Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Darren Boamah, a prisoner at HMP Wormwood Scrubs, on 3 January 2024

## A report by the Prisons and Probation Ombudsman

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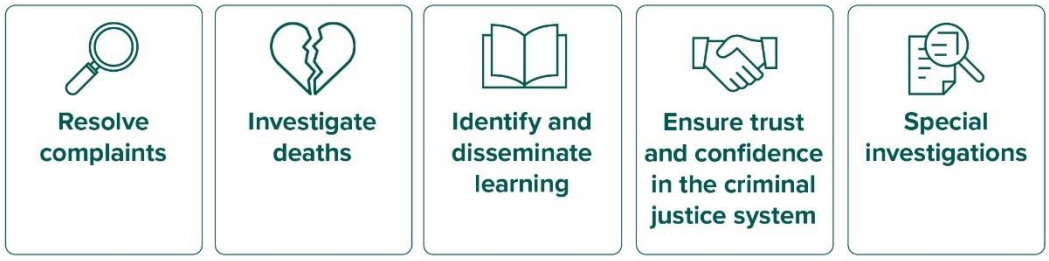
## OUR VISION

**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 Darren Boamah was found dead in his cell at HMP Wormwood Scrubs on 3 January 2024. The post-mortem examination found that his cause of death was Sudden Death in Epilepsy. He was 32 years old. I offer my condolences to Mr Boamah's family and friends.

Mr Boamah had been in prison for only six days. He had been diagnosed with epilepsy but was not taking his medication.

The clinical reviewer concluded that the care Mr Boamah received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community.

Wing staff did not know that Mr Boamah had epilepsy. Although it may not have altered the outcome in this case, I consider that more should be done to make prison staff aware of prisoners with serious, potentially life-threatening medical conditions, particularly if they are not taking their medication.

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** **October 2024**

# Contents

# Summary

## Events

1. On 28 December 2023, Mr Darren Boamah was remanded to HMP Wormwood Scrubs for alleged indecent exposure and possession of cannabis. It was not his first time in prison.

2. During his initial health screen, Mr Boamah told the nurse that he had epilepsy. He said he had had an epileptic seizure around two weeks before. Mr Boamah said he was not taking his medication.

3. On 29 December, Mr Boamah refused a secondary healthcare screening. A GP saw him later that day and Mr Boamah agreed to have some blood tests which, due to a liver condition he had, were needed before the GP could prescribe any medication. Mr Boamah said he did not want to take any medication and told the GP he could not remember when he had last had an epileptic seizure.

4. At 1.45am on 3 January 2024, Mr Boamah pressed his emergency cell bell. When an officer responded, Mr Boamah showed her that the pipe under his sink was broken and the cell was flooding. Staff tried to turn off the water supply but hot water continued to flow into the cell. The officer reported the issue to managers. Mr Boamah remained in his cell and staff checked on him throughout the rest of the night. CCTV shows that an officer last checked on Mr Boamah at 5.16am. The officer said she checked on him again at around 6.50am, before she went off duty, and recorded this in the observation book but the CCTV shows she did not. The observation book, along with other documentation relating to Mr Boamah, has been lost according to the prison.

5. At around 7.55am, two managers went to Mr Boamah's cell to assess the situation with a view to moving him. When they got to the cell, they found Mr Boamah lying on his bed, unresponsive. Staff called a medical emergency code. Healthcare staff arrived shortly afterwards, moved him from the cell onto the landing, and started CPR. Staff stopped CPR at 8.05am when they realised that Mr Boamah had signs of rigor mortis. Paramedics arrived shortly afterwards and confirmed that Mr Boamah had died.

6. The post-mortem report concluded that Mr Boamah's cause of death was Sudden Death in Epilepsy.

## Findings

7. The clinical reviewer concluded that the care Mr Boamah received at Wormwood Scrubs was equivalent to that which he could have expected to receive in the community.

8. Wing staff were unaware that Mr Boamah had epilepsy and was not taking his medication. We are aware that other prisons have information sharing protocols in place for prisoners with epilepsy so that wing staff are aware. While we do not know if this knowledge would have resulted in a different outcome for Mr Boamah, we consider that healthcare staff at Wormwood Scrubs need to consider sharing

information with prison staff about prisoners with serious health conditions, such as epilepsy, particularly when they are not taking their medication.

