

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Humphries a prisoner at HMP Long Lartin on 18 May 2018

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Michael Humphries died in hospital on 18 May 2018 after being found collapsed in his cell at HMP Long Lartin earlier that day. He died from an overdose of his prescribed medication. Mr Humphries was 54 years old. I offer my condolences to Mr Humphries' family and friends.

Mr Humphries was serving a life sentence for murder and had spent over 12 years in prison. He maintained his innocence throughout. Because he never acknowledged his guilt, he had not engaged in any risk reduction work and so had not progressed through his sentence. In December 2017, his offender supervisor referred him for a place in the prison's Psychologically Informed Planned Environment (PIPE) unit. Mr Humphries was keen to move there as he thought it would help him progress. Around three weeks before he died, he found out that he had not been accepted into the PIPE and staff recognised that he was very disappointed.

Mr Humphries was also unhappy about his cell move ten days before he died. The same week, there were delays in him receiving his in-possession medication, which he was unhappy about because it meant he had to collect his medication daily.

In his suicide note, Mr Humphries said he had spent 12 years in prison for something he had not done and was frustrated that his good behaviour in prison had got him nowhere. He said that he had tried to progress by applying to the prison's PIPE unit but no one had even interviewed him before rejecting him.

Although staff recognised that Mr Humphries was low in mood in the weeks before his death, I am satisfied that Mr Humphries gave little indication that he was at increased risk of suicide or self-harm in the days leading up to his death and that prison staff could not have foreseen his actions on 18 May.

However, the investigation identified a number of concerns that contributed to Mr Humphries' low mood.

Although Mr Humphries was not progressing in his sentence, staff did not review his sentence plan and consider the available options but instead left it to Mr Humphries to propose ideas. The offender supervisor also raised false expectations by referring Mr Humphries to the PIPE unit when it was clear he was not eligible, and the rejection was not communicated to him as sensitively as it should have been. A few months before Mr Humphries' death, HM Inspectorate of Prisons found that offender supervisors at Long Lartin did not have sufficient time to carry out the full range of their duties and this may have contributed to the shortcomings in the way Mr Humphries was managed.

The investigation also found that there were delays in supplying Mr Humphries with his in-possession medication, and that he was moved into an unacceptably dirty cell, both of which caused him frustration.

Finally, the officer who unlocked Mr Humphries' cell on the morning of 18 May did not carry out a welfare check as he should have done and failed to identify that Mr Humphries was unwell. This resulted in a short delay in Mr Humphries receiving emergency medical care, although the delay is unlikely to have affected the outcome.

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

February 2019

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Summary

Events

1. Mr Michael Humphries was sent to prison in February 2006 charged with murder. In January 2007, he was sentenced to life in prison with a minimum term of 30 years. He was sent to HMP Long Lartin on 3 April 2007.
2. Mr Humphries had a triple heart bypass operation in 2013 and was prescribed medication for heart disease, which he kept in his possession.
3. Throughout his time in prison, Mr Humphries said he was innocent. As he never acknowledged his guilt, he did not engage in any risk reduction work and so did not progress through his sentence, although his behaviour in prison was good. In December 2017, his offender supervisor made a referral for Mr Humphries to move to the prison's Psychologically Informed Planned Environment (PIPE) unit. Mr Humphries was keen to move there because he thought it would help him progress. At the end of April 2018, Mr Humphries found out that he had not been accepted into the PIPE. He was very unhappy with the news.
4. On 8 May, all the prisoners on Mr Humphries' wing were moved to a different wing. Mr Humphries was unhappy about the move as the cell he was moved to was dirty. He asked to move cells but staff refused. A prison manager told us that he arranged for wing cleaners to clean Mr Humphries' cell and he did not complain after that.
5. On 13 May, a nurse noted that Mr Humphries was still waiting for his in-possession medication and was having to collect his medication daily. On 15 May, Mr Humphries told a nurse that he did not want to collect his medication anymore and would wait for his in-possession medication to arrive. The nurse gave him two boxes of stock medication because she was concerned he would stop collecting it. The next day, Mr Humphries returned the stock medication after he was given his in-possession medication.
6. Around 7.45am on 18 May, an officer unlocked Mr Humphries' cell. The officer told the investigator that he saw Mr Humphries asleep in bed. He said he did not speak to Mr Humphries as he did not have time to speak to every prisoner he unlocked.
7. Shortly before 8.00am, a prisoner found Mr Humphries collapsed on the floor of his cell. The prisoner alerted a prison officer who went to Mr Humphries' cell. When the officer saw Mr Humphries on the floor, he called a medical emergency code over his radio. Mr Humphries was breathing and mumbling. Healthcare staff arrived around five minutes later and found Mr Humphries had a very slow heart rate and faint pulse. Ambulance paramedics arrived at Mr Humphries' cell at 8.25am and treated him for around an hour before transferring him to hospital. Mr Humphries died in hospital later that day.
8. The post-mortem examination found that Mr Humphries died from an overdose of bisoprolol, medication he had been prescribed to treat high blood pressure and heart disease.

