Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Humphries, a prisoner at HMP Stafford, on 15 April 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 2017

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.

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Derek Humphries died in his cell at HMP Stafford on 15 April 2020 of left coronary artery atheromatous occlusion (a build-up of fatty deposits in a coronary artery which restricts the blood supply to the heart). Mr Humphries was 74 years old. I offer my condolences to Mr Humphries' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Humphries received at Stafford was equivalent to that he could have expected to receive in the community. Despite this, she found that Mr Humphries should have had a medication review and electrocardiogram (ECG – a test used to check the heart's rhythm and electrical activity). However, the clinical reviewer concluded that these omissions did not impact on Mr Humphries' death. We draw the Governor and Head of Healthcare's attention to the clinical reviewer's recommendations.

5. We found that there was a three-minute delay in requesting an ambulance for Mr Humphries after the medical emergency had been radioed.

Recommendation

The Governor should ensure that staff immediately request an ambulance once a medical emergency code is radioed.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Humphries' clinical care at HMP Stafford. The clinical reviewer's report is attached as Annex 1. The following three annexes are records of interviews carried out for this investigation.

7. The PPO investigator has investigated non-clinical issues, including Mr Humphries' location, liaison with his family and the emergency response. She interviewed two members of staff. The investigator also tried to interview Mr Humphries' cellmate but he declined to speak to her.

8. The PPO family liaison officer wrote to Mr Humphries' next of kin to explain the investigation. She did not respond to our letter.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Stafford

10. Mr Humphries was the sixth prisoner to die at Stafford since April 2018. All of these deaths were due to natural causes. None of the previous deaths raise issues relevant to this investigation. Since Mr Humphries' death, there has been one further death due to natural causes which we are still investigating.

Key Events

11. On 29 May 2018, Mr Derek Humphries was convicted of serious sexual assaults against a child. He was taken to HMP Birmingham. Mr Humphries had an irregular heartbeat for which he was prescribed bisoprolol. He also had chronic vascular insufficiency (poor circulation in the veins of his legs) for which he was prescribed creams and bandaging to try to lessen his symptoms. On 22 June 2018, Mr Humphries was sentenced to 21 years imprisonment.

12. On 17 October 2019, Mr Humphries transferred to HMP Stafford. A nurse assessed him, noted that he had a leg ulcer and he was prescribed antibiotics. His leg ulcers were subsequently regularly reviewed and dressed by nurses and GPs.

13. On 5 February, a GP told Mr Humphries that his vitamin D level was low and prescribed him vitamin D tablets. Mr Humphries told the GP that he had had pain in his left leg for ten days. The GP referred Mr Humphries to a nurse. On 20 February, a nurse assessed Mr Humphries' leg pain. He diagnosed that he had sciatica (nerve pain) and prescribed him naproxen (a painkiller).

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

Events on 15 April

15. On 15 April at 5.35am, an Operational Support Grade (OSG) did the morning roll check, looking into all prisoners' cells on the wing. She did not notice anything unusual in Mr Humphries' cell.

16. An officer did another roll check around 7.00am. The officer told the investigator that it looked like Mr Humphries was sitting up in his bed, leaning against the wall on the bottom bunk watching television.

17. At approximately 9.06am, the officer unlocked Mr Humphries' cell to ask him and his cellmate if they would like a shower or exercise. His cellmate told the officer that he was concerned as Mr Humphries had coughed around an hour earlier but had not moved much since. The officer shouted to Mr Humphries, but he did not respond. The officer told the investigator that Mr Humphries was sat on his bed with his eyes open and a towel wrapped around his head. The officer assumed Mr Humphries had used this to keep himself warm overnight. He was in the same position as when he had checked him earlier.

18. Since the officer was unsure of the seriousness of the situation, he went to the cell door and shouted to a second officer on the landing below for urgent

assistance. The officer estimated she got to the cell within ten seconds. He then shook Mr Humphries to try and rouse him and checked for a pulse, as did the second officer but they could not find one. The second officer radioed a code blue. (This is an emergency code indicating that a prisoner is unconscious or having breathing difficulties.) Staff recorded in the incident log that it was 9.10am. The officer said that Mr Humphries was pale, did not feel cold and was floppy. The officers were about to move Mr Humphries onto the floor to try to resuscitate him when a nurse got to the cell with the emergency medical bag.

19. The nurse checked Mr Humphries for a pulse. A second nurse arrived and also checked for signs of life. They could not detect a pulse so requested the defibrillator from the wing. The second nurse recorded that Mr Humphries skin was “tepid” and he was “waxy” in colour. The nurse radioed the communication room to request an ambulance. At 9.13am, staff recorded in the incident log that they had requested an ambulance.

20. Staff moved Mr Humphries so that he was flat on the bed and the second nurse started cardio pulmonary resuscitation (CPR). The nurse administered oxygen. Another nurse arrived with the defibrillator which they attached to Mr Humphries, but no shock was advised. At 9.17am, the paramedics arrived at the prison. They moved Mr Humphries to the cell floor and then onto the wing landing. Prison staff continued chest compressions while paramedics directed treatment and ventilated Mr Humphries. The paramedics pronounced Mr Humphries had died at 9.53am.

Contact with Mr Humphries’ family

21. A Supervising Officer (SO) was appointed as family liaison officer. Due to restrictions on face to face contact during the COVID-19 pandemic, the SO telephoned Mr Humphries’ next of kin to inform her of his death. After several unsuccessful attempts, the SO spoke to Mr Humphries’ next of kin at 1.00pm, passed on the news and offered her condolences. The SO remained in contact with Mr Humphries’ next of kin and offered a contribution to funeral expenses in line with Prison Service policy.

Post-mortem report

22. The post-mortem report concluded that Mr Humphries’ cause of death was left coronary artery atheromatous occlusion (a build-up of fatty deposits in a coronary artery which restricts blood flow to the heart).

Non-Clinical Findings

Emergency response

23. When an officer was first alerted to Mr Humphries’ cellmate’s concerns, he shouted to Mr Humphries but did not get a response. He sought assistance from another officer who arrived within seconds before approaching Mr Humphries. They both then tried to rouse Mr Humphries and assessed him for signs of life. We believe this was reasonable given that it was a shared cell and the gravity of the situation was not immediately apparent.

24. Staff in the communications room recorded that officers radioed the code blue at 9.10am. They also recorded that they requested an ambulance at 9.13am after it had been specifically asked for by staff on the wing.

25. Prison Service Instruction (PSI) 03/2013 says that as soon as a code blue is radioed, staff in the communication room should automatically call an ambulance. There was a delay of three minutes on this occasion. Furthermore, ambulance documents indicate that there were only two minutes between the call for an ambulance and paramedics arriving at the prison. Given the timings recorded in the incident log, this suggests that the delay in calling an ambulance may have been longer than three minutes.

26. While a nurse confirmed that an ambulance should always automatically be called after a code blue, an officer said that this was not the case. Despite requests the investigator has not had access to Stafford's local emergency response protocol and has not been able to contact the person who requested the ambulance in the communications room. Any delay calling an ambulance in a medical emergency could be crucial. We make the following recommendation:

    The Governor should ensure that staff immediately request an ambulance once a medical emergency code is radioed.

Sue McAllister CB
Prisons and Probation Ombudsman **September 2020**

Prisons & Probation
Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141