

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Humphreys a prisoner at HMP Altcourse on 21 July 2016

**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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Humphreys was found hanged in his cell on 21 July 2016, at HMP Altcourse. He was 38 years old. I offer my condolences to Mr Humphreys' family and friends.

When Mr Humphreys arrived at Altcourse, around seven weeks before his death, staff did not identify him as at risk of suicide, despite clear information that he was at heightened risk. I have identified similar failings in previous investigations at Altcourse.

I am also concerned that, when staff initiated suicide and self-harm prevention procedures a month after Mr Humphreys' arrival, healthcare staff had limited input and Mr Humphreys' issues were not properly addressed or resolved.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2017

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	5
Findings.....	9

Summary

Events

1. On 3 June 2016, Mr Darren Humphreys was remanded to HMP Altcourse. Court staff completed a suicide and self-harm warning form, highlighting that Mr Humphreys had recently threatened to hang himself. His escort record, which also went with him to the prison, repeated this information and described Mr Humphreys as at “high risk” of harming himself. Reception staff and a nurse assessed Mr Humphreys, but did not identify him as at risk of suicide and self-harm.
2. On 1 July, Mr Humphreys made a serious cut to his arm, which required hospital treatment. He told prison staff that he had intended to take his life. An officer began suicide and self-harm procedures, known as ACCT. Healthcare staff admitted Mr Humphreys to the prison’s inpatient unit on his return.
3. On 2 July, an officer assessed Mr Humphreys, and recorded that Mr Humphreys was concerned as he had not received good news at court the previous day. The officer said Mr Humphreys was upset about correspondence he had received from his ex-partner. Later that day, a nurse and the assessor held a case review as Mr Humphreys was about to return to his residential unit. Shortly afterwards, a manager held the official first case review, seemingly without input from healthcare staff or the assessor. The case manager ended ACCT monitoring at the next case review on 10 July.
4. On 21 July, the officer who unlocked Mr Humphreys in the morning did not check his welfare, as national instructions require. Around 15 minutes later, a prisoner found that Mr Humphreys had hanged himself. Staff began cardiopulmonary resuscitation, but there was a short delay of around a minute before anyone made a medical emergency response radio call. After further emergency treatment, paramedics recorded that Mr Humphreys had died.

Findings

5. We found that reception staff did not fully consider Mr Humphreys’ risk factors for suicide and self-harm when he arrived at Altcourse. Important information about his risk was not shared with everyone who should have seen it.
6. When staff managed Mr Humphreys under ACCT suicide and self-harm prevention procedures, they did not consider all of the issues that had led to procedures being started and did not properly involve healthcare staff in the assessment and management of his risk.
7. The officer who unlocked Mr Humphreys’ cell on the morning of his death should have checked his welfare at the time and, later, should have radioed a medical emergency at the earliest opportunity.

Recommendations

- The Director should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.
- The Director should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:
 - ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.
 - ACCT caremap actions are specific and meaningful, identify all of the issues identified during the assessment interview and at case reviews, and that ACCT monitoring does not stop until all caremap actions have been completed.
 - Post-closure reviews take place within seven days of closing ACCT procedures.
- The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use their radio to communicate the nature of a medical emergency quickly and effectively.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Altcourse, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Altcourse on 1 August. He obtained copies of relevant extracts from Mr Humphreys' prison and medical records, and interviewed two prisoners who knew him.
10. The investigator interviewed ten members of staff and two prisoners from August to October.
11. NHS England commissioned a clinical reviewer to review Mr Humphreys' clinical care at the prison. She joined the investigator for interviews with clinical staff.
12. We informed HM Coroner for Liverpool of the investigation. We have given the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Humphreys' parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Humphreys' parents asked the following questions:
 - What information arrived with Mr Humphreys at Altcourse, how prison staff assessed him on arrival and whether they judged him as at risk of suicide or referred him for a mental health assessment.
 - When prison staff monitored Mr Humphreys under ACCT suicide and self-harm prevention procedures, and why they ended ACCT procedures.
 - What happened on 1 July, when Mr Humphreys told his father that he had cut his wrist.
 - Why Mr Humphreys was in a cell by himself when he died, and whether he should have been in a single cell given his vulnerability.
14. Mr Humphreys' parents received a copy of the initial report. They did not make any comments.

