

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Boxall, a prisoner at HMP Elmley, on 22 May 2020

A report by the Prisons and Probation Ombudsman

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 Daniel Boxall died on 22 May 2020 from aspiration of vomit after taking illicit drugs at HMP Elmley. He was 37 years old. I offer my condolences to Mr Boxall's family and friends.

HM Inspectorate of Prisons highlighted the easy availability of drugs at Elmley when they last inspected the prison in April and May 2019. While Elmley has strengthened its drugs strategy, Mr Boxall's death highlights the need for continued vigilance.

My investigation identified delays and other concerns with the emergency response. The delays did not affect the outcome for Mr Boxall, but they could make a critical difference in a future medical emergency.

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

Sue McAllister CB
Prisons and Probation Ombudsman

October 2021

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Summary

Events

1. Mr Daniel Boxall arrived at HMP Elmley in the early hours of 20 May 2020. He arrived from hospital where he had been treated following his arrest.
2. Mr Boxall had a long history of drug misuse and he gave a urine sample later that day that was positive for cocaine, opiates and methadone.
3. On 21 May, a substance misuse worker was suspicious of the way Mr Boxall appeared to be interacting with other prisoners. When she heard about Mr Boxall's death, she made a retrospective entry in the wing observation book.
4. At 5.46am on 22 May, an Operational Support Grade (OSG) was making a roll check when she saw Mr Boxall lying against the side of his bed in an awkward position. She could see no signs that he was breathing, and she thought he was probably dead. She radioed for the night orderly officer (NOO) to attend but did not go into the cell. The NOO asked the communications room to call an emergency ambulance.
5. The NOO and other officers reached Mr Boxall's cell at 5.50am and went in but did not move him.
6. A nurse arrived at 5.53am. Mr Boxall was in the same position as when staff found him. Officers moved Mr Boxall and the nurse noted that he was cold and had stiffness in his jaw (a sign of rigor mortis). She started giving cardiopulmonary resuscitation (CPR) and then the officers took over. Ambulance paramedics arrived at 6.43am and they pronounced Mr Boxall dead 15 minutes later.
7. Post-mortem examination and toxicology tests showed that Mr Boxall died from aspiration pneumonitis and airways obstruction in association with misuse of psychoactive substances (PS) and polydrug use.
8. While staff were trying to resuscitate Mr Boxall, they discovered 20 wraps of cocaine hidden on his person.

Findings

9. Mr Boxall continued to use psychoactive substances (PS) and other drugs in prison despite being warned of the dangers.
10. The substance misuse worker should have submitted a security intelligence report after observing Mr Boxall's suspicious behaviour.
11. The OSG did not use an emergency response code and did not go into Mr Boxall's cell when she found him unresponsive. The NOO did not call an emergency response code when the OSG contacted him about Mr Boxall. As a result, there was a delay before an ambulance was called and the prison nurse was not sure what equipment to take with her. This did not affect the outcome for Mr Boxall, as he was dead when he was found, but it could make a difference in future medical emergencies.

12. When officers arrived, they did not move Mr Boxall away from his bed.
13. There were indications that Mr Boxall was already dead when he was discovered, but inappropriate efforts were nevertheless made to try to resuscitate him.

Recommendations

- The Governor should continue to identify and address weaknesses in measures to prevent supply of drugs into Elmley and revise the substance misuse strategy in light of the findings.
- The Governor and Head of Healthcare should ensure that all staff, including healthcare staff, complete an intelligence report when a prisoner is noticed to be behaving or interacting with others in a suspicious manner.
- The Governor should ensure that all prison staff are made aware of, and understand their responsibilities during medical emergencies, including that staff:
 - understand and use the appropriate emergency code when they discover a medical emergency;
 - enter cells as quickly as possible in life-threatening situations where it is safe to do so;
 - move the prisoner away from any constricted area;
 - examine the prisoner for signs of life; and
 - commence CPR without delay unless there are signs that the prisoner is already dead.
- The Governor should share a copy of this report with the OSG and the NOO and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare staff fully understand the circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.
- The Head of Healthcare should share a copy of this report with the response nurse and arrange for her clinical supervisor to discuss the Ombudsman's findings with her.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. No-one responded.
15. The investigator obtained copies of relevant extracts from Mr Boxall's prison and medical records. She interviewed 11 members of staff at Elmley in September 2020. All of the interviews were conducted by telephone due to revised working practices during the COVID-19 pandemic. The investigation was subsequently reallocated to another investigator. He interviewed one further witness.
16. NHS England commissioned a clinical reviewer to review Mr Boxall's clinical care at the prison.
17. We informed HM Coroner for Mid Kent and Medway of the investigation. The Coroner gave us Mr Boxall's cause of death. We have given the Coroner a copy of this report.
18. The Ombudsman's family liaison officer contacted Mr Boxall's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Boxall's mother wanted to know whether her son rang his cell-bell and called for help at some time before he was found.