9. Mr Humphries left a suicide note which said that he had spent 12 years in prison for something he had not done, he had not progressed in that time and he had behaved himself in prison for nothing. He said that he had applied to the PIPE to try to progress but no one had even bothered to interview him.

Findings

10. Although staff knew that Mr Humphries was low in mood, we are satisfied that Mr Humphries gave little indication that he was at increased risk of suicide and self-harm in the period leading up to his death and that prison staff could not reasonably have foreseen Mr Humphries' actions on 18 May 2018.
11. Mr Humphries was clearly disappointed at the news that he had not been accepted into the PIPE. It is unfortunate that his offender supervisor referred him when it was apparent he would not be eligible (because his reason for lack of progression was the failure to acknowledge his guilt rather than personality issues). We consider that the offender supervisor raised false expectations for Mr Humphries by making the PIPE referral. We also consider that a member of staff should have met with Mr Humphries to tell him that he had not been accepted into the PIPE so that they could have explained the decision to him and assessed his reaction.
12. We are concerned that offender supervisors at Long Lartin may not have sufficient time to carry out the full range of their role, including working proactively with prisoners who are failing to progress.
13. We are satisfied that it was appropriate for Mr Humphries to have in-possession medication. However, there were times when Mr Humphries failed to receive his in-possession medication on time, which caused him frustration because he had to collect it daily from the medication hatch.
14. We are concerned that the cell Mr Humphries was moved into on 8 May was dirty. We consider this was unacceptable.
15. The officer who unlocked Mr Humphries on the morning of 18 May did not try to get a response from him, as he should have done. There was a short delay in the medical emergency response as a result. This is unlikely to have affected the eventual outcome for Mr Humphries but it is important that unlock procedures are carried out correctly so that any concerns for a prisoner's welfare are identified at the earliest opportunity.

Recommendations

- The Governor should ensure that offender supervisors have sufficient time to undertake their roles in full and receive the necessary training and supervision.
- The Governor should ensure that when prisoners are considered unsuitable for offending behaviour programmes they are given feedback in person and that the impact on the prisoner is considered.
- The Head of Healthcare should review the process for repeat prescriptions to ensure that prisoners receive their medication without interruption.

- The Governor should ensure that cells are checked and properly cleaned before prisoners are moved into them.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator visited HMP Long Lartin on 29 May 2018. She obtained copies of relevant extracts from Mr Humphries' prison and medical records.
18. NHS England commissioned a clinical reviewer to review Mr Humphries' clinical care at the prison.
19. The investigator and clinical reviewer interviewed seven members of staff and three prisoners at Long Lartin on 10 and 11 July. The investigator interviewed a further two members of staff by phone on 6 August.
20. We informed HM Coroner for Worcestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. The investigator contacted Mr Humphries' son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Humphries' son did not raise any issues.
22. We shared a copy of our initial report with the Prison Service. They identified two factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.
23. We provided Mr Humphries' son with a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Long Lartin

24. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Care UK, with mental healthcare subcontracted to South Staffordshire and Shropshire NHS Foundation Trust Mental Health Team.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that strategic management of suicide and self-harm prevention was good and ACCT case management for prisoners at risk of suicide and self-harm was implemented well.
26. Inspectors found that the prison did not have an offender manager policy and practice was largely based on custom and practice. The role of offender management and how its work was integrated into the prison was not clear and there was no longer a dedicated team of offender supervisors. Inspectors found that officers were rarely allocated to the role of offender supervisor on consecutive days, which affected continuity of provision. As a result of limited time, offender management had focused almost exclusively on the completion of offender assessments, recategorisation reviews and sentence planning meetings. The wider role of offender supervisors, including contact with and support of prisoners to meet sentence plan targets, was underdeveloped.
27. HMIP recommended that offender supervisors should have sufficient time to undertake their roles in full, should receive the necessary training and supervision, and that Long Lartin should have an offender management policy.
28. A considerable number of prisoners had achieved progressive moves in the previous six months, but prisoners' expectations were not always managed effectively, and many prisoners still expressed frustration at a lack of progress out of the high security estate. Inspectors reported that the prison ran a Motivation and Engagement course targeted at those prisoners who were in denial of their offence. They noted that this was 'much needed' as 37% of the prison's population fell into this category.
29. The PIPE unit had opened in August 2017 as part of the national offender personality disorder pathway and network. Its role was to prepare prisoners who would benefit from entering the pathway but were resistant to change. Inspectors said it was promising, but in its very early stages, with few participants.
30. Medication prescriptions could be accessed from stock within 24 hours of being prescribed, with non-stock orders taking around 72 hours, although urgent medicines not in stock could be accessed more readily by use of a community prescription.

Independent Monitoring Board

31. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2018, the IMB reported that during the reporting year the work of the Offender Management Unit had been hindered by the diversion of staff to other areas of work.

