	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Minister of State for Prisons, Probation and Reducing Reoffending ('Minister for Prisons')** **2. NHS England, Prison Healthcare Commissioners for HMP Lowdham Grange ('NHSE')** **3. [redacted], Managing Director for Justice and Immigration Services, Serco** **4. [redacted], Justice Director, Sodexo** **5. [redacted], Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust**
1	**CORONER** I am Miss Laurinda Bower, HM Area Coroner for **Nottingham City and Nottinghamshire**
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5 April 2023, I commenced an investigation into the death of Anthony Binfield, David William Richards and Rolandas Karbauskas. The investigation concluded at the end of an inquest, heard before a jury, calling evidence on dates between 4 November 2024 and 7 February 2025. The conclusion of the inquest was that Anthony, David and Rolandas had all died as a result of self-inflicted ligature asphyxiation, while in state detention at HMP Lowdham Grange, within a 19-day period of one another. The jury found multiple failings and missed opportunities in their care had probably more than minimally contributed to their deaths.
4	**CIRCUMSTANCES OF DEATH** Serco had operated HMP Lowdham Grange, Nottinghamshire, for 25 years under the provisions of a Private Finance Initiative ('PFI'). When the PFI expired on 15 February 2023, the Ministry of Justice awarded the prison operator contract to Sodexo. This was the first private provider to private provider prison transfer to take place in England and Wales. To facilitate the contract exit and transfer, Serco, Sodexo and HMPPS each established their own mobilisation and transfer team to oversee the project between August 2022 and February 2023. Sodexo assumed operational control of the prison on 16 February 2023. On 6 March 2023, Anthony Binfield was declared deceased inside his cell, having died as a result of using a ligature. His death was the result of suicide. On 13 March 2023, David William Richards was declared deceased outside his cell, having died as a result of using a ligature. His death was accidental. On 25 March 2023, Rolandas Karbauskas was declared deceased outside his cell, having died as a result of using a ligature. His death was the result of suicide.

	All three men had vulnerabilities and had been in contact with prison and healthcare staff concerning these vulnerabilities in the period shortly before their deaths. There were multiple missed opportunities to have considered the risk pertinent information held within various systems and records when engaging with all three men. The jury found that there were shortcomings in the culture and systems with regards to prison and healthcare services, which contributed to the three self-inflicted deaths. Further, the jury found that the way in which the mobilisation and transfer of the prison contract had been conducted, probably more than minimally contributed to the deaths.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – **Matters of Operational Concern** While the evidence called at inquest relates to HMP Lowdham Grange, these issues are likely to be relevant across the prison estate, and for that reason I highlight my concerns to both the Minister for Prisons and NHS England as commissioners for prison healthcare. **1. Recruitment, retention and training of prison and healthcare staff (response required by the Minister for Prisons and NHSE)** *Staffing levels* I heard compelling evidence from prison and healthcare staff who told me they were overwhelmed, over-burdened and under-supported in their work at HMP Lowdham Grange. I understand from both prison providers (Serco and Sodexo) and the Healthcare Trust (Nottinghamshire Healthcare NHS Foundation Trust), that recruitment and retention of staff was a persistent challenge, meaning more often than not the staff on shift were required to cover more than their fair workload. This led to low staff morale, higher levels of sickness absence, and an inevitable deterioration in prisoner safety. The inadequate prison and healthcare staffing levels led to a restricted regime and healthcare provision. The prison was unable to offer keywork to all men, and the mental health team could no longer offer a named nurse service. Both of these aspects of care are fundamental to supporting the most vulnerable prisoners. For months prior to the deaths, the Trust failed to fulfil its commissioned obligations to provide a nurse during night state. Prison staff have only basic first aid training and lacked the expertise of a medical professional when attempting to provide CPR to Anthony. *Skill mix and experience* I am concerned by the failure to retain experienced prison officers and healthcare staff. The private prison operator and the Authority were focused on the number of staff, rather than the skills set or experience of the staffing body as a whole. One PCO told me that he was considered the most senior on shift in the houseblock with less than 2 years' experience of working as a prison officer. The healthcare team had worked for a protracted period with no permanent Head of Service in post. Without a sufficient number of experienced staff, the prison had lost organisational memory, allowing poor custom and practice to become the norm amongst inexperienced and overwhelmed staff. *Training* All of the prison staff had completed the ITC programme, and yet there was widespread evidence of failures to do the basics. Staff failed to ensure the welfare of prisoners at roll count, failed to challenge flagrant breaches of prison rules such as passing items under cell doors, and did not know how to properly deal with obscured cell observation hatches. This calls into question the adequacy of their basic training, and the system for supervision and mentoring during the early years of practice.

