HM Prison &
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Miss Laurinda Bower
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10 June 2025

Dear Miss Bower,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS –
ANTHONY BINFIED, DAVID WILLIAM RICHARDS, ROLANDAS KARBAUSKAS.

Thank you for your Regulation 28 report of 7 February 2025 following the inquests into the deaths of Anthony Binfield, David William Richards and Rolandas Karbauskas at HMP Lowdham Grange, which was sent to the Ministry of Justice. I am responding on behalf of His Majesty's Prison and Probation Service (HMPPS) as Director General of Operations.

Thank you for agreeing an extension to the usual deadline for this response. As you know your report raised a wide range of matters of concern and I am grateful for your understanding that it has taken longer than usual to bring together a full response.

I know that you will share a copy of this response with the bereaved families, and I would firstly like to express my condolences for their loss. Every death in custody is a tragedy and the safety of those in our care is my absolute priority.

As you are aware, at the time of the deaths HMP Lowdham Grange had recently transferred from management by Serco to Sodexo, with HMPPS providing contract management. In December 2023 HMPPS, concerned re standards, stepped in and on 1 August 2024 brought the prison under HMPPS management and leadership.

As heard at the inquest, the transition detailed above significantly impacted on a challenging recruitment picture and the low staffing levels along with a reduction in staff with a significant length of service and experience. As you are aware, healthcare staffing is a matter for the healthcare provider, who have responded separately.

Since taking over the management of Lowdham Grange HMPPS has taken a number of steps to improve recruitment and retention, including the provision of additional support to the prison to undertake recruitment activity.

The site has been in receipt of support from other establishments in the form of National Detached Duty of prison officers. They are also supported by bonus schemes that incentivise staff to commit to overtime hours in return for a bonus paid out at the end of a qualifying period.

Recent recruitment marketing campaigns have included a high-profile national campaign with additional support provided to the Long Term High Security Estate (LTHSE), which includes Lowdham Grange. This included TV and local and national radio advertising, and a range of digital advertising.

As a result of this activity the site currently has a pipeline of 275 applicants at various stages of the recruitment process and are predicted to be close to full staffing by the end of September 2025.

Key to creating a stable, effective prison with a positive culture is a strong Senior Management Team (SMT), and I am pleased to say that this this is now in place, led by an experienced HMPPS Governor and Deputy Governor who are committed to driving improvements. The SMT are overseeing a drive to create a skilled and committed workforce, and with support from national resources have introduced a number of initiatives aimed at ensuring staff are able to meet the expectations of their role and understand the importance of doing so.

Following the introduction of New Colleague Mentors, made up of experienced staff to support newly arrived prison officers, an ‘Induction Passport’ has been created. This document provides comprehensive information and guidance on the key duties of staff, as well as detail on how to seek support. Alongside the Induction Passport a ‘buddy’ system is in place, providing new recruits with a link to a more experienced member of staff to provide support and guidance. Packages have also been delivered to line managers to help them steer new and less experienced staff confidently and effectively.

At a national level, as we know that sufficient and skilled frontline staffing is fundamental to delivering safe, secure, and rehabilitative prison regimes, the department operates a centralised recruitment model, providing targeted support to prisons with acute local recruitment problems - we continuously review our recruitment process to ensure officers are best suited to their role. In addition to this, HMPPS have a retention oversight process in place - all establishments are required to regularly review their attrition and determine local action supported by a retention toolkit to tackle their main drivers of attrition. We have invested in several new initiatives to improve the experience of our new joiners and increase retention of our employees.

The identification and management of risk is a vital element of core prison officer duties. A range of measures are being introduced by the SMT at Lowdham Grange to ensure risks are

identified and appropriately shared across all disciplines and agencies. Work is ongoing to develop a triggers database, to ensure shift handovers are effective in communicating issues, and to improve first night and induction processes.

Work is also ongoing to create a positive and collaborative relationship between the prison and the healthcare provider, to build better working relationships and ensure all are aware of their responsibilities in sharing information with colleagues. It will be reinforced to staff in all areas that information should be shared using the relevant systems, such as NOMIS, SystmOne, and observation books, rather than through emails.

