

**Prisons &
Probation**

Ombudsman
Independent Investigations

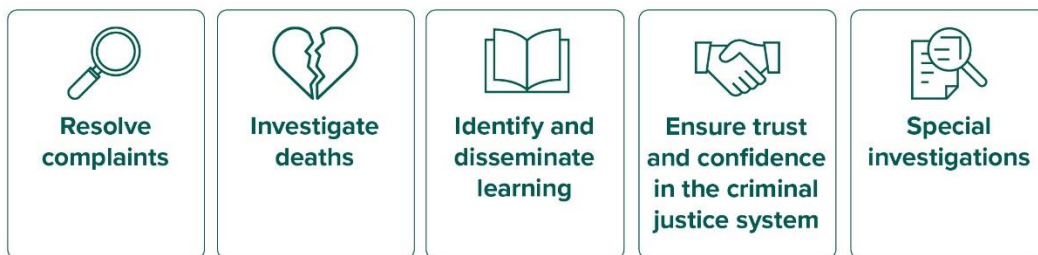
Independent investigation into the death of Mr Kane Boyce, a prisoner at HMP Lowdham Grange, on 3 October 2021

A report by the Prisons and Probation Ombudsman

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



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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 Kane Boyce died after he was found hanged in his cell at HMP Lowdham Grange on 3 October 2021. The post-mortem toxicology results established that he had ethanol (alcohol) in his system, and the post-mortem report established that ethanol intoxication contributed to, but did not cause, his death. Mr Boyce was 41 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Boyce received appropriate physical and mental health care at Lowdham Grange. There is no evidence that he was at imminent risk of suicide or self-harm in the days before his death.

I am concerned that Mr Boyce was able to access alcohol with apparent ease at Lowdham Grange. The prison needs to continue its efforts to prevent the supply of, and demand for, illicit substances. While the prison has taken some steps to reduce alcohol and drug supply, this case is a clear indicator that more still needs to be done to reduce the serious harm caused by substance misuse.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

October 2022

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Summary

Events

1. Mr Kane Boyce was remanded into custody in November 2013 and sentenced to life in prison in March 2015. He spent time in a number of prisons before he was transferred to HMP Lowdham Grange in March 2019.
2. Mr Boyce had a history of depression and was receiving treatment for deep vein thrombosis (DVT). He received positive reports from staff at regular key worker meetings. They maintained that Mr Boyce had settled in prison and had no significant issues, had no thoughts of suicide or self-harm and did not use alcohol or drugs.
3. On the evening of 2 October, Mr Boyce made several telephone calls which included calls to a female friend and to his sister. The majority of these calls were unanswered. During the conversations, Mr Boyce gave no indication that he intended to harm himself. (Mr Boyce's telephone calls were not monitored by prison staff until after his death.)
4. In the early hours of the morning on 3 October, staff told Mr Boyce repeatedly to lower the volume of his music, which he was playing loudly. Mr Boyce refused to do so, and subsequently staff turned off the electricity supply to his cell. Although he denied this, there were conflicting views from staff as to whether he may have been under the influence of alcohol.
5. At 1.51am, during a routine welfare check, Mr Boyce was found hanged in his cell. An officer radioed a medical emergency code blue and staff responded quickly. Prison and healthcare staff tried to resuscitate Mr Boyce until paramedics arrived and took over. They were unable to resuscitate him and pronounced that he had died.

Findings

Mr Boyce's risk of suicide and self-harm

6. We are satisfied that prison staff reviewed Mr Boyce's risk information, appropriately assessed his risk of suicide and self-harm both when he arrived and during his time at Lowdham Grange, and that they could not reasonably have prevented his death.

Mr Boyce's alcohol use

7. There is no evidence that staff at Lowdham Grange had ever seen Mr Boyce under the influence of alcohol or were aware that he drank it. We cannot say whether or not he drank alcohol regularly.
8. The clinical reviewer concluded that the clinical care that Mr Boyce received at Lowdham Grange was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

9. However, we share the clinical reviewer's concern that healthcare staff were not keeping accurate medical records and on one occasion failed to follow up on mental health concerns raised by Mr Boyce.

