Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Francis Boateng a prisoner at HMP Elmley on 31 January 2017

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*

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Boateng was found hanged in his cell at HMP Elmley on 31 January 2017. Mr Boateng was 34 years old. I offer my condolences to Mr Boateng's family and friends.

Mr Boateng, who had received an indeterminate sentence, had been released from prison on licence but was recalled to HMP Elmley on 28 January 2017. He was upset and agitated at being recalled, unclear what this meant for him, and in Reception refused to comply with the process and had to be restrained. He was referred to the mental health team for assessment for further support. He had never previously been judged to be at risk of harming himself and gave nobody any indication that he was a threat to himself.

It is troubling that the mental health team were unaware that Mr Boateng had been recalled as an indeterminate-sentenced prisoner, which can increase the stress on those recalled to prison. There is, however, no suggestion that Mr Boateng's death could have been prevented or that anyone could have anticipated his actions.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **December 2017**

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Summary

Events

1. Mr Boateng was recalled to prison on 28 January and taken to HMP Elmley. He said he did not know why he had been recalled. He refused to comply with the reception process, and was eventually restrained by staff and taken to the Care and Separation Unit. Once there, Mr Boateng became calm and was taken to the first night houseblock where he continued the reception process. He was given a health screening and, as he had been prescribed anti-depressant medication, the nurse offered him a referral to the mental health team. Mr Boateng declined this. However, one of the prison officers who had spoken to Mr Boateng in reception was concerned that he might need support and submitted a referral to the mental health team.

2. The following day, a prison doctor saw Mr Boateng to confirm his prescribed medication. She tried to ascertain why he was on the combination of medicines he had been prescribed, but Mr Boateng would not answer her questions. She had some concerns at his behaviour, but as the prison officer had already submitted a mental health referral, she did not repeat the referral. She arranged to see Mr Boateng again two weeks later.

3. The mental health team considered the referral but decided that Mr Boateng did not need their help at that stage. They wrote to him informing him of this and noted where he could get help if he felt that he needed it.

4. On 31 January, Mr Boateng told prison officers that he needed to speak to his offender manager in the Probation Service. The officers arranged this and that afternoon he spoke to his offender manager. She explained to him why he had been recalled to prison. Mr Boateng asked how long he would be there and she said that as he was an indeterminate-sentenced prisoner (that is, given a sentence that was not of a specified length) she was not able to say. She said she would contact him within two weeks to work with him further.

5. The prison officer who sat with Mr Boateng during the call said that while he was initially agitated, he became calmer as the call progressed. After the call, he seemed more settled and returning to his cell, was talkative and grateful to staff.

6. Approximately three-quarters of an hour later, prisoners were being unlocked to collect their evening meals. When a prison officer unlocked Mr Boateng's cell he found him hanging. The officer shouted for a colleague to press the alarm, lowered Mr Boateng to the ground and began to provide first aid. He was joined by colleagues including medical staff, but they were unable to revive Mr Boateng.

Findings

Risk assessment

7. Mr Boateng had been in prison before, but had never been assessed as presenting a risk of harming himself. On arrival at Elmley he received a comprehensive health screening from a mental health nurse, who saw no indication that he was a threat to himself. A prison officer referred Mr Boateng to

the mental health team for additional support but not from any fear that he might harm himself. When Mr Boateng told a prison officer that he was struggling to cope, she asked him whether he needed the support of Prison Service procedures for those at risk of harming themselves. Mr Boateng said he had no intention of harming himself.

8. There is evidence to suggest that prisoners being recalled to prison can be at increased risk of self-harm and the uncertainty of an indeterminate sentence can compound that risk. Limited information can cause additional distress, and Mr Boateng was upset that he did not know the reason for his recall or for how long he might be kept in prison. Reception staff at Elmley do not have a risk assessment checklist to indicate when prisoners might be at raised risk of self-harm.

Emergency response

9. The prison officer who found Mr Boateng hanging did not have a radio, so called to a colleague to raise the alarm. The colleague did so without knowing the nature of the emergency, so did not use a medical emergency code. Although it did not cause delay in medical assistance reaching Mr Boateng, it did cause a short delay in the prison requesting an ambulance. Additionally, although the prison officer who raised the alarm was carrying a radio, it was not working.

