Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leroy Scott a prisoner at HMP Stocken on 30 October 2017

A report by the Prisons and Probation Ombudsman

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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 Scott died on 30 October 2017 of epilepsy, related to a previous brain injury, while a prisoner at HMP Stocken. He was 36 years old. I offer my condolences to Mr Scott's family and friends.

The care Mr Scott received for his physical health was largely equivalent to that which he could have expected to receive in the community. However, I am concerned that his mental health was not adequately assessed. Although the clinical reviewer does not feel it would have affected the outcome for Mr Scott, I am concerned that Mr Scott may not have taken his anti-epilepsy medication regularly because of untreated mental health issues.

I am also concerned that the first morning roll check does not appear to have been sufficiently thorough, that prison staff delayed going into Mr Scott's cell when he was found unresponsive, and staff did not use an emergency code, which led to a delay in calling an ambulance.

I am also disappointed that family liaison was ineffective and the family had to contact my office for assistance which might reasonably have been provided by the prison.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2018**

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Summary

Events

1. On 12 February 2014, Mr Scott was sentenced to five and a half years imprisonment. On 27 July 2016, he was released from prison on licence but was recalled on 31 July 2016. On 9 August 2016, Mr Scott was transferred to HMP Stocken.

2. Mr Scott had a history of drug misuse in the community and, in 2003, had experienced drug-induced psychosis.

3. In 2010, Mr Scott had sustained a serious head injury, which led to him developing epilepsy. During his time at Stocken, Mr Scott repeatedly refused to take his anti-epilepsy medication and frequently had seizures. Healthcare staff tried a variety of strategies and prison staff reminded him to collect his medication from the medication hatch.

4. Mr Scott was at times unkempt and reported hearing voices. He was seen by a Mental Health Support Worker on a variety of occasions but her role was to fact-find, not to assess. Mr Scott was never assessed by a mental health nurse.

5. On 29 October, the evening before Mr Scott's death, Mr Scott's friend, a prisoner, spoke to him. He said he seemed his usual self. A member of staff completed the roll check that evening at 8.30pm, and the following morning at 5.50am but did not remember seeing Mr Scott and said that he did not note anything unusual.

6. Another officer completed a further roll check on the morning of 30 October, reaching Mr Scott's cell at 7.18am, and saw that Mr Scott was on the floor. He knocked on the cell door and called to Mr Scott to get a response. Mr Scott did not respond and the officer radioed for assistance. The officer did not go into Mr Scott's cell and he did not use an emergency code.

7. Staff in the control room asked healthcare staff to attend and prison staff also attended. When the officers went into the cell one of them described Mr Scott's arm as cold and stiff. As more prison staff arrived, a manager asked an officer to ask the control room to call an ambulance. This was three minutes after Mr Scott was first discovered.

8. Prison and healthcare staff delivered cardio-pulmonary resuscitation (CPR) until paramedics arrived. They confirmed Mr Scott's death at 7.58am.

Findings

9. We are satisfied that the care Mr Scott received for his physical health was equivalent to that which he could have expected to receive in the community. However, Mr Scott's mental health was never properly assessed, and the clinical reviewer concluded that this aspect of care was not equivalent to that he could have expected to receive in the community.

10. We are concerned that the presence of rigor mortis when Mr Scott was found shortly after 7am, suggests he might have already been dead at the time the first roll check was carried out between 5.30am and 6.05am. We are also concerned

that the officer waited for other staff to arrive before going into Mr Scott's cell, and that no member of staff called an emergency code.

11. Although the news of Mr Scott's death was broken to the family in a timely and correct manner, the family contacted my office for assistance because they said the prison family liaison officer (FLO) did not keep them informed of developments.

Recommendations

- The Head of Healthcare should establish a protocol to ensure that there is a threshold at which prisoners reporting mental health symptoms can expect to be assessed by a registered mental health nurse.
- The Governor should ensure that staff conduct roll checks thoroughly.
- The Governor and Head of Healthcare should ensure that staff are familiar with the local policy on emergency codes and are confident in using them.
- The Governor should ensure that all staff are aware that the preservation of life must take precedence over usual arrangements for opening cells.
- The Governor should ensure that prison Family Liaison Officers fully understand the remit of their role and that refresher training is provided where necessary.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking anyone with relevant information to contact her. Two people responded.

13. The investigator obtained copies of relevant extracts from Mr Scott's prison and medical records.

14. The investigator interviewed seven members of staff and a prisoner on various dates in November 2017, April 2018 and June 2018.

