Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Howley, on 6 March 2024, following his release from HMP Wealstun

A report by the Prisons and Probation Ombudsman

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

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

T I 020 7633 4100

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

Summary

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

2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Scott Howley died of quetiapine toxicity, with ischaemic heart disease (heart weakening caused by reduced blood flow to the heart) contributing to but not causing the death, on 6 March 2024, following his release from HMP Wealstun on 29 February. He was 40 years old. We offer our condolences to those who knew him.

5. Mr Howley was prescribed quetiapine (an antipsychotic) in prison and was issued with 56 tablets on release. He left notes that indicated that he took an overdose of this medication in a deliberate attempt to end his life. Around six weeks before his release, Mr Howley harmed himself, told staff that this was something he did regularly, and said that he had daily thoughts of suicide and self-harm. Prison and healthcare staff did not start suicide and self-harm prevention procedures (known as ACCT), as Mr Howley said that he had no immediate thoughts of self-harm at the time. Had they done so, they would have been better placed to identify and address Mr Howley's risk factors and triggers, and help him prepare for release.

6. Mr Howley had a number of mental health diagnoses and had been prescribed quetiapine for several years. Release accommodation was only secured shortly before he was released from prison and Mr Howley himself only found out where he would be living at a post-release probation appointment. Prior to this, it was uncertain in which area he would live, which made referrals to community mental health services complicated and meant he was released with a four-week supply of medication.

Recommendation

- The Governor and Head of Healthcare should issue guidance to staff to ensure that they properly consider and record the range of risk factors when a prisoner harms themselves, and that they always start ACCT procedures unless there has been a significant change in circumstances and risk since the self-harm.

The Investigation Process

7. We were notified of Mr Howley's death on 21 June 2024. We do not know the reason for the delay.

8. The PPO investigator obtained copies of relevant extracts from Mr Howley's prison and probation records.

9. We informed HM Coroner for West Yorkshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy, and we have amended this report accordingly.

11. There was no recorded next of kin for Mr Howley.

Background Information

HMP Wealstun

12. HMP Wealstun is a category C prison near Wetherby, West Yorkshire. There are eleven residential units. Practice Plus Group provides health care services.

Probation Service

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

Assessment, Care in Custody and Teamwork

14. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

15. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

16. On 2 September 2021, Mr Scott Howley was remanded to HMP Hull for robbery offences. When he arrived, Mr Howley reported a history of heroin misuse and began a methadone detoxification programme. (Methadone is an opiate substitute.) He was diagnosed with anxiety, depression and a paranoid personality disorder and prescribed quetiapine (medication for schizophrenia, bipolar disorder and major depressive disorders) for this.

17. On 2 February 2022, Mr Howley was sentenced to 60 months in prison.

18. From September 2021 to September 2022, Mr Howley was transferred to several prisons where prison staff monitored him under suicide and self-harm prevention procedures (known as ACCT). Mr Howley's last ACCT was started in March 2022, when he told staff that he had tried to take his life by suffocation. Staff closed the ACCT procedures in May 2022.

19. On 1 September 2022, Mr Howley was transferred to HMP Wealstun. Healthcare staff noted his mental health diagnoses and continued the quetiapine prescription. Mr Howley told staff that he had attempted suicide by hanging and suffocation within the last two months. He said that he had no suicidal or self-harm thoughts at the current time. Staff referred Mr Howley to the mental health team and substance misuse team. Mr Howley was also referred to a consultant psychiatrist.

20. From September 2022 to November 2023, Mr Howley continued to be supported by the mental health and substance misuse teams. He was seen regularly by healthcare staff. He completed his detoxification and was no longer prescribed methadone. Mr Howley remained under the care of a consultant psychiatrist for mental health assessments.

21. On 30 November 2023, Mr Howley told a GP at Wealstun that he felt tired all of the time and experienced persistent suicidal thoughts. The GP diagnosed depression and prescribed sertraline (antidepressant medication).

22. On 29 December, a GP reviewed a recent ECG (a scan of the heart) that Mr Howley had received. Mr Howley reported no cardiac symptoms, but the GP noted that the ECG identified Q-waves (which might indicate a previous heart attack or cardiac incident).