Background Information

HMP Altcourse

15. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young men. G4S manage the prison and provide primary healthcare services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Altcourse was in June 2014. Inspectors reported that levels of self-harm were higher than at similar prisons. They found that ACCT entries were excellent and prisoners in crisis spoke positively about the care they had received. However, inspectors found that prison staff had not addressed all of the learning points from recent self-inflicted deaths.

Independent Monitoring Board

17. 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 June 2016, the IMB reported that there had been a rise in the number of incidents of self-harm, and a subsequent rise in the number of ACCT documents opened. They found that the safer custody team made continuing efforts to ensure Altcourse was a safe prison, although staff shortages had had a significant impact throughout the prison.

Previous deaths at HMP Altcourse

18. Mr Humphreys was the fifth prisoner to die at Altcourse in 2016, but the first to take his own life. Our investigation into the most recent death of a prisoner to take his own life in September 2014, found that reception staff did not fully consider and record all of the man's risk factors for suicide and self-harm.

Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

20. Mr Darren Humphreys was remanded to HMP Altcourse on 3 June 2016, charged with the false imprisonment of his former partner. Mr Humphreys' Person Escort Record (PER, a form that accompanies prisoners on all journeys to communicate information including about risk factors) said that he was at "high risk" of suicide and self-harm and had threatened to hang himself on 1 June (when he was arrested). The PER also said that Mr Humphreys had a cut to his wrist, although no further information was provided about this. A member of court staff completed a suicide and self-harm warning form, which said that Mr Humphreys had "threatened to hang himself" on 1 June and, at court, had said he had "things going on in his head".
21. At 4.50pm, Mr Humphreys arrived at Altcourse. This was his second time in prison, having previously served a short sentence in 2009. The admissions manager signed the PER and suicide and self-harm warning form and interviewed Mr Humphreys when he arrived. He told us he could not remember Mr Humphreys. He did not assess Mr Humphreys as at risk of suicide and self-harm and did not begin ACCT procedures.
22. A nurse assessed Mr Humphreys and did not record any physical or mental health issues. He recorded that Mr Humphreys appeared settled, stable and "firmly denied" any thoughts of suicide or self-harm. He did not refer to the contents of either the PER or suicide and self-harm warning form. He told us that he did not remember Mr Humphreys well and presumed that the lack of reference to these documents meant that he did not see them. The admissions manager told us that the reception nurse would not normally see the PER, but would see a suicide and self-harm warning form if it was scanned and attached to the medical record. Mr Humphreys' form was not scanned and attached to his medical record.
23. The nurse recorded that he had referred Mr Humphreys for a mental health assessment, but there is no evidence that anyone from the mental health team saw Mr Humphreys in the following days. He said he could not remember whether he intended to refer Mr Humphreys or if this was a coding error on the template. (The health screen template is computer based and includes several questions to which the nurse selects the relevant answer or option from a drop-down box.) He did not assess Mr Humphreys as at risk of suicide and self-harm and did not begin ACCT procedures.
24. Prison healthcare staff asked Mr Humphreys' community GP for his medical records. These arrived on 7 June, highlighting that Mr Humphreys had been assessed for stress on 1 June, and had overdosed on drugs in 2004.
25. A nurse assessed Mr Humphreys on 7 June. He recorded that Mr Humphreys had no concerns about his physical health and there was no evidence of mental illness. He recorded that Mr Humphreys told him he had "threatened to hang himself while on the run from the police". He said that Mr Humphreys indicated he did not mean this and was trying to manipulate the police. Mr Humphreys also said he had no current intention of harming himself. He said that Mr

Humphreys appeared settled in prison and he did not assess him as at risk of suicide and self-harm.