9. The officer's claim that she checked on Mr Boamah at 6.50am is not corroborated by CCTV. She said she had recorded this check in the observation book. It is possible that the officer misremembered the time of her check. If she did record a check at 6.50am that she did not do, that would be a serious conduct matter. We have been unable to check what she recorded as the observation book, along with other documentation relating to Mr Boamah, has been lost according to the prison. This is unacceptable and should be investigated.

10. Mr Boamah was not moved from his cell even though hot water continued to flow in. Although the conditions in Mr Boamah's cell were unsatisfactory, we accept that it was difficult for staff to move him during the night and that they were planning to reassess the situation in the morning to see if they could move him then. We consider that the staff response to the situation was appropriate in the circumstances. We found no clear evidence that the conditions in Mr Boamah's cell contributed to his death.

## Recommendations

- The Governor and Head of Healthcare should review their information sharing protocol for prisoners with serious medical conditions such as epilepsy.

- The Governor should investigate what led to the documentation about Mr Boamah being lost and ensure that documentation is retained and stored securely in future.

# The Investigation Process

11. HMPPS notified us of Mr Boamah's death on 3 January 2024.

12. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

14. NHS England commissioned an independent clinical reviewer to review Mr Boamah's clinical care at the prison.

15. The investigator and another PPO investigator interviewed four members of staff at the prison in April 2024.

16. We informed HM Coroner for West London of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr Boamah's sister to explain the investigation and to ask if the family had any matters they wanted us to consider. Mr Boamah's sister wanted to know what happened in the days leading to her brother's death and what duty of care the prison had towards him. We have addressed these issues in the report.

18. We shared our initial report with Mr Boamah's sister. She did not raise any factual inaccuracies.

19. We shared our initial report with the Prison Service. The Prison service did not raise any factual inaccuracies with our report.

# Background Information

## HMP Wormwood Scrubs

20. HMP Wormwood Scrubs is a category B local male prison. The prison accepts sentenced and remand prisoners over the age of 21 as well as young adults (18-21 years old) on remand only. The prison has five main wings, with two wings providing single-cell accommodation.

21. Practice Plus Group (PPG) provides primary healthcare services and Barnet, Enfield and Haringey NHS Mental Health Trust provides mental health services.

## HM Inspectorate of Prisons

22. The last inspection of Wormwood Scrubs was in June 2021. Inspectors found that there had been improvement since their previous inspections in 2017 and 2019, with a calm, well-ordered and safer atmosphere. The first night centre provided a reasonably welcoming environment where staff were friendly and approachable. The peer-led induction covered essential information well, and a more in-depth programme was planned as the COVID-19 pandemic restrictions were eased. A telephone call was provided to new arrivals and welfare checks were conducted every hour during the first night. Considerable work had been undertaken to improve the assessment and care of new arrivals by healthcare staff, although there were some difficulties in ensuring that interviews were always private. However, initial risk screenings completed by reception staff were brief and not followed up with more in-depth interviews in the first night centre.

23. Health services were well led by a strong management team. Most clinics had restarted since the COVID-19 pandemic and had reasonable waiting times. The management of long-term conditions had improved but support for some patient groups was insufficient and care plans were not sufficiently personalised.

## Independent Monitoring Board

24. 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 May 2023, the Board was concerned that the prison had become increasingly short of space due to an increase in operational capacity and population pressures on the wider prison estate.

25. The Board noted that the prison managed increasing numbers of vulnerable prisoners as well as prisoners with complex, serious mental and physical health needs. Staff shortages and staff turnover adversely impacted the provision of an effective mental health service, as well as the provision of therapeutic services, support, and interventions to many vulnerable prisoners. Staff shortages also resulted in the cancellation of medical appointments, although the position had improved since the last reporting year.

## Previous deaths at HMP Wormwood Scrubs

26. Mr Boamah was the 15th prisoner to die at Wormwood Scrubs since January 2021. Of the previous deaths, six were self-inflicted, six were from natural causes, one was drug related and one is currently unascertained.