23. On 15 January 2024, Mr Howley had a joint psychology and mental health assessment. He told healthcare staff that he had experienced thoughts of suicide and self-harm since he was nine years old. Mr Howley said that he had these thoughts daily and had previously acted on them, having last attempted suicide in 2022. He said that he last harmed himself the previous week, by cutting his leg. Mr Howley said that he acted on the thoughts about twice a week and had recently stabbed himself with a plastic knife in the arm. Healthcare staff asked Mr Howley if he had any current plans to harm himself or end his life. Mr Howley said he did not. Mr Howley said that he hoped to engage with cognitive behavioural therapy (CBT- talking therapy that can manage problems by changing ways of thinking and behaving) in the community to address the thoughts he was having.

24. Healthcare staff later discussed the assessment with safer custody staff, who agreed to see Mr Howley the next day and offer support. They recorded that they considered starting ACCT procedures but chose not to do so because Mr Howley said that he had “no intention to harm himself in the near future” (despite him saying that he acted on his thoughts of self-harm about twice a week).

25. Staff contacted Mr Howley’s community offender manager (COM and told her that Mr Howley did not wish to return to Bradford on release. They asked her to share information around Mr Howley’s self-harm so community teams would be aware. Healthcare staff arranged to have another session with Mr Howley in two weeks.

26. On the same day, the COM emailed the prison offender manager (POM) for a case handover as Mr Howley was close to his release date. They discussed the support Mr Howley would require on release, and his plans when he was released.

27. On 30 January, Mr Howley attended a review appointment with healthcare staff following a joint session with the psychologist. He was provided with information on "coping with suicidal thoughts" and a "safety plan" worksheet, which he was encouraged to read. Mr Howley said he understood concerns around his reported self-harm but was adamant he did not want to kill himself and that he harmed himself as a "release". Mr Howley discussed his release plans with healthcare staff and told them it was difficult to plan as he still did not know where he would be living. Staff agreed to provide community support information for both Bradford and Leeds, which Mr Howley could access on release.

28. On 30 January also, the COM introduced herself by telephone to Mr Howley. Mr Howley spoke about his plans once he was released, and what support he would require on release. Mr Howley told her he did not have accommodation and she said she could make a housing referral for him. Mr Howley said he would receive Universal Credit and would apply for a Personal Independence Payment (PIP) once he was out of prison. Mr Howley told her that his mental health was "okay for now”.

29. The COM said that after the case handover on 30 January, the POM sent her an email to make her aware that Mr Howley had harmed himself approximately two weeks previously. As a result of this, the COM said she made additional licence conditions for Mr Howley prior to release, so he could be supervised and get the help he needed in the community. They included support for his psychological and medical issues, and drug and alcohol misuse. She made a CAS3 referral (provides accommodation to people on probation at risk of being homeless upon being released from prison or as part of their resettlement) for Mr Howley and communicated with the POM on this.

30. On 12 February, Mr Howley attended an ECG appointment. There was no GP review of the results before Mr Howley was released, and it is unclear when the results were received at Wealstun.

31. On 20 February, Mr Howley met with healthcare staff for a review appointment. He told them he was meant to have a phone call regarding housing the previous week but was not contacted. Staff said they would email St Giles Trust (a national charity providing advice, training and support) to find out what happened and if the

call had been rearranged. Mr Howley said that he thought he would have to live in Bradford on release but wanted to move to Leeds, where he had friends.

32. Healthcare staff told Mr Howley they would provide community support information for both Bradford and Leeds, so that he knew how to contact community mental health teams and other support services in both areas. They advised Mr Howley of the importance of accessing community support and continuing to work towards goals, short and long term, following his release. The mental health team reviewed Mr Howley and gave him printouts of his two most recent psychiatrist entries from his treatment record to provide to his community GP on release.

33. On 26 February, probation staff provisionally allocated Mr Howley single occupancy CAS3 accommodation in Halifax. (There was no accommodation available in Bradford at the time.) This accommodation was confirmed the next day.

34. On 29 February, Mr Howley was released from prison on licence. He was issued 56 quetiapine tablets on the morning of his release (a four-week supply) and was also given sertraline. Mr Howley was no longer supported by the drug and alcohol recovery service (DARS) at Wealstun so did not receive a naloxone kit on release.

Post Release

35. On 29 February, Mr Howley attended his initial probation appointment with his COM, where he presented well and appeared happy to be out of prison. She spoke to Mr Howley about his accommodation in Halifax. She said that Mr Howley seemed happy with the accommodation and said that he knew the area. She went through an induction pack with Mr Howley that he completed.

36. The COM went through Mr Howley's release licence and the consequences of not complying. Mr Howley was next due to attend a probation appointment on 6 March. As he was subject to weekly reporting, she told Mr Howley that she would send a travel warrant to his address for the appointment, so he did not struggle financially getting to the office.