26. On 1 July, Mr Humphreys attended a hearing at Crown Court, where he was remanded in custody until October. At around 6.00pm, Mr Humphreys telephoned his father. Prisoners at Altcourse have telephones in their cells. Their calls are recorded and we listened to recordings of Mr Humphreys' calls. Mr Humphreys told his father that he had cut himself and lost a lot of blood. Mr Humphreys' father advised him to call prison staff, which he did. An officer attended and called a code red medical emergency, indicating that a prisoner has lost a lot of blood. She began ACCT procedures, and recorded that Mr Humphreys said he had not had a good day in court and did not want to be alive anymore.
27. A nurse treated Mr Humphreys. She recorded that he told her he had made a serious attempt to kill himself and that he still wanted to die. Mr Humphreys said he was a carer for his father, who was ill, and thought he should be at home with his family. Mr Humphreys went to hospital for further treatment. He returned to Altcourse on 2 July, and was admitted to the prison's healthcare centre for observation.
28. The nurse put Mr Humphreys on a list for daily sessions with a mental health nurse. A nurse who saw Mr Humphreys for some of these sessions, explained that their purpose is to provide additional support for prisoners in crisis. A nurse saw Mr Humphreys on the morning of 2 July. He said he regretted his actions but was upset that his trial date had been put back until October. Later that morning, a prison doctor prescribed an antidepressant.
29. That afternoon, an officer assessed Mr Humphreys as part of ACCT procedures. Mr Humphreys said he had tried to take his life as he had had a bad day. He said he had expected to receive a two-year sentence at court, but was instead told that he would not face trial until October. Mr Humphreys said he was upset because he had received a letter from his ex-partner, whom he was not allowed to contact because of an injunction. The officer recorded that Mr Humphreys' trial and contact with his ex-partner were his key issues and might be a trigger for suicide or self-harm.
30. Staff recorded two separate ACCT case reviews that afternoon. A nurse recorded the first case review at 3.45pm. She recorded that an officer was also present, but not Mr Humphreys. She completed a 'review prior to discharge from healthcare' template and recorded that Mr Humphreys was remorseful about his actions and had no further thoughts of harming himself. She recorded that Mr Humphreys wanted to move back to his wing rather than remain in the healthcare centre.
31. At 4.15pm, a residential manager held the formal first ACCT case review. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that the assessor attend with, wherever possible, the member of staff who raised the initial concern, and a member of healthcare staff. If those invited cannot attend in person, they can exceptionally give a written account of their input. He recorded that Mr Humphreys and the manager of Mr Humphreys' wing and the ACCT case manager were present. However, the wing manager told us that he did not

- attend. The residential manager told us that other staff were also present, including an officer and a nurse. However, the officer said that the two case reviews were separate and he could not remember if he contributed to the residential manager's case review.
32. The residential manager recorded that Mr Humphreys appeared more positive, but was still a little tearful about his father's illness. He entered two actions on the ACCT caremap: for Mr Humphreys to be prescribed antidepressants and to begin counselling. There is no record of any discussion about Mr Humphreys' trial or contact with his ex-partner. Mr Humphreys returned to his wing shortly after the case review.
 33. On 3 July, Mr Humphreys told a nurse that he felt a lot more settled now he had returned to his wing. He said he regretted harming himself and had no thoughts of doing so again.
 34. On 6 July, Mr Humphreys saw a prison counsellor for an introductory session. Mr Humphreys told him that he had tried to take his life in the past, but did not provide details of these incidents. He said he had a job emptying the bins at the prison and this helped take his mind off things. Mr Humphreys said he preferred to speak to his family about his problems and would think about whether he wanted to continue counselling.
 35. On 7 July, a nurse saw Mr Humphreys. She recorded that Mr Humphreys said his session with a prison counsellor had gone well and his mood had started to lift. She concluded that he did not need additional daily sessions, as he no longer appeared to be in crisis.
 36. On 10 July, a manager and an officer held an ACCT case review. Mr Humphreys said he felt much better, and that his medication and counselling had helped. The manager told us that Mr Humphreys' medication and counselling appeared to have relieved the stress that initially caused him to harm himself. He signed the two caremap actions as complete, and stopped ACCT monitoring.
 37. A prisoner moved into Mr Humphreys' cell on 12 July. He said that Mr Humphreys was worried about the sentence he expected to receive. He said that Mr Humphreys' told him he had cut himself earlier that month, but appeared fine when they shared a cell and had no issues in the prison.
 38. On 14 July, the prison counsellor visited Mr Humphreys for a counselling session. Mr Humphreys declined the session and said he did not think counselling was right for him.
 39. A manager scheduled an ACCT post closure review for 17 July but no review took place then or over the following days.
 40. On 20 July, Mr Humphreys' cellmate was transferred to another prison. Mr Humphreys now lived in the cell by himself. He telephoned his mother twice that day. In both calls, Mr Humphreys said he "felt like shit" and was really down. He said he knew he was looking at a long sentence but would have to cope with it.
 41. At 7.28am on 21 July, Officer A unlocked cells on Mr Humphreys' landing. CCTV footage shows that he looked through the door observation panels for the cells