Previous deaths at HMP Long Lartin

32. Mr Humphries was the seventh prisoner to die at Long Lartin since May 2015. Of the previous deaths, three were self-inflicted and three were homicides. There has been one death since, which was self-inflicted. In a previous investigation, we found that prisoners' welfare was not checked when they were unlocked.

Incentive and Earned Privileges (IEP) scheme

33. The IEP scheme aims to encourage and reward responsible behaviour. Prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

34. On 1 February 2006, Mr Humphries was charged with murder and sent to HMP Bullingdon. Mr Humphries had a history of suicide attempts and told staff in reception that he did not want to live and had a plan to kill himself. Staff started suicide and self-harm procedures (known as ACCT) and continued to monitor Mr Humphries under ACCT until September 2006.
35. On 19 December 2006, Mr Humphries was convicted of murder and on 26 January 2007 he was sentenced to life imprisonment with a minimum term of 30 years. Mr Humphries was sent to HMP Woodhill on 4 February 2006 but was returned to Bullingdon on 4 December 2006.

HMP Long Lartin

36. On 3 April 2007, Mr Humphries was sent to HMP Long Lartin where he remained.
37. Mr Humphries had limited contact with the mental health team at Long Lartin. On 13 February 2011, a forensic psychologist noted that Mr Humphries had been assessed in 2010 and met the criteria for antisocial personality disorder. There is no evidence in his medical notes that he received any treatment or support for his personality disorder. On two occasions in 2015, Mr Humphries told a mental health nurse that he was feeling 'down' because people on the wing had been coming to him to talk about their problems. The mental health nurse suggested a wing move and Mr Humphries said he would think about it. There was no further input from the mental health team.
38. Mr Humphries' prison record shows that he had positive relationships with staff and prisoners and was an enhanced prisoner under the IEP scheme. On 12 October 2016, Mr Humphries was allocated a job cleaning the Mandatory Drug Testing suite.

Health and medication

39. In April 2013, Mr Humphries had a heart attack and was taken to hospital. On 25 May he had a triple heart bypass operation and went back to prison on 3 June 2013. Mr Humphries' heart disease continued to be monitored by prison healthcare staff and was managed with medication and hospital outpatient visits.
40. A prison nurse told the investigator that Mr Humphries was not always compliant with his treatment and sometimes did not collect his medication or attend his monitoring appointments. Healthcare staff spoke to Mr Humphries about the risks of this given his heart condition.
41. Prisoner A, a friend of Mr Humphries, told the investigator that the healthcare department was a long walk from the wing and Mr Humphries was often dizzy and used a walking stick, so it was difficult for him to walk to the treatment room to have his blood pressure monitored.
42. From 2016, nursing staff made several entries in Mr Humphries medical record noting that he had either refused to take his medication or was angry because he had not received his medication. A prison nurse told the investigator that Mr Humphries had not been very compliant with taking his medication or attending

appointments to check his blood and urine. She said that Mr Humphries had a long history of not attending appointments and of telling GPs that he was not taking his medication and she often nagged him on the wing to come and make an appointment. She said that Mr Humphries' compliance with medication and monitoring had improved over the past 12 months and he had started to engage a lot more with his care and treatment.

43. On 7 February 2017, Mr Humphries met with a pharmacist to discuss his concerns about receiving his medication and she agreed to provide his medication in boxes.
44. On 20 July 2017, a prison nurse reviewed Mr Humphries' suitability for having his medication in-possession. She noted that he had no history of misusing his medication and had last been seen by a mental health practitioner several years ago. She noted that Mr Humphries was suitable for having his medication in-possession.

Sentence progression

45. Throughout his sentence, Mr Humphries maintained that he was innocent. This made it difficult for him to show that his risk had reduced or to engage in programmes and courses to address his offending behaviour as they usually require prisoners to talk about their offence.
46. On 10 September 2015, Mr Humphries had his latest sentence planning review. The panel noted that Mr Humphries had several risks that he needed to work on and that he should 'place considerable effort on his motivation to provide an open and honest account of his index offence' to progress and work towards reducing his risk. The panel recommended that Mr Humphries attend a motivational course.
47. Mr Humphries' category A status was reviewed annually but because he had not undertaken any risk reduction work and there was no evidence of a significant reduction in risk, they did not recommend a downgrade and he remained a category A prisoner. (Category A prisoners are those whose escape would be extremely dangerous to the public, the police and national security. Prisoners can be recategorised as they progress through their sentence if they show that their risk has reduced.)
48. In December 2017, Mr Humphries asked his offender supervisor to refer him to the Psychologically Informed Planned Environment (PIPE) unit at Long Lartin. (The PIPE unit is designed for prisoners who have been diagnosed with a personality disorder and aims to provide progression support following a period of high intensity treatment or offending behaviour programmes in custody. Prisoners who come into the PIPE are expected to have successfully completed such programmes and be motivated to apply what they have learnt in the PIPE environment.)
49. The offender supervisor noted that Mr Humphries had not completed any programmes or courses because he did not think they would help because he said he was innocent and would not take responsibility for his offence. He noted that Mr Humphries' behaviour in custody had been excellent, he worked well with

other prisoners and had just applied to be a safer custody representative. The offender supervisor thought that the PIPE unit might help Mr Humphries to progress as he seemed to have a psychological barrier about his offence. He also thought that Mr Humphries needed a change in his sentence planning because he had progressed with his education but not in other areas. On 13 December, he and an officer submitted Mr Humphries' referral to the PIPE unit.

