Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nathaniel Humphreys, a prisoner at HMP Littlehey, on 11 July 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Nathaniel Humphreys died in hospital from aspiration pneumonia on 11 July 2022 while a prisoner at HMP Littlehey. This was caused by an overdose of methocarbamol, a medication which Mr Humphreys had been prescribed. He was 34 years old. I offer my condolences to his family and friends. Mr Humphreys also had myotonic dystrophy (a muscle-wasting condition), fatty liver disease and systemic granulomatous disease (a genetic disorder which affects white blood cells) which did not cause but contributed to his death.

Prison staff did not share important risk information about Mr Humphreys after suicide and self-harm procedures, known as ACCT, were started. No one from the healthcare team attended Mr Humphreys' ACCT case reviews despite his complex medical history. They therefore missed an opportunity to identify early that Mr Humphreys was at an increased risk of suicide and self-harm. In addition, staff failed to assess his risk of keeping and administering his medication once ACCT monitoring began.

There was no formal assessment or care plan in place to support Mr Humphreys' muscular dystrophy and mobility needs.

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

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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Summary

Events

1. Mr Nathaniel Humphreys was remanded into custody in February 2022, charged with sexual offences. It was his first time in prison. In March, he was transferred to HMP Littlehey. He was a vulnerable prisoner who had a history of attempted suicide and self-harm. He also had muscular dystrophy and depression, for which he was prescribed medication.

2. On 1 July 2022, staff started suicide and self-harm procedures, known as ACCT, after Mr Humphreys made cuts to his wrists. Shortly afterwards, he attended the healthcare wellbeing drop-in clinic, but his ACCT document did not accompany him so healthcare staff did not know that he was being monitored. Healthcare staff did not attend Mr Humphreys' ACCT case reviews and did not reassess whether he should continue to keep and administer his prescribed medication.

3. On 8 July, Mr Humphreys' cellmate raised concerns about him when he found him unconscious and vomiting, with obstructed breathing. An officer radioed an emergency code, and an ambulance was called. Staff and paramedics responded and provided emergency care. Mr Humphreys was taken to hospital by ambulance. He died three days later, on 11 July 2022.

4. The post-mortem report noted that he died from aspiration pneumonia caused by a methocarbamol overdose.

Findings

5. Prison staff appropriately assessed Mr Humphreys when he arrived at Littlehey. Later, on 1 July, when Mr Humphreys cut his right wrist, prison staff appropriately started ACCT procedures.

6. There were deficiencies in the prison's operation of ACCT procedures. The ACCT plan did not travel with Mr Humphreys when he attended the healthcare wellbeing clinic shortly after ACCT monitoring began. This meant that healthcare staff were initially unaware that he was being monitored under ACCT procedures and did not record any potential concerns about him in the document. When ACCT procedures were started, healthcare staff did not assess whether Mr Humphreys should continue to keep and administer his prescribed medication.

Recommendations

- The Governor and Head of Healthcare should ensure that in line with Prison Service Instruction (PSI) 64/2011:
  - Staff are aware that the ACCT plan should travel with the prisoner when he leaves his wing, including when he participates in activities; and
  - When ACCT monitoring is started, healthcare staff assess a prisoner's risk to determine whether he should continue to keep and administer prescribed medication.

The Investigation Process

7. The PPO was notified of Mr Humphreys' death on 12 July 2022. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Humphreys' prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Humphreys' clinical care at the prison. The investigator and clinical reviewer jointly interviewed 12 members of staff and one prisoner at Littlehey.

10. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem report. We have sent him a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Humphreys' next of kin to explain the investigation and to ask them if they had any matters they wanted us to consider. They asked whether the prison was aware of Mr Humphreys' history of attempted suicide and whether he was being monitored under ACCT procedures. We have addressed these issues in this report.

12. Mr Humphreys' next of kin received a copy of the initial report. They did not make any further comments.

13. The initial report was shared with HM Prison and Probation Service (HMPPS) and NHS England. They identified two factual inaccuracies which have been amended in the final report. All recommendations were accepted.