near to Mr Humphreys', to check the prisoners' wellbeing, but did not look in Mr Humphreys' cell. He said he did not know why he failed to check Mr Humphreys' wellbeing.

42. At 7.43am, a prisoner went to Mr Humphreys' cell. He looked through the observation panel and said he could see Mr Humphreys hanging. He waved and shouted to wing officers. Officer A ran up the stairs and went into Mr Humphreys' cell 30 seconds later. He found Mr Humphreys hanging from a bed sheet that he had tied to the bed frame. He pressed the 'first response' button on his radio, which alerts staff that an incident has occurred. He told us that he also radioed a medical emergency code blue, indicating a life threatening situation, although the control room operator did not record or relay such a message.
43. Officer A removed the ligature and began cardiopulmonary resuscitation. A manager arrived at the cell around a minute after Officer A, and radioed a medical emergency code blue. The control room operator called for an ambulance immediately. A nurse arrived 20 seconds after the manager and took over cardiopulmonary resuscitation. She applied a defibrillator, which advised not to apply an electric shock and to continue with chest compressions.
44. Paramedics arrived at Mr Humphreys' cell at around 7.58am. They initially continued cardiopulmonary resuscitation, but recorded that Mr Humphreys had died at 8.20am.

Contact with Mr Humphreys' family

45. The Acting Director and a prison chaplain visited Mr Humphreys' father, his nominated next of kin, on the morning of 21 July, and informed him of Mr Humphreys' death. Mr Humphreys' funeral was held on 11 August. In line with Prison Service instructions, the prison contributed to the costs.

Support for prisoners and staff

46. After Mr Humphreys' death, the Acting Director 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.
47. The prison posted notices informing other prisoners of Mr Humphreys' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Humphreys' death.

Post-mortem report

48. The results of the post-mortem examination, and the established cause of death, were outstanding when we issued our report.

Findings

Identifying risk of suicide and self-harm

49. 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 to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.
50. Court staff completed a suicide and self-harm warning form, which said that Mr Humphreys had very recently threatened to hang himself. The PER identified Mr Humphreys as at “high risk” of suicide and self-harm. In addition, Mr Humphreys was charged with a violent offence against his ex-partner, a recognised risk factor.
51. PSI 07/2015, about early days in custody, has a mandatory action that reception staff must examine the PER and any other available documentation to identify any immediate needs or recorded risks. Neither the admissions manager nor the nurse remembered Mr Humphreys. The admissions manager signed both the suicide and self-harm warning form and PER, but it is not clear whether he read and noted the information about risk, as he should have done. The nurse did not remember if he saw these documents. The admissions manager said that the reception nurse never sees the PER and only sees a warning form if it is scanned to the medical record – which did not happen.
52. In a PPO Learning Lesson Bulletin, published in February 2016, about early days in custody, we found that staff need to identify – from the information and documents available to them – record and act on all known risk factors during reception and first night.
53. We are concerned about reception procedures at Altcourse. There is no record that any member of staff identified or took into account Mr Humphreys’ risk factors when assessing his risk of suicide and self-harm. We are also concerned that not all reception staff see and review key documents. We make the following recommendation:

The Director should ensure that reception staff have a clear understanding of their responsibilities and the need to share all relevant information about risk, and that they consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.