Drug and alcohol strategy at Lowdham Grange

10. Although Lowdham Grange has taken some steps to address its alcohol and drug supply issues, Mr Boyce's death is a stark reminder that more needs to be done to reduce the availability and detection of drugs and alcohol. The availability of illicit substances remains a problem across the whole prison estate and should remain a priority for Lowdham Grange.

Sharing of PPO reports

11. We consider that it is important for staff who were involved in Mr Boyce's care to see the findings of our investigation.

Recommendations

- The Director should ensure that staff are vigilant for signs of drug use and take appropriate action when a prisoner appears to be under the influence of drugs.
- The Head of Healthcare should remind staff of the need to refer prisoners to mental health services if they disclose that they have mental health issues.
- The Head of Healthcare should ensure that all medical records are audited as a matter of urgency and that they comply with the Nursing and Midwifery Council's Code of Practice.
- The Director should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
13. The investigator visited Lowdham Grange on 12 October 2021. He obtained copies of relevant extracts from Mr Boyce's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Boyce's clinical care at the prison.
15. The investigator and clinical reviewer jointly interviewed six members of prison staff. The investigator interviewed them in person at Lowdham Grange, and the clinical reviewer joined the interviews by telephone.
16. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.
17. The Ombudsman's family liaison officer wrote to Mr Boyce's sister to explain the investigation and to ask whether she had any matters she wanted us to consider. She wanted to know the circumstances leading up to Mr Boyce' death and asked:
 - Why did staff not refer Mr Boyce to the healthcare team if he was considered drunk. Where did he get alcohol from?
 - Did staff turn off the electricity in his cell?
 - Was medication found in his cell?We have addressed these issues in this report and in the clinical review.
18. Mr Boyce's family legal representative received a copy of the initial report. The solicitor representing Mr Boyce's family wrote to us raising one issue that did not impact on the factual accuracy of this report.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified two factual inaccuracies which have been amended in the final report. All recommendations were accepted. Their action plan is attached as an annex.

Background Information

HMP Lowdham Grange

20. HMP Lowdham Grange is a medium security prison, managed by Serco. It holds a maximum of 920 men. There are five house blocks, each typically housing 120-130 men. Lowdham Grange holds long-term prisoners, many of whom are serving life sentences or indeterminate sentences. Nottinghamshire Healthcare NHS Foundation Trust provides general healthcare, including 24-hour nursing cover.

HM Inspectorate of Prisons (HMIP)

21. An unannounced inspection of HMP Lowdham Grange was conducted in August 2018. The report was “reasonably positive” but inspectors reported that self-harm had increased since their last inspection. They found that safety remained a concern. They noted that security management was much improved and there was evidence that the availability of illicit drugs had reduced. They found that the use of technology to scan mail used to import drugs was a very useful initiative.
22. HMIP carried out a scrutiny visit at Lowdham Grange on 12 January and 2 February 2021 to review the conditions and treatment of prisoners during the COVID-19 pandemic. They found a well-led prison that had faced some considerable challenges during the pandemic, including a serious outbreak of COVID-19 in late September 2020. Inspectors noted that prolonged periods locked in cells were clearly taking their toll on prisoners and many had raised concerns about the impact of restrictions on their wellbeing.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to January 2021, the IMB reported that due to the COVID-19 pandemic, Lowdham Grange continued to operate a restricted regime throughout the remaining 10 months of the reporting period. They noted that the prison managed the outbreak well through close co-operation between Public Health England (PHE), prison managers and healthcare staff. They concluded that the introduction of a body scanner towards the end of the reporting period appeared to contribute to the efforts needed to curb the import of drugs and illicit items.

Previous deaths at HMP Lowdham Grange

24. Mr Boyce was the seventh prisoner to die at Lowdham Grange since January 2019, and the first to have taken his own life. Of the previous deaths, two were drug related. In one death we investigated, we made recommendations for staff to be vigilant for signs that prisoners were taking drugs and to take appropriate action if a prisoner was considered under the influence. Lowdham Grange responded to this recommendation, in January 2021, by issuing a Drugs in Prison and Probation booklet for staff to increase their awareness and knowledge of drug use. A staff notice was also issued in April 2021, reminding staff of the importance of remaining

vigilant and of the appropriate steps to take when they consider that a prisoner is under the influence of an illicit substance.