15. NHS England commissioned a clinical reviewer to review Mr Scott's clinical care at the prison. He conducted two interviews with the investigator.

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

17. One of the Ombudsman's family liaison officers contacted Mr Scott's cousin, who was the point of contact for Mr Scott's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked what was put in place to deal with Mr Scott's mental health needs. They said that he had stopped caring for himself, which was out of character for him as he was always clean, tidy and well kept. They also asked what records were kept of Mr Scott's seizures and how often he was monitored.

18. Mr Scott's mother raised a number of other concerns which have been addressed in a separate letter, outside of this report.

19. We sent Mr Scott's mother a copy of our initial report. The family responded with comments but did not raise any factual inaccuracies.

20. The initial report was also shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Stocken

21. HMP Stocken is a medium security prison in Rutland which holds up to 842 men. Healthcare is provided by Care UK, and mental health services are sub-contracted to Northamptonshire Foundation NHS Trust. GP provision is provided by two permanently employed GPs who provide ten GP sessions per week.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Stocken was conducted in July 2015. Inspectors reported that health services were good, particularly in identifying and supporting prisoners with complex health needs. Waiting times for GP, nurse and dental service appointments were acceptable but prisoners waited too long for most other health services.

Independent Monitoring Board

23. 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 their latest annual report, for the year to April 2017, the IMB reported that healthcare at HMP Stocken had recently changed contractor to Care UK. Waiting lists for dental and optician treatment had reduced although “Did Not Attends” remained too high. The number of hospital appointments cancelled due to lack of escorts was being addressed.

Previous deaths at HMP Stocken

24. Mr Scott was the fifth prisoner to die from natural causes at Stocken since October 2014. There were no significant similarities with the other deaths.

Key Events

25. On 12 February 2014, Mr Leroy Scott was sentenced to five and a half years imprisonment for robbery and possessing an offensive weapon. He was released from prison on 27 July 2016. On 31 July 2016, Mr Scott was recalled to prison for failing to return to his approved premises and was sent to HMP Peterborough. On 9 August 2016, he was transferred to HMP Stocken.

26. Mr Scott had a history of substance misuse and, in 2010, he had had a serious road traffic accident which left him with a significant head injury. He developed epilepsy as a result of the head injury and took medication to help control it.

27. Throughout Mr Scott's time at Stocken, entries on P-NOMIS (the Prison Service's computerised record system) said that Mr Scott had difficulties working and keeping himself and his cell in a hygienic condition. He was on a basic regime because of his refusal to work (he often said he felt too ill), and he rarely cleaned his cell despite frequent prompts from officers to do so.

28. On his arrival at Stocken, a nurse and a prison GP noted Mr Scott's historical head injury and that he had had surgery for it. The GP referred him for an urgent GP review for his epilepsy, which had been arranged for 12 August. Mr Scott did not attend this appointment and he also missed multiple pharmacy appointments thereafter.

29. On 22 August, Mr Scott had three seizures and was taken to hospital. He had not been taking his epilepsy medication. On 23 August, at a multi-disciplinary team (MDT) meeting, healthcare staff decided they would supervise Mr Scott more closely. They were to remind him to collect his medication and refer him to a GP if he did not collect his medication, or if they thought he had not taken it. Again, a number of entries in Mr Scott's medical record suggested that he missed his pharmacy appointments to collect his medication. There was no note in the records to indicate Mr Scott was referred to a GP.

30. On 2 November, Mr Scott had an appointment at the epilepsy clinic with a nurse. During the appointment, Mr Scott had a seizure and hit his head when he fell off a chair. The nurse opened an epilepsy care plan to monitor and control his condition better. A prison GP saw Mr Scott the next day and explained to him the importance of taking his medication as prescribed but, again, despite reviews and conversations with staff, Mr Scott frequently failed to collect and his take his medication.

31. Mr Scott told healthcare staff that he did not take his medication because he did not understand how his medication worked, the tablets were too large and they caused urination issues. Despite staff attempts to explain how the medication worked (including that they might consider smaller tablets but that he would have more of them to take), Mr Scott still did not comply with taking his medication.

32. On 18 January 2017, Mr Scott had two seizures. Paramedics were called and attended to him. On 20 January, a prison GP noted that he had explained again to Mr Scott the dangers of not taking his medication. A nurse saw Mr Scott on 30 January and noted that he no longer thought that the epilepsy medication was causing his urinary issues because it had improved with taking other tablets. Mr

Scott said that he thought he would be able to manage his medication in possession and the nurse said she would refer him to the GP and see him herself in six weeks' time.

