Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Scovell a prisoner at HMP Stocken on 25 November 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 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 2015

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

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

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

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 Scovell was found hanged in his cell at HMP Stocken on 25 November 2015. He was 45 years old. I offer my condolences to Mr Scovell's family and friends.

Mr Scovell had been in prison since August 2014. He had no history of attempted suicide, self-harm or mental health problems and appeared to settle well in prison. However, he used 'Spice', a new psychoactive substance, which was found in his blood when he died. We cannot be sure what part, if any, the use of Spice played in Mr Scovell's death, but the dangers associated with the use of new psychoactive substances to the physical and mental health of prisoners, and the links to suicide are an increasing concern. I am satisfied that Stocken is aware of the dangers and is taking steps to help address the problem.

The emergency response was poor. There was a delay calling an ambulance after the initial alarm was raised and it took too long to get paramedics to the cell after they arrived at the prison. While it appears this would not have affected the outcome for Mr Scovell, in other emergencies such delays could be crucial.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2016**

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 6
Findings 10

Summary

Events

1. In August 2014, Mr Edward Scovell was remanded to prison and in October was sentenced to seven years and three months in prison for burglary and wounding with intent to cause grievous bodily harm. It was not his first time in prison. He had no history of self-harm or attempted suicide.

2. On 8 July 2015, Mr Scovell transferred to HMP Stocken. At his initial health assessment, Mr Scovell told a nurse that he had been using half a gram of heroin daily at Bullingdon but declined substance misuse treatment and support.

3. In October, officers found a list of prisoners' debts on the wing and Mr Scovell appeared on the list. Two weeks later, an officer suspected that Mr Scovell and two other prisoners were making up 'wraps' of drugs, but found no evidence when he looked in their cells. Officers submitted security intelligence reports on both occasions, but no other action was taken.

4. At 6.00pm on Tuesday 24 November, Mr Scovell went to a Buddhist meditation session in the chapel, which he did not usually go to. An officer was suspicious that many more prisoners than usual attended and noted that drugs had been found in the chapel the previous week. The officer submitted a security intelligence report about this. Mr Scovell got back to the wing at 7.13pm and an officer locked him in his cell.

5. At 5.52am on 25 November, the night patrol officer saw Mr Scovell apparently standing in his cell. He thought he had a ligature around his neck but did not go into the cell because he could not see clearly what had happened, but radioed an emergency medical code. Other officers arrived, went into the cell and found that Mr Scovell had hanged himself. The officers agreed that it was apparent that Mr Scovell had been dead for some time, so did not try to resuscitate him. At 6.04am, a communications room officer called an ambulance, which arrived at the prison at 6.20am. It took another 14 minutes for paramedics to get to Mr Scovell's cell. At 6.42am paramedics recorded that Mr Scovell had died.

Findings

6. We do not consider that prison staff could have reasonably foreseen that Mr Scovell was at risk of suicide and therefore could not have been expected to take action to help prevent it. His actions might have been prompted by his use of 'Spice', a new psychoactive substance (NPS) which Mr Scovell smoked frequently. It is apparent that NPS are widely available at Stocken. However, we understand that the prison has recognised this problem and has begun to take some measures to tackle the issue.

7. Staff did not call an ambulance immediately as should have happened when the emergency medical code was broadcast. After the ambulance arrived at the prison, there was a further delay in paramedics reaching Mr Scovell's cell. While it would not have altered the outcome for Mr Scovell who appears to have been dead when staff went into his cell, in future emergencies, such a delay could be crucial.

Recommendations

- The Governor should ensure that the local emergency protocol meets the requirements of PSI 03/2013, that the communications room calls an ambulance as soon as an emergency medical code is called, and that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator visited Stocken on 27 November 2015 and obtained copies of relevant extracts from Mr Scovell's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Scovell's clinical care at the prison.

11. The investigator interviewed 14 members of staff and two prisoners at Stocken between December 2015 and February 2016. The clinical reviewer joined him for interviews with healthcare staff.

