Ms Laurinda Bower
HM Area Coroner
Nottingham City and Nottinghamshire
The Council House
Old Market Square
Nottingham
NG1 2DT

By email only [redacted]

03 April 2025

Dear Ms Bower,

Thank you for your Prevention of Future Death Report ('PFDR') dated 7 February 2025 following the conclusion of the inquests into the deaths of Mr Binfield, Mr Richards and Mr Karbauskas who all sadly died in March 2023 at HMP Lowdham Grange.

I am responding on behalf of Serco to matters of concern that you have raised in the PFDR, in so far as they relate to Serco. I am aware that you will share a copy of this response with the families of Mr Binfield, Mr Richards and Mr Karbauskas and I would like to express my sincere condolences for their loss. Every death in custody is a tragedy, and the safety of those detained in our prisons is our absolute priority.

I am grateful to you for bringing the matters of concern to my attention and have responded to the issues below:

Failure to identify and share risk pertinent information between prison and healthcare staff.

Over the many years that we have been operating prisons on behalf of the MOJ, Serco has established and maintained excellent working relationships with the various Healthcare providers commissioned by NHS England to provide Healthcare provision within the prisons we manage. In the prisons that we manage on behalf of the Ministry of Justice, the Heads of Healthcare meet regularly with the relevant prison Director and the HMPPS Controller, and they attend our daily Senior Management Team (SMT) morning meetings, so they are able to engage with the SMT and raise any issues of concern on behalf of their own management team and staff. For those prisoners who have been identified as being at risk of self-harm and suicide members of the relevant Healthcare team are invited to ACCT Case Review and they give invaluable input to assist us in keeping the men in our care safe. Our staff are also aware of the need to liaise with Healthcare staff and make appropriate referrals to Healthcare or signpost prisoners to do so. However, as you will be aware, due to medical confidentiality requirements, custodial staff are not permitted to access the healthcare IT system, System One. As a result, we rely on healthcare staff communicating any risk pertinent information to custodial staff or our Safer Custody Departments if and when they feel that medical information, or information disclosed by prisoners which may be relevant to their risks come to their attention.

As you will appreciate many prisoners have multi-facetted issues including substantive histories of suicide attempts and self-harm, physical and mental health issues, substance misuse issues, and debt. Assisting them in managing such issues can be very challenging, particularly when, for whatever reason a prisoner feels unable to disclose their concerns to either healthcare or custodial staff. As you will no doubt appreciate, when used correctly, PNOMIS is an invaluable tool for recording and checking risk pertinent information for the prisoners in our care, particularly as it contains information from previous establishments. Previous ACCTs can also be very valuable. However, in many cases the PNOMIS account is very lengthy and if a prisoner has been on numerous ACCTs in a previous prison, the old ACCTs (if closed) may not be received with the prisoner, and even if they are, they are often too voluminous for staff to review meaningfully. This is particularly the case in local remand prisons, given the high number of new prisoners arriving daily, many of whom have a substantial history of self-harm and/or suicidal ideation. In addition, often the risks detailed in old ACCTs are not still relevant at the time a

prisoner is transferred as individuals' risks can change with their circumstances. Unfortunately, due to resource constraints, it is not always possible for staff to fully review PNOMIS or old ACCTs, although the expectation would be that staff prioritise these tasks for prisoners who have only recently been on an ACCT or are on an ACCT at the time of their arrival. Of course, any risk pertinent information should be communicated to the Safer Custody team on a prisoner's arrival, so that necessary steps can be put in place to keep that prisoner safe. Serco staff are always encouraged to record all risk pertinent information and to share this information with each other (via handovers and wing observations books), with Safer Custody and with Healthcare, where applicable, by telephone or email. Your concern regarding email being used to communicate with specific members of the healthcare team is also noted, and I have requested a review of the practice used across the Serco estate to ensure that staff are not just communicating with specific email addresses, in case the individual to whom the emails are addressed are not on shift.

Failure to learn from deaths over many years.

By way of background, I can confirm that Inquests relating to deaths of prisoners in Serco's custody are managed by our in-house Inquest Solicitor. She works closely with the staff and management of the prisons Serco manage, and particularly with the Heads of Safer Custody. Her role includes reporting to me, the Serco Justice and Immigration Director, Prison Directors and Prison Heads of Safer Custody throughout the Inquest process, starting upon notification of a death right through to the inquest conclusion and beyond. She liaises with the Prison Directors and Heads of Safer Custody to ensure that swift and comprehensive action is taken to remedy any issues identified following a death in custody, not only in the prison where the death occurred, but across our custodial estate.

Our Inquest Solicitor reports to and attends quarterly Safety Forum meetings, along with the Heads of Safer Custody and members of the Serco Psychology Team for each prison. These pan custodial meetings are chaired by the Head of Prisons and Immigration Removal Centres and a Serco Prison Director. Our Inquest Solicitor reports on issues arising from investigations, PPO reports and Inquests, so that a full and frank discussion can take place to ensure that learnings are cascaded, and relevant changes/improvements put in place and are rolled out across the estate.