33. On 1 February, the MDT discussed Mr Scott's case again and agreed to give him a dossette box for his medication, but that nurses would still need to check his compliance. A nurse conducted a compliance check on 12 February and found that Mr Scott had eight tablets left, when he should have had two at the most. She asked Mr Scott why there were so many tablets left and he said he forgot to take them. Mr Scott saw a clinical access role about his medication compliance the next day. He said that if he could take his two doses later in the day, he thought he might remember to take them better. She agreed to this and arranged for a nurse to review his progress. A review with a nurse showed that Mr Scott had remembered all his doses, except for one, and he was pleased with his progress. She told an unnamed GP and noted she would continue to monitor Mr Scott's compliance.

34. On 31 March, Mr Scott had three seizures and was admitted to hospital. He was discharged on 2 April, and the dosage of his epilepsy medication was increased. Although the problems with Mr Scott's compliance persisted, he seemed to take it more regularly than before.

35. On 13 July, Mr Scott had two seizures and was taken to hospital. He told a nurse that he had missed a dose of tablets. The hospital discharged him on 14 July and a prison GP decided that Mr Scott should not have responsibility for his own medication any longer, and would need to attend the medication hatch twice a day to collect his medication.

36. Mr Scott's compliance with medication remained inconsistent and he sometimes failed to collect his tablets.

37. On 1 September, a mental health support worker recorded in Mr Scott's medical record that wing staff had reported concerns about his presentation. Staff felt he had no concept of time and was asking repetitive questions. She saw him the same day and recorded that neither she nor Mr Scott had any concerns about his mental health. She said Mr Scott had denied using any substances, although he laughed when she asked him about this.

38. On 19 October, Mr Scott had an epilepsy review with a nurse. She recorded that he was collecting most of his medication but admitted that he sometimes missed collecting it because he felt too tired to get out of bed. Mr Scott asked her if she would consider him having his medication in-possession again and she said she would discuss it with a GP. There is no record that this happened.

39. On 26 October, Mr Scott did not collect his medication and the nurse asked an officer to go and get him, but Mr Scott refused to get up.

Events leading up to 30 October 2017

40. During the afternoon of 29 October, Mr Scott visited his friend in his cell. His friend said that Mr Scott 'seemed his usual self'.

41. At approximately 5.00pm, a Supervising Officer (SO) began locking up prisoners on Mr Scott's landing. He told the investigator that Mr Scott was sitting on his bed reading a newspaper. Mr Scott made eye contact with the SO and then continued to read his newspaper.

42. An Operational Support Grade (OSG) conducted the evening roll check at approximately 8.30pm. He told the investigator that he had engaged with most prisoners. However, he had no recollection of having had any interaction with Mr Scott.

43. On 30 October, the OSG started the morning roll check at 5.30am, but it was suspended part way through because of an incident with another prisoner. At approximately 5.50am, the morning roll check was re-started. He estimated that he finished the roll check at about 6.05am and there were no issues with Mr Scott, although he did not specifically recall looking into his cell.

44. At approximately, 7.10am, Officer A started another roll check. When he arrived at Mr Scott's cell, approximately eight minutes later, he saw that Mr Scott was on the floor by his bed. He banged on the door several times but Mr Scott did not respond. At 7.18am, he used his radio to ask for assistance. He gave his location and said there was an unconscious prisoner on his cell floor. Staff in the control room responded by putting out a call for assistance including healthcare.

45. Officer B attended and when he arrived Officer A opened Mr Scott's door and they went into the cell. Officer A touched Mr Scott's arm, which he described as cold and stiff. Officer B said he saw blood on the side of Mr Scott's face and in a pool by his head.

46. A Custodial Manager (CM) attended and other prison staff also attended at various times. Officer A asked for someone to get a defibrillator from another wing. An officer went for it. The CM asked an officer to contact the control room to ask for healthcare staff to attend and to call an ambulance. Staff in the control room called an ambulance at 7.21am and healthcare staff arrived at approximately 7.25am. A nurse said Mr Scott was cold and his teeth were clamped together. The duty governor arrived at approximately 7.35am.

47. Prison staff assisted nursing staff with resuscitation attempts. In total, prison and healthcare staff delivered 48 cycles of cardio-pulmonary resuscitation, but they could not revive Mr Scott.