12. We informed HM Coroner for Rutland and North Leicestershire District of the investigation who gave us the results of the toxicology report and post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted a friend of Mr Scovell's, who he had named as his next of kin, and his family to explain the investigation. They wanted to know why Mr Scovell was not sharing a cell.

14. Mr Scovell's family and his friend received a copy of the initial report. Mr Scovell's friend raised one issue that did not impact on the factual accuracy of this report and has been addressed through separate correspondence.

15. The Service also received a copy of the initial report.

Background Information

HMP Stocken

16. HMP Stocken is a medium security prison in Rutland, which holds up to 842 men. Nottinghamshire Healthcare NHS Foundation Trust provides primary physical health and substance misuse services and Northamptonshire Healthcare NHS Foundation Trust provides mental health services. Nurses are on duty from 7.30am until 6.30pm Monday to Friday, and from 8.30am until 6.30pm at weekends. There are 12 GP clinics a week.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Stocken was in July 2015. Inspectors reported that the number of self-harm incidents was lower than other similar prisons, but the quality of suicide prevention procedures varied. There had been an increase in violence at Stocken due to gangs, debt and the availability of NPS. Weaknesses in relationships between staff and prisoners undermined dynamic security, but inspectors found that security intelligence was well managed and a recently formed ‘new psychoactive substance committee’ was bringing a renewed strategic approach to tackling drugs. The drug and alcohol team delivered a comprehensive and well-integrated service.

Independent Monitoring Board

18. 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 April 2015, the IMB was concerned about the increased availability of NPS at the prison. The IMB considered that Stocken had previously been effective at controlling substance misuse through sound intelligence gathering, search methods and excellent work by healthcare staff and the drug treatment service, but this had been undermined by the increase of NPS in the prison.

Previous deaths at HMP Stocken

19. Mr Scovell was the first prisoner to die at HMP Stocken since March 2013. His death was the first self-inflicted death at Stocken for more than 10 years.

New Psychoactive Substances (NPS)

20. NPS are an increasing problem in prisons. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Their use can lead to paranoia and psychotic episodes.

21. As well as emerging evidence of dangers to both physical and mental health, there are links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.

22. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

23. Mr Edward Scovell was remanded to HMP Bullingdon on 6 August 2014, charged with wounding with intent to cause grievous bodily harm and burglary. It was not his first time in prison. He had a history of substance and alcohol misuse, but there was no record that he had ever self-harmed, attempted suicide or been diagnosed with any mental health problems.

24. When he arrived at Bullingdon, healthcare staff noted Mr Scovell had a history of using cocaine, heroin, crack and ecstasy, as well as alcohol dependence. The prison's substance misuse team offered Mr Scovell treatment for his drug and alcohol addiction, but he did not want medication to manage withdrawal symptoms and did not want any support from the substance misuse team. In September 2014, Mr Scovell received a punishment of 14 days segregation for smoking cannabis. On 15 October, Mr Scovell was sentenced to seven years and three months in prison.

25. Over the next months, Mr Scovell worked as a cleaner at Bullingdon. An officer noted in his prison record that he was always polite and an example to others with his work standards. There was no further record of any involvement in drug taking.

HMP Stocken

26. On 8 July 2015, Mr Scovell transferred to HMP Stocken. At an initial health assessment, Mr Scovell told a nurse that he had used half a gram of heroin every day at Bullingdon. The nurse referred Mr Scovell to the substance misuse clinic. The nurse recorded that Mr Scovell was not at risk of suicide or self-harm and had no mental health problems.

27. On 9 July, a substance misuse nurse reviewed Mr Scovell, who repeated that he had been using heroin daily until 7 July. He explained that they were unable to prescribe methadone (an opiate substitute) because the prison's dispensing equipment had been damaged during a recent disturbance at the prison. Mr Scovell said that he did not want to take methadone in any event. He told Mr Scovell that a prison GP could prescribe lofexidine to relieve withdrawal symptoms, but healthcare staff needed to check whether he had any heart problems first. He arranged an ECG (an electrocardiogram) and an assessment of his opiate withdrawal, using the COWS scale (Custody Opiate Withdrawal Health Observation Scale) for later that day.

