Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Payne, a prisoner at HMP Wayland, on 15 May 2022

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

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 Richard Payne was found hanged in his cell on 15 May 2022 at HMP Wayland. He was 42 years old. I offer my condolences to Mr Payne's family and friends.

Mr Payne had a number of risk factors for suicide and in the weeks leading to his death, there were indications that his risk was increasing. I am concerned that, while there was some good support for Mr Payne, staff did not take all of the relevant risk factors into consideration and missed opportunities to ensure his safety.

Before his death, Mr Payne had reported being bullied, but the correct measures were not put in place to support him.

I am also concerned that not all staff dealing with prisoners had the appropriate training in suicide and self-harm procedures. There is no 24-hour healthcare function at HMP Wayland, and we found that staff working nights with no medical support did not have up to date first aid or life support training.

The clinical reviewer concluded that the clinical care Mr Payne received at HMP Wayland was equivalent to that which he could have expected to receive in the community.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **June 2023**

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Summary

Events

1. In 2009, Mr Payne was convicted of murder and sentenced to life imprisonment. In 2019, he was transferred to HMP Wayland. Mr Payne had been on suicide and self-harm prevention measures (known as ACCT) periodically throughout his time in prison. In November 2021, he attempted suicide but staff found him and he was unharmed.

2. On 2 February 2022, Mr Payne was monitored under ACCT procedures again after he told staff that prisoners on his wing had threatened him and he was worried about his upcoming parole hearing. Support actions were put in place, and the prison's mental health team attended regular meetings with him. The ACCT was closed 15 days later when all the support actions had been completed.

3. On 14 March, prison staff searched Mr Payne's cell and found an improvised weapon and alcohol. Staff thought he might be being bullied, but Mr Payne took responsibility for the illegal items. Staff offered him a cell move but he declined. Staff did not begin violence reduction procedures despite their concerns about bullying.

4. On 4 April, Mr Payne's cell was searched again, and he was found with more illegal items. He was downgraded to the basic regime for seven days. Staff tried to find out if he was being bullied or pressured to hold items but he denied that he was. Again, staff did not begin violence reduction procedures.

5. On 11 April, Mr Payne was involved in a fight with another prisoner in the showers. Both prisoners were downgraded to the basic regime. Staff did not begin violence reduction procedures. Five days later, Mr Payne told a member of prison staff that he was being bullied and was under threat from other prisoners on the wing. He also said he was in debt due to the items being found in his cell. Staff began violence reduction procedures.

6. On 8 May, a mental health nurse met with Mr Payne. During the meeting Mr Payne threatened to self-harm unless he was moved to a different wing or transferred to another prison. The nurse did not open an ACCT or share any concerns with wing staff.

7. On 15 May, at around 5.15am, an officer conducted a routine check. When he came to Mr Payne's cell, he noticed that the light was on and, through the partly blocked observation panel, saw Mr Payne hanging. The officer called a medical emergency code and waited outside the cell until another member of staff arrived. Other officers arrived shortly after and began cardiopulmonary resuscitation (CPR).

8. Paramedics arrived at approximately 5.55am. At 5.59am, the paramedics confirmed that Mr Payne had died.

Findings

9. While Mr Payne received some good support, we are concerned that the events of the months before his death were treated in isolation. Better communication and training might have led to his risk factors being considered holistically. Mr Payne had a number of known risk factors for suicide, including previous suicide attempts, suicidal thoughts and depression. Additionally, he told various members of staff he was being bullied, he was involved in violent incidents and spoke of heightened anxiety ahead of his parole window, all of which should have been treated as escalating risk factors.

10. Mr Payne told the nurse that he would self-harm if he did not get a cell move, and this should have triggered ACCT procedures. Staff did not consider the wider context of Mr Payne's risks in the months leading to his death.

11. Not all staff at HMP Wayland who had contact with Mr Payne were ACCT trained, and while this does not appear to have had a direct bearing on what happened, it is a Prison Service requirement.

12. In March and April, Mr Payne was caught holding illicit items. Staff suspected he was being bullied, which he later confirmed. Staff should have initiated violence reduction procedures (a Challenge Support Intervention Plan (CSIP)) in line with local policy but they failed to do so.

13. The officer who found Mr Payne hanging in his cell said that his understanding of policy and procedure was that an officer would never enter a cell on their own. He saw Mr Payne suspended by a ligature, which indicated an immediate danger to life but he did not conduct a dynamic risk assessment and chose to wait until other officers arrived before entering the cell.