48. At approximately 7.58am, paramedics attended and confirmed Mr Scott's death.

Contact with Mr Scott's family

49. The prison appointed a family liaison officer (FLO) on the morning of 30 October. The FLO and a prison chaplain travelled to Mr Scott's mother's home to break the news of her son's death. On 1 November, Mr Scott's mother and other members of his family travelled to Stocken to visit his cell and speak to staff. The next record of contact by the FLO was 28 December, when he contacted Mr Scott's mother to see if she had any questions.

50. On 5 January, a member of Mr Scott's family contacted the Prisons and Probation Ombudsman's office and spoke to a manager. She said that the family

were unhappy with the lack of contact by the prison FLO and that they had not been kept abreast of developments or informed that the prison could contribute towards funeral costs. The investigator wrote to the prison Governor about these concerns. The FLO contacted Mr Scott's mother on 16 January 2018 to clarify that the prison would make a contribution towards the funeral costs.

51. Mr Scott's funeral was held on 23 March 2018. No-one from the prison attended because the FLO was unaware that Mr Scott's body had been released and that the funeral was being arranged. The prison contributed towards the funeral costs in line with national policy.

Support for prisoners and staff

52. After Mr Scott's death, a senior manager 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.

53. The prison posted notices informing other prisoners of Mr Scott's 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 Scott's death.

Post-mortem report

54. The post-mortem report concluded that Mr Scott had died from 1a) Post-traumatic epilepsy and 1b) Head injury.

Findings

Clinical care

55. We agree with the clinical reviewer that the physical care Mr Scott received was largely equivalent to that which he could have expected to receive in the community. However, more could have been done to explore his unusual behaviour and the concerns raised by prison staff. This aspect of his care was not equivalent to what he could have expected to receive in the community (see below).

Capacity to make decisions, epilepsy management and medication

56. The clinical reviewer is satisfied that Mr Scott had the mental capacity to decide whether he wanted to take his medication or not. GPs and a nurse had documented in his medical record that he understood his illness and recognised the risks associated with not taking the medication. Staff were confident when interviewed by the clinical reviewer, that Mr Scott had the mental capacity to make decisions about his care and treatment. Healthcare staff also confirmed that they had had training in this area.

57. Mr Scott's epilepsy was appropriately managed and his frequent seizures were responded to by reviews and hospital admissions. Mr Scott attended an epilepsy clinic at the prison and a nurse was familiar with Mr Scott and his on-going needs.

58. Mr Scott repeatedly failed to take his anti-epilepsy medication, which was key in preventing his seizures. We are satisfied that healthcare staff reviewed Mr Scott appropriately and looked at multiple options to persuade him to comply with taking his medication and reminded him to collect his tablets. Healthcare staff frequently reminded Mr Scott of the dangers of not taking his medication and tried various strategies, including allowing him to have his medication in possession.

59. Mr Scott's family asked why they were not informed he was not taking his tablets because they felt they might have been able to persuade him to take his medication. There are legal and professional requirements on the sharing of confidential medical information, even with close relatives, that healthcare professionals are required to observe. Because Mr Scott had the mental capacity to make decisions about his care and treatment, we make no recommendation.

Mental health assessment

60. Mr Scott was not diagnosed with a mental illness although staff raised concerns about his apparent self-neglect and little concept of time. Mr Scott also reported hearing voices in March and June 2017.

61. A mental health support worker saw Mr Scott on a number of occasions in March, June and September 2017, including when Mr Scott asked to see the mental health team. After his appointment on the 7 March, she concluded that Mr Scott did not have any mental illness because he was relaxed and talkative throughout her interview with him. She reached the same conclusion when she reviewed

him again on 26 June. She told the investigator that she was not unduly concerned when wing staff reported on 1 September that Mr Scott had no concept of time and kept asking the same questions repeatedly. She recorded that she saw no evidence of this behaviour.

62. The investigation found that the mental health support worker's appointments with Mr Scott were 'fact finding' and she reported back at team meetings. The notes of those meetings, however, were stored on the team's shared drive and were not attached to Mr Scott's medical record.