50. On 3 April, Mr Humphries spoke to his son on the phone about his referral to the PIPE. He said that he was still waiting to hear about his referral and had been waiting since November. Mr Humphries told his son that he had argued with staff about his referral.
51. On 23 April 2018, a senior forensic psychologist spoke to Mr Humphries as part of his upcoming categorisation review. She noted that she spoke to Mr Humphries about his engagement in the regime at Long Lartin over the past 12 months. She recorded that Mr Humphries appeared motivated to attend the PIPE but that he did not seem to be aware of the purpose of the unit. When she asked what his goals would be if he did not get into the PIPE, he said they were to continue to improve his health by maintaining his medication, adhering to his diet and having regular exercise.
52. The senior forensic psychologist suggested that Mr Humphries attend a Motivation and Engagement programme, which instead of focusing on his offence would explore 'what individuals care about and the strengths they possess to help achieve their goals'. Mr Humphries said he did not know how this would help him but agreed to think about it.
53. On 24 April, a trainee psychologist wrote to Mr Humphries to tell him that he did not meet the criteria for the PIPE because his barrier to progression was that he would not take responsibility for his offence because he said he was innocent, rather than because of his personality disorder.
54. On 27 April, the senior forensic psychologist spoke to Mr Humphries about her report for his categorisation review and provided him with a copy. In her report, she concluded that she could not support a downgrade for recategorisation because Mr Humphries had not yet engaged in core risk reduction work. The report noted that Mr Humphries should be encouraged to continue to take steps to improve his health and quality of life in prison as well as maintain employment, and to 'discuss his engagement in his sentence plan with his support network (both personal and professional) to help inform his decision making'. Mr Humphries asked if he could have time to read the report before discussing it so the senior forensic psychologist agreed to come back and speak to him again after the weekend.
55. On 30 April, the senior forensic psychologist spoke to Mr Humphries about her report for his categorisation review. Mr Humphries said that he was unhappy that he had not been downgraded and was angry at the fact that the PIPE team had not assessed him before deciding he was unsuitable. He told the senior forensic psychologist that he thought it was unprofessional that he had not received an assessment or letter from PIPE confirming this and that he had had to find out he was not suitable through his offender supervisor and in his categorisation report. She explained to him that the PIPE assessed men who meet the criteria and

because he did not meet the criteria, his referral could not be processed further for assessment. Mr Humphries told her that he was still thinking about the Motivation and Engagement course but thought he would still not be downgraded in category even if he completed the course. She encouraged him to speak to his offender supervisor about the course and what he could gain from completing it.

56. The same day, Mr Humphries spoke to his son on the phone. He said that he had argued with staff about being told he did not meet the criteria for the PIPE and had spoken to the psychologist about it who said she would come back to speak to him in a couple of days when he had calmed down.

May 2018

57. On 8 May, prisoners on Mr Humphries' wing, F Wing, were moved to E Wing so that their former wing could be refurbished. Mr Humphries was unhappy about the move because his new cell was dirty. Prisoner A said that the cell Mr Humphries was allocated was 'disgusting' and staff did not move his disabled handle, which he had in his cell on F Wing near the toilet. Prisoner B said that Mr Humphries was on his hands and knees cleaning the cell and when he and his friends told him to stop, he said, 'I can't sleep in here, its stinking'. Prisoner C said that Mr Humphries was 'extremely stressed' about the wing move.
58. Mr Humphries' personal officer told the investigator that Mr Humphries' mood went down a little bit after the move to E Wing. The officer asked Mr Humphries if he was okay and he said, 'No, not really' and that his cell was in a 'shit state', but he later said he was okay.
59. Prisoner B said that Mr Humphries tried to move cells but was told he needed to stay in the cell he was allocated. Prisoner C said that Mr Humphries found out that another prisoner had moved cells because of the poor condition of the cell he was moved into and this had caused problems. Prisoner C said that Mr Humphries did not unpack and kept arguing with staff to move him to a different cell.
60. A prison manager said that prisoners were moved to the same cell location on F Wing that they had been allocated on E Wing (for example cell 112 on F Wing moved to cell 112 on E Wing). He said that when Mr Humphries was unhappy with the state of his new cell on E Wing, he personally inspected the cell and asked two wing cleaners to clean the cell for him. He said that Mr Humphries did not complain about his cell after that.
61. On 11 May, Mr Humphries wrote to the trainee psychologist to complain about the outcome of his PIPE referral. Mr Humphries asked whether she had considered the report from his forensic psychologist and questioned both her qualifications and the qualifications of the Referrals and Assessment Team who considered his referral. Mr Humphries was also unhappy that she had considered the recommendation of his probation officer and that the decision about his referral was made without meeting him in person. Mr Humphries said that the officers in the PIPE could be put to proper use on the wings instead of 'pretending to be important to the rehabilitation of prisoners when in truth you are doing more damage than good'.