Background Information

HMP Littlehey

14. The HMP Littlehey is a medium security Category C prison in Cambridgeshire, holding around 1,200 men. A high proportion of prisoners at Littlehey have been convicted of sex offences. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

15. HMIP's most recent full inspection of Littlehey was carried out in July and August 2019. Inspectors reported that Littlehey continued to be an overwhelmingly safe prison and although self-harm had increased in recent years, it remained low. Inspectors found that the quality of ACCT documentation was good, there were a sufficient number of Listeners (prisoners trained by the Samaritans to provide confidential and emotional support) to meet the needs of the population and prisoners in crisis said they were well cared for.

Independent Monitoring Board

16. 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 2022, the IMB reported that overall, HMP Littlehey continued to be a safe and secure prison.

Previous deaths at HMP Littlehey

17. Mr Humphreys was the thirty-sixth prisoner to die at Littlehey since June 2019. Of the previous deaths, all but one were from natural causes. There are no similarities between our findings in the investigation into Mr Humphreys' death and our investigation findings for the previous deaths. Since Mr Humphreys' death, there have been a further 12 deaths at Littlehey. All but one was from natural causes.

Assessment, Care in Custody and Teamwork

18. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

19. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. PSI 64/2011 on safer custody sets out how staff should operate ACCT procedures.

Key Events

20. On 23 February 2022, Mr Nathaniel Humphreys was sentenced to four years in prison for sexual offences against a child family member, possession of extreme pornographic images and distributing indecent images of children. He was sent to HMP Chelmsford. It was his first time in prison.

21. Mr Humphreys arrived at Chelmsford with a suicide and self-harm warning form which had been opened while he was in police custody and noted that he had a history of self-harm and attempted suicide and had current suicidal thoughts. He was considered a vulnerable prisoner due to the nature of his offence and because he had muscular and myotonic dystrophy (a muscle-wasting disease which affected his mobility). Staff started suicide and self-harm prevention procedures, known as ACCT, and noted that Mr Humphreys felt low, and he found it difficult to engage in conversation.

22. A nurse completed Mr Humphreys' reception health screen. She noted his history of attempted suicide (by medication overdose) and that he had depression, for which he was prescribed mirtazapine and sertraline. Mr Humphreys told the nurse that he had muscular and myotonic dystrophy which reduced his mobility and that he was prescribed medication, promethazine and methocarbamol (to treat muscle spasms) and codeine phosphate (for pain relief). The nurse referred him to the GP and the mental health team.

23. The next day, staff completed Mr Humphreys' first ACCT case review and agreed that he no longer needed to be monitored under ACCT procedures. They noted that Mr Humphreys had said that he would harm himself due to frustration but had no intention to do so and had no thoughts of suicide or self-harm. He said he had the support of his mother and fiancée whom he planned to marry when he was released from prison.

24. Healthcare staff checked the medication Mr Humphreys had been prescribed in the community. These included methocarbamol, mirtazapine and sertraline. The GP re-prescribed them. Mr Humphreys was assessed as unsuitable to keep and administer his medication himself due to his history of overdose.

25. Staff raised no further concerns about Mr Humphreys. He lived on the ground level on a residential wing due to his mobility restrictions and settled into the prison regime.

HMP Littlehey

26. On 10 March, Mr Humphreys was transferred to HMP Littlehey. His person escort record (which provides information about a prisoner's risk as they move between police custody, court and prison) noted that he had a history of self-harm and attempted suicide and that he had been monitored under ACCT procedures until 24 February.

27. A nurse completed Mr Humphreys' initial health screen in Reception. She examined him and noted his diagnosis of myotonic dystrophy and muscular dystrophy, that he used a walking stick and needed to live on the ground floor. Mr Humphreys

disclosed that he had a history of drug overdose and self-harm but denied thoughts of self-harm. He said he had anxiety and depression and was prescribed sertraline and mirtazapine. She noted his medication and dispensed his usual daily dose. She referred him to the mental health team, and then completed a secondary health screen.