The Safety Intervention Meeting (SIM) is being refreshed so that it provides a more effective mechanism for all those involved in the care of prisoners and to discuss those at risk, share information and ensure a strategic overview that pulls in all relevant information and agencies to ensure support is tailored to the individual. The Governor is committed to learning from deaths that have occurred and has introduced a meeting to focus on work to address issues raised in Reports to Prevent Future Deaths.

At national level our policy is clear, both in Prison Service Instruction (PSI) 7/2015, Early Days in Custody – reception in, first night in custody, and induction to custody, which places a requirement on prisons to make use of all the information available for the purposes of risk assessment on reception, and in the Prison Safety Policy Framework, which requires that Governors put in place an effective process to identify and record a prisoner's relevant risk information, keep this up to date as the prisoner progresses through their time in custody and make it accessible to all staff involved in their care.

We know that achieving full compliance with these policies can be challenging and we continue to work with healthcare partners and others to support Governors in implementing them, including through the HMPPS/NHSE Information Sharing Advisory Group which meets regularly to tackle issues in this area. For example, we are currently working with NHSE to devise revised guidance on information sharing in prison reception areas, focused particularly on healthcare staff access to the digital Person Escort Records (dPER).

We are also revising the training provided to prison staff deployed in reception areas to provide increased focus on their role in identifying risk, including where to look for risk information, details of cohorts that are known to be at higher risk and a clear warning against relying solely on the prisoner's presentation when making decisions about risk levels.

The decision on how men move through the prison system is determined by the National Allocation Protocol and the National Offender Flows, and in line with the Security Categorisation Policy Framework and indeterminate prisoners with the Progressive Transfers for Indeterminate Sentence Prisoners.

Since Mr Richards' transfer from HMP Chelmsford to HMP Lowdham Grange the way that prisoners are allocated from reception prisons to appropriate category B prisons has developed significantly. Now, prisoners with 27 years left to serve would generally be allocated to a dispersal prison, particularly if it is their first time in custody and little is known about them and their risk to themselves and others. Where possible prisoners will be allocated to prisons close to their home area.

Decisions to move prisoners between establishments must take into account a range of factors including the needs of the prisoner to support their progression, wider population management and the stability of prisons. To support this, Category B prisons can arrange transfers between establishments, and in the LTHSE this is done by the LTHSE population management team. Factors such as vulnerable prisoner (VP) status will be considered. The issues surrounding VP status are complex and prisoners are not managed solely based on this status. Some prisoners who hold VP status in one prison are able to reside safely on normal location in other prisons as the demographics of the population vary significantly and the risk is abated.

While appropriate considerations will be made regarding individuals' wishes regarding their location, in order to effectively manage the prison population and stability, it is not always possible or appropriate to move prisoners to a prison of their request. Wherever possible there should be discussion with prisoners and where requests are denied reasons should be given (unless there are security or other valid consideration that prevent this). Prisoners may appeal through the prison's internal appeal process, and if requests are still denied, or were not considered within 30 days, they have recourse to complain through the independent Prisons and Probation Ombudsman (PPO).

You raise concerns about services for Foreign National Offenders (FNO) and the risk that these individuals may become isolated. HMPPS has several national policies which consider the needs of FNOs, including the PSIs on Early Days in Custody and Prisoner Communications. These policies set out the support that is available to FNOs to maintain contact with their family members.

During the inquest you heard evidence concerning access to The Big Word translation service. The Ministry of Justice is committed to ensuring that the justice system is supported by high-quality language services that meet the needs of all users. In 2016, Thebigword Group Ltd was appointed as the supplier of language services, specifically spoken face-to-face, telephone, and video interpretation services, as well as foreign language-related translation and transcription services. The department's contracts provide a robust governance structure and performance regime, including the monitoring of telephone interpretation to ensure compliance with the contracted standards. Thebigword has confirmed that their data shows no evidence presently of waiting times over an hour to service any calls at Lowdham Grange.

However, we are committed to working with both suppliers and venues to investigate any connectivity issues or unreasonable waiting times when raised, and establish the root cause

of the issue, as it may be that there is another issue contributing to this experience (for example, equipment connectivity).