27. In a previous investigation into a death in November 2021, the prison was unable to locate the wing observation book which meant we could not verify staff's accounts. We recommended that the prison should ensure all information relating to a death in custody is secured and made available to the PPO. The prison's action plan said that the Head of Residence and Head of Security were undertaking a review of the process for storing wing observation books to ensure they were archived and stored as required.

# Key Events

28. On 28 December 2023, Mr Darren Boamah was remanded to HMP Wormwood Scrubs for alleged indecent exposure and possession of cannabis. Mr Boamah had been in prison before and was last released in 2020. Prior to his remand, the Liaison and Diversion Team tried to assess his mental health needs and his suitability for custody but he refused to engage. (Liaison and Diversion services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system.)

29. During his initial health screen at Wormwood Scrubs, Mr Boamah told the nurse that he had epilepsy, a liver condition, and mobility issues due to muscle mass loss in his legs. He also had a history of mental health and substance misuse issues and a learning disability. Mr Boamah told the nurse that he was not taking any medication for his physical or mental health conditions. He said that he thought he had had an epileptic seizure around two weeks before, but he could not remember exactly. He said he had not lost consciousness during his last seizure.

30. Mr Boamah told staff that he had been an in-patient at a mental health hospital in 2019 after attempting suicide. Staff noted he was reluctant to engage fully about his mental health issues, but he told them he experienced frightening visual hallucinations and heard voices. Mr Boamah said that he did not like it when it was quiet and preferred to have distractions. He said he often struggled to sleep and used cannabis to help with this.

31. Staff made referrals to the mental health and substance misuse teams and requested a medication review with the GP. Staff noted that they provided Mr Boamah with a vape pen and offered him a phone call which he refused. Following his induction, staff moved Mr Boamah to a single cell on the first night centre. (Records indicate that Mr Boamah was assessed as high risk for cell sharing. The Cell Sharing Risk Assessment Form was not provided to the investigator as the prison said that it, along with other documentation relating to Mr Boamah, had been lost.)

32. On the morning of 29 December, a nurse tried to carry out a secondary healthcare screening with Mr Boamah but he refused. The nurse returned with a GP who knew Mr Boamah from a previous sentence. The GP spoke to Mr Boamah who told him that he was not taking any medication. Mr Boamah agreed to have the secondary healthcare assessment later that day. The GP contacted the hospital responsible for monitoring Mr Boamah's liver condition in the community. The hospital confirmed that Mr Boamah would need to have blood tests before starting any medication.

33. At around 11.00am, an occupational therapist tried to carry out an assessment with Mr Boamah but he refused. The occupational therapist noted that she would try to see him at a later date.

34. At 2.20pm, the GP saw Mr Boamah, who agreed to have some blood tests. Mr Boamah said he did not want to take any medication. Mr Boamah told the GP that he had not had a seizure for a long time.

35. On 2 January 2024, a substance misuse worker tried to carry out an assessment with Mr Boamah but could not do so as he was asleep.

## Events of 3 January

36. On 3 January, an officer responded to Mr Boamah's cell bell at around 1.45am. In interview, the officer said that Mr Boamah pointed underneath the sink and told her to fix it. She then realised that water was flowing from the sink onto the floor. She said that Mr Boamah then pulled the pipe under the sink, causing the water to gush out. The officer said she asked Mr Boamah why he had broken the pipe and he laughed. She said she went to report the damage and get some help.

37. The officer said that she reported the incident to the orderly officer and staff attended to turn off the water supply to the cell. However, they were unable to fully turn off the hot water and the cell was warm. The officer said that Mr Boamah said he wanted to come out of the cell but, when she said he could not because there were no available cells to move him to, he used his television to break the viewing panel on the cell door. The officer said that he then took in some air from outside and seemed fine. She said that, due to the condition of his cell, she continued to check on him at various times throughout the night. Checks by the officer and other staff members can be seen on CCTV footage.

38. CCTV shows that the officer last looked into Mr Boamah's cell at around 5.16am. The officer told the investigator that she had checked him at around 6.50am before she went off duty and would have signed the observation book to confirm this. She said she saw him dancing around in his cell and had no concerns about him. The investigator was unable to check what was written in the observation book as the prison said this had been lost along with other documentation.

39. At around 7.55am, two prison managers attended the first night centre to assess the situation with a view to moving Mr Boamah from the damaged cell. When they got to the cell, they found Mr Boamah lying on his bed, unresponsive. One prison manager called a code blue (an emergency code which tells the control room that a prisoner is unconscious and that an ambulance is required immediately).

