

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Lisa Humphries, on 26 March 2022, following her release from HMP Foston Hall

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

OGL

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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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of a prisoner's release.
3. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
4. Ms Lisa Humphries died of a drug overdose on 26 March 2022, following her release from HMP Foston Hall on 25 March. She was 39 years old. I offer my condolences to those who knew her.
5. We found that Ms Humphries' Community Offender Manager (COM) was unclear on referral processes and how to complete these. Ms Humphries' COM secured temporary accommodation the day before her release but failed to communicate this to her. We are concerned that Ms Humphries might have thought that she was homeless when released.
6. We are also concerned that while Ms Humphries' COM shared with other professionals that Ms Humphries was being monitored using suicide and self-harm prevention procedures (known as ACCT) in prison, she did not share appropriate details, including that Ms Humphries had told staff that she planned to overdose on drugs when released.

Recommendations

- The Head of the Birmingham Probation Delivery Unit should ensure that COMs:
 - receive training on completing Community Rehabilitative Services referrals; and
 - are aware of the duty to refer and the need to complete this referral as part of release planning for prisoners facing homelessness.
- The Head of the Birmingham Probation Delivery Unit should ensure COMs understand their responsibilities within release planning and liaise effectively with prisons during this process.
- The Head of the Birmingham Probation Delivery Unit should ensure COMs provide all relevant information when sharing concerns about suicide with external professionals.
- The Head of the Birmingham Probation Delivery Unit should ensure that COMs record all contact and actions completed on individual cases within nDelius (the Probation Service's case management system).

- The Head of the Birmingham Probation Delivery Unit and the Governor of HMP Foston Hall should ensure officers are made aware of external support available following the death of an individual in their caseload.
- The Head of the Birmingham Probation Delivery Unit should arrange for a manager to share this report with the COM and discuss the Ombudsman's findings with her.

The Investigation Process

7. The PPO investigator obtained copies of relevant extracts from Ms Humphries' prison and probation records.
8. The investigator interviewed two members of staff from the women's charity, Anawim on 9 June 2022. He interviewed Ms Humphries' Prison Offender Manager (POM) at HMP Foston Hall on 14 June, and Ms Humphries' COM and Senior Probation Officer (SPO) at Birmingham Probation on 21 June. All the interviews were conducted by video.
9. We informed HM Coroner for Birmingham of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.
10. The Ombudsman's family liaison officer contacted Ms Humphries' next of kin, her sister, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Foston Hall

12. HMP Foston Hall is a prison in Derbyshire which holds up to 296 adult female prisoners, who have either been convicted or are on remand.

Probation Service

13. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

14. On 18 October 2021, Ms Lisa Humphries was convicted of breaching a criminal behaviour order and sentenced to eight weeks imprisonment. She was sent to HMP Foston Hall.
15. On 12 November, Ms Humphries was released to temporary accommodation provided by Trident Reach, which was arranged by her Community Offender Manager (COM). She was also receiving support from Anawim (a women's charity which provide support on matters such as social inclusion and accommodation).
16. On 8 January 2022, Ms Humphries was allocated a new COM.
17. Ms Humphries' engagement with probation and other professionals declined while in the community. In February, police declared Ms Humphries as a missing person. She was not in touch with professionals and had not returned to her accommodation for several weeks.
18. On 8 February, Anawim caseworker emailed the COM to explain that Anawim would be closing Ms Humphries' case as she was not engaging with them. However, the caseworker continued contact with probation services and other agencies involved to try and support Ms Humphries.
19. Anawim told the investigator they were not aware of the caseworker's continued involvement with Ms Humphries' case after they had closed it. For Anawim to start officially working with Ms Humphries again, the COM would have needed to make a referral to the Commissioned Rehabilitative Services (CRS, the probation system used to request support from external partnerships).
20. On 4 March, Ms Humphries was arrested for breaching her criminal behaviour order and was remanded in police custody. She was sentenced the following day to six weeks imprisonment and sent to Foston Hall.
21. On 9 March, a substance misuse worker provided Ms Humphries with an appointment for the day of her release at her local drug and alcohol support charity. She also spoke to Ms Humphries about the risk of overdose on release and completed naloxone training with her. (Naloxone is a drug used to reverse the effects of overdose.) Ms Humphries agreed to take a naloxone kit when released.
22. That day, Ms Humphries shared with a probation officer in the Resettlement Team at Foston Hall that she would be homeless when released. The officer contacted the COM, asking whether she was going to make a referral to the CRS referral team and on the Duty to Refer (DTR) system (which is the referral system which makes local councils aware that an individual is homeless). She received no response.
23. The COM told the investigator that she was not aware she needed to make a CRS referral as the Anawim caseworker was still involved in communications about Ms Humphries' release planning. She also told the investigator she did not know what a DTR was.