14. While we accept that the delay in entering the cell is unlikely to have affected the outcome for Mr Payne, in future cases, it could be critical.

15. There is no 24-hour healthcare presence in Wayland. The officer who found Mr Payne said he had never received first aid or basic life support training, and a number of other officers said they had not received refresher training in recent years.

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

Recommendations

- The Governor and the Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular:
    - The need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.
    - All staff receive appropriate ACCT training.

- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are appropriately supported and protected.

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life-threatening situations, subject to a dynamic risk assessment.

- The Governor should ensure that a senior manager shares this report with Officer A and discusses the Ombudsman's findings with him.

- The Governor should ensure that suitable arrangements are made to contact the next of kin in line with PSI 64/2011.

- The Governor should ensure that operational staff have up to date training in order to administer basic first aid.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asking anyone with relevant information to contact him. One prisoner contacted him but did not have relevant information.

18. The investigator requested information from HMP Wayland on 16 May 2022. He obtained copies of relevant extracts from Mr Payne's prison and medical records.

19. The investigator interviewed 13 members of staff at HMP Wayland on 21 and 22 June 2022.

20. NHS England commissioned an independent clinical reviewer to review Mr Payne's clinical care at the prison. The clinical reviewer conducted all interviews jointly with the investigator.

21. We informed HM Coroner for Norfolk of the investigation. The Coroner provided a summary of the results of the post-mortem examination. We have sent the Coroner a copy of this report.

22. The Ombudsman's family liaison officer contacted Mr Payne's next of kin, his parents, to explain the investigation and to ask if they had any matters they wanted us to consider. They raised no specific issues but wanted to know more about why Mr Payne took his life before his upcoming release.

23. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies but asked for the third recommendation to be amended, to which we agreed. They provided an action plan which is annexed to this report.

24. We sent a copy of our initial report to Mr Payne's parents. They did not notify us of any factual inaccuracies.

Background Information

HMP Wayland

25. HMP Wayland is a training and resettlement prison in Thetford, Norfolk. As of April 2022, it holds 890 prisoners. Mental and physical healthcare is provided by Practice Plus Group. Nurses are on duty between 8.30am and 5.30pm every day.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Wayland was in April 2022. Inspectors reported the number of self-harm incidents was higher than at comparator prisons. Most recommendations made by the Prisons and Probation Ombudsman after investigation of deaths had been achieved, but there was no overarching strategy or action plan to reduce self-harm and support vulnerable people. Additionally, safety intervention meetings were not well attended and produced few meaningful actions.

27. Inspectors noted some concerns with the delivery of ACCT processes and not all prisoners on ACCTs felt well supported. Care planning was not used well to address underlying issues, there were some gaps in entries from staff and supervisors, and case reviews were not sufficiently multidisciplinary.

28. Inspectors found risk management processes, especially pre-release, were carried out systematically, and staff participated well in multi-agency working. However, inspectors noted resettlement provision had deteriorated considerably since the last inspection. With no resettlement worker in post, support for release was not well coordinated.

Independent Monitoring Board

29. 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 2021, the IMB reported that an examination of the ACCT records indicated that the main issues raised in staff discussions with prisoners were their safety and debt, frequently leading to cases of isolation and self-harm. The Board also noted some evidence of poor ACCT administration.

Previous deaths at HMP Wayland

30. In the two years up to 15 May 2022, there were five deaths at HMP Wayland, including Mr Payne. The four other deaths were from natural causes. There are no similarities between the findings from our investigation into Mr Payne's death and our previous investigations.

Assessment, Care in Custody and Teamwork

31. Assessment, Care in Custody and Teamwork (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.

32. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

Key Events

33. On 20 May 2009, Mr Richard Payne was convicted of murder and sentenced to life imprisonment. Ten years later, in April 2019, he was transferred to HMP Wayland. Mr Payne had been monitored under ACCT procedures nine times before he arrived at Wayland mainly for suicidal thoughts and low mood.

34. Mr Payne had been diagnosed with anxiety and depression and had epilepsy which affected him at night. He also had hypervigilance (a symptom of mental health disorders), irritability, and recurring dreams of his offence. Mr Payne also had a history of hearing voices which would urge him to self-harm.

35. A nurse said that she first met Mr Payne when he arrived at Wayland. She said her impression was that he did not cope very well with stress, and he said he would seek the support of the mental health team when he felt he was not coping well.