28. An officer completed Mr Humphreys' first night induction interview. He noted that Mr Humphreys had no thoughts of suicide or self-harm. Mr Humphreys lived on the ground floor of E Wing, the induction wing.

29. A pharmacist at Littlehey checked Mr Humphreys' medication and re-prescribed them. He was not assessed as suitable to keep and administer his own medication and had to collect them from the medication hatch at set times and be supervised by healthcare staff while taking them. Mr Humphreys was referred to the asthma clinic for further evaluation of his asthma.

30. On 17 March, a nurse from the mental health team saw Mr Humphreys and completed a mental health assessment. She noted that he engaged well, and she was not concerned about how he presented. She noted his history of self-harm and evaluated his current mental health needs. Mr Humphreys asked to be referred to the asthma nurse. He said that he got tired when walking to the medication hatch. She noted that wing staff would provide him with a wheelchair, when needed. She noted that she would discuss Mr Humphreys at the next healthcare multidisciplinary team meeting.

31. The nurse discussed Mr Humphreys at the healthcare multidisciplinary team meeting that day, and it was agreed that Mr Humphreys would be given self -help guides and be added to the waiting list for the Mental Health Skills Group.

32. On 18 March, Mr Humphreys failed to collect his medication. On 23 March, he submitted an application to the healthcare team which said that he found it difficult to walk the distance to the medication hatch to collect his medication, due to his poor mobility. He asked to keep his medication in his cell. The pharmacist agreed to consider his request. On 24 March, Mr Humphreys again failed to collect his medication.

33. On 25 March, the pharmacist saw Mr Humphreys and assessed whether he should be allowed to keep and administer his medication, taking into account his history of overdose and self-harm and that he had been given weekly doses of his medication to keep in the community. She decided that he could keep a week's supply of his medication in his cell.

34. On 13 May, a GP operating at Littlehey saw Mr Humphreys who had asked for his pain relief medication dosage to be increased. This was declined due to the addictive nature of the medication. Instead, the GP increased Mr Humphreys' sertraline dosage.

35. On 15 June, an officer completed a key work session with Mr Humphreys. This was his first key work session due to restrictions imposed as a result of the COVID-19 regime. Mr Humphreys said it was his first time in prison and that he was worried about his elderly mother who was part of his support network. He was aware of the prison visits procedure and had used the PIN telephone system to contact his

fiancée and mother. He explained that he had a muscle-wasting disease, and this affected his ability to work. He spent most of his time in the prison library. She encouraged Mr Humphreys to apply for a job in the education unit. She agreed to see him fortnightly for key work sessions.

36. On 17 June, Mr Humphreys was relocated to a ground floor cell on B Wing.

37. On 25 June, an officer completed a wellbeing check. He noted that Mr Humphreys had attended the staff office in an emotional state after a bad phone call with his fiancée. Mr Humphreys' cellmate told staff that his relationship with his fiancée had ended. It was noted in the wing observation book that staff should monitor Mr Humphreys.

38. On 29 June, an officer noted that he spoke to Mr Humphreys because he had not collected his evening meal. Mr Humphreys said he had not felt like eating much since the weekend. The officer offered him support, but Mr Humphreys said he was okay. It was noted that staff would monitor Mr Humphreys over the next few days.

39. At 11.30am on 1 July, an officer started ACCT procedures after Mr Humphreys made cuts to his right wrist. ACCT monitoring was initially set at hourly intervals. Mr Humphreys told staff that he felt low because his relationship with his fiancée had ended. Staff removed razor blades from his cell and arranged for Mr Humphreys to see a nurse.

40. On Fridays, Littlehey holds drop-in wellbeing clinics that prisoners can attend without appointment. Each appointment lasts approximately ten minutes. At interview, an officer told us that wing staff would have been aware if prisoners had asked to attend a drop-in clinic.