Key Events

25. Mr Kane Boyce was remanded into custody in November 2013, charged with the murder of his girlfriend. He was sentenced to life in prison in March 2015 and sent to HMP Highdown.
26. When he arrived, he had depression. His records showed that he had no history of attempted suicide or self-harm but used illicit substances. He had a history of gastritis (inflammation of the lining of the stomach), deep vein thrombosis (DVT, occurs when a blood clot forms in a deep vein) and diverticulitis (an infection or inflammation of pouches that can form in the intestines).
27. Mr Boyce was managed on four occasions under suicide and self-harm prevention procedures (known as ACCT) between November 2013 and January 2017.

HMP Lowdham Grange

28. Mr Boyce was transferred to HMP Lowdham Grange on 8 March 2019.
29. At his reception health screen, a nurse noted that Mr Boyce's prescribed medications included tramadol (a strong painkiller), mirtazapine (used to treat depression) and rivaroxaban (a blood thinner) due to his history of DVT. Mr Boyce said that he had no mental health problems and his mirtazapine was to help him sleep. He denied thoughts of suicide or self-harm and substance misuse problems. The nurse completed an alcohol audit screen that suggested that Mr Boyce was not dependent on alcohol. Mr Boyce was assessed as being able to keep and administer his medication.
30. There is no evidence that a second reception health screen was undertaken.
31. Staff completed weekly key work sessions with Mr Boyce. He raised no significant concerns and appeared to have settled well at Lowdham Grange. He told staff that he felt safe in the prison, he was not using any illicit substances and had no thoughts of suicide or self-harm. He used the prison gym regularly and had a prison job. He spent his earnings on phone credit to maintain contact with his friends and family. He had no family visits as it was too expensive for them.
32. In December, a nurse examined Mr Boyce after he complained of constant pain in his heel and lower leg. He was prescribed a pain relief gel and given a cortisone injection to relieve the pain.

2020

33. From January 2020, Mr Boyce continued to have key work sessions.
34. In June, Mr Boyce complained of abdominal pain. He was examined in hospital, where doctors queried his diverticulitis diagnosis and prescribed medication. When he returned to prison, Mr Boyce asked for a high fibre diet at the hospital's recommendation.

35. On 30 June, staff started ACCT procedures after Mr Boyce stated that he was going to “kill himself” because he had not been given a high fibre diet which caused him stomach pains. Prison kitchen staff spoke to Mr Boyce and assured him that there were plenty of suitable food options available that could be ordered from the wing kiosk. Mr Boyce disputed this and said he felt hopeless, depressed and the pain made him feel suicidal. However, Mr Boyce said that he had no intention of harming himself and had only said that to get support. The ACCT panel immediately asked the kitchen staff to provide Mr Boyce with a more appropriate diet. ACCT monitoring was stopped two days later as Mr Boyce’s food concerns had been resolved.
36. Mr Boyce tested positive for COVID-19 in October and recovered.

2021

37. In his key work session on 7 January 2021, Mr Boyce said that he was happy and had no issues to discuss.
38. On 11 January, the security team intercepted a letter, addressed to Mr Boyce from his alleged fiancée who was in custody in another prison. It was covered with an illicit substance.
39. At a key work session in February, Mr Boyce said that he was looking forward to the prison returning to a normal regime (following the COVID-19 pandemic) so that he could return to his job. He said that he had recently got engaged and he had tried to arrange for a ring to be sent to her. Mr Boyce said he was trying to stop smoking vapes.
40. On 8 March, the security team reported that they had received a complaint from Mr Boyce’s ex-wife who said that Mr Boyce had phoned her late at night and was abusive and drunk. The Public Protection Team spoke to Mr Boyce and told him that he was not allowed to contact his ex-wife. Her contact details were removed from his PIN phone account.
41. On 19 March, Mr Boyce referred himself to the mental health team, stating that he felt stressed and was struggling to sleep.
42. On 25 March, a nurse from the mental health team assessed Mr Boyce. He noted that he displayed no acute mental illness or psychotic symptoms, was not under the influence of any illicit substances and had no thoughts of suicide or self-harm. Mr Boyce was still taking tramadol and mirtazapine. The nurse had no concerns about him but recognised that the COVID-19 restrictions in place had not helped his sleep pattern. The nurse noted that there was no evidence that Mr Boyce was at risk to himself or others and discharged Mr Boyce from the mental health team’s caseload. He asked the prison GP to prescribe him a short course of promethazine to help him sleep.
43. In May, the pharmacy gave Mr Boyce ibuprofen as he had leg pain.
44. In July, the prison GP saw Mr Boyce as he had swelling and discomfort in his right leg. The GP noted that Mr Boyce had gained a significant amount of weight over the years and had a history of DVT. The GP reduced Mr Boyce’s mirtazapine dose as