Healthcare staff were often not included in the same training as prison staff, and where agency staff were used to fill vacancies, they were not part of Trust training. Again, this led to poor custom and practice such as failing to read medical records before reviewing the mental health and wellbeing of the prisoners.

Accepting there is a complex interplay between staffing numbers, experience and quality of training, I highlight to you my concern that continued understaffing of prison and healthcare teams will undoubtedly contribute to future deaths in custody.

2. **A complete failure to identify and share risk pertinent information between prison and healthcare staff, and within those teams (response required from the Minister for Prisons, NHSE, Serco, Sodexo and Nottinghamshire Healthcare NHS Foundation Trust)**

The staff remaining at the prison in March 2023 were, by their own admission, firefighting what was in front of them, rather than working in a collaborative and holistic way to better serve prisoner safety.

There was a complete breakdown in the system of risk identification and information sharing. Prison and healthcare staff did not routinely consider information captured within the electronic systems, nor did they update the systems with risk pertinent information gathered during interactions with the prisoners.

The prison records (the core file and P-NOMIS) and healthcare records (systemone) are a valuable source of risk pertinent information, that will enable prison and healthcare staff to comply with the mandatory requirement of PSI 64/2011 *"All staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence, and take appropriate action*."

Many prison and healthcare witnesses believed there was no working system in place at HMP Lowdham Grange to allow them to identify and share risk pertinent information. As a result, operational decisions were made in silo, and interactions with Anthony, David and Rolandas, were conducted without due consideration of their risk pertinent information.

This causes concern from both a training and policy perspective.

It would be impossible for prison and healthcare staff to remember the triggers for each and every prisoner in their care. Therefore, the system in place needs to make it as easy as possible for staff to quickly and readily understand the risk that exits for the prisoner and what might trigger that risk to materialise in any given circumstance. In this case, as in previous deaths, there was excessive focus on the prisoner's *current* presentation (i.e. the absence of saying they were going to harm themselves) without any understanding of their previous self-harm and suicidality.

Specific missed opportunities included:

- a failure by prison and healthcare staff to read the incoming prisoner's core file. This hard copy file contains valuable information such as previous ACCT documents and SASH warning forms, yet instead of reviewing this material and pulling out key triggers for past self-harm and suicidality and recording the same on P-NOMIS and/or systemone, the files were sent straight to storage. This is despite the fact that a background history of deliberate self-harm is an evidence-based risk factor for suicide as set out in PSI 64/2011
- Healthcare staff concluding on Friday 3 March 2023 that Anthony's inability to attend a candle lighting service might be a trigger for self-harm, but such was not communicated to prison staff or safer custody or recorded on any prison systems
- David's PNOMIS file clearly indicated his fear of joining the general prison population led to him requiring VP status in his previous establishment. However, the officers who sought to move him from the induction wing had not read his notes nor were they aware of the content of his previous ACCTs.

HMPPS, prison and healthcare providers need to carefully scrutinise the system for identifying risk pertinent information to ensure that the staff on the ground know how and when to access that information to support timely risk assessment when engaging with prisoners. This is especially important in the early days in custody setting, but not exclusively so.

I am also concerned by the use of email to convey risk pertinent information. In this case, prison staff communicated their concerns about Anthony's mental health to individual nursing Sodexo email inboxes, which the nurses were not expected to regularly access. The use of email means that such concerns are not accessible to other members of staff as they would be if they were recorded in PNOMIS or Systemone.

Again, this needs to be addressed in policy and re-enforced in training. Staff told me that while the PSI mandates they should be aware of risks and triggers, there was no clearly documented system setting out how and when this should occur.

3. **The system for transfer of prisoners between establishments is disorganised and unsafe (Minister for Prisons)**

I heard evidence in the course of exploring David's death, that he was transferred from the vulnerable prisoner unit ('VPU') at HMP Chelmsford to HMP Lowdham Grange, a prison which did not offer a VPU. David had been afforded VP status as a result of publicity about his business affairs and the nature of the offence that had resulted in his incarceration. He was scared that he might be targeted for violence and/or extorsion by fellow prisoners on account of this.