62. On 13 May, a prison nurse noted that Mr Humphries was still waiting for his in-possession medication. He recorded that Mr Humphries had had to collect his perindopril, bisoprolol and amlodipine (medications used to treat high blood pressure and heart disease) and omeprazole (used to treat reflux and ulcers) on a daily basis from the pharmacy hatch. The nurse noted that some stock had been taken from the pharmacy and left in the trolley on E Wing to give to him daily until his in-possession medication arrived, to save him having to go to the hatch. The nurse did not give Mr Humphries spironolactone (medication used to treat fluid build-up due to heart disease) because it was not available in the pharmacy.
63. On 15 May, the nurse in charge noted that Mr Humphries had been without his in-possession medication for two to three days and instead was required to collect it daily. She said that Mr Humphries' medication had been prescribed but it had not arrived from the external pharmacy. Mr Humphries told her that he did not want to come and collect his medication anymore and he would just wait until his in-possession medication arrived. She said that she decided to give Mr Humphries two boxes of stock medication because she was worried he would stop collecting his medication. She documented that she gave Mr Humphries aspirin, atorvastatin (medication to lower lipids and prevent heart disease), bisoprolol, perindopril and omeprazole.
64. On 15 May, a pharmacy technician noted that Mr Humphries' in-possession medications had been received from the external pharmacy and put in the blue bag to be given to the night staff.
65. On 16 May, a prison nurse noted that Mr Humphries came to collect two boxes of medication. The nurse said that she was confused because Mr Humphries had several in-possession medications to collect but he only asked for two of them. The nurse recorded that she needed to investigate to find out why Mr Humphries only needed two boxes of medication and not all his in-possession medication. Mr Humphries explained that the nurse in charge had given him some of his medication the day before because his in-possession medication had not arrived. A healthcare assistant said that he remembered the stock boxes being taken from the trolley.
66. The nurse asked Mr Humphries to return the boxes of stock medication that the nurse in charge had given him the day before. She noted that she had replaced the stock boxes with Mr Humphries' in-possession medication and told the pharmacy and the nurse in charge. The nurse in charge told the investigator that she also checked the medication Mr Humphries had returned.
67. Prisoner C said that there was one box of medication that Mr Humphries did not give back that had something written on the box in a blue pen. Prisoner C could not remember what was written on the box, but said that Mr Humphries had put it to one side and gave everything else back.
68. On 16 May, the trainee psychologist responded to Mr Humphries' complaint about the outcome of his referral to the PIPE. She explained that although the report from the forensic psychologist noted that he met the criteria for antisocial personality disorder, this alone would not necessarily warrant treatment as part of the Offender Personality Disorder (OPD) treatment pathway. She said that the

referral team tried to determine if there was any more evidence to support a referral or if he had the capacity to 'engage with and benefit from mainstream offending behaviour programmes' given he would not discuss his offence. She said that the team found that the barrier to accessing the next stage of his treatment pathway was his view on his offence, rather than being related to 'personality factors'. She said that this indicated he did not meet the suitability criteria for the PIPE but she asked him to let them know if he could provide further information supporting his referral.

69. On the evening of 17 May, Prisoner D said that Mr Humphries came back from the medication hatch and he could see that he was 'completely stressed' about his medication and was pale and his lips were blue. Prisoner C said that Mr Humphries also did not get his canteen order in the week before he died. Mr Humphries used a vape cigarette and was stressed because he did not receive this. Prisoner C said that Mr Humphries was always telling him that he had 'had enough' and that Mr Humphries had started reading the Bible about two days before he died, which was out of character for him.
70. Mr Humphries' personal officer told the investigator that he had been aware that Mr Humphries had been having issues with his medication in the week before he died, but he was not concerned about him because he carried on with his part-time work and doing all the things he normally did.