Background Information

HMP Elmley

19. HMP Elmley holds around 1,200 remanded and sentenced men in six houseblocks with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Elmley was in April and May 2019. Inspectors noted that 46% of prisoners said it was easy to get illicit drugs in the prison, and that the mandatory drug testing positive rate was above target and indicated significant drug use, particularly of psychoactive substances. However, inspectors found that neither the security meeting nor the drug strategy meeting was focused on reducing drug supply, and there was no formal drug supply reduction strategy or action plan. Inspectors also found that there was too little suspicion testing to provide a meaningful deterrent for prisoners. Inspectors noted that the new dog handler resource was underused because of a shortage of dogs, so visitor searching was much less effective than it could have been.
21. Inspectors found that the volume of security intelligence reporting had increased since the previous inspection but was still lower than they would expect of this type of prison. They noted that there was a large backlog of unprocessed reports with an associated delay in processing reports: they pointed out such delays undermined the intelligence procedure.

Independent Monitoring Board

22. 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 October 2020, the IMB noted that while there were continued problems with illicit drugs coming into the prison, a number of positive steps had been taken: a drug itemiser had been installed, there had been increased use of drug detection dogs and all correspondence was being photocopied to avoid the risk of drug contaminated paper entering the prison.

Previous deaths at HMP Elmley

23. Mr Boxall was the fifth prisoner to die at Elmley since May 2018. Two of the previous deaths were from natural causes, one death was self-inflicted, and one death was from an overdose of prescribed medication. There were no similarities between Mr Boxall's death and the previous deaths.

Psychoactive Substances

24. Psychoactive substances or PS (formally known as 'new psychoactive substance' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked

levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

25. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
26. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drug testing arrangements.

Key Events

27. On 14 May 2020, Mr Daniel Boxall was arrested for robbery and possession of a bladed article in a public place. He remained in police custody until 17 May, when he was admitted to hospital for treatment of an injury to his left wrist.
28. The police contacted HMP Elmley on the afternoon of 17 May, and the prison sent bedwatch officers to the hospital. When the bedwatch officers arrived, Mr Boxall was effectively deemed to have entered custody at Elmley. (Mr Boxall had been in prison, and at Elmley, a number of times before.)
29. On 19 May, the bedwatch officers telephoned Elmley to say that Mr Boxall was to be discharged from hospital that evening. His left wrist was bandaged. Mr Boxall arrived at Elmley in the early hours of 20 May. He was strip searched as he would have been if he had arrived during the normal working day. He was also checked with a body scanner to ensure that he had not concealed any items, such as a mobile phone, internally. (The scanner would not have detected if Mr Boxall had concealed a soft package, such as a drug package, internally. Since Mr Boxall's death, Elmley has acquired new equipment that can detect soft packages.)
30. After being checked by a nurse, Mr Boxall was moved into a single cell on Houseblock 1 (the induction wing).
31. Due to revised working practices during the COVID-19 pandemic, prison induction procedures were not running as normal at Elmley. Induction packs were being sent to prisoners, often two to three days after their arrival. (Mr Boxall did not undergo induction before his death. He was given a £2.00 telephone credit, but he did not make any calls.)
32. In the late morning of 20 May, another nurse saw Mr Boxall for his immediate physical and mental health prescribing needs. (This was not Mr Boxall's healthcare reception interview.)
33. That afternoon, a nurse prescriber saw Mr Boxall for his substance misuse needs. The nurse noted that Mr Boxall had started using illicit substances at the age of 15 and that he had a history of using various substances. Mr Boxall said that he had been using "dodgy" benzodiazepine (a sedative that may be abused) on a daily basis. Mr Boxall's urine sample was positive for cocaine, opiates and methadone (a heroin replacement medication). Mr Boxall was prescribed methadone at a starting dose of 20 millilitres (ml) a day.
34. On the morning of 21 May, a different nurse saw Mr Boxall for his healthcare reception interview. The nurse noted that Mr Boxall was in a stable and relaxed mood and had no suicidal thoughts. The nurse noted that Mr Boxall had been prescribed methadone in the community but was also using crack cocaine. Mr Boxall had a standard follow-up healthcare reception interview later that morning.
35. Mr Boxall was also seen on 21 May by a substance misuse worker. She advised him of the dangers associated with illicit drug use, including PS misuse. At some point, she noticed Mr Boxall and two other prisoners interacting in what she thought was a suspicious manner. She told the investigator that she had not