28. A prison GP reviewed Mr Scovell's ECG results in the afternoon. He noted that the ECG showed that he might have a heart condition, which would mean he could not take lofexidine. The GP recorded that Mr Scovell scored five (a low level) on the COWS scale, which indicated he had very few signs of opiate withdrawal. The GP asked nurses to repeat the ECG and carry out blood tests to investigate the abnormalities before he could safely prescribe lofexidine.

29. The substance misuse nurse spoke to Mr Scovell about the outcome of his tests and Mr Scovell said that he did not think he would benefit from lofexidine anyway. He offered him paracetamol, ibuprofen and mebeverine (a medicine for the treatment of abdominal cramping) to help manage his withdrawal symptoms, but

Mr Scovell said he did not want any medication and would manage on his own. The nurse scheduled blood tests, a repeat ECG and an appointment with a prison GP for the next day, but Mr Scovell did not go to the appointments.

30. Mr Scovell had a single cell on a standard wing and started work as a cleaner. (He had been assessed as a high risk for cell sharing because there was a racist element to his offence, and was not allowed to share a cell.) Officers recorded that he associated well with other prisoners and had no problems, although he preferred to be left alone.

31. On 15 October, an officer gave a colleague a list he had found in a prisoner's cell, with prisoners' names and what appeared to be details of debts. It was not clear whether this was a list of debts owed by the prisoner whose cell it was or whether the other prisoners on the list were in debt to him. Mr Scovell's name was on the list, with one ounce (likely to refer to tobacco) against it. The officer submitted a security incident report, but there is no record that anyone took any further action.

32. On 29 October, an officer was outside in the exercise yard. As he was walking past a cell, he thought he saw Mr Scovell and two other prisoners making up 'wraps' (small packages) of drugs. When he went inside to check, he found no evidence of any drugs. He submitted another security incident report, but there is no record that anyone followed this up with Mr Scovell.

33. Mr Scovell's personal officer said he often saw Mr Scovell on the wing but rarely spoke to him. He said Mr Scovell was very reserved and quiet, and he never suspected that he was taking drugs. However, a close friend of Mr Scovell's told the investigator that Mr Scovell frequently used Spice (a new psychoactive substance), which he bought from other prisoners. He said Spice was widely available in the prison.

Tuesday 24 November

34. At 8.15am on 24 November, Mr Scovell emptied the bins on the wing and went back to his cell. At 12.00pm, he had lunch and at 12.30pm, he went outside with other prisoners for some time in the open air. He then worked until 4.00pm, when he came back to the wing and spent two more hours on the wing with other prisoners. A prisoner said that Mr Scovell played chess that afternoon. He noticed nothing unusual about him. At about 6.00pm, officers started to lock some prisoners in their cells, while others (including Mr Scovell) went to religious services.

35. A prisoner told the investigator that he and Mr Scovell had wanted to go to Buddhist meditation for a while and he had arranged for them to go that evening for the first time. He told the investigator that they had been reading books about Buddhism and wanted to understand the religion better.

36. An officer noticed that far more prisoners than usual, 18 instead of about six, including Mr Scovell, went to the Buddhist meditation session that week. He told the investigator that he was suspicious, as a week earlier, during Muslim prayers, officers had found Spice hidden in the chapel toilet. The Buddhist meditation also took place in the chapel, but officers did not supervise it because usually

very few prisoners went. He recorded his concerns in a security intelligence report and in the wing observation book.

37. A prisoner told the investigator that the prisoners listened to a Buddhist monk, then sat in silence for some time. He said that he thought Mr Scovell was very quiet that day and seemed to be worried about something. He said that no one used Spice or other drugs during the Buddhist meditation session and he did not see Mr Scovell using Spice or any drug that night.