41. At 2.45pm, Mr Humphreys attended the wellbeing clinic. A Healthcare Assistant (HCA) from the mental health team and an assistant psychologist completed his mental health assessment. At interview, the psychologist told us that Mr Humphreys entered the triage room using a walking stick. She said that he looked unkempt and sad. They told us that they did not know that Mr Humphreys was being monitored by ACCT procedures until he showed them the cuts on his wrist. (The prisoner's ACCT plan is supposed to follow them as they move around the prison, this ensures that any member of staff is aware of the plan and associated risks and can make entries as appropriate in the ongoing record.)

42. Mr Humphreys was tearful and said that he was struggling due to the breakdown of his relationship. However, he denied that he had any current thoughts of self-harm. He disclosed that he had wanted to die to take the pain away and admitted that this was his fourth attempt to take his own life, the last attempt he had made was four years earlier. He said his cellmate and his mother were supporting him. He was also aware of the support network available in prison. The staff reminded Mr Humphreys that he would be monitored under ACCT procedures, he had access to the Samaritans by phone and the wing mental health representative (a designated prisoner who supports other prisoners). The HCA told us that Mr Humphreys was in a "better mood" by the end of the consultation. (Later that day, the wing mental health representative delivered distraction packs to Mr Humphreys.)

43. The HCA confirmed at interview that Mr Humphreys attended the clinic at 2.45pm but her entry in his medical record reflected this contact was made at 4.17pm.

44. At 3.06pm, Mr Humphreys attended the primary care triage drop-in clinic. A nurse examined him and noted that he had "very superficial self-harm wounds" to his wrist that he told her he had made the previous day. She noted that he was being monitored under ACCT procedures. She told us that Mr Humphreys said he was "absolutely fine". She said that although she was aware that Mr Humphreys had attended the mental health (wellbeing) clinic, she had not known what he had said there as she had not seen the relevant entry in his medical record.

45. Later that day, a Supervising Officer (SO) chaired Mr Humphreys' first ACCT case review which Mr Humphreys, and two officers attended. The SO noted that a nurse was unable to attend but had contributed verbally before the review. He told us that he had spoken to the nurse before the ACCT review. They agreed that Mr Humphreys should continue to keep and administer his medication. There was no entry in Mr Humphreys' medical or prison records to evidence the outcome of this conversation or the rationale for the decision.

46. The SO noted that Mr Humphreys continued to feel low. While he said he had thoughts of suicide, he had no current plans to take his own life. He understood that it would take time for his mood to improve. He acknowledged that his mother was now his only external support and said he would speak to her soon. He said he attended educational activities and had been given distraction packs. The SO said that Mr Humphreys would be referred to the mental health team and that one officer in particular would be able to support him as they had a good rapport. Mr Humphreys' ACCT checks were set at four random observations between 7.30pm and 7.00am daily and two daily conversations. The next ACCT review was scheduled for 6 July.

47. The SO identified three actions to support Mr Humphreys. These were for Mr Humphreys to use the distractions packs given to him, to keep attending his educational classes to make constructive use of his time and for an officer to refer him to the mental health team. The care plan noted that Mr Humphreys' main support included contact with his mother and cellmate.

48. On 4 July, Mr Humphreys used his in-cell PIN telephone to call his ex-fiancée. During their conversation, he cried and was upset about the breakdown of their relationship.

49. On 5 July, an officer saw Mr Humphreys for a key work session. Mr Humphreys disclosed that his relationship with his fiancée had ended because she was seeing someone else. He said he did not feel mentally strong but said he had the support of his mother and cellmate. He also made good use of his time by attending educational activities and the library. The officer told Mr Humphreys that she would see him again in two weeks' time to check on him.

50. On 6 July, a SO chaired an ACCT case review. An officer attended. The SO noted that a nurse from the mental health team was unable to attend but had contributed verbally before the review. There was no entry in Mr Humphreys' medical or prison records to evidence the outcome of this conversation. Mr Humphreys said that he had spoken to his ex-fiancée. He said that although he felt low, he had no thoughts

of self-harm. The SO noted that Mr Humphreys had not left his cell much and encouraged him to engage with the prison regime and attend his educational classes. He also referred Mr Humphreys for counselling. The review panel agreed that ACCT monitoring would continue at the same level. The next case review was scheduled for 12 July.