36. On 23 November 2021, staff responded to a cell bell from Mr Payne's cell. Staff found Mr Payne with an electrical cable tied around his neck, attached to a locker. Staff cut the cable and Mr Payne regained consciousness. An ambulance attended but Mr Payne did not want to engage or attend the medical wing. An officer opened an ACCT and observations were set at five per hour.

37. The next day, Mr Payne took a mix of medication, some of which was not his. When he made staff aware, an ambulance was called, and he was taken to hospital. He returned the same day.

38. On 25 November, a supervising officer (SO) offered Mr Payne a move from the wing, but he declined. A full, multidisciplinary ACCT review was held in the afternoon. Mr Payne spoke about hearing other prisoners shout insults at him, and he expressed anxiety over his parole hearing the following spring. The ACCT care map was updated and observations were reduced to three per hour.

39. On 26 November, Mr Payne moved cells to a different location on the same wing.

40. On 29 November, an SO conducted an ACCT review. Mr Payne had an appointment scheduled with the wellbeing team in December and seemed more stable. He said he did not have any thoughts of suicide or self-harm. Observations were lowered to two per hour.

41. On 3 December, an SO closed the ACCT following a review. The SO worked through the care plan and noted good progress, and Mr Payne said he felt settled after moving cell. The ACCT entered the seven-day closure period where daily conversations occur to ensure there are no concerns. The ACCT was closed after seven days with no further concerns.

42. On 2 February 2022, an SO began ACCT procedures again for Mr Payne after he submitted paperwork requesting a wing move and he said he was under threat from other prisoners. Mr Payne told staff that other prisoners had been putting him under pressure to steal things, and that he was stressed because his parole hearing had been delayed. He said that his epilepsy was triggered by stress and he was considering self-harming because he felt low. The SO directed staff to check Mr Payne at least twice an hour. The SO did not begin violence reduction procedures

(known as Challenge Support Intervention Plan – CSIP – which can offer additional support to prisoners considered to be at risk of violence and bullying).

43. The next day, an SO conducted the first ACCT case review with Mr Payne. A nurse was also present. Mr Payne talked about the factors that were having an impact on his mood, such as his parole hearing being delayed and losing his job as a result of an earlier adjudication for stealing. Mr Payne was offered a move to a different wing, but he said he was happy to remain where he was. The SO recorded that he had added actions to Mr Payne's action plan, which included speaking about his parole with the offender management unit and to seek employment. It was also recorded that his medication would be reviewed due to paranoia.

44. In interview, the nurse said that Mr Payne had shown signs of hypervigilance and was worried that prisoners on the wing were out to get him. She said that she felt there was a threat of bullying and harm to Mr Payne, while prison staff said there was no evidence at that time. The nurse referred Mr Payne to the psychiatrist for an up-to-date assessment of his mental health and to review his medication.

45. On 10 February, an SO conducted another ACCT case review, with an officer and a nurse. The SO noted that Mr Payne engaged well and they worked through his care map, which had been completed, and that he had an upcoming appointment with a psychiatrist. Mr Payne told staff at the meeting that he had not self-harmed and had no intention to. Staff noted that he seemed settled and stable. The nurse said that Mr Payne did not present as at an acute risk of suicide or self-harm during the ACCT process. The staff concluded that the ACCT should remain open for the time being.

46. On 16 February, staff held a restorative justice meeting after Mr Payne handed an improvised weapon (altered razor blade) to staff which he said was for self-defence. Staff said this incident was due to his paranoia and anxiety, and that the most appropriate course of action was to support Mr Payne, rather than take punitive action. The SO said that he was engaging with the mental health team and would be accompanied to meetings for support.

47. The next day on 17 February, at an ACCT review, the staff closed the ACCT. The post-closure booklet shows that staff felt the support actions had been completed and Mr Payne was more positive about his parole hearing, and the possibility of release, and the staff support available to him. The SO said that Mr Payne knew that his parole window (the period when he could be considered for a parole hearing) was coming up and he had found a job on the wing, which made him seem more settled.

48. On 28 February, a consultant psychiatrist saw Mr Payne. Mr Payne told him that the voices in his head were becoming louder, he was having trouble sleeping and his medication for his anxiety was no longer working. The psychiatrist prescribed Mr Payne new antipsychotic medication and made a follow up appointment for six weeks' time.