38. The Buddhist monk told the investigator that he had been surprised about the number of prisoners who came to meditate that evening, but he was not concerned. He said that prisoners gathered in the foyer of the chapel before the session, while he telephoned the control room to confirm how many prisoners there were from each wing. He said that he could not easily supervise prisoners during this time, but that was not usually a problem. He had a key to the toilet and had to unlock it for prisoners to use it if they needed it, but he did not use the key that evening. He told the investigator that he did not see prisoners using or dealing drugs during the session. He could not specifically remember Mr Scovell, but he said that prisoners asked questions about Buddhism and engaged well during the meditation session.

39. CCTV (closed-circuit television) shows that at 7.13pm, Mr Scovell arrived back on the wing from the meditation session. An officer said Mr Scovell was the last prisoner to come back and he asked him why he was later than the others. Mr Scovell just said that it was a long way from the chapel to the wing. Mr Scovell said that it had been a good service and that he had no problems. The officer said he did not notice anything unusual about him and locked him in his cell.

40. At around 8.00pm, the night patrol officer came on duty on Mr Scovell's wing. At 9.00pm, he did a routine check that all prisoners were present in their cells. He said he saw Mr Scovell through the door observation panel but did not notice anything concerning. Mr Scovell did not press his cell bell all night and the officer said he did not hear any noises coming from his cell.

Wednesday 25 November

41. At 5.48am, the night patrol officer started a routine morning check of prisoners. When he arrived at Mr Scovell's cell about three minutes later, he looked through the observation panel and saw that Mr Scovell appeared to be standing behind the door. He then noticed that Mr Scovell seemed to have a ligature around his neck. He banged on the door and at 5.52am, when Mr Scovell did not respond, he radioed a code blue medical emergency (indicating circumstances such as when a prisoner is unconscious or not breathing). He told the investigator that he did not go into the cell immediately because he could not see Mr Scovell well enough to risk assess the situation.

42. A unit manager responded quickly to the code blue, together with two officers. Officer A unlocked the cell and Officer B held the door open while the unit manager and Officer A went in. The unit manager said that Mr Scovell had tied ripped sheets around his neck and was hanging from the back of the cell door.

43. Officer A cut the sheet and he and the unit manager lay Mr Scovell down on the floor. The unit manager removed the sheet from Mr Scovell's neck and noted that his body was cold and stiff. There was lots of bruising around his neck. Officer A checked for a pulse but found none. They agreed not to try to resuscitate Mr Scovell because they considered it was apparent that he had been dead for some time.

44. The unit manager went to the wing office and telephoned the communications room officer to ask for an ambulance. Ambulance service records show that they received a call from the prison at 6.04am and they arrived at the prison at 6.20am. CCTV shows that paramedics reached Mr Scovell's cell at 6.34am. They confirmed that rigor mortis was present and assessed that Mr Scovell had been dead for at least two or three hours. At 6.42am, the paramedics recorded that Mr Scovell had died.

Contact with Mr Scovell's family

45. At 12.50pm, an officer and the Head of Residence went to inform a friend of Mr Scovell, who he had named as his next of kin, that he had died. The Head of Residence also informed Mr Scovell's partner, who did not want any further involvement. The coroner's office found contact details for Mr Scovell's mother and the prison contacted her and offered support.

46. Mr Scovell's funeral was held on 14 December 2015. The prison offered to contribute to the funeral costs in line with national instructions.

Support for prisoners and staff

47. After Mr Scovell's death, the Governor debriefed the staff involved in the emergency response. No one identified any immediate issues. He offered his support and that of the staff care team.

48. The prison posted notices informing staff and prisoners of Mr Scovell's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Scovell's death.

Post-mortem report

49. A post-mortem examination established the cause of death as hanging. Toxicology analysis revealed that Mr Scovell had used NPS (Spice) before he died, although the amount was not a fatal level.