51. Around 5.30pm, an officer noted in the ACCT ongoing record that she spoke to Mr Humphreys. She noted that he had remained in his cell during the period when prisoners mix with each other but had not raised any concerns.

52. At 7.48am on 7 July, Mr Humphreys telephoned his ex-fiancée. Their conversation was amicable, and Mr Humphreys said he would call her the following week.

53. That morning, an officer noted in the ACCT ongoing record that he spoke to Mr Humphreys. He noted that Mr Humphreys still felt low.

54. At around 3.10pm, Mr Humphreys collected his weekly supply of medication from the medication hatch.

55. That evening, Mr Humphreys told an officer that he had used all his vapes. His cellmate said that he had no concerns about him.

56. An Operational Support Grade (OSG) started his night duty at around 8.30pm. No concerns were raised during his handover from the day duty staff. He completed four random ACCT checks on Mr Humphreys between 9.00pm and 7.30am on 8 July and had no concerns.

Events on 8 July

57. In his statement, the cellmate said that he woke up at around 6.00am, turned on the television, got ready for work and was reading on his bed. At the time, he believed Mr Humphreys was sleeping. He had heard him snoring and although it sounded odd and he appeared to be struggling to breathe, he was not overly concerned as he knew he had asthma.

58. The OSG handed over to an officer just before 7.00am. The officer conducted a routine check on B Wing and had no concerns about Mr Humphreys.

59. Soon after this, the cellmate said that Mr Humphreys vomited on himself, but he remained lying in bed and did not move. He vomited twice more and then appeared to choke on his vomit. This alerted the cellmate, who then got out of bed and tried to put Mr Humphreys on his side in the recovery position. This proved difficult so he pressed the emergency cell bell. The OSG and officer responded and attended the cell.

60. The officer opened the cell door observation panel. The cellmate told the officers that Mr Humphreys was choking. The officer radioed a medical emergency code blue (indicating a life-threatening medical emergency), while simultaneously unlocking and entering the cell.

61. The OSG who worked in the control room told us that she received the emergency code blue radio message at 6.56am, which only provided the location of the

incident. She told us that she did not call the ambulance service immediately because she knew they would need details about the incident. Staff on the scene were therefore asked to switch their radio network to the prison's security net (a secure and specific channel) so that she could confirm whether an ambulance was needed and pass details more easily to the ambulance service.

62. When he entered the cell, the officer saw Mr Humphreys lying on his bed, making a loud, snoring noise, with vomit all over his face and hair. He placed Mr Humphreys on the floor in the recovery position, cleared and ensured his airway was open and gently patted his back while trying to get a response from him. Another officer and a Custodial Manager (CM) responded to the emergency and arrived at the cell within two minutes. The CM ensured Mr Humphreys' airways remained open. (Healthcare staff are not on duty until 7.30am.)

63. After an initial delay of three to four minutes due to staff switching to the security net, the OSG in the control room told us that she confirmed the request for an ambulance at 7.00am. At this point, the CM had switched his radio to the security network and talked directly to the ambulance control room and answered their questions about Mr Humphreys' condition, while they waited for the ambulance to arrive. The CM continued to check Mr Humphreys' airway and pulse. Mr Humphreys continued to make a loud, snoring noise and was breathing but remained unresponsive.

64. While in the cell, staff found an empty prescribed medication bottle with Mr Humphreys' name on it. The cellmate told staff that he did not know if Mr Humphreys had taken any substances.

65. An ambulance paramedic arrived at 7.23am and took over Mr Humphreys' care. More paramedics arrived from 7.33am and continued to provide emergency care.

66. At 7.39am, a nurse (who had just started her shift) arrived at Mr Humphreys' cell. She updated the paramedic crew on Mr Humphreys' medical history. From a short discussion with the paramedics, it was believed that Mr Humphreys might have taken an overdose of prescribed methocarbamol.