Events of 18 May

71. An officer told the investigator that he unlocked Mr Humphries' cell at around 7.45am on 18 May. He said he looked through the observation hatch and saw Mr Humphries asleep in bed with his leg sticking out from under the bed cover. He did not speak to Mr Humphries and said he did not have time to speak to every prisoner he unlocked.
72. Prisoner D told the investigator that after staff had opened his door, he noticed that Mr Humphries had not emptied his bin and the door to his cell was shut, which was unusual. He made himself a coffee and then went to Mr Humphries' cell. He opened the door and saw Mr Humphries lying on the floor. He shook him and waited for him to say something but he did not respond.
73. Prisoner D closed Mr Humphries' door and ran to Prisoner C's cell. He banged on the door and told Prisoner C that he had found Mr Humphries on the floor and did not know if there was something wrong with him or whether he was just asleep on the floor. Prisoner D told the investigator that the weather had been hot and it was cooler to sleep on the floor.
74. Prisoner C went with Prisoner D to Mr Humphries' cell. He looked through the hatch then went into the cell and patted Mr Humphries on the back and he moved slightly. Prisoner D said that Mr Humphries felt lukewarm when he touched him but Prisoner C said he was cold to touch. Prisoner C could not find a pulse so he put his hand in front of Mr Humphries' mouth and felt a shallow breath. Prisoner C told Prisoner D to get a member of staff while he stayed with Mr Humphries. Prisoner C slapped Mr Humphries on the arm and got a reflex response, so slapped him on the back and Mr Humphries groaned and moved to the side.

75. Prisoner D ran to an officer and said, 'Quick, come here'. The officer went to Mr Humphries' cell and Prisoner C told him that Mr Humphries was breathing but he could not find a pulse. Prisoner C told the officer that it might be a code blue (a medical emergency radio code indicating that a prisoner is not breathing or is having difficulty breathing). The officer saw Mr Humphries lying on his back on the floor so he told Prisoners C and D to leave the cell. Prisoner D said that he was shaking and in shock and asked to be locked in his cell so he could be alone.
76. At 7.59am, the officer called a code blue. He went into Mr Humphries' cell and tried to put him in the recovery position. He noted that Mr Humphries was breathing. Mr Humphries' personal officer arrived and said he heard Mr Humphries mumbling but could not understand what he was saying. Mr Humphries was semi-responsive and his personal officer noted that he moved his right arm from across his stomach to his right thigh. The officer asked Mr Humphries if he fell out of bed and he said, 'Yeah'.
77. Approximately five minutes later, healthcare staff arrived at Mr Humphries' cell. A nurse noted that Mr Humphries was lying on the floor between his bed and table. Mr Humphries told him that he was not in pain and he did not know how he got on the floor. The nurse asked Mr Humphries if he had taken his medication and he said that he had. He asked where his medication was and Mr Humphries told him it was in the boxes, but the nurse said he could not find any boxes in the cell. The nurse recorded that Mr Humphries had a very slow heart rate and a very faint pulse. He said that because Mr Humphries was wedged in between his bed and the table, he could not get him in a position where he was able to take a blood pressure reading. The nurse gave Mr Humphries oxygen and noted that he remained responsive.
78. At 8.16am, ambulance paramedics arrived at that gate and were at Mr Humphries' cell nine minutes later. The paramedics asked staff to move Mr Humphries onto the landing and continued to monitor his vital signs and gave him oxygen. Paramedics asked staff if Mr Humphries had any medication in his cell. Two officers and a prison manager searched the cell but could not find his medication. Staff put Mr Humphries in prison issue trousers worn for security reasons when a category A prisoner leaves the prison, and took him to the ambulance on a stretcher. At 9.27am, paramedics left the prison with Mr Humphries.
79. Staff searched Mr Humphries' cell and found an empty packet of medication and a suicide note. Mr Humphries' note said that he had spent 12 years in prison for something he did not do and that he had behaved himself but had not progressed in prison. Mr Humphries said that he had 'had enough of this bullshit' and was not going to progress because he would not admit to something he had not done. He criticised the police, the prosecutors and the judge in his case and said that he had tried progressing by applying to the PIPE but the staff there could not be bothered to interview him. He said that he was now stuck on a 'shit wing which everybody hates' and that he had behaved well for 12 years for nothing. He said his only regret was leaving his son and his son's mother.
80. At 9.51am, Mr Humphries arrived at Alexandra Hospital, Redditch. A prison nurse phoned the hospital to tell them that Mr Humphries' medication had not

been found in his cell and that a suicide note had been left. The nurse told hospital staff that it was a potential overdose and that Mr Humphries had been issued medication between 12 and 16 April but this was to be confirmed as the search was ongoing. Hospital staff told the nurse that Mr Humphries remained very unstable and they could not rule out a cardiac event.

81. At 1.15pm, the nurse noted that the prison governor had been told that Mr Humphries had died.

Contact with Mr Humphries' family

82. At 12.00pm on 18 May, the prison family liaison officer called Mr Humphries' son to tell him that his father was unwell and in hospital with a suspected heart attack. At 1.15pm, she arrived at the hospital and was told that Mr Humphries had died. She phoned Mr Humphries' son who was on his way to the hospital and met him when he arrived. The prison contributed to the costs of Mr Humphries' funeral, in line with national guidance.

Support for prisoners and staff

83. There was a short debrief for staff involved in the emergency response after Mr Humphries was taken to hospital. After Mr Humphries' death, a prison manager debriefed escort staff at the hospital. The staff care team also offered support.
84. The prison posted notices informing other prisoners of Mr Humphries' 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 Humphries' death.