seen anything specific, it was more a feeling about their interaction that made her uneasy. She said that she spoke to an officer on the landing above, but the officer told her that the lower landing was not covered by CCTV so it would not be possible to investigate. (When she learned the next day of Mr Boxall's death, she made a retrospective entry in the wing observation book about the incident.)

36. At 5.20pm, an officer completed an evening roll check of Mr Boxall's houseblock.
37. An Operational Support Grade (OSG) told the investigator that she would have arrived for work at around 8.00pm and would make a check of the prisoners. She said that she would note anything that appeared amiss. However, she said as there had been nothing untoward on the evening of 21 May, she could not recall anything about Mr Boxall from that check.
38. Records from Elmley show that Mr Boxall did not ring his cell-bell on either 21 or 22 May.

22 May

39. On 22 May, the OSG carried out an early morning roll check. CCTV shows that she reached Mr Boxall's cell at 5.46am. She said that when she looked into the cell, she saw him lying on the floor next to his bed in what appeared to be an awkward position. She banged on the door and called Mr Boxall's name, but gained no response. His room was well lit as day light was coming through his window. She looked at his chest for any sign that he was breathing but saw none and she thought he was probably dead. She used her radio to ask for the NOO to attend and she waited outside the cell until he arrived with other officers three to four minutes later. (The investigator asked her why she did not go into Mr Boxall's cell straightaway, and she said she did not think it would be safe to do so.)
40. The NOO told the investigator that he heard the OSG's call and began to make his way to Houseblock 1 with several colleagues. The OSG's tone of voice made him believe it was serious, so he asked one of the officers to collect a nurse. He also radioed the communications room OSG to contact the response nurse and to ask for an emergency ambulance.
41. The communications room OSG's log of events shows that she classed the NOO's call as a code blue call, although she did not call the ambulance service until five minutes later. In follow-up email correspondence with the investigator, she said that her first priority was to ensure that immediate assistance was on its way from the NOO and the response nurse, and she would then have contacted the ambulance service. She said that at that time it was taking longer than usual to get through to the ambulance service control room due to the COVID-19 pandemic. She also speculated that the apparent five-minute delay might in part have been because she recorded the time from her own watch at the end of the call to the ambulance service. (It should be noted that there is an apparent three-minute discrepancy in the timing as indicated by the CCTV evidence and the timing shown in her log of events; such discrepancies are typical.)

42. The NOO reached Mr Boxall's cell at 5.50am. He looked through the observation panel and unlocked the door. He touched Mr Boxall's body and noted that he was cold.
43. The response nurse told the investigator that she was told about an emergency on Houseblock 1 but, as it was not a code blue call, she was unsure of the nature of the emergency. She reached Mr Boxall's cell at 5.53am. She told the investigator that Mr Boxall was leaning against his bed and she asked the officers to put him in a lying position. She said that the officers had not started CPR. She noted that Mr Boxall was unresponsive, was cold to the touch and had no pulse. Mr Boxall's jaw was stiff, so she was unable to insert an airway to help provide oxygen. She started CPR, but she found it hard to achieve the correct depth of compressions, so she asked the officers to take over.
44. The officers continued CPR until the ambulance paramedics arrived at 6.43am. They took over Mr Boxall's care, but certified his death around 15 minutes later.

Contact with Mr Boxall's family

45. Mr Boxall had named his mother as next-of-kin. In line with Government advice on COVID-19 working practices, a Senior Officer (SO) telephoned Mr Boxall's mother's home at 7.50am, but a family friend answered and said that she was out shopping. The SO made two further calls at 8.30am and 9.00am, but Mr Boxall's mother had still not returned home.
46. The SO was aware that Mr Boxall's brother was also in the prison. She feared he might hear the news of his brother's death from another prisoner, so she asked a colleague to inform Mr Boxall's brother and to tell him that prison staff would continue to try to contact his mother. At 10.30am, Mr Boxall's mother telephoned the prison and she confirmed that another of her sons had told her the news.
47. Elmley contributed to the cost of Mr Boxall's funeral in line with national instructions.