24. On 11 March, prison staff started suicide and self-harm prevention procedures (known as ACCT) because Ms Humphries had used a plastic knife to make deep marks on her arm. During an ACCT review the following day, she told prison staff that she planned to kill herself by overdose when released.
25. On 14 March, Ms Humphries' Prison Offender Manager (POM) shared Ms Humphries' plan to overdose with the COM.
26. On 18 March, a probation officer in the Resettlement Team contacted the COM, again asking if there was any update on Ms Humphries' housing situation. Up to this point, there is no record of the COM working to source accommodation for Ms Humphries. The COM told the investigator she had been exploring suitable accommodation options between 9 and 18 March.
27. On 21 March, the COM emailed police and other organisations involved in Ms Humphries' case, saying she was currently being monitored under ACCT procedures. She did not explain what this meant or provide any further information.
28. That day, the COM made a CRS referral to Anawim. The referral was sent incorrectly and had to be amended by her, which caused further delays. The referral did not contain any information about Ms Humphries being in prison or her imminent release date. Anawim also told the investigator that had the referral been received earlier or given her release date, they could have supported Ms Humphries with sourcing accommodation or provided practical support such as picking her up from prison when she was released.
29. On 24 March, the COM sourced temporary accommodation for Ms Humphries with Trident Reach. She did not share this information with Ms Humphries' POM or any staff at Foston Hall, for them to make Ms Humphries aware. She told the investigator she expected that Trident Reach would be responsible for passing this information to Ms Humphries.
30. On 25 March, Ms Humphries was released from Foston Hall. She did not attend the probation office, her pre-arranged drug misuse appointment, or her approved accommodation.
31. The following day, police attended the property of Ms Humphries' associate after they reported finding her unresponsive on the floor. Ms Humphries was pronounced dead at 10.24am on 26 March.

Post-mortem report

32. The post-mortem report concluded that Ms Humphries died of opioid (heroin and methadone) poisoning and cocaine toxicity. Antidepressant (mirtazapine and sertraline) toxicity was listed as a contributory factor.

Support for staff

33. During interview, Ms Humphries' POM said that she found out about her death from a senior manager at Foston Hall and spoke to her Senior Probation Officer (SPO)

following this. She said she was not made aware of external support that she could access.

34. The COM said she found out about her death from an email sent by police. She spoke to her SPO following this. She said she was not made aware of external support that she could access.

Contact with Ms Humphries' family

35. It is unclear how Ms Humphries' next of kin, her sister, was made aware of Ms Humphries' death.
36. On 6 April, a family liaison officer at Foston Hall tried to telephone Ms Humphries' sister several times, but she did not answer. She sent her a letter offering his condolences and provided contact details should she wish to make contact in the future.

Findings

Referrals for support with Ms Humphries' accommodation

37. We acknowledge that the Anawim caseworker continued involvement in Ms Humphries' case following its closure by Anawim may have caused confusion. However, we are concerned that the COM did not seek to clarify if a new referral was needed, particularly after the Resettlement Team officer prompted her to do so on 9 March.
38. When the COM made the CRS referral on 21 March, it was completed incorrectly. It also did not say that Ms Humphries was in prison and due for release in four days' time.
39. We are also concerned that the COM was not familiar with the DTR process. Although the officer in the Resettlement Team prompted her to complete a DTR referral, she did not respond or seek clarity. We recommend:

The Head of the Birmingham Probation Delivery Unit should ensure that COMs:

- **receive training on completing Community Rehabilitative Services referrals; and**
- **are aware of the Duty to Refer and the need to complete this referral as part of release planning for prisoners facing homelessness.**

Communicating release plans to Ms Humphries

40. The COM secured accommodation for Ms Humphries the day before her release. However, she told the investigator she was not aware it was her responsibility to ensure this information was passed to Ms Humphries.
41. We are concerned that when Ms Humphries was released, she was unaware that she had accommodation and was under the impression she was homeless. We consider this may have affected her decision to engage with probation services following release. We recommend:

The Head of the Birmingham Probation Delivery Unit should ensure COMs understand their responsibilities within release planning and liaise effectively with prisons during this process.

Sharing of ACCT concerns

42. While the COM shared that Ms Humphries was subject to ACCT monitoring with other external professionals involved in her case, she did not explain what an ACCT was or that Ms Humphries had shared that she planned to overdose upon release.
43. Probation staff should not assume that external professionals will be familiar with prison terminology. We consider that the COM should have also shared that Ms Humphries planned to overdose upon release, which would have given

professionals a better insight into the concerns about Ms Humphries and might have led to further safety planning being completed. We recommend:

The Head of the Birmingham Probation Delivery Unit should ensure COMs provide all relevant information when sharing concerns about suicide with external professionals.

Quality of record keeping

44. Despite the COM telling the investigator that she had made efforts to source accommodation for Ms Humphries between 9 and 18 March, there is no evidence of this. Overall, record keeping was of a poor standard. We recommend:

The Head of the Birmingham Probation Delivery Unit should ensure that COMs record all contact and actions completed on individual cases within nDelius (the Probation Service's case management system).

Staff support

45. Probation Service guidance, "Supporting staff after a death under supervision – Guidance for Line Managers", says that officers should be made aware of support services available to them, such as counselling, after a death. While line managers checked in with the officers, both the COM and the POM were unaware of external support that was available to them. We recommend:

The Head of the Birmingham Probation Delivery Unit and the Governor of HMP Foston Hall should ensure officers are made aware of external support available following the death of an individual in their caseload.

Learning from this investigation

46. We consider it important for staff to learn from our investigation findings. We recommend:

The Head of the Birmingham Probation Delivery Unit should arrange for a manager to share this report with the COM and discuss the Ombudsman's findings with her.

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Acting Prisons and Probation Ombudsman

November 2022

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