of suicide and self-harm, delays in carrying out mental health assessments and failings in the operation of the key worker scheme. Our most recent reports have recommended that the Executive Director of Custodial Contracts for HM Prison and Probation Service should satisfy himself that processes are in place at Doncaster to ensure that the Ombudsman's recommendations are being implemented and embedded and write to the Ombudsman to report his findings.

22. In January 2021, the Executive Director of Custodial Contracts wrote to the Ombudsman and said that he had served an Improvement Notice against Serco. The Executive Director told us that he was in the process of reviewing the findings and recommendations of a review of progress against the Improvement Notice. He said, in his letter, that he would send an update on the progress that had been made, but we have not received that update at the time of writing this report.

Assessment, Care in Custody and Teamwork (ACCT)

23. 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. 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.

24. 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. 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 worker scheme

25. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.

- Key workers must have completed the required training.

- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week to deliver the key worker role, which includes individual time with each prisoner.

- Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

26. On 28 September 2017, Mr Anthony Payling was remanded in custody to HMP Doncaster, charged with sex offences. This was his first time in prison.

27. A nurse assessed Mr Payling and recorded that he reported a history of anxiety and depression, for which he was prescribed citalopram (antidepressant medication). The nurse recorded that Mr Payling said he had thought of harming himself and that he appeared to be in a low mood. She started ACCT procedures and referred him to the mental health team. Mr Payling also began a short alcohol detoxification programme.

28. The following day, a mental health nurse triaged Mr Payling. He said he had harmed himself in the past, most recently by burning himself with a lighter. Mr Payling also reported symptoms of depression and anxiety.

29. Prison staff ended ACCT procedures after two weeks.

30. In November, Mr Payling told a mental health nurse that he felt stressed about his trial and the charges he faced, but was otherwise settled and had no concerns. At his next review, a month later, Mr Payling spoke of his worries for his mother, who was terminally ill. Mr Payling's mother died in December.

31. On 9 March 2018, Mr Payling was sentenced to 15 years in prison. On his return, he described his conviction and sentence as a "miscarriage of justice" but said he could "cope" with it.

32. During 2018, Mr Payling received several positive entries from prison staff. He was promoted to the enhanced regime (on a scale of basic, standard and enhanced) on the prison's Incentives and Earned Privileges (IEP) Scheme (which aims to encourage and reward responsible behaviour in prisons). Mr Payling also trained to be a safer custody buddy (a role that involves intervening with prisoners involved in debt or bullying to resolve any issues and prevent violence).

33. In October, Mr Payling told a mental health nurse that, other than being in prison, he was fine. He reported no symptoms of mental ill health and the nurse recorded that he had observed no such symptoms. The nurse and Mr Payling agreed that he could be discharged from the mental health team's caseload.

34. In December, prison staff assessed Mr Payling's risk of sharing a cell as high and identified that he should no longer share a cell with another prisoner. This followed information from prison healthcare staff that he suffered from cluster migraines which, Mr Payling said, could make him extremely aggressive and violent.

35. In January 2019, prison staff recorded intelligence that Mr Payling had taken medication from other prisoners and had bullied others into storing illicit alcohol for him. Over the following months, he received several positive entries from prison staff.

36. In 2020, Mr Payling continued to receive positive entries from prison staff. He worked as a wing painter and safer custody buddy and told staff that he felt "safe and happy" on the wing where he lived.

37. On 28 July, prison staff found fermenting liquid ('hooch') in Mr Payling's cell. They reduced his IEP level to basic as a result, and he lost his prison jobs. A month later, Mr Payling's IEP was raised to standard.

38. On 15 October, a Prison Custody Officer (PCO) made a key worker entry on behalf of Mr Payling's designated key worker, another PCO. (During his time at Doncaster, many of Mr Payling's key worker entries were made by staff who were not his designated key worker.) She recorded that Mr Payling said that he felt safe and had no immediate concerns or thoughts of suicide and self-harm.

39. On 30 October, a PCO recorded in a key worker entry that Mr Payling was "okay" and enjoyed his job. (He now worked as a wing laundry cleaner.) She recorded that Mr Payling had no issues on the wing.