49. On 14 March, staff conducted an intelligence led search of Mr Payne's cell. During the search they found a number of bottles of alcoholic fermenting liquid (hooch) along with an improvised weapon, similar to the one he had handed in in February. Under prison rules, the possession of both alcohol and weapons is illegal. When

challenged, Mr Payne said that the items belonged to him. He was placed on report for having prohibited items in his cell, to face an adjudication. (An adjudication is a hearing of the alleged offence by either a senior member of staff, or judge, who decides whether the prisoner is guilty of the offence and determines the punishment.) The following day, Mr Payne told staff that that he felt safe on the wing and did not want to move and that he would say he was guilty at the upcoming adjudication.

50. On 16 March, staff held the adjudication meeting. Mr Payne was placed on basic regime for seven days. This meant that he had certain privileges, such as access to a TV and canteen spending, reduced.

51. On 4 April, staff conducted another intelligence led search of Mr Payne's cell. During the search, another ten litres of hooch were found and Mr Payne took responsibility for this. As a result, he was downgraded to the basic regime for seven days. Staff said that they believed that Mr Payne was keeping the hooch in his cell for other prisoners.

52. In interview, an SO said that Mr Payne would not tell staff who was pressuring him to hold items, and when they offered him a cell move, he said the issues would just follow him. The SO said that Mr Payne never confirmed that he was being bullied, however, as a precaution, he was moved to a different section of the wing. Staff did not consider beginning a CSIP to support Mr Payne.

53. On 5 April, the psychiatrist saw Mr Payne for a follow up appointment. Mr Payne told the psychiatrist that the voices he was hearing had reduced, but that he was still feeling paranoid. Mr Payne also complained of tremors in his hands, but the psychiatrist said that this was a common side effect of his epilepsy medication.

54. On 11 April, an SO recorded that Mr Payne had fought with another prisoner in the wing showers. The SO noted that due to a lack of evidence about the cause of the fight, or who had started it, neither prisoner was placed on report. The SO told the investigator that neither Mr Payne nor the other prisoner would say what had happened, but both were downgraded to basic regime as a result and that staff thought the other prisoner was the likely aggressor. The SO said that Mr Payne told him he was being asked to hold items and was tired of getting in trouble for it, and that this may have been what the fight was over. A CSIP was not started.

55. On 16 April, Mr Payne approached the SO and told him that he was being bullied and that he was under threat on the wing for a debt he incurred when his cell was searched and the illicit items were confiscated. He said that he was being forced to pay the debt. The SO offered him a wing move, but he declined and said that he did not want to be labelled 'a grass'. Again, staff did not start a CSIP. Mr Payne told the SO that he did not want to be at Wayland any longer. The SO contacted the duty governor who authorised Mr Payne's move to D Wing to ensure his safety as a prison move was not practical at short notice.

56. On 20 April, a probation officer went to see Mr Payne at his request. She recorded that from her observation, Mr Payne was struggling with the parole process and said that he had been self-sabotaging and felt institutionalised and scared. She also noted that Mr Payne was very tearful and shaky during their meeting. Mr Payne told her that some legal papers were left behind in his cell when he moved wings and he

believed that other prisoners had become aware of his offence and rumours had started about him.

57. Mr Payne told the probation officer that he could not stay at Wayland any longer and that he would assault an officer to get transferred to a different prison. She asked him why he had been found with hooch. Mr Payne said that it was for financial gain, but after it was found he was now in debt. She agreed a move to an alternative prison might help his mental health and behaviour while he was in the parole window. She submitted an intelligence report and informed safer custody of the conversation she had had with Mr Payne. She said that she did not believe Mr Payne posed a risk to himself and so did not consider beginning ACCT procedures, but she thought that he was self-sabotaging ahead of his parole window.

58. On 28 April, Mr Payne's new key worker met Mr Payne. He recorded that Mr Payne came across as paranoid and he contacted the prison's mental health team about Mr Payne's presentation.

59. On 3 May, the psychiatrist saw Mr Payne. Mr Payne said that anxiety was still a problem, but he also felt that he was being targeted within the prison. Mr Payne told him that other prisoners knew about his offence, that it would continue to follow him and asked if he could change prison. The psychiatrist said he considered Mr Payne's feelings that he was being targeted were based on anxiety. He said that Mr Payne was already on the maximum dosage of an antidepressant and asked the prison's mental health team to review Mr Payne more often. The psychiatrist made a follow up appointment for four weeks' time.