Support for prisoners and staff

48. A prison manager held a hot debrief with the staff and the staff care team also offered support.
49. The prison posted notices informing other prisoners of Mr Boxall'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 Boxall's death.

Post-mortem report

50. The pathologist gave Mr Boxall's cause of death as aspiration pneumonitis and airways obstruction in association with PS misuse and polydrug use. The pathologist explained in the post-mortem report that the use of PS would have caused reduced levels of consciousness and that Mr Boxall had vomited, leading to aspiration (inhalation) of vomit into his airways.
51. Toxicology tests showed that Mr Boxall had used PS before he died.

Events following Mr Boxall's death

52. While staff were carrying out CPR, they found 20 wraps containing a white substance concealed in the bandage on Mr Boxall's hand. The wraps were tested and found to contain cocaine. Staff also found the residue of a smoked substance and that Mr Boxall's kettle had been dismantled and the wires exposed: this is a common method used by prisoners to ignite and inhale drugs.

Findings

Elmley's Drug Strategy

53. During their inspection of HMP Elmley in April and May 2019, HM Inspectorate of Prisons found that almost half of prisoners said drugs were easy to get. Elmley accepted the recommendations made by HMIP and said they would develop a new drug strategy and associated action plan by March 2020 and would monitor progress via the drug supply reduction meeting. Elmley also said they would develop systems for disrupting the supply of drugs and would increase the use of suspicion-based drug testing. Elmley said that progress in positive drug testing would be monitored via the drug supply reduction meeting.
54. We note that Elmley's revised drug strategy has a clear focus and plan on restricting drug supply, including effective use of drug detection dogs and increased surveillance of both staff and visitors. The strategy also sets out clear plans on the other key strands of reducing demand for drugs and building recovery for those who wish to overcome their substance dependency.
55. Mr Boxall arrived in Elmley at just after midnight on 20 May. Around 12 hours later, he provided a urine sample that was positive for cocaine, opiates and methadone. He was also found to have an extensive drug supply in his possession after he died. It is possible that Mr Boxall acquired the drugs while in Elmley, although it seems more plausible that they were concealed on his person when he came into Elmley on 20 May. We are pleased that since Mr Boxall's death, Elmley has installed more sophisticated equipment that can detect soft packages that have been stored internally. While we are unable to identify the source of the drugs, we nevertheless make the following recommendation:

The Governor should continue to identify and address weaknesses in measures to prevent supply of drugs into Elmley and revise the substance misuse strategy in light of the findings.

Mr Boxall's substance misuse

56. The clinical reviewer found that Mr Boxall received a good level of support from both the mental health and substance misuse teams throughout his various periods of custody. The clinical reviewer also noted that during his various times in custody, Mr Boxall had been found under the influence of illicit substances on 35 occasions. On three of these occasions, he had had to be transferred to local hospitals for further monitoring and care.

Intelligence reporting

57. On 21 May, a substance misuse worker noticed what she thought was suspicious behaviour involving Mr Boxall and two other prisoners. She mentioned this to an officer but was told that there was no CCTV covering that part of the prison. She took no further action until after she heard that Mr Boxall had died, when she made a retrospective entry in the wing observation book.
58. Prisons use an intelligence reporting system which can be used by any member of staff. Intelligence reports provide vital evidence in identifying prisoners

involved in the prison drug culture and other illicit activity. The reports help establish a picture of groups of prisoners who might be associating to engage in illicit activity and can support intelligence-led cell searches and suspicion drug testing of prisoners (tools to disrupt the supply and demand for drugs in prisons). It is critical that any evidence identifying illicit activity is recorded and reported to the prison's security department. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff, including healthcare staff, complete an intelligence report when a prisoner is noticed to be behaving or interacting with others in a suspicious manner.