40. On 1 November, Mr Payling made several telephone calls. (All prisoners' telephone calls are recorded. Security staff listen to some at random, and some calls will be listened to if staff have intelligence that might indicate information about the safety of individuals or the prison has been discussed. None of Mr Payling's calls were monitored until after his death.) Mr Payling telephoned his brother and left voicemail messages in which he asked his brother to answer his calls and said, "Without you, I've got nothing, and I can't live with nothing."

41. Mr Payling also telephoned a friend and said that he had "a noose" in his cell. He also said:

> "I can't take it anymore. I've been strong for three years and it's taking its toll on me … It's affecting my mentality … If I don't have drugs or beer, I'm so miserable … If I don't have [them], all I think about is ending it."

42. On 5 November, a PCO recorded in a key worker entry that Mr Payling felt "okay" with his location and had no issues or concerns. The PCO made similar entries on 11 and 16 November.

43. On 9 November, security intelligence named Mr Payling as one of several prisoners brewing illicit alcohol.

44. On 25 November, a Custodial Operations Manager (COM) made a key worker entry and recorded that Mr Payling "feels safe" and that he had no issues to raise. She recorded that Mr Payling would like to speak to staff from the Offender Management Unit (OMU) and that she advised him to complete an application for this.

45. On 1 December, the COM completed another key worker entry. She recorded that Mr Payling felt safe, he was happy on the wing, he had no issues to raise and that he "speaks to his family". The COM told us that her question to Mr Payling, and subsequent entry, referred to friends and family rather than just family. She told us that she did not know that Mr Payling had not spoken to a family member for several months. The COM said that Mr Payling seemed the same as usual and that there were no indicators of increased risk of suicide or self-harm.

46. That day, Mr Payling reported flu-like symptoms. He took a COVID-19 test and began a period of isolation in his cell. The next day, the test result confirmed that he had the COVID-19 virus.

47. On 6 December, a nurse telephoned Mr Payling for a welfare check. She recorded that Mr Payling said that he was feeling “okay”, other than shortness of breath on exertion. The nurse told us that Mr Payling said that he had no other concerns.

48. On 7 December, a Healthcare Assistant telephoned Mr Payling. She recorded that Mr Payling said he was feeling a little groggy but was “okay”.

49. On 8 December, a nurse conducted a welfare check. She recorded that Mr Payling was “feeling okay” and had no concerns.

9 to 10 December 2020

50. At around 6.30pm on 9 December, Mr Payling was locked in his cell for the night. At 9.19pm, he telephoned a friend and told him that he had just had a “major breakdown” and cried for around one and a half hours. He told his friend that it was his brother’s birthday tomorrow (10 December) and that his brother was not talking to him. Mr Payling also spoke about the death of his mother two years earlier.

51. At 10.05pm, Mr Payling telephoned his friend again and told him that he had written a letter to his grandparents that he intended to post in the morning.

52. At 2.23am on 10 December, Mr Payling telephoned his friend. He was quiet during the call and replied “yeah, fine” when his friend repeatedly asked him if he was okay. Mr Payling said that he appreciated everything that his grandparents and friend had done for him.

53. At 2.46am, Mr Payling telephoned his friend again. He spoke little during the call and said that he just wanted to hear a voice.

54. At 6.14am, a PCO conducted a count of prisoners, including Mr Payling’s cell. At 6.23am, Mr Payling briefly switched on the light in his cell.

55. At around 9.50am, a prisoner went to Mr Payling’s cell. He told us that he looked through the observation panel and saw that Mr Payling was lying on the floor of the cell. He and another prisoner summoned a PCO, who opened the cell and found that Mr Payling had made cuts to his wrists.

56. At 9.51am, a PCO radioed a medical emergency code red (indicating heavy blood loss), followed by a code blue (indicating a prisoner is not breathing). The control room operator telephoned for an ambulance. The PCO began cardiopulmonary resuscitation. At around 9.53am, healthcare staff arrived and took over the resuscitation attempt. They attached a defibrillator, which indicated no shockable rhythm and to continue chest compressions. At around 10.10am, paramedics arrived. At 10.34am, they confirmed that Mr Payling had died.

Contact with Mr Payling’s family

57. At around 11.40am, a senior manager and a prison family liaison officer telephoned Mr Payling’s brother and told him of his death. (Family liaison officers usually break the news of a death in person but were instructed to do so by telephone during the COVID-19 pandemic.)