60. On 8 May, Mr Payne went to see an SO and told her that he did not want to be on the wing anymore. She asked other senior managers what his options were. Later, Mr Payne refused to speak to the SO about this and so she took this to mean Mr Payne wanted to remain on D Wing. She recorded on his NOMIS record that he was aware of his limited options at that time. We were unable to interview the SO as she had left the Prison Service by the time of the investigation.

61. A mental health nurse said that wing staff had asked her to go and see Mr Payne. Mr Payne said that he was being bullied and wanted to move wings. The nurse said that they discussed his options, and that he was visibly anxious. She was also aware that he had heightened anxiety about his upcoming parole review. Mr Payne told the nurse that he was considering harming himself if nothing was done to support him in moving off the wing.

62. The nurse asked Mr Payne if he needed an ACCT to be opened for additional support, and he said no. She said that she was not aware that he had made a previous suicide attempt in November 2021. She did not start ACCT procedures or share any concerns with wing staff.

63. At around 5.00pm on 14 May, Mr Payne was in another prisoner's cell watching football. An officer told Mr Payne to go back to his cell and he locked him up for the evening. The officer said that he did a head count around 30 minutes later and Mr Payne was in his cell watching the football. The officer said that he did not have any concerns about Mr Payne at that time.

64. Between 8.30 and 9.00pm, Officer A conducted a routine check. He said that Mr Payne was sitting in his cell watching TV. Officer A said he also did not have any concerns and Mr Payne did not ring his cell bell or try to talk to him throughout the night. Officer A had no reason to check on Mr Payne or look into his cell during the night.

Events of 15 May

65. At around 5.15am on 15 May, Officer A conducted a routine check. Officer A noticed that the light was on in Mr Payne's cell, and the majority of the observation panel in his cell door was covered (he could not remember with what). When he looked through a gap in the observation panel into the cell, he saw Mr Payne hanging from the window. He radioed a code blue medical emergency (indicating a prisoner is unconscious or is having breathing difficulties), and waited outside the cell until he was joined by another member of staff.

66. Officer A said that, although he had a cell key for emergency situations, he did not go into the cell straight away because he thought that he should not enter a cell alone at night. Officer A said that he could not remember exactly where this advice came from, but said he froze a bit when he found Mr Payne.

67. At approximately 5.17am, control room staff called an ambulance.

68. Officer B said that he was outside D Wing at the time the code blue was called and went straight to the cell. As he arrived at the end of the corridor, Officer A entered the cell and cut the ligature, a dressing gown cord, from the window frame. Officer B said that by the time he entered the cell, Officer A was placing Mr Payne on the floor.

69. Officer B removed the ligature from Mr Payne's neck. He said that Mr Payne was cold to the touch. Another officer then arrived and told the officers that they needed to carry out CPR as they were unsure if Mr Payne was dead.

70. A custodial manager (CM) and an officer also made their way to Mr Payne's cell in response to the code blue call. The officer said that, on the way, he heard staff request a defibrillator over the radio, so he ran to E Wing to collect one. He then went to Mr Payne's cell and arrived around two minutes later. He said that when he arrived Mr Payne was on the floor, a defibrillator had been attached already, and Officer B was doing CPR.

71. The officers continued CPR and follow the defibrillator's instructions. The defibrillator did not advise any shocks be delivered. At approximately 5.55am, paramedics arrived. At 5.59am, they confirmed that Mr Payne had died.

Contact with Mr Payne's family

72. The prison appointed a family liaison officer. Mr Payne's next of kin, his father, lived in Leeds, and so the prison asked the local police in Leeds to inform him that Mr Payne had died. HMPPS guidance on informing the next of kin sets out that a family liaison officer from a prison local to that person should be used to inform them of the death.

73. At around 8.30am, Mr Payne's family were informed of his death. Mr Payne's father contacted a CM in the safer custody team 15 minutes later, and she advised him that a family liaison officer would be in touch. The family liaison officer contacted Mr Payne's father shortly after, offered condolences and provided the family with details of the next steps.

74. The prison offered to contribute to the cost of Mr Payne's funeral, in line with national guidance.

Support for prisoners and staff

75. After Mr Payne's death, staff involved in the emergency response were debriefed and offered support. The staff care team also offered support.

76. 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

77. The post-mortem examination found that the cause of death was hanging. The toxicology report was made available to the PPO and showed that Mr Payne was using the medicine he was prescribed.

Findings

Identifying the risk of suicide and self-harm

78. 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 Wayland should have recognised Mr Payne as at risk and begun ACCT procedures to support him.