I am aware of your concern that following previous deaths in custody, learnings do not appear to have been fully embedded operationally by staff 'on the ground'; this is also a concern for me, particularly when I learned during these Inquests of the 'cultural issues' at Lowdham Grange prior to and after the handover of the prison to Sodexo. As you will no doubt be aware, some of the issues identified during these Inquests are issues that are repeated in other Inquests involving deaths in custody across the prison estate, not just in Serco-run prisons. Sadly, some of the issues relate to the most basic requirements upon PCOs such as ensuring that proper checks are completed to ensure that prisoners are safe at roll counts and welfare checks, the covering of observation hatches is challenged, and that risk pertinent information is properly recorded in PNOMIS.

I am aware that the jury made findings that IT issues, poor staffing levels, and several cultural legacy issues contributed to the deaths of all three prisoners and that many of the issues have been raised in previous cases at Lowdham Grange. I note and share your concern that lessons have not been fully learned from previous deaths in custody. However, it is my understanding that the vast majority of the staff confirmed in evidence that they were aware of the correct processes, and had received training on the issues, but could either not specifically recall the detail of such training or re-training, or simply failed to follow the correct processes, despite being aware of them. It is my understanding that several middle managers at the prison also accepted during their evidence that it was not only their responsibility to ensure that PCOs were following the correct processes, but that they failed to do so. Serco is grateful to you for alerting us to this issue, and we are taking steps to ensure that staff in middle management positions are fully tasked with ensuring that more junior staff are not only aware of the numerous prison processes, are regularly reminded of them, and that managers ensure that the processes are consistently followed and enhanced quality control checks are put in place.

As you will be aware, staff receive training in the initial training course and are regularly reminded of issues identified as requiring updates. Traditionally notices to staff and Toolbox Talks have been utilised to remind staff of the requirements, but I share your concern that the message is not fully 'landing with staff' and unacceptable

practices persist. In light of the concerns that the issues identified, and remedial actions are not fully embedded across our estate we have recently created a new role of Pan Custodial Safety Lead and appointed an Assistant Director with extensive operational experience. She is responsible for driving the safety and well-being of individuals across all custodial sites by leading initiatives that improve outcomes related to self-harm, suicide, violence, and debt. She will assist in chairing the Safety Forum meetings and will liaise with the Inquest solicitor, to ensure that lessons are learned and that improvements are fully embedded operationally following review of investigations, PPO reports, Inquests and any PFDRs issued in the future. Serco sees her appointment as bridging the gap between the legal team and the operational issues, and it is certainly intended that her appointment will assist in ensuring that lessons can be fully embedded following all future deaths and Inquests.

As you may also be aware Serco has introduced initiatives across our prison estate, above and beyond the safety measures required by HMPPS, as a direct result of learnings from previous deaths, which we believe assist staff in keeping the men in our care safe. Examples of this are 'Under the Influence' processes trialled in some of our prisons and ensuring regular welfare checks are embedded in the prison regimes. We are also in the process of establishing a joint operational forum with other private providers – to identify common operational issues and share good practice and lessons learned to assist in keeping the men in our care safe.

I can assure you that Serco will continue to learn lessons from deaths of prisoners across our estate, and we are continuing to strive to ensure that all remedial actions are embedded operationally, which will continue to be monitored by our Pan Custodial Lead.

A failure to act with candour when engaging in post-death investigations.

As Serco no longer operated the prison at the time of the deaths of Mr Binfield, Mr Richards or Mr Karbauskas, we did not receive any official notification of their deaths and initially the only information known to Serco was that published in the press. We were not made aware that there were issues with the transfer of the prison which could potentially have impacted on the deaths of the three prisoners until your office notified us. As we no longer managed the prison when the deaths occurred, we were not entitled to see any documentation relevant to the three prisoners nor were we entitled to contact any staff involved in the deaths, as by that time they were Sodexo employees. It was therefore not possible for Serco to carry out investigations into the deaths to ascertain whether there were any issues which we could assist you with.

Once Serco had been granted IP status, our Inquest solicitor attempted to collate any relevant information and documentation to assist you in your investigations. As I understand was made clear during the Inquests, there were some technical issues during the transition to Sodexo, which resulted in difficulties in various documents being located, for which I apologise.

In relation to the issue of candour, I understand that several issues, including certain points of culture, only came to light during the oral evidence of the various witnesses through questioning from you, and were not fully detailed in the written statements disclosed before the Inquest commenced. In addition, the facts that all three men died after the transfer of the prison to Sodexo, that two of the men arrived at the prison after the transfer and our lack of visibility of issues prevailing in the prison after the transfer, led to inevitable difficulties in Serco being in a position to make admissions, to assist the jury by limiting the issues they were required to consider. However, I understand that the senior Serco leaders who gave evidence did make appropriate concessions during their evidence. I can however provide an assurance that in similar cases in other jurisdictions the issue of candour is fully considered and, where appropriate, admissions are considered and made.

In addition to the issues you have raised in you PFDR, given some of the issues aired during the cluster Inquests we have made a commitment to undertake a 'lessons learned' exercise with the MOJ and Sodexo, facilitated by the Cabinet office to identify aspects of the transition that went wrong, with a view to production of a Transitions Playbook for future use

Thank you again for bringing your concerns to my attention. I can assure you that Serco is fully committed to keeping the often-vulnerable men on our care safe and well and I hope you are reassured by this response to the issues raised .

If I can be of any further assistance, please do not hesitate to contact me.

Yours faithfully

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Managing Director, Justice & Immigration
Serco UK & Europe