Findings

Identifying risk of suicide

50. Mr Scovell had no history of suicide or self-harm and had never been identified as at risk during his time in prison. We consider that there was nothing to indicate to prison staff that Mr Scovell was at immediate risk of suicide in the days before his death. His actions were sudden and unexpected, he had no clear risk factors for suicide and we do not consider that prison staff could have predicted or prevented his death. Mr Scovell left no note to explain his actions, but we cannot discount that the possibility that his mind had been affected by the use of new psychoactive substances.

Substance Misuse

51. Mr Scovell had a history of substance misuse before he came to prison but always refused any treatment or support to help him address this problem. When he arrived at Stocken, he said he had been using heroin daily at Bullingdon. The prison was not able to offer methadone treatment at the time but Mr Scovell said he would not have wanted it. Although he initially agreed to have test to check his suitability for lofexidine, he did not pursue this and told staff that he would prefer to manage on his own.

52. The post-mortem examination and toxicology report showed that Mr Scovell used Spice before he died. Prisoners who knew Mr Scovell told the investigator that he often used Spice. None of the officers and healthcare staff we interviewed knew that Mr Scovell was using Spice.

53. The evening before Mr Scovell died, an officer noticed that Mr Scovell and a number of other prisoners went to Buddhist meditation for the first time and was suspicious. He submitted a security intelligence report, but this would not have been seen by the security department until the next morning. He did not contact any manager at the time to check whether additional security might be needed that evening.

54. We do not know whether Mr Scovell's actions were as a result of his use of new psychoactive substances but we note that both HM Inspectorate of Prisons and the Independent Monitoring Board for Stocken identified the use of such substances as an increasing problem at the prison. Stocken has recognised the problem and has begun to take some steps to address it. The prison has formed a new psychoactive substance committee to tackle the problem strategically, has issued guidelines for managing prisoners suspected of using NPS, and delivers a variety of different short courses to prisoners, which include NPS awareness sessions. We therefore make no recommendation.

Emergency Response

55. Stocken's local instruction about opening a cell at night says that if a prisoner's life is in immediate danger staff must *consider* entering the cell on their own but must balance the preservation of life against the security of the prison. The night patrol officer said he decided not to go into the cell alone because he could not see Mr Scovell clearly enough to assess the risk. While we would usually expect

staff to go into cells immediately when a prisoner is hanging, we accept that he made an individual assessment and was not clear about the risk. There was little delay before other staff arrived.

56. The night patrol officer radioed an emergency code blue but no one called an ambulance immediately. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires governors to have a protocol that instructs staff how to communicate the nature of a medical emergency using agreed emergency codes and ensures that the control room calls an ambulance automatically. The PSI explicitly states that it should not be a requirement for a member of healthcare staff or anyone else to attend the scene to confirm an ambulance is needed before emergency services are called.

57. Stocken's local policy at the time Mr Scovell died was dated 20 February 2013, but did not reflect the mandatory requirements of PSI 03/2013, which was issued the same month. In particular, the local policy required officers to call an emergency code and to request an ambulance separately. It was 12 minutes after the night patrol officer radioed the code blue before anyone called an ambulance. The communications room officer told the investigator that when officers call an emergency medical code, she always waits until healthcare staff or another officer confirms that an ambulance is required. On 25 November, she waited until the unit manager told her that one was needed.

58. PSI 03/2013 requires that there should be no unnecessary delay in escorting ambulances and paramedics to the prisoner in an emergency. It took paramedics 14 minutes to reach Mr Scovell's cell, after arriving at the prison, which we consider is too long to in an emergency.

59. None of the delays would have affected the outcome for Mr Scovell, as it was apparent he had been dead for some time when he was hanged in his cell. However, in other emergencies, such delays could be critical to a prisoner's chances of survival. We make the following recommendation:

    The Governor should ensure that the local emergency protocol meets the requirements of PSI 03/2013, that the communications room calls an ambulance as soon as an emergency medical code is called, and that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141