Post-mortem report

85. The post-mortem report says that Mr Humphries died from an overdose of bisoprolol. This medication was prescribed to Mr Humphries to treat high blood pressure and heart disease.

Findings

Assessment of risk of suicide and self-harm

86. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists several risk factors and potential triggers for suicide and self-harm. Mr Humphries had some of these risk factors including previous suicide attempts, a life sentence and sense of hopelessness.
87. Staff knew that in the weeks leading up to his death, Mr Humphries was upset that his application to go to the PIPE unit had been refused, that he was unhappy about the move to E Wing and that he was frustrated and stressed about problems receiving his in-possession medication. Prisoner B said that the 'spark had gone' from Mr Humphries in the week before his death and staff also noted a change in his mood.
88. However, although Mr Humphries had had a history of suicide attempts when he first entered prison in 2006, and had been monitored under ACCT from February to September 2006, he had given no cause for concern since then that he might be at risk of suicide or self-harm. Although we accept that Mr Humphries appeared low in mood, we consider that there was little indication that Mr Humphries was at a raised risk of suicide or self-harm in the days before his death, and that it would have been difficult for staff to have foreseen that he would take his life.

Offender management

89. Mr Humphries said in his suicide note that he could see no future because he was not able to progress in his sentence. He had been convicted of a very serious offence and was serving a life sentence with a very lengthy tariff. In these circumstances he was never going to progress quickly and could expect to spend years in a high security prison. This was particularly the case as he was maintaining his innocence, since most of the programmes to help prisoners address their offending behaviour require the prisoner to talk about his offence. However, we are concerned that Mr Humphries had served 12 years of his sentence without being offered any realistic options to help him progress. He had become 'stuck' with no obvious way forward.
90. Like other long-term prisoners, Mr Humphries had a sentence plan aiming at reducing the risk of serious harm he posed. PSI 19/2014 'Sentence Planning', says that a prisoner's sentence plan must be reviewed whenever there is a significant change that impacts on the risk of reoffending and/or serious harm posed by the offender. This includes where progress is not being made and alternative options need to be considered. The PSI also says that, in considering a programme, an offender's eligibility for the programme should first be considered.
91. When asked about his plan to help Mr Humphries progress, his offender supervisor said that Mr Humphries only spoke to him when he wanted something. He said that Mr Humphries approached him in December and said he wanted to go to the PIPE. He referred Mr Humphries because he thought he might open up in the PIPE and talk about his offence.

92. After Mr Humphries received the letter saying that he did not meet the criteria for the PIPE, his offender supervisor said that he did not have anything else in mind to suggest as part of his sentence plan and had not spoken to Mr Humphries about what he wanted to do next because he did not want to push him after this disappointment. His offender supervisor was not aware that Mr Humphries had written to the trainee psychologist to complain about not being accepted onto the PIPE.
93. We are concerned that the offender supervisor did not play a proactive role in helping Mr Humphries to progress. Although Mr Humphries was not making progress after 12 years, the offender supervisor did not consider alternative options in line with PSI 19/2014. He might, for example, have suggested that Mr Humphries do the Motivation and Engagement programme which is specifically designed for prisoners who are in denial of their offence. Instead he left it to Mr Humphries to suggest ideas. We are also concerned that the offender supervisor did not understand the referral criteria for the PIPE or the purpose of the unit, as we would have expected him to do in his offender supervisor role, and that he gave Mr Humphries false expectations by making the PIPE referral.
94. We note that HMIP found in January 2018 that the role of offender supervisors to engage with and support prisoners to meet their sentence plan targets was underdeveloped at Long Lartin, and that offender supervisors were not well trained or supervised and did not have sufficient time to undertake the wider aspects of their role. We, therefore, repeat HMIP's recommendation on this subject:

The Governor should ensure that offender supervisors have sufficient time to undertake their roles in full and receive the necessary training and supervision.

95. The clinical lead for the Preparation PIPE said that Mr Humphries did not meet the criteria for the PIPE because the barrier to him progressing through his sentence was not his personality disorder but his inability to admit to his offence. She explained that the PIPE aims to improve relationships and emotional regulation and this would not have affected Mr Humphries' stance on his offending. She said that they do not assess prisoners in person unless they meet the criteria for the PIPE, and when they send a letter telling prisoners they have not met the criteria, they also send a copy to the referrer (in this case, the offender supervisor). She said that she would expect that the referrer would take responsibility for sitting down with the prisoner and giving face to face feedback because, at this point of the process, staff in the PIPE do not have a relationship with the prisoner.
96. The senior forensic psychologist said that when she spoke to Mr Humphries on 23 April, she told him that she did not think he would meet the criteria for the PIPE because his barrier to progression was that he would not admit to his offence and this would not change in the PIPE. On 27 April, Mr Humphries told She that he was 'slightly annoyed' that he did not meet the criteria for the PIPE and was frustrated and annoyed about the way he was given information about the outcome of his PIPE referral.