this was known to increase weight. Mr Boyce was referred to hospital, where his rivaroxaban prescription was changed to apixaban. Mr Boyce refused to take the hospital's prescribed medication despite healthcare staff warning him of the potential impact on his health.

45. On 18 August, staff gave Mr Boyce a discipline warning after he had a heated and abusive argument with another prisoner. This resulted in him being suspended from his prison job and being moved to another wing.
46. At his key work session on 20 August, Mr Boyce said that he was happy on his new wing.
47. On 23 August, Mr Boyce got his job back.
48. That day, at a routine healthcare appointment, Mr Boyce told a Health Care Assistant (HCA) that he "was not in a good place" since the GP had reduced his medication. He explained that he had had an altercation with another prisoner and felt fed up and depressed. The nurse contacted the pharmacist, who said that a GP would review his medication. Mr Boyce failed to attend his GP appointment on 25 August.
49. A prison GP phoned Mr Boyce on 26 August to discuss his medication. Mr Boyce said that he had not taken his mirtazapine for around a week. He said that he believed this had affected his mood and caused him to argue with another prisoner. He said that he had resumed his medication and now felt stable. The GP noted that she would review him in four weeks' time.
50. On 29 August, staff noted that Mr Boyce was a positive influence on the wing. He was described as polite and helpful to staff and prisoners.

September 2021

51. On 11 September, the security team, with the aid of drug dogs, conducted an intelligence-led search of Mr Boyce's cell but found nothing. On 11, 16 and 18 September, at his key work sessions, Mr Boyce told staff that he was settled on his wing and was working. He said that he continued to keep in touch with his friends and family.
52. On 15 September, a prison GP changed Mr Boyce's DVT medication from apixaban to rivaroxaban.

2 October 2021

53. CCTV footage shows that staff completed a roll check at 5.48pm.
54. On the evening of 2 October until just after midnight, Mr Boyce made at least 50 telephone calls from his cell PIN phone, including to his brother, his sister and a female friend. He was playing loud music from his stereo in the background. The majority of his calls were unanswered and he left messages.
55. Mr Boyce phoned a female friend on four occasions between 6.38pm and 8.38pm. In one conversation he said that he had "a litre of rum", the "stereo banging. I'm

flying already". Mr Boyce said that he planned to have a dance in his cell. During one call, Mr Boyce's female friend hung up on him because she did not like the way he spoke to her. He also telephoned his daughter but she did not answer.