Locally, Lowdham Grange is recruiting for an FNO manager who will ensure FNOs are effectively managed and supported, as well as developing an assurance process to determine the use of Big Word.

Your report identifies the significant risk posed by psychoactive substances (PS). HMPPS recognises the risks relating to drug and alcohol use including most significantly the risk to life and actively works to reduce these. Evidence obtained through drug testing and intelligence identifies that, from a national perspective, the most prominent drugs used in prisons are synthetic cannabinoids (also referred to as SCRAs/PS).

HMPPS has a prison drug strategy that adopts a whole system approach to restricting supply and reducing the demand for drugs and to building recovery. PS is often used in conjunction with other drugs, and as a result our strategy sets out a set of principles and actions that are sufficiently flexible to apply across the estate, rather than a drug-specific approach. As the risk and impact of drug and alcohol use is variable between prisons it is the responsibility of each prison to understand local risk and develop local strategies to ensure the risks are identified, understood, and effectively managed.

However, to ensure staff understand the risks specific to PS use, an eLearning package is available for all staff to access. This course has been designed to increase awareness of the types of synthetic cannabinoids: understanding their effects, how to deal with them and where to signpost for support to assist staff in reducing the demand for these substances, managing the associated risks and promoting recovery from dependency.

In addition to this the HMPPS Drug and Alcohol Operational Framework (an internal guidance document published in January 2025) has been designed to support frontline staff in their day-to-day work. It emphasises the importance of taking a person-centred approach when working with people who use drugs and alcohol to support individuals to access the treatment and recovery support they need.

At Lowdham Grange the drug strategy is overseen at a monthly meeting attended by senior leaders and operational managers, and there are two dedicated drug strategy officers in place. Supply restriction measures include work to prevent drone drops, body scans for prisoners, and a network of security liaison officers are on each houseblock to ensure that information on those organising and using illicit items is passed on. Future plans include the installation of windows that will prevent the entry of parcels and a publicity programme to raise awareness in the community of the drone problem and to encourage the reporting of suspicious behaviour. The local drug strategy also includes various measures to reduce demand, enable recovery and reduce harm. These include a video on the dangers of synthetic opioids that was created

in house and is played on the in cell TV system and the availability of naloxone, with staff trained in its use.

As stated at the inquest, we are committed to learning from the experience of the transfer of Lowdham Grange from one provider to another to inform subsequent competitions for contracts and their mobilisation, and a number of changes have already been made in response.

Future competition documentation has been amended to add requirements to develop a culture plan to ensure there is a clear focus from operators on assessing and building on the existing culture at a prison. Additionally, future competitions will see increased weighting in the evaluation for the response on safety, and all bidders are now required to submit a safety response which outlines how the supplier intends to understand, identify, monitor and review safety risks and achieve their intended outcomes.

To assist bidders with a better understanding of the prison at the point of competition, the project now provides a Current Regime and Services document as part of the Prison Specific Competition Data Room. This amalgamates previous disparate pieces of information and provides more detailed data, so bidders have a clear overview of all aspects of the prison. The project has also introduced an improved process for operating procedures from HMP Altcourse mobilisation onwards, which assists incoming Operators in identifying current processes in place and provides them with clear templates and guidance to streamline the process.

Improvements have also been made to the mobilisation process as a result of the findings of this inquest. Timelines for submission of key mobilisation documents such as local operating procedures have been revised to enable a new operator to stagger activity and keep focused on operations and critical systems in the lead up to handover and a staff communications toolkit has been developed to ensure alignment of messaging between all parties.

The Mobilisation Blueprint was updated to provide further information about the expectations of what activity should take place in each phase to ensure bidders understand what the priority is for each phase and include realistic timelines for their activity in their plans.

Visits to expiring private prisons have been agreed with the HMPPS National Safety Group during the mobilisation stage, focusing on the early days processes including reception, first night and induction, with a follow up visit during the transition period. The Safety Group share their findings via a report to the site to ensure all parties are aware of what areas need focus.