79. Mr Payne had some risk factors for suicide and self-harm. He had been in prison since 2009 and had been appropriately supported by ACCT procedures a number of times, most recently in February, when he attempted suicide. He had a history of mental health problems including anxiety and paranoia and was under the care of the MHIT.

80. In the weeks leading to his death, Mr Payne had been caught with weapons and hooch, was in debt to other prisoners and fearful of reprisals, moved wing, complained of being bullied, was involved in a fight, and spoke of heightened anxiety and paranoia. He was also nervous about his approaching parole window.

81. While Mr Payne received some good support in response to his worries, we are concerned that the events of the months before his death were treated in isolation. Better communication and training might have led to his risk factors being considered holistically. Different officers and healthcare staff knew of his concerns but no one considered that they might suggest his risk of suicide or self-harm was increasing.

82. On 8 May, Mr Payne told a nurse that he would self-harm if he did not get a cell move. The nurse asked Mr Payne if he needed the support of the ACCT process but when he said he did not, she took no further action. We consider that the nurse should have opened an ACCT regardless of whether she believed Mr Payne to be serious. This would have given wing staff an opportunity to provide Mr Payne with additional support and explore his concerns.

83. Not all staff at HMP Wayland who had contact with Mr Payne were ACCT trained, including the nurse. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular:

- **The need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated; and**
- **All staff receive appropriate ACCT training.**

Violence reduction and bullying

84. Wayland's violence reduction policy requires staff to submit a Challenge Support Intervention Plan (CSIP) referral if there is a risk of violence or a violent incident is identified. The policy outlines a number of potential actions to take where appropriate such as submitting an intelligence report and making NOMIS and wing observation book entries, dealing with issues through adjudications, and police referrals among others.

85. In April, Mr Payne was found with hooch and weapons in his cell and he told staff he was being bullied. Even before Mr Payne admitted he was being bullied, staff suspected that he was holding the items for other prisoners. Staff should have initiated CSIP procedures in line with local policy as there was clear indication that Mr Payne might be at risk of violence, but they failed to do so. Being managed under CSIP procedures could have given Mr Payne the additional support and reassurance he might have needed at that time, and would have allowed staff to investigate the circumstances. We make the following recommendation:

    The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are appropriately supported and protected.

Emergency Response

86. PSI 24/2011 on the management and security of nights states that staff have a duty of care to prisoners, to themselves, and to other staff, and that the preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be an immediate danger to life, a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.

87. Officer A said his understanding of policy and procedure was that an officer would never enter a cell on their own. He saw Mr Payne suspended by a ligature, which would indicate an immediate danger to life, and as he was in a single cell with the light on, Officer A should have conducted a dynamic risk assessment.

88. While we accept that the delay entering the cell is unlikely to have affected the outcome for Mr Payne, in future cases, it could be critical. We make the following recommendation:

    The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life-threatening situations, subject to a dynamic risk assessment.

    The Governor should ensure that a senior manager shares this report with Officer A and discusses the Ombudsman's findings with him.

89. There is no 24-hour healthcare presence in Wayland. Officer A said he had never received first aid or basic life support training, and a number of other officers said that they had not received refresher training in recent years. PSI 29/2015 sets out that first-aid provision must be 'adequate and appropriate in the circumstances'. This means that sufficient first-aid equipment, facilities and personnel need to be

available at all times. Given the risks and expectations of staff working nights, staff should be given up to date training in life support and first aid. We make the following recommendation:

The Governor should ensure that operational staff have up to date training in order to administer basic first aid, in line with the provisions of PSI 29/2015.

Contact with Mr Payne's family

90. Prison Rule 22 requires that the Governor should inform families at once when a prisoner dies. PSI 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death. It notes that time is of the essence to try to ensure that the family does not find out about the death from another source. If the next of kin lives a long distance away, consideration must be given to asking a family liaison officer from the nearest prison for help.

91. Mr Payne's next of kin lived some distance from the prison, however a local prison was not asked to contact the next of kin. The family were contacted initially by the police, at the prison's request. We make the following recommendation:

The Governor should ensure that suitable arrangements are made to contact the next of kin in line with PSI 64/2011.

Clinical care

92. The clinical reviewer concluded that the clinical care Mr Payne received at HMP Wayland was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that the overall engagement with the mental health team and care plans were of a good standard.

Inquest

93. The inquest, heard on 20 March 2023, concluded that Mr Payne died from suicide.

Prisons & Probation Ombudsman
Independent Investigations

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