Healthcare

10. Mr Boateng had a good reception health screening and was offered the services of the mental health team. He was quickly referred to a doctor to confirm his medication. The doctor had some concerns at his behaviour but, as a prison officer had already made a mental health referral, she did not do so. Nor did she note her concerns on Mr Boateng's record. When the mental health team considered the referral they were therefore not aware of her concerns. Nor were they aware that Mr Boateng was a recalled indeterminate-sentenced prisoner. They assessed him as not needing their support at that stage.

Recommendations

- The Governor should ensure that there are mechanisms in place so that staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm.
- The Governor should ensure that sufficient staff carry working radios to enable them to call an emergency quickly.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including the correct use of emergency codes.
- The Head of Healthcare should ensure that all staff make appropriate notes in prisoners' records when they have concerns
- The Head of Healthcare should ensure that decisions around whether to offer mental health input are made with all risk factors taken into consideration.

The Investigation Process

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

12. The investigator visited Elmley and obtained copies of relevant extracts from Mr Boateng's prison and medical records. The houseblock where Mr Boateng lived was not covered by CCTV. He interviewed eight members of staff and two prisoners at Elmley in March and April. He remained in ongoing contact with the police officer in charge of the police investigation and had access to police witness statements.

13. NHS England commissioned a clinical reviewer to review Mr Boateng's clinical care at the prison. The clinical reviewer and the investigator conducted joint interviews of healthcare staff.

14. We informed HM Coroner for Mid-Kent and Medway of the investigation and he sent us the results of the post-mortem examination. We have given the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted solicitors acting on behalf of Mr Boateng's family, to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. The solicitors asked why Mr Boateng had been recalled to prison and enquired about the telephone call he made to his offender manager on 31 January. Mr Boateng's family's solicitors received a copy of our initial report, and did not offer any comments.

Background Information

HM Prison Elmley

16. HMP Elmley serves the courts in Kent and holds up to 1,252 men, remanded and sentenced, in six houseblocks, with a mixture of single, double and triple cells. The healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Elmley was conducted in October and November 2015. Inspectors reported that the prison had greatly improved, with a higher degree of safety and stability. Healthcare had improved since the last inspection. Risk assessment processes on arrival were regarded as sound, and incidents of self-harm had reduced by about a third.

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 31 October 2016, the IMB reported that while the prison had improved, there were still problems with staffing levels. Induction arrangements were good.

Previous deaths at HMP Elmley

19. Mr Boateng was the second prisoner to apparently take his own life at Elmley since 2014. In a number of previous investigations, we have made recommendations about the need for prison staff to use the required emergency code and to call an ambulance in a life-threatening situation. We have also previously raised the recording of risk factors in reception.

Indeterminate Public Protection Sentences (IPP)

20. Indeterminate public protection sentences were abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk.

Key Events

21. Mr Francis Boateng was remanded into custody in February 2007 and in February 2008 received an Indeterminate Sentence for Public Protection for manslaughter and conspiracy to rob. His tariff was set at four and a half years. He was released on licence in February 2015. During his time in prison he was not judged to be at risk of self-harm and was never managed under Prison Service procedures for those thought to be at risk.

22. Mr Boateng was issued with warning letters by the Probation Service in September 2015 and October 2016 for failing to attend appointments and not maintaining contact with his offender manager. The letters informed him that if he did not comply with the conditions of his licence - which included maintaining contact - then he risked being recalled to prison. Mr Boateng had some problems related to his accommodation and appeared in court on 25 January 2017 to address them. He had an appointment with his offender manager on 27 January. She tried to contact Mr Boateng to remind him that he had an appointment that day, but was unable to reach him. She sent a text message asking Mr Boateng to contact her, but he did not do so. She reported this to her manager and it was decided to recall Mr Boateng to prison.

23. On Saturday 28 January 2017 Mr Boateng arrived at HMP Elmley. On arrival, Mr Boateng said that he did not know why he had been recalled. Reception staff completed a cell sharing risk assessment, but the form does not show the level of risk Mr Boateng was judged to present. When a prison officer told him that they would need to photograph him, he refused. An officer tried for over an hour to persuade Mr Boateng to comply, without success. Mr Boateng remained polite, and staff decided to take him through the rest of the reception process and return to the photograph later. When staff asked him to take off his t-shirt to be searched, Mr Boateng refused. Staff restrained him and took him to the Care and Separation Unit.