40. Healthcare staff arrived promptly, and staff moved Mr Boamah onto the landing before starting CPR. The Head of Healthcare said that Mr Boamah was warm due to the temperature in the cell, so it was difficult to tell if he was already dead. However, she soon noticed signs of rigor mortis and told staff to stop CPR at around 8.05am. Paramedics arrived shortly afterwards and confirmed that Mr Boamah had died.

## Contact with Mr Boamah's family

41. Mr Boamah did not provide next of kin details when he arrived at the prison. After making enquiries and visiting possible addresses for Mr Boamah's family members, staff eventually traced his sister. A prison manager spoke to Mr Boamah's sister on the telephone on 10 January and told her that her brother had died. The prison service contributed to Mr Boamah's funeral expenses in line with national instructions.

## Support for prisoners and staff

42. A prison 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.

43. The prison posted notices informing other prisoners of Mr Boamah's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Boamah's death.

## Post-mortem report

44. The post-mortem report concluded that Mr Boamah died from Sudden Death in Epilepsy. Toxicology tests found that Mr Boamah had used cannabis at some time prior to his death.

# Findings

## Clinical care

45. The clinical reviewer concluded that the care Mr Boamah received was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community. She found that Mr Boamah underwent appropriate assessment of his physical health conditions at the time of his reception screening. Appropriate, specialist clinical advice was sought prior to commencement of medication, however, Mr Boamah died before this could be actioned.

## Location

46. Mr Boamah was in a single cell. We understand that in some prisons, best practice is for prisoners with epilepsy to share a cell so that if they have a seizure, their cellmate can use the emergency cell bell to summon help. It appears from the records that Mr Boamah was assessed as high risk for sharing a cell but the reasons for this are not clear as the Cell Sharing Risk Assessment (CSRA) form has been lost. We are unable to say whether the decision to place him in a single cell was appropriate given that we have not had access to his full documentation.

47. Staff left Mr Boamah in his cell after it was flooded, and hot water continued to flow in as staff were unable to fully turn off the hot water supply. Although the conditions in Mr Boamah's cell were unsatisfactory, we accept that staff were unable to move him during the night because there were no suitable cells available in the prison. Mr Boamah did not appear distressed about being in the cell and we are aware that staff were planning to reassess the situation in the morning and potentially move him then. We consider that the staff response to the situation was appropriate in the circumstances. We found no clear evidence that the warm conditions contributed to Mr Boamah's death.

## Information sharing

48. Staff on the first night centre were unaware that Mr Boamah had epilepsy and was not taking his medication. We are aware that other prisons have a protocol for information sharing between healthcare and prison staff to ensure that wing staff are aware of potential risks to prisoners who have serious medical conditions. We do not know whether this knowledge would have changed the outcome for Mr Boamah, but we consider that it is important for wing staff to know if a prisoner has a serious, potentially life-threatening medical condition, particularly if they are not taking their medication. We recommend:

    **The Governor and Head of Healthcare should review their information sharing protocol for prisoners with serious medical conditions such as epilepsy.**

## Missing documentation

49. Documentation relating to Mr Boamah's transfer from court and his early days in custody, including his CSRA and the wing observation book, were not provided to the investigator as the prison said they had been lost.

50. The lack of observation book meant that we were unable to verify whether the officer had recorded that she had completed a check at 6.50am. CCTV shows that the last check was at 5.16am. If the officer signed for a check at 6.50am that she did not do, then this is a serious matter. Alternatively, she may have misremembered the time and signed only for the 5.16am check. Either way, the missing documentation is concerning and should be investigated. A death in custody cannot be properly investigated if the prison has lost important documentation relating to that prisoner.

51. In a previous investigation into a death at Wormwood Scrubs in November 2021, the wing observation book could not be located. The prison told us that they were reviewing how observation books were stored. It is unacceptable that this has happened again. We recommend:

    **The Governor should investigate what led to the documentation about Mr Boamah being lost and ensure that documentation is retained and stored securely in future.**

## Inquest

52. The inquest, held on 10 June 2025, concluded that Mr Boamah died from natural causes.

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