56. Mr Boyce telephoned his sister at 8.40pm. His music can be heard in the background. He twice tried to phone his female friend again but she did not answer. Mr Boyce then made seven calls to his sister between 9.02pm and 10.41pm. He told her that it was his 41st birthday and he was "mash up" (intoxicated). Mr Boyce again phoned his female friend at 9.38pm. His speech sounded slurred, and Mr Boyce's friend ended the call abruptly.
57. At 9.49pm, two Prison Custody Officers (PCO) conducted a night roll check on the wing. Mr Boyce was playing music, but it was considered to be at an acceptable level.
58. CCTV footage at 11.13pm shows that a PCO, followed shortly afterwards by a second PCO attended Mr Boyce's cell as he was playing extremely loud music which could be heard from the staff office on the landing. A PCO knocked on Mr Boyce's cell door and asked him to lower the volume of his music, which he initially did. Mr Boyce said that it was his birthday. The PCO had only walked a couple of metres away from the cell when Mr Boyce resumed playing his music, with the volume even louder. She returned to Mr Boyce's cell with the second PCO who told us that Mr Boyce started to laugh, said it was his birthday and that staff were taking "fucking liberties". The officers tried to explain that the level of the music was reverberating around the wing and other prisoners were trying to sleep. The PCO told us that Mr Boyce did not appear under the influence of any substance but was very "verbal" towards them and ignored their instructions. The second PCO told us that he thought that Mr Boyce appeared to be intoxicated, although Mr Boyce denied it. The PCO told Mr Boyce that if he did not lower the volume of his music, the security team would be told and the power to his cell would be switched off. Mr Boyce continued to play music loudly. The officers contacted a PCO from the night security team, who held the key for the electrical access cupboard.
59. CCTV footage shows that the PCO arrived on the wing at 11.29pm and spoke to Mr Boyce through his cell door. Mr Boyce refused to lower the volume of his music. The PCO thought that Mr Boyce may have been under the influence of alcohol. He unlocked the electricity service door next to Mr Boyce's cell door and at 11.30pm, switched off the electricity power supply to his cell. (His cell light and emergency cell bell still worked.) Mr Boyce immediately pressed his emergency cell bell. He said that staff were "taking liberties" and asked for the power to be put back on so that he could continue to party. All three PCOs spoke to Mr Boyce for several minutes. They then turned his emergency cell bell light off. Mr Boyce promised to lower the volume of his music if his power was turned back on. A PCO reinstated the electricity supply to his cell at 11.42pm.
60. After a few minutes, Mr Boyce started playing loud music again. Two PCO's attended his cell. A PCO told us that Mr Boyce was standing close to his cell door, laughing. He said that he was having a party and refused to lower the volume of the music. A PCO again turned off the electricity supply to the cell and walked away. Mr Boyce pressed his emergency cell bell straightaway and asked for his electricity supply to be restored.

3 October

61. At 12.01am on 3 October, a PCO responded to Mr Boyce's emergency cell bell and reset it. He explained to Mr Boyce that the electricity supply to his cell would remain off until the morning because he had continued to refuse to lower the volume of the music. As soon as the PCO left Mr Boyce's cell, Mr Boyce pressed his emergency cell bell again, and started banging his door and shouting across the wing. The PCO told the control room that Mr Boyce was misusing his cell bell. (He did this because the control room is automatically notified if prison staff do not respond to cell bells after a specified time.)
62. Mr Boyce tried to phone his sister at 12.05am but she did not respond.
63. At 12.08am, a Custodial Operational Manager (COM) spoke to Mr Boyce about his loud music and misusing the emergency cell. He turned off Mr Boyce's emergency cell bell light. Mr Boyce was standing close enough to the cell door for the COM to speak to him and see him through the observation panel. He told us that Mr Boyce was pleasant, spoke clearly and did not appear under the influence of any substance. Mr Boyce said that it was his birthday recently and he wanted to play music and dance in his cell. He said that he did not want any trouble but just wanted to be out of prison to see his wife and children.
64. As soon as the COM finished talking to Mr Boyce and left his cell, Mr Boyce again pressed his emergency cell bell (at 12.13am) and started shouting across the wing again. This lasted for around 10 minutes. Staff did not respond immediately as they were aware that Mr Boyce had persistently misused his cell bell.
65. CCTV footage shows that a PCO checked on Mr Boyce at 12.50am. She turned his emergency cell bell light off and closed his observation panel. Mr Boyce told her to "F*** off".
66. At 1.21am, aware that Mr Boyce had now quietened down, the PCO returned to his cell with a view to switching the power back on. When he looked into the cell, it was dark and he could not see Mr Boyce clearly but he heard him moving around. The PCO decided not to turn the power back on as he believed that Mr Boyce would have started to play music loudly again.
67. CCTV footage shows that at 1.49am, staff started the welfare check of prisoners on Mr Boyce's wing. When she arrived at Mr Boyce's cell, the PCO shone her torch through the cell door observation panel. She saw Mr Boyce, sitting up, slumped against his bed. He looked asleep, with his head tilted down towards his chest and some bubbles on his mouth. She thought that Mr Boyce did not look quite right and so called the PCO, who was across the landing. A second PCO joined the PCO, and they looked through the observation panel. They immediately saw something that looked like a ligature, attached to the top bunk.