37. The COM told us that Mr Howley did not attend his appointment on 6 March. It does not appear that he made any contact with community mental health services following release.

Circumstances of Mr Howley's death

38. On 6 March, the COM contacted housing support staff when Mr Howley did not attend his appointment. They found him unresponsive in his flat. There were multiple empty packs of quetiapine, with 56 tablets missing. The post-mortem report stated that Mr Howley left notes indicating suicidal intent. (We have not seen copies of these notes.)

Post-mortem report

39. The post-mortem report concluded that Mr Howley died of quetiapine toxicity, with ischaemic heart disease (heart weakening caused by reduced blood flow to the heart) a secondary condition that contributed to but did not cause the death.

40. The toxicologist noted that Mr Howley's blood quetiapine concentration was much higher than the usual therapeutic range but a little lower than the range usually encountered in deaths attributed to quetiapine use alone. They also identified evidence of recent cocaine use. Sertraline was present within the therapeutic range.

Findings

Identifying the risk of suicide and self-harm

41. Prison Service Instruction (PSI) Prison Service Instruction (PSI) 64/2011, which was in place at the time of Mr Howley's death, governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

42. Mr Howley had several risk factors for suicide and self-harm. He had a history of harming himself and had previously attempted to take his life in prison. He had a history of mental-ill health, for which he was prescribed medication. Mr Howley also had a history of substance misuse and completed a detoxification programme in prison.

43. In January 2024, Mr Howley told healthcare staff that he had daily thoughts of suicide and self-harm and that he acted on these around twice a week. He said that he had recently harmed himself by cutting his leg and stabbing himself in the arm. Prison and healthcare staff considered whether to start ACCT procedures but recorded that they did not do so because he did not have any immediate plans to harm himself or end his life.

44. It is right that prison and healthcare staff considered whether to start ACCT procedures in light of this information. However, their conclusion was based on Mr Howley's suggestion that he had no current intention to harm himself, which contradicted his statement that he thought about harming himself every day and acted on this twice a week. Mr Howley's recent self-harm, together with his statements, history and other risk factors, should have led staff to start ACCT procedures. This would have allowed them to identify, consider and address the factors that led to Mr Howley's thoughts of suicide and self-harm in a multi-disciplinary environment.

45. Mr Howley was released from prison around six weeks later with 56 quetiapine tablets, which he seemingly took shortly afterwards to harm himself or deliberately end his life. While there was some good practice, including identifying his history of self-harm to his COM, had Mr Howley's recent risk been properly identified and ACCT procedures started then this might have led to a wider discussion about whether it was safe to release him with such a quantity of medication. We make the following recommendation:

    The Governor and Head of Healthcare should issue guidance to staff to ensure that they properly consider and record the range of risk factors when a prisoner harms themselves, and that they always start ACCT procedures unless there has been a significant change in circumstances and risk since the self-harm.

Referrals to community services

46. Mr Howley had a history of substance misuse and mental health issues. He engaged with substance misuse support in Wealstun, and successfully completed a methadone maintenance programme. At the time of his release he was no longer under the care of Wealstun's drug and alcohol team. Nevertheless, his community offender manager identified drug and alcohol requirements in his licence.

47. Around a week before his release, mental health staff at Wealstun reviewed Mr Howley. At the time, he did not have confirmed release accommodation, which meant referring him to community mental health services was difficult as it was not certain to which area they should direct the referral. Healthcare staff provided Mr Howley with contact details for community teams in two areas in which he expected to live and gave him copies of his most recent psychiatrist reviews to share with community services. This also meant that Mr Howley was released with a four-week supply of medication, to ensure he had sufficient supply until he could arrange a community prescription.

48. Mr Howley had several mental health diagnoses, was prescribed antipsychotic medication and was under the care of a psychiatrist in prison. It is not unusual that release accommodation is only identified very close to a prisoner's release date, which makes referrals to community services difficult. It is not ideal that prisoners on the caseload of the mental health team – especially those with complex histories – are released without identified community support and this investigation highlights the particular challenges faced by prison mental health teams in these circumstances.

Inquest

49. The inquest into Mr Howley's death concluded on the 21 August 2025. The coroner confirmed that Mr Howley's death was drug related.

Adrian Usher
Prisons and Probation Ombudsman **October 2025**

Prisons & Probation Ombudsman
Independent Investigations

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

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

T I 020 7633 4100