24. An officer was concerned at Mr Boateng's behaviour and sent an urgent mental health referral form to the mental health team. He said in interview that he was not concerned that Mr Boateng might harm himself, but he seemed to be upset at being recalled to prison and might need some support.

25. A Supervisory Officer (SO), who was on duty on the Care and Separation Unit, said that Mr Boateng was agitated but appeared less concerned about being restrained than about not understanding why he had been recalled. He explained that when the Offender Management Unit staff returned on Monday they would give him his recall pack. This would include details of why he had been recalled. Mr Boateng calmed down, and was taken from the Care and Separation Unit to the first night centre to complete the reception process.

26. A nurse then gave Mr Boateng a reception health screening. He told her that he had been recalled to prison for missing probation appointments. As Mr Boateng had been prescribed antidepressant medication she offered him a referral to the mental health team, but Mr Boateng declined.

27. That evening Mr Boateng made a telephone call to his brother. He said that he was angry, and did not know for how long he would be back in prison.

28. On 29 January, Mr Boateng had a secondary health screening. He then saw a prison GP to confirm his prescribed medication. She noted that he had what she considered to be an unusual, though not dangerous, combination of anti-depressant medication and tried to ascertain why. Mr Boateng would not answer her questions but was concerned that he should receive his Mirtazapine because it helped him to sleep. She confirmed his prescription and booked a further appointment for two weeks' time. She discussed Mr Boateng's behaviour with an officer, who told her that he had made a referral to the mental health team.

29. On the afternoon of 29 January, an officer told Mr Boateng that he had made a referral to the mental health team, although Mr Boateng said that he did not need this. The officer said that he might not realise that he needed help, and Mr Boateng agreed that being recalled to prison was a traumatic time. He agreed to let the referral continue.

30. On the morning of 30 January, the mental health team assessed Mr Boateng's referral. They considered the fact that a mental health nurse had completed his reception health screening and not noted any mental health problems. Mr Boateng had also seen a prison GP, who had prescribed him antidepressant medication and not referred him to the mental health team. There had been no concerns that Mr Boateng was a risk to himself. A nurse wrote to Mr Boateng saying that the team did not think he needed the care of the mental health team at that stage. She offered him the opportunity to engage with them if he wanted to in the future and advised him of the support services available.

31. That morning, an officer took Mr Boateng to have his photograph taken and to collect any of the allowed property that he had left in reception. Another officer completed Mr Boateng's basic custody screening process. Mr Boateng was polite through the process but was agitated that he had been recalled. The officer advised him to contact his offender manager. The section of the screening form that addresses risks, including vulnerability or risk of self-harm is blank.

32. A custodial manager (CM) gave Mr Boateng his recall notification and held an induction interview. Mr Boateng was agitated about not knowing why he had been recalled, although he believed it was due to a missed appointment. The CM did not have any information about the recall. Mr Boateng was worried about his accommodation, and said that he had already spoken to the resettlement team about this. The report of the interview noted that nobody had explained the reasons for recall and ensuing process to Mr Boateng.

33. Later that day, Mr Boateng told an SO that he was struggling with being back in prison, and could not cope with the noise. She told him that he needed to allow himself time to readjust. She asked him if he wanted to see someone from the mental health team but he said not. She asked if he needed the support of ACCT procedures. (Assessment, Care in Custody and Teamwork is the Prison Service's system to support prisoners at risk of self-harm.) Mr Boateng said that he had no thoughts of harming himself and did not need ACCT support. That afternoon Mr Boateng spoke to a fellow prisoner. The prisoner said that while Mr Boateng was disappointed to be back in prison and concerned about his flat, he did not display any behaviour that caused him to be concerned about him.

34. On the morning of 31 January, Mr Boateng told an officer that he needed to speak to his offender manager but did not have enough credit on his telephone account. The wing manager arranged for him to make a call using the office telephone and at 2.30pm an officer took him to the office where he telephoned his offender manager. The call lasted approximately half an hour. She explained why his licence had been revoked. Mr Boateng asked if his recall was for a definite period. She said that as he was an indeterminate sentence prisoner, it was not and she did not know how long he would be in prison. He told her that he needed to make arrangements around his accommodation and finances. She said that she would be in touch with him about the arrangements for the next steps of his recall process within the following two weeks. The prison officer said that at the beginning of the call Mr Boateng had been frustrated and angry but as the call progressed, and he was able to discuss his situation, he relaxed.