Emergency response

68. A PCO unlocked and entered the cell. The PCO radioed a medical emergency code blue at 1.51am, indicating a life-threatening situation. They called an ambulance. A PCO lifted Mr Boyce off the floor to relieve the tension of the ligature, a dressing gown cord. A PCO used her cut-down tool and cut the ligature, which

was then removed from around Mr Boyce's neck. A PCO checked on Mr Boyce for signs of life (breathing and pulse) but found none. She immediately started cardiopulmonary resuscitation (CPR). A PCO collected a defibrillator from the wing office (approximately 15 metres away).

69. A PCO responded to the emergency code within 90 seconds. In his statement, the PCO noted that Mr Boyce was lying flat on his back, with his head towards the cell door. He was supple and warm but had a grey, ashen face, with a blue tinge to his lips. A PCO had set up the defibrillator, which advised no shock and that CPR should continue. One of the PCO's immediately took over CPR from the PCO.
70. At 1.55am, the only nurse on duty during night state, arrived at the cell. Unfortunately, the nurse's medical records that night lacked detail about the emergency response. The nurse told us that he assessed Mr Boyce but as he saw no signs of life, he quickly got additional medical equipment, including oxygen, from the wing medication cabinet, and returned in approximately 30 seconds. He said that he set up the oxygen and administered medical care while the PCO continued chest compressions. The nurse then took over chest compressions while additional prison staff arrived, including the duty prison manager.
71. CPR continued until paramedics arrived at 2.14am and took over. At 2.23am, the paramedics stopped resuscitation efforts and pronounced that Mr Boyce had died.

Contact with Mr Boyce's family

72. Two members of the Offender Management Unit were appointed as the prison's family liaison officers (FLO). From 7.07am, A FLO attempted numerous times to telephone Mr Boyce's sister who was his next of kin. As she did not answer her phone, a FLO tried to call Mr Boyce's other sister, his father and ex-wife but could not make contact with any of them. The FLO eventually managed to contact Mr Boyce's sister, his next of kin, at 8.03am. She broke the news of Mr Boyce's death and offered her condolences. The family liaison officers also spoke to Mr Boyce's other sister, his father and his fiancée that day.
73. In line with national instructions, Lowdham Grange offered to contribute to the costs of Mr Boyce's funeral.

Support for prisoners and staff

74. After Mr Boyce's death, the COM briefed 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.
75. The prison posted notices informing other prisoners of Mr Boyce's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Boyce's death.

Post-mortem report

76. Post-mortem examinations showed that Mr Boyce died as a result of hanging. The toxicology report noted that Mr Boyce had ethanol (alcohol) and tramadol in his

system. The pathologist stated that the concentration of ethanol detected would likely cause effects, including disorientation, mental confusion, exaggerated emotional states, increased pain threshold, apathy and lethargy. The level of tramadol found in Mr Boyce's system was insignificant.

Other information after Mr Boyce's death

77. The nurse said that he noticed that there were empty bottles (labelled Coke) on the floor of Mr Boyce's cell, which was wet. The police provided the investigator with photographs taken when they attended Mr Boyce's cell. These show two empty Coke bottles on the floor. A clear jar which appeared to contain strips of medication can also be seen. Neither the police nor prison tested the contents of the bottles to determine whether the bottles contained alcohol.
78. Prison staff also found medication on his shelves and returned it to the pharmacy team for safe disposal.

Findings

Identifying risk of suicide and self-harm

79. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list risk factors and potential triggers for suicide and self-harm. When Mr Boyce arrived at Lowdham Grange in 2019, he had some risk factors for suicide and self-harm: he had killed his partner, he had depression, physical pain and could not see his family. Despite this, he had no recent history of attempted suicide or self-harm and no current mental health or substance misuse concerns. Staff monitored Mr Boyce under ACCT procedures for a week in June 2020. After this, there was no evidence to suggest that he posed an imminent risk of suicide or self-harm.
80. While staff were aware that Mr Boyce was unhappy that he was unable to play his music loudly the night before he died, we are satisfied that they could not reasonably have known that he was at imminent risk of suicide.