67. At around 8.00am, the paramedic crew transferred Mr Humphreys to Hinchingbrooke Hospital. His condition was critical, and he was placed in an induced coma.

68. Mr Humphreys had identified his ex-fiancée as his next of kin. At 8.11am, the Head of Security, who is also a family liaison officer, phoned Mr Humphreys' ex- fiancée and told her that he was suspected of taking an overdose and was very unwell in hospital. She also phoned Mr Humphreys' mother and told her of the same. She said she would keep Mr Humphreys' mother and ex-fiancée updated about changes to his condition.

69. Over the next day, the Head of Security spoke to Mr Humphreys' mother and ex-fiancée and both were given the opportunity to visit Mr Humphreys in hospital.

70. At 7.10pm on 11 July, hospital staff confirmed that Mr Humphreys had died.

Contact with Mr Humphreys' family

71. After Mr Humphreys' death, the Head of Security broke the news of Mr Humphreys' death to his mother and ex-fiancée and offered them support. She also spoke to Mr Humphreys' brother that evening.

72. The following day, a CM and a SO were appointed as the prison's family liaison officers. The CM phoned Mr Humphreys' mother and ex-fiancée to introduce himself and offer his condolences. In line with national instructions, the prison contributed towards the costs of Mr Humphreys' funeral.

Support for prisoners and staff

73. After Mr Humphreys' death, the Head of Residence 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.

74. The prison posted notices informing other prisoners of Mr Humphreys' death and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Humphreys' death. Mr Humphreys' cellmate was offered support and relocated to another cell.

Other information

75. On 12 July, the police visited Littlehey and searched Mr Humphreys' cell, which had been sealed since 8 July. The police noted that they did not find any illicit drugs or medications, except those prescribed to either Mr Humphreys or his cellmate. Medication that belonged to Mr Humphreys included a packet of sertraline, with only one tablet remaining; empty bottles of methocarbamol (labels confirmed when full each had contained 21 tablets); two empty blister packets of methocarbamol; a Ventolin inhaler; codeine and lansoprazole tablets.

Post-mortem report

76. A post-mortem examination and toxicology report completed noted that Mr Humphreys died from aspiration pneumonia (when food or liquid is breathed into the airways or lungs), caused by methocarbamol overdose (his prescribed medication). Myotonic dystrophy (a genetic condition that causes progressive muscle weakness and wasting), fatty liver disease and systemic granulomatous disease did not cause but contributed to his death.

Findings

Management of Mr Humphreys' risk of suicide and self-harm

77. When Mr Humphreys arrived at Littlehey in March 2022, he had a number of risk factors: it was his first time in custody, he had a history of depression and was taking antidepressant medication, he had substance misuse issues and a history of attempted suicide and self-harm (cutting and overdose). He was considered a vulnerable prisoner due to his offence and he had a physical medical condition. He had last been monitored under ACCT procedures (for one day) in February 2022, and since then, no concerns had been raised about him. During his reception interviews, Mr Humphreys gave staff no indication that he was distressed or raised any concerns that he may be at risk of suicide or self-harm. Staff raised no concerns about Mr Humphreys, and he was referred to see the mental health team. There was therefore no immediate reason for staff at Littlehey to monitor him under ACCT procedures when he arrived at Littlehey. Later, on 1 July, when Mr Humphreys cut his right wrist, prison staff appropriately started ACCT procedures.

78. The clinical reviewer noted that the care Mr Humphreys received was of a reasonable standard and equivalent to that which he would have received in the community.

Management of ACCT procedures

79. Generally, this investigation found that staff offered Mr Humphreys good, personalised care. Their entries in the ACCT plan demonstrated that they kept a watchful eye on him, noting when he did not leave his cell, or collect his meals, and the occasions when he seemed low in mood or unkempt. Mr Humphreys received consistent support from several members of staff who clearly invested time to get to know and support him. This is good practice, and the Governor will want to reflect this to relevant staff.