35. Mr Boateng told the officer that he was grateful for having been allowed to make the call, and on the way back to his cell he went into wing manager's office to thank him. The officer said that he and Mr Boateng were making small talk on the way back to the cell, and that he had no concerns about Mr Boateng's wellbeing. He was talkative and more relaxed than before making the call, and wanted to get on with the administrative proceedings relating to his recall. The officer locked Mr Boateng in his cell at approximately 3.15pm.

36. Another prisoner was in the cell next to that of Mr Boateng. That afternoon, he was falling asleep on his bed when he heard knocking from the next cell. He assumed Mr Boateng wanted to speak with him, and made a mental note to do so when they were unlocked.

37. Officers began to unlock prisoners for their evening meals and, at approximately 3.55pm, an officer unlocked Mr Boateng's cell. He looked through the observation panel and saw Mr Boateng apparently sitting by the window, facing the door. As he opened the door, however, he saw that Mr Boateng was hanging from the window by a ligature made from a bed sheet. He was not carrying a radio so shouted to another officer to press the general alarm. The ligature was not tied but wrapped round Mr Boateng's neck a number of times. He unwrapped the ligature and lowered Mr Boateng to the ground. Mr Boateng was not breathing and he began to perform cardiopulmonary resuscitation (CPR). While he was doing so a nurse arrived with a defibrillator. The defibrillator could find no detectable heartbeat and advised them to continue to try to resuscitate him. Other staff responded to the alarm, and one of them radioed the control room to request an ambulance. Further nursing staff arrived and took over attempts to resuscitate Mr Boateng. They continued to do so until joined by ambulance staff. At 4.50pm, Mr Boateng was pronounced dead.

Contact with Mr Boateng's family.

38. One of the prison's managers was appointed as family liaison officer. Mr Boateng had not provided contact details for next of kin but the manager eventually managed to contact Mr Boateng's father and, subsequently, other members of his family.

Support for prisoners and staff

39. After Mr Boateng's death, the duty governor 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. Healthcare staff were unable to attend the debrief due to another emergency, so a separate debrief was held for them later that afternoon.

40. The prison posted notices informing other prisoners of Mr Boateng's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Boateng's death.

Post-mortem report

41. The post-mortem report showed that Mr Boateng died as a result of hanging. There was no sign of third party involvement. Toxicology reports did show traces of cannabis use but it was not possible to say whether this had been ingested before or after Mr Boateng's return to prison.

Findings

Reception

42. On reception into Elmley, Mr Boateng refused to have his photograph taken, and when being searched refused to take off his t-shirt. Reception staff devoted a good deal of time to trying to persuade him to do so. He was taken to the Care and Separation Unit, but as soon as he became calm staff took him back to the first night centre to complete his reception process.

Risk assessment

43. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others* (Safer Custody), and PSI 7/2015, *Early Days in Custody – Reception in, first night in custody, and induction to custody*, both list a number of risk factors and potential triggers for suicide and self-harm. These factors include being an indeterminate-sentence prisoner, and being a prisoner on licence recall. All staff who come into contact with prisoners are expected to be aware of these risk factors. We published a Learning Lessons bulletin in February 2016 on early days in custody, which again noted recall to prison being a known risk factor for self-harm, and that the limited availability of information to prisoners can increase distress.

44. Staff judgement is fundamental to assessing risk. The system relies on staff using their experience and skills, as well as local and national assessment tools. It is not an exact science. A mental health nurse gave Mr Boateng a comprehensive reception health screening. She had no concerns that he was a threat to himself. An officer referred Mr Boateng to the mental health team but said in interview that he had no concerns that he was at risk of self-harm, only that he might benefit from some support. The investigator interviewed two prisoners who spoke to Mr Boateng, and while Mr Boateng was disappointed to be back in prison, neither had any sense that he might harm himself. A SO said that when Mr Boateng told her he was struggling with being back in prison she asked him if he wanted the support of ACCT procedures. He said he had no thoughts of harming himself. His offender manager said that during her telephone call with him on the afternoon of 31 January, Mr Boateng had said that he felt low and was struggling with prison. However, she got no indication that he was a risk to himself and nothing in their telephone call gave her any cause for concern as regards his wellbeing.