97. The fact that Mr Humphries suggested a transfer to the PIPE himself showed that he was motivated to find some way of progressing, as the senior forensic psychologist recognised when she spoke to him. When his offender supervisor made the referral, Mr Humphries was entitled to think that he met the referral criteria. It is unclear how Mr Humphries found out about the rejection of his PIPE application. His offender supervisor said that Mr Humphries was told in a letter, but Mr Humphries told the senior forensic psychologist that he had not had a letter and had found out through his offender supervisor and through his categorisation review, and he said he was unhappy with the way he was informed. However he found out, it is clear from Mr Humphries' suicide note that he was upset by the rejection and could see no way forward.
98. We are concerned that there was no risk assessment process when giving Mr Humphries information that had the potential to be upsetting. It is important that prisoners have such decisions explained to them in person, before they learn of it by other means, so that staff can gauge their reaction and consider whether it affects their risk in any way. His offender supervisor was aware that Mr Humphries was disappointed about his rejection by the PIPE team and we are concerned that he did not speak to Mr Humphries to suggest other options but instead waited to see what Mr Humphries wanted to do next. We are also concerned that the trainee psychologist's letter to Mr Humphries showed no appreciation of the impact the rejection might have and simply assumed that his offender supervisor would take responsibility for talking to Mr Humphries.
99. We make the following recommendation:
- The Governor should ensure that when prisoners are considered unsuitable for offending behaviour programmes they are given feedback in person and that the impact on the prisoner is considered.**

In-possession medication

100. The Head of Healthcare at Long Lartin said that the prison had been struggling to recruit a pharmacist and that this had made medication administration more difficult. The nurse in charge said that the prison had to order medication from external pharmacies and sometimes there were errors in the medication that was sent or the outside pharmacy did not have the medication requested.
101. Prisoner C said that when Mr Humphries' in-possession medication finally arrived, he put one box of the stock medication he had been given aside and gave everything else back. The nurse in charge and another nurse said that when Mr Humphries returned the medication he had been given from stock, they checked it and noted that it had all been returned.
102. The Head of Healthcare said that the healthcare department was introducing a process where they would spot check two prisoners a month to make sure they had the correct amount of medication. She also said that once they recruited a pharmacist, they would run clinics for prisoners receiving in-possession medication.

103. The Head of Healthcare said that prisoners on repeat medication had to put in an application to have their prescription renewed. A nurse said there could be delays in prisoners getting their medication with the current system. The nurse in charge said there could also be delays in medication because there was no prescriber or GP available on weekends. Prisoner A told the investigator that he had also experienced delays in getting his repeat medication.
104. The nurse in charge said that although Mr Humphries was not always compliant in taking his medication, there were occasions where he did not receive his in-possession medication and this is confirmed by his medical records. Prisoner C said that Mr Humphries had a continuous struggle with healthcare trying to get his in-possession medication on time. Prisoner A said that Mr Humphries was not happy about the issues with his medication and he had been at the medication hatch with him morning and night when he was arguing with healthcare about his medication. Prisoner B had also seen Mr Humphries having problems getting his medication that week and said he had been upset about it.
105. Given that Mr Humphries gave little indication that he was at risk of suicide or self-harm in the time leading up to his death, we are satisfied that it was appropriate for him to have in-possession medication. However, we are concerned that there were delays in prisoners receiving repeat prescription medication and make the following recommendation:

The Head of Healthcare should review the process for repeat prescriptions to ensure that prisoners receive their medication without interruption.

Cell cleanliness

106. Mr Humphries complained that his new cell was dirty. A prison manager inspected the cell and arranged for two cleaners to clean it. We are satisfied that this indicates that cell was indeed dirty. We consider it unacceptable that a Mr Humphries or any other prisoner should have been put in a dirty cell in the first place. We make the following recommendation:

The Governor should ensure that cells are checked and properly cleaned before prisoners are moved into them.

Unlock procedures

107. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual says, 'Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead'.
108. Prison Service Instruction 75/2011 says that 'there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process'.

109. The officer who unlocked Mr Humphries' cell told the investigator that he looked through the observation hatch before unlocking the cell and saw him asleep in bed. He said he did not speak to him as he did not have time to speak to every prisoner he was unlocking. Less than 15 minutes later, a prisoner found Mr Humphries lying semi-responsive on his cell floor.
110. We consider that, if the officer had tried to get a response from Mr Humphries when he unlocked his cell, it would have been obvious that Mr Humphries was unwell. The officer's failure to try to get a response meant that there was a short delay in Mr Humphries receiving emergency medical care. Although the delay is unlikely to have affected the eventual outcome, it is important that the unlock procedures are carried out properly so that any concerns with a prisoner's welfare are identified at the earliest opportunity. We make the following recommendation:

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

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