Mr Boyce's use of alcohol

81. The post-mortem examination and toxicology results established that Mr Boyce was intoxicated with alcohol before his death, and that this contributed to his death.
82. We are concerned that Mr Boyce was able to obtain alcohol at Lowdham Grange, particularly when COVID-19 restrictions were in place. Both HMIP and the IMB have expressed concern about the availability of illicit substances at Lowdham Grange, although they also noted that the prison was taking steps to tackle the problem.
83. In June 2020, Lowdham Grange implemented a new drug and alcohol strategy that focused on reducing the supply of, and demand for, drugs and building recovery for those who use illicit substances. This strategy was reviewed and updated in June 2021.
84. The only indication that Mr Boyce drank alcohol in prison was when his ex-wife alleged in March 2021 that he had phoned her, drunk. We saw no evidence to establish whether or not Mr Boyce drank alcohol regularly at Lowdham Grange, and staff had not seen him under the influence of drugs or alcohol before his death. There was no intelligence to suggest that he was using illicit substances and a full cell search on 11 September supported this.
85. Before he was found hanged in his cell, staff interacted with Mr Boyce over a period of three hours. Their general assumption was that Mr Boyce was acting in an unusual manner as he was normally polite and quiet. There were conflicting views from staff about whether they had considered that Mr Boyce was under the influence of alcohol. In any case, none of the officers sought healthcare intervention in line with prison policy. While it is unlikely to have changed the outcome for Mr Boyce, this was a missed opportunity for the healthcare team to assess and monitor him.

86. It is important that the prison continues its efforts to prevent the supply of, and demand for, illicit substances and that its drugs strategy is implemented fully. We make the following recommendation:

The Director should ensure that staff are vigilant for signs of drug use and take appropriate action when a prisoner appears to be under the influence of drugs.

Clinical care

87. The clinical reviewer noted that the care that Mr Boyce received was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. However, she made a number of recommendations which the Head of Healthcare will need to address.

Mental health

88. Mr Boyce had minimal contact with mental health services at Lowdham Grange. When he referred himself to the mental health team and was assessed in March 2021, they found no concerns. However, when he told a nurse during a routine health check that he “was not in a good place” and felt fed up and depressed, he was not referred to the mental health team (although a referral was made to review his medication). This was a missed opportunity to identify and address his issues. We make the following recommendation:

The Head of Healthcare should remind all staff of the need to refer to Mental Health Services if a prisoner discloses that they have mental health issues.

Record keeping

89. The clinical reviewer noted that, in general, record keeping was of a high standard, with detailed entries noted for Mr Boyce’s reception screen and physical and mental health assessments. However, the nurse’s entry about the emergency response when Mr Boyce was found hanged was inadequate and lacked detail and clarity. It failed to state any details about the calling of the emergency code blue, it contained no description of his findings when he arrived at the cell or of the actions that he took. The record also failed to record the other staff members who attended and their actions. This fell short of the requirements of the Nursing and Midwifery Code. Although the nurse was an agency nurse and not a regular member of the healthcare team at Lowdham Grange, it is important that all registered nurses adhere to the required standard of record keeping. We therefore make the following recommendation:

The Head of Healthcare should ensure that all medical records are audited as a matter of urgency and that they comply with the guidance contained within the Nursing and Midwifery Council’s Code of Practice.

Sharing of PPO reports

90. We consider that it is important for staff who were involved in Mr Boyce’s care to be aware of the findings of our investigation. We make the following recommendation:

The Director should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

Inquest

91. The inquest into Mr Boyce's death was held in November 2023. The conclusion was that Mr Boyce's death was caused by a ligature. The level of alcohol found in his body had caused significant impact on Mr Boyce's judgement and mood. This, along with the fact that he had not taken his prescribed antidepressant medication for at least five days prior to his death, contributed to this death.

**Prisons &
Probation**

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