45. There would appear to be no reason for staff who had dealings with Mr Boateng to have identified him as being a risk to himself. Even the officer who was concerned about his behaviour had no fear that he posed a threat of self-harm. Prison staff could not have anticipated Mr Boateng's actions on 31 January.

46. There were, however, gaps in the risk assessment process. Reception staff at Elmley do not have a set risk assessment pro forma or list of criteria that could highlight prisoners who might be at raised risk of self-harm. The section of the basic custody screening form addressing risks was left blank. A note on Mr Boateng's electronic record stated "documentary evidence suggests that he should be high risk" of sharing a cell, but his cell sharing risk assessment form does not indicate the level of risk he was judged to present.

The Governor should ensure that there are mechanisms in place so that staff consider and record all the known risk factors of a newly-arrived prisoner when determining risk of suicide or self-harm.

Emergency response

47. Prison Service Instruction 03/2013, *Medical emergency response codes,* states that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly states that control room staff should automatically call an ambulance whenever an emergency code is called. Elmley uses the emergency codes 'blue' and 'red' to meet the requirements of PSI 03/2013. Code blue means a prisoner is unconscious or having difficulty breathing, code red means that a prisoner is losing blood.

48. An officer not carrying a radio found Mr Boateng hanging so he called to his colleague to press the general alarm. The colleague was not aware of the nature of the emergency when he did so. When he arrived at the cell he found that his radio had switched itself off. Radio traffic in Elmley is not recorded, so we have been unable to ascertain what messages were relayed. However, the control room log does not indicate that an emergency code was used. None of the statements staff made in their notebooks detailing their part in the emergency response include reference to a code blue call, only the general alarm. The control room log shows that the general alarm was activated at 3.55pm, and the ambulance was called at 3.59pm.

49. The first officer said that there were only limited numbers of staff radios on each houseblock, and not all members of staff carry one. The second officer said that he did have a radio but when he went to use it, it had turned itself off. He said that this does sometimes happen with these radios.

The Governor should ensure that sufficient staff carry working radios to enable them to call an emergency quickly.

50. The first officer, a trained first aider, immediately began to try to resuscitate Mr Boateng, and was quickly joined by medical staff. Nevertheless, the lack of a code blue call meant that there was a delay of some four minutes in requesting an ambulance. Time can be critical in a medical emergency and it is important that prison staff understand their roles. We have made several previous recommendations to Elmley about proper procedures being followed in medical emergencies. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including the correct use of emergency codes.

Healthcare

51. On reception, Mr Boateng was given a comprehensive health screening. He was offered the services of the mental health team but declined. He was quickly referred to a prison GP to confirm his prescribed medication. The clinical reviewer noted that there was little evidence of Mr Boateng presenting a suicide

risk and that he was offered mental health input. She wrote that he received healthcare equivalent to that which he could have expected in the community.

52. A prison GP was unable to clarify with Mr Boateng why he had been prescribed two separate anti-depressant drugs, Mirtazapine and Citlapram. It is not unusual for patients to be prescribed different anti-depressant medicines as they can address different issues. These two are not dangerous when prescribed together, and the clinical reviewer is content that the GP's actions were reasonable. The GP booked an appointment to see him again two weeks later. She noted potential mental health concerns in his record but, having been told that an officer had made a mental health referral, did not do so herself nor did she write up her concerns in his records.

53. When the mental health team considered the officer's referral, they were therefore unaware of the GP's concerns. Nor were they aware that Mr Boateng had been recalled as an indeterminate-sentence prisoner. Without seeing him, they decided that he did not need mental health input. They wrote to him saying so, and pointing out that he could request help if he felt he needed it.

54. The mental health team made their decision without seeing Mr Boateng, without being fully aware of the GP's concerns, and without knowing that Mr Boateng had particular risks as a recalled indeterminate-sentence prisoner. It was therefore unaware of the additional stress he was under. We make the following recommendations:

The Head of Healthcare should ensure that all staff make appropriate notes in prisoners' records when they have concerns.

The Head of Healthcare should ensure that decisions around whether to offer mental health input are made with all risk factors taken into consideration.

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Independent Investigations

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