80. When prison staff started ACCT procedures and before Mr Humphreys' ACCT assessment and first case review on 1 July, he left his wing and attended the healthcare drop-in wellbeing clinics. However, his ACCT document did not travel with him when he left the wing. Primary and mental health staff knew that Mr Humphreys was being monitored under ACCT procedures because he told them during his consultation. However, because the ACCT document had not accompanied him to the clinics, healthcare staff could not update the ongoing record in his ACCT plan with relevant risk information from their assessments. Information from these consultations was subsequently not shared with prison staff to inform the forthcoming ACCT assessment and case review.

81. Additionally, verbal input from healthcare staff into Mr Humphreys' ACCT case reviews confirmed they were aware that he was being monitored due to his risk of harm and this should have prompted them to re-assess his risk of keeping and administering his medication. This did not happen. This was especially important given that Mr Humphreys had disclosed thoughts of self-harm and had a known history of overdose of his prescribed medication.

82. Mr Humphreys' attendance at the drop-in clinic and a review of his medication once ACCT monitoring started were missed opportunities to share relevant risk information with staff about him. We agree with the clinical reviewer that communication needs to improve between prison and healthcare staff for prisoners subject to ACCT procedures. We recommend that:

- **The Governor and Head of Healthcare should ensure that, in line with PSI 64/2011:**
    - **Staff are aware that the ACCT plan should travel with the prisoner when he leaves his wing, including when he participates in activities; and**
    - **When ACCT monitoring is started, healthcare staff assess a prisoner's risk to determine whether he should continue to keep and administer prescribed medication.**

Governor to note

Emergency response

83. We are satisfied that the emergency response was swift and appropriate in the circumstances. Our only concern was that staff who radioed the code blue emergency gave no additional information about the emergency situation, and when control room staff received the code blue, they did not call an ambulance immediately. Instead, they asked staff at the scene to switch to the security net so that they could confirm whether an ambulance was needed. This led to a delay of three to four minutes before the ambulance was called. The Governor will wish to consider whether there is any learning from this case.

Head of Healthcare to note

84. Although the clinical reviewer noted that the care Mr Humphreys received was of a reasonable standard and equivalent to that which he could have expected to receive in the community, healthcare staff did not complete a formal assessment or care plan to support Mr Humphreys' muscular dystrophy and mobility needs and did not record their contribution to the ACCT process.

Governor and Head of Healthcare to note

Healthcare input into ACCT reviews

85. The healthcare team did not attend Mr Humphreys' first or second ACCT case reviews in person, but it was recorded in the ACCT document that they had provided verbal contributions. Healthcare staff did not record in Mr Humphreys' medical record that they had contributed to the ACCT process. PSI 64/2011 requires that ACCT case reviews are multidisciplinary, and that healthcare staff are always invited to attend or contribute. Given Mr Humphreys' known medical conditions, ideally healthcare staff would have attended the ACCT reviews in person.

86. The Head of Healthcare told us that healthcare staff sometimes could not attend ACCT reviews when they were scheduled at nurses' busiest times. We appreciate that scheduling ACCT reviews to maximise multidisciplinary attendance, among the

numerous other priorities in prison, is difficult. The Governor and Head of Healthcare may wish to consider whether there is more that could be done to allow for healthcare attendance.

Inquest

87. An inquest was concluded on 12 August 2025, that the cause of Mr Humphreys' death was from aspiration pneumonia (when food or liquid is breathed into the airways or lungs), caused by methocarbamol overdose (his prescribed medication).

88. The coroner concluded the circumstances of Mr Humphreys' death was due to suicide. He gave a verdict in which he said the probable cause of this was:

"Mr Humphreys intentionally took an excessive quantity of his prescribed medication which ultimately led to his death. The circumstances were that Mr Humphreys had mental and physical health issues, a recent relationship breakdown, contributing to his low mood and subsequent overdose."

Prisons & Probation Ombudsman
Independent Investigations

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