Emergency response

59. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, requires prisons to have a two-code medical emergency response system. Elmley's local policy instructs staff to use a code blue where a prisoner is unconscious or otherwise showing signs of breathing difficulties or a code red when a prisoner is bleeding or severely burned. Calling an emergency medical code should automatically trigger the control room to call an ambulance and for healthcare staff to attend with the appropriate medical equipment.
60. PSI 24/2011, *Management and Security of Nights*, states that under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two or three staff are present, one of whom should be the NOO. However, the PSI goes on to say:

“Staff have a duty of care to prisoners, themselves and to other staff. The preservation of life must take precedence ... Where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO ... and an individual member of staff may enter the cell on their own.”
61. The PSI also says that staff should not take action that they feel would put themselves in unnecessary danger, that staff must make every effort to first gain a verbal response from the prisoner, that they must make a rapid dynamic risk assessment on whether to enter the cell immediately or wait for assistance, and that they must inform the communications room before entering the cell. Elmley's local protocol on entering cells at night, reflects the guidance given in the PSI.
62. When the OSG checked Mr Boxall, she could see no signs that he was breathing, and she thought he was dead. However, she did not call a code blue emergency, but called for the attendance of the Night Orderly Officer. She waited outside the cell until her colleagues arrived.
63. We accept that the OSG knew nothing about Mr Boxall and that it was not unreasonable for her to consider it might be unsafe to enter his cell on her own. However, she should have called a code blue before contacting the NOO.
64. The NOO said he realised from the OSG's voice when she called him that it was serious. We consider that he should have called a code blue himself. Although he asked communications room OSG to contact the nurse and to call an

ambulance, the use of an emergency medical code would have alerted healthcare staff to the nature of the emergency and the fact that it was life-threatening, so they would know what equipment to bring.

65. The communication room OSG's log suggests a five-minute delay in calling an ambulance, but she said that she contacted the ambulance service immediately after contacting the NOO and the response nurse. If a code blue had been called, she would not have had to contact the NOO or the nurse and could have called an ambulance immediately.
66. As there was no code blue call, the response nurse said that she was unclear of the nature of the emergency and we also note there was a delay in bringing a defibrillator.
67. The failure by the OSG and the NOO to call a code blue, therefore, contributed to a delay before an ambulance was called and before a nurse arrived with the correct equipment. This did not affect the outcome for Mr Boxall, as it is clear that he had been dead for some time when he was found, but even a short delay may make a significant difference in other medical emergencies.
68. Recordings from CCTV and a body-worn video camera (BWVC) show that the response nurse arrived three minutes after the officers first went into the cell. When she entered, Mr Boxall was in a half lying position with his chest against his bed. It is clear that the officers had not started CPR before she arrived, and she had to ask them to move Mr Boxall away from his bed and onto his back so she could examine him.
69. We make the following recommendations:

The Governor should ensure that all prison staff are made aware of, and understand their responsibilities during medical emergencies, including that staff:

- **understand and use the appropriate emergency code when they discover a medical emergency;**
- **staff enter cells as quickly as possible in life-threatening situations where it is safe to do so;**
- **move the prisoner away from any constricted area;**
- **examine the prisoner for signs of life; and**
- **commence CPR without delay unless there are signs that the prisoner is already dead.**

The Governor should share a copy of this report with the OSG and the NOO and arrange for a senior manager to discuss the Ombudsman's findings with them.

70. In September 2016, Professor Sir Bruce Keogh, the National Medical Director at NHS England, wrote to the Heads of Healthcare for prisons in England and Wales to introduce new guidance to support staff on when not to perform CPR.

This guidance was designed to address the issue of inappropriate resuscitation after a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 which state: “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”. The guidelines give examples of futility as including the presence of rigor mortis. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased.

71. There were indications that Mr Boxall was already dead when he was found. When the response nurse tried to insert an airway, she should have recognised there were signs of rigor mortis, meaning that Mr Boxall had been dead for at least two hours and that attempts at resuscitation would be futile. We are concerned that, despite this, she attempted CPR and asked prison staff to take over from her and continue with CPR. Staff continued to try to resuscitate Mr Boxall for around 50 minutes until ambulance paramedics arrived. We make the following recommendation:

The Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare staff fully understand the circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.

The Head of Healthcare should share a copy of this report with the response nurse and arrange for her clinical supervisor to discuss the Ombudsman’s findings with her.

Clinical care

72. The clinical reviewer found that Mr Boxall’s care at Elmley was equivalent to, if not better, than that which he could have expected to receive in the community. The reviewer noted, however, that there was a delay in Mr Boxall receiving his healthcare reception assessment. The clinical reviewer also noted that the healthcare provider identified concerns with the response nurse’s resuscitation technique, although he acknowledged that there is no suggestion that the outcome for Mr Boxall would have been any different.
73. We make no recommendation.

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