58. Doncaster contributed to the costs of Mr Payling's funeral in line with Prison Service instructions.

Support for prisoners and staff

59. After Mr Payling's death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

60. The prison posted notices informing other prisoners of Mr Payling's death and offering support.

Post-mortem report

61. A post-mortem examination identified the cause of death as hypovolaemic shock (severe blood loss) caused by cuts to the wrists.

Findings

Identifying the risk of suicide and self-harm

62. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Doncaster should have recognised Mr Payling as at risk and begun ACCT procedures to support him.

63. Mr Payling had some risk factors for suicide and self-harm. He was serving a long sentence for a serious sexual offence. He had harmed himself in the past (but not in custody) and had been prescribed antidepressant medication for several years. There was evidence that he drank illicitly brewed alcohol in prison, and in telephone calls to a friend, Mr Payling also said that he used illicit drugs. He was isolating in his cell after testing positive for COVID-19. Most significantly, evidence in the telephone calls he made before his death indicates that Mr Payling struggled greatly with a lack of family contact, particularly with his brother. The content of these calls was not known to prison staff at the time.

64. While Mr Payling had these risk factors, and we have some concerns about staff-prisoner relationships, we are satisfied that there was little to indicate to staff that he was at immediate risk of suicide and self-harm at the time of his death.

Staff-prisoner relationships

65. Under the Offender Management in Custody model, each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner. In March 2020, HMPPS suspended key work due to the COVID-19 pandemic. On 12 May 2020, key work was reintroduced but delivered in a more limited way in line with an Exceptional Delivery Model, where priority prisoners received key work. The Head of Residence told us that senior managers at Doncaster chose to go beyond the minimum requirements of the Exceptional Delivery Model and continued to offer key work to all prisoners.

66. During his time at Doncaster, most of Mr Payling’s key worker entries were made by staff who were not his designated key worker. Entries were made frequently but not always weekly. Many of the entries were generic, with no evidence that current issues were discussed. The last entry erroneously stated that Mr Payling “speaks to his family” and there was no key worker conversation during the time that Mr Payling had to isolate in his cell after testing positive for COVID-19.

67. While we appreciate the pressures that prisons are under, particularly with providing consistent staffing during the COVID-19 pandemic and the impact this has on key work, we consider the key worker role to be vital in helping to ensure meaningful engagement between staff and prisoners and identifying any underlying issues a prisoner might have. More consistent or meaningful key worker sessions might, for

example, have identified that Mr Payling was having difficulties in his family relationships.

68. We expressed concern about the operation of the key worker scheme at Doncaster following self-inflicted deaths in January and July 2019. Despite reassurances from Doncaster that the key worker scheme had been fully implemented, we identified similar failings following a self-inflicted death in June 2020. Our report into the circumstances of that death was issued in January 2021, shortly after Mr Payling's death.

69. In that report, we recommended that the Director should ensure that the key worker scheme is effective in providing meaningful support to prisoners, that a named key worker is allocated to each prisoner and any changes in key worker allocation are kept to a minimum, and that contacts take place in line with the national policy framework.

70. As a result of our repeated findings and recommendations in this and other areas, including the assessment of risk of suicide and self-harm, we also recommended that the HMPPS Executive Director of Custodial Contracts should satisfy himself that processes are in place at Doncaster to ensure that the Ombudsman's recommendations are being implemented and embedded and that he should write to the Ombudsman to report his findings.

71. The Executive Director of Custodial Contracts subsequently wrote to the Ombudsman on 25 January 2021. He told us that Serco Ltd (who are contracted to manage HMP Doncaster) had been served an Improvement Notice in July 2020, which related to a variety of issues including insufficient progress against an agreed safety action plan (issued August 2019). The Executive Director of Custodial Contracts told us that he had received a full review of actions and progress against the Improvement Notice and was in the process of reviewing its findings and recommendations. The Executive Director said that he would update us once this review was complete. We have not yet received this update.

72. These measures were being taken at the time of Mr Payling's death and we expect to see that the measures taken have made a difference in future investigations. We make the following recommendation:

The Executive Director of Custodial Contracts should write to the Ombudsman to update her on the outcome of the review about the Improvement Notice within one month of the date of this report.

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