63. The clinical reviewer concluded that given the number of times Mr Scott referred himself to healthcare, he could have expected to have been seen at some point by a registered mental health nurse. This did not happen. Although the clinical reviewer found that it would not have affected the outcome for Mr Scott, we are concerned that an underlying and undiagnosed mental health issue might have impacted on his decision to not comply with medication. We also consider that it was unacceptable that Mr Scott was not assessed by a fully qualified mental health nurse. We make the following recommendation:

The Head of Healthcare should establish a protocol to ensure that there is a threshold at which prisoners reporting mental health symptoms can expect to be assessed by a registered mental health nurse.

Welfare checks

64. The OSG said that he could not recall specifically seeing Mr Scott when he conducted a roll check between 5.50am and 6.05am. The officer said that when he entered the cell shortly after 7.18am, Mr Scott was lying on the floor and his arm was cold and stiff. Rigor mortis generally sets in between two and four hours after death and it is, therefore, likely that Mr Scott was already dead and on the floor when the OSG conducted his roll check. If so, we would have expected him to have noticed that Mr Scott was lying on the floor when he carried out the roll check and to have checked on his well-being, as the officer did when he carried out his roll check an hour or so later. The fact that he said he did not notice anything unusual, raises questions about how thoroughly he conducted his check.

65. We therefore make the following recommendation:

The Governor should ensure that staff conduct roll checks thoroughly.

The emergency response

66. PSI 24/2011, which mandates procedures for management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own.

67. When the officer saw Mr Scott lying on the floor in his cell, he did not enter the cell until another officer arrived. The investigator asked him if understood when it was necessary to enter a prisoner's cell. He said that when he had done his

training some five years ago, his understanding was that staff should never enter a cell alone but should summon help and go in with a colleague. He said that more recently, where life was clearly in danger, staff were encouraged to conduct an on the spot dynamic risk assessment and consider entering, even if they were on their own.

68. The officer was unable to say why he had not entered Mr Scott's cell immediately. He said that Mr Scott had had seizures on many previous occasions and that in some cases it was more obvious that someone's life was in danger (for example, where a ligature had been applied). We make the following recommendation:

The Governor should ensure that all staff are aware that preservation of life must take precedence over usual arrangements for opening cells.

69. When staff entered the cell at around 7.18am, Mr Scott was cold and stiff which suggested that rigor mortis had set in. The clinical reviewer asked a nurse why she had continued with resuscitation attempts given Mr Scott's presentation. She said that she could not detect skin tone changes (such as mottling and blue skin) and was not completely convinced that CPR was futile. The clinical reviewer was satisfied that she understood guidance around CPR and did not detect a lack of guidance from management on the issue. We therefore make no recommendation.

70. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. Its provisions are mirrored in local policies at Stocken. Those policies were not, though, followed and, as a result, there was delay and confusion after Mr Scott was found.

71. Although it is unlikely to have affected the outcome for Mr Scott, staff did not call a code blue (which indicates that a prisoner is unconscious or having difficulties breathing), and there was a three-minute delay between the officer discovering Mr Scott was unresponsive at 7.18am and the control room staff calling an ambulance at 7.21am. Prison staff did not appear to know that healthcare staff were already on their way (the control room had asked them to attend) as the CM asked an officer to call for healthcare staff assistance (and an ambulance via the control room). Staff in the control had not at that point called an ambulance, but did so at 7.21am.

72. The investigator asked the first officer if he understood the emergency codes in use at Stocken and if staff routinely used them. The officer was able to describe when red or blue codes should be called (red for profuse bleeding and blue for breathing difficulties), and knew that healthcare should attend immediately, if on duty, with appropriate equipment, and that staff in the control room would call an ambulance. He had heard codes being used in the prison before. He could not explain why he did not use an emergency code, but told the investigator that this was the first time he had been in that situation and he felt very shocked.

73. We note that, no members of staff used an emergency code and, when the investigator spoke to healthcare staff, they said that the use of codes was 'patchy' (although improving). We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are familiar with the local policy on emergency codes and are confident in using them.

Family Liaison

74. Although Mr Scott's family were informed of his death in a timely and correct manner, the prison FLO did not maintain contact with the family or tell them that they were entitled to receive a contribution towards the funeral costs from the prison. The investigator intervened and wrote to the Governor on 10 January 2018. He responded to our letter on 12 January and confirmed he had called a team meeting to ensure liaison with the family was put back on track. Although we welcomed his response, we were disappointed to learn that no-one from the prison attended Mr Scott's funeral, at least partly because the FLO had not kept on top of the case and only found out about the funeral when it had passed. We make the following recommendation:

The Governor should ensure that prison Family Liaison Officers fully understand the remit of their role and that refresher training is provided where necessary.

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