Managing the risk of suicide and self-harm

54. Mr Humphreys was managed under ACCT procedures which were closed around 11 days before he hanged himself. We are concerned that the procedures were poorly managed. While this might not have affected the eventual outcome, it is possible that more effective ongoing support might have helped address Mr Humphreys’ underlying risk of suicide.
55. PSI 64/2011 requires case reviews to be multidisciplinary where possible and says that, for the first case review, the assessor, the person who raised the initial

concern and a healthcare representative must attend. It also says that the caremap must reflect the prisoner's needs, level of risk, and the triggers of their distress.

56. There are conflicting accounts about who attended Mr Humphreys' first case review. Only two attendees were listed, and one of these told us he was not there. There is no record that Mr Humphreys' trial or contact with his ex-partner – the two key issues that emerged from his assessment interview – were discussed at the first case review. Instead, the two issues listed in the caremap amounted to referrals to services only.
57. Although Mr Humphreys had begun a course of antidepressants and had started seeing a prison counsellor when the manager ended ACCT procedures, we are concerned that the closing case review was not multidisciplinary. Given these two caremap actions, it is concerning that there is no evidence of any input from healthcare staff or the counsellor in the decision to stop ACCT monitoring. Instead, a manager relied too heavily on what Mr Humphreys told him and did not properly consider his risk.
58. PSI 64/2011 instructs that a post-closure review must take place within seven days of closure. No one held a post-closure review for Mr Humphreys, resulting in a missed opportunity to reassess his risk.
59. In a PPO Learning Lessons Bulletin, published in March 2015, about the self-inflicted deaths of prisoners in 2013-14, we found that staff should ensure that prisoners at risk of suicide and self-harm are managed in line with national instructions and guidance. We found that this should include holding multidisciplinary case reviews and completing relevant caremap objectives. We make the following recommendation:

The Director should ensure that prison staff manage prisoners at risk of suicide and self-harm in line with national guidance, including that:

- **ACCT case reviews are multidisciplinary where possible and include all relevant people involved in the prisoner's care, with healthcare staff attending all first case reviews.**
- **ACCT caremap actions are specific and meaningful, identify all of the issues identified during the assessment interview and at case reviews, and that ACCT monitoring does not stop until all caremap actions have been completed.**
- **Post-closure reviews take place within seven days of closing ACCT procedures.**

Unlock procedures

60. When officers unlock cells, they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that, "Prior to unlock, staff should physically check the presence of the occupants of 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 had not escaped, is ill or dead". PSI 10/2011 also expects officers to check prisoners when unlocking their cells.

61. Officer A unlocked Mr Humphreys' cell at around 7.28am on 21 July. He did not check Mr Humphreys' wellbeing, although he had checked on prisoners in nearby cells. He told us that he understood the national instructions for unlocking cells, and did not know why he did not check Mr Humphreys.
62. A prisoner found Mr Humphreys hanged in his cell around 15 minutes after Officer A unlocked it. We cannot say whether Mr Humphreys' death could have been prevented if he had been checked earlier, but failure to get a response from a prisoner and check their wellbeing when unlocking a cell could prevent an effective emergency response.
63. Four days after Mr Humphreys' death, the Acting Director issued local instructions (Notice to Staff 39/2016), reminding staff of the need to obtain a response from prisoners when unlocking cells. We therefore make no further recommendation.

Emergency response

64. PSI 03/2013, on Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.
65. Altcourse's local instruction on emergency response codes (Notice to Staff 57/2015) instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious.
66. Officer A told us he thought he radioed 'code blue' when he arrived at Mr Humphreys' cell. Control room records only highlight a 'first response' call, which is a broader request for assistance and does not automatically lead to an ambulance being called. A manager radioed a 'code blue' emergency call around a minute later. While we cannot say that this delay had any impact on the outcome for Mr Humphreys, it is important that staff understand their roles in a medical emergency, as early intervention when someone is found hanging might save their life. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use their radio to communicate the nature of a medical emergency quickly and effectively.

**Prisons &
Probation**

Ombudsman
Independent Investigations