We have also agreed with the Performance, Assurance, Risk (PAR) Group to conduct Safety Audits at these sites, closer to the mobilisation period. The Safety Audits are usually unannounced, however, given the challenging nature of transferring a site from one Operator to another, we have agreed that these safety audits are carried out 6 – 9 months prior to expiry for these sites (the incumbent operator still won’t be notified prior to them going in). Final

Reports and recommendations for the incumbent will be shared with the Private Prison Expiry Team and Controller Team to help inform key areas of focus and provide recommendations.

Your report references the role of Controllers within the contracted estate, particularly in the context of learning from deaths in custody.

The role of the Controller within contracted prisons is vital and is responsible for ensuring the establishment operates in line with the contract and to HMPPS standards, and for overseeing the processes related to learning from deaths within the private prison estate. This includes ensuring that all action plans created following a death are reviewed systematically and thoroughly and that the implementation of recommendations is overseen by physically testing processes in the prison and reporting on compliance against prison service policy frameworks. Controllers work closely with the providers and local Safety teams to ensure that changes are made to prevent future deaths and improve care quality and are responsible for applying necessary contractual action as required to drive continuous improvement.

To assure themselves that the provider is learning from deaths, Controllers conduct regular compliance and assurance testing of the prison's safety strategy and processes to ensure compliance with national guidelines and internal policies. These checks help verify that lessons learned are being effectively integrated into practice. Controllers have established governance structures where findings from assurance are discussed, promoting a culture of continuous learning and improvement. Controllers are also responsible for monitoring the impact of implemented changes through ongoing evaluation. They track the provider's performance and outcomes to assess the effectiveness of actions taken and make further offers of support and/or required challenge to the providers where adjustments are needed.

By fulfilling these responsibilities, Controllers play a crucial role in ensuring that our provider is not only learning from deaths but also continuously improving the quality of care provided to prisoners.

More generally HMPPS is committed to learning from all deaths and to taking action to address any issues that are identified as a result. The Follow-up to Deaths in Custody policy framework describes the early learning review process for all apparently non-natural deaths, through which cases are reviewed by the group safety lead and the resulting report considered by the Governor, the Prison Group Director and the National Safety Group. It also explains our commitment to supporting the various independent investigation processes that follow a death and particularly to meeting our duty of candour, including by disclosing all relevant documents.

The National Safety Group uses PFD reports alongside other sources of learning to identify themes to inform improved guidance, regular learning bulletins and the development of our approach to prison safety more generally. These themes are also discussed at regular meetings of group safety leads who share the learning with the prisons in their groups.

I am sorry that there were delays in the disclosure of material during these inquests. We have reviewed the handling of the inquests with Government Legal Department (GLD) and we believe that this was the result of the unusual circumstances of this case, which had a broad scope that reached into areas that are not commonly subject to such investigation. The Follow-up to Deaths in Custody policy framework sets out very clearly the requirement to retain documents relevant to the death and specifically notes that there may be a considerable delay between the death and the inquest, and that the coroner may ask for documentation not requested by either the police or the PPO, pointing out that it is therefore crucial that prisons retain all documentation available. In the vast majority of cases prisons are complying with this guidance and it is proving sufficient to meet the needs of coroners.

I am committed to a culture of transparency and openness throughout the organisation's work and this extends to our participation in all investigations into deaths in custody. It is vital that individual staff and the organisation is able to reflect on their actions and admit where failures have occurred. At an inquest, this approach is reflected in ensuring staff at all grades and in all circumstances are aware of our duty of candour and give their evidence honestly.

To date we have considered this approach to meet our duty of candour and have not routinely sought to make formal admissions in the way that you have advocated. Rather it has seemed appropriate to us to allow the jury to make their findings based on the evidence, as elicited by the Coroner and the representatives of the interested parties. Not making formal admissions in the context of the inquest does not imply any reluctance on our part to acknowledge failures or any lack of will to learn from them.

Following this inquest and the concerns that you have expressed about this approach we will review and consider this position with GLD and Counsel. If you have further thoughts on this issue that you believe would be useful for us to consider during this process we would be very glad to hear them.

Thank you again for bringing your concerns to my attention. I trust that this response provides assurance regarding ongoing work at HMP Lowdham Grange.

Yours sincerely,

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Director General of Operations