David had been on 4 open ACCTs at HMP Chelmsford and had told his ACCT case co-ordinator that he was fearful of losing his VP status on transfer. While the Prison Director said he would have expected both HMP Chelmsford and HMP Lowdham Grange to have spoken about this risk in advance of the transfer, there is no evidence that any individual fully explored this potential trigger, and David was not informed that his VP status was being rescinded on leaving HMP Chelmsford.

Between 20 October 2021 and 10 January 2022, Anthony made 17 applications to transfer to another prison because he did not feel safe at HMP Lowdham Grange. There were numerous intelligence reports to substantiate that Anthony was at risk of harm from others, and that, on occasion, he had been assaulted. Anthony's applications were dealt with in a haphazard manner. He did not receive a formal answer to his transfer request and had to chase many times for updates. This left Anthony feeling frustrated.

I heard evidence that there is no formal policy framework or system for managing the progress of prison-to-prison transfers, including a lack of expected response times or formal escalation plan if a prison fails to provide any response.

Notwithstanding the pressures on prison population management, it was agreed that the system for administering such applications should be co-ordinated and predictable, regardless of the success or otherwise of the application, rather than leading to prisoner frustration in waiting for answers that never come.

4. **Failure to reduce isolation of Foreign National Prisoners (Minister for Prisons)**

Prison can be an isolating experience for any prisoner, but especially so for one who does not speak English.

I heard evidence that the Big Word translation service did not work on multiple occasions across multiple sites within the prison. Staff gave evidence that even when the system did connect, they could be waiting in a queue for up to an hour to access an appropriate interpreter.

There was no plan to seek to reduce Rolandas' obvious isolation, and seemingly no provision for expediting his induction so that he could be housed with fellow Lithuanian speakers.

I have seen no evidence of a national or local plan to support Foreign National Prisoners. There is a clear risk of future self-inflicted deaths if language barriers and isolation are not adequately addressed.

5. **Drugs (Minister for Prisons)**

HMP Lowdham Grange, like many establishments, continues to face challenges related to novel psychoactive substance misuse.

There is no requirement for prisons to have an NPS specific drug policy and I am concerned that generic drug reduction strategies are ineffective against this particular threat.

NPS is highly dangerous and carries a risk of death. I am concerned that more young men will die in custody as a result of NPS use.

Matters relating to the transfer of the prison contract

6. **The process of transferring the prison from one private provider to another, lacked sufficient scrutiny of the safety of the prison before, during and after the contract exit/transfer process (Minister for Prisons)**

Safety was not front and centre of the Mobilisation and Transfer project.

I heard evidence from the HMPPS witnesses that there was a willingness to ensure that nothing like this ever happens again. However, I invite a formal response detailing exactly what action has been taken or is proposed, as it is likely that further transfers shall occur across departments when PFIs expire, or contracts change provider.

Matters relating to learning from deaths in custody

7. **Persistent Failure to learn from deaths over many years (Serco Justice Director, Minister for Prisons)**

Embedding learning from deaths
I heard evidence that many of the contributory factors leading to the deaths of Anthony, David and Rolandas, had been raised as issues in the investigations following previous deaths in custody at HMP Lowdham Grange.

While Serco no longer manage HMP Lowdham Grange, they continue to manage prisons, and there is a risk of future deaths if the organisation is unable to create a robust culture of seeking to identify issues early, adopt learning, and continually monitor culture to ensure any action taken is embedded to reduce the risk of future deaths.

From a HMPPS perspective, while private prison providers assume the operational risks of running the establishment, the HMPPS Controllers remain responsible for assuring a safe, decent and secure prison. I am concerned that the Controllers at HMP Lowdham Grange did not have a sufficient grasp of the longstanding cultural issues pertaining to safety. This raises the question of the efficacy of the Controller role and exactly how Controllers assure themselves that the provider is learning from deaths.

8. **A failure to act with candour when engaging in post-death investigations (Minister for Prisons, Serco, Sodexo)**

Full, frank and timely disclosure of potentially relevant material to those investigating deaths

The quality of any post-death investigation is predicated by the openness, honesty and transparency of the agencies involved.

This inquest was beset with disclosure failures by HMPPS. A significant volume of disclosure, running to thousands of pages, was provided to the court towards the end of the hearing despite many months of active case management.

HMPPS conduct their business primarily through emails, rather than any case management system, and it took a long time to review and supply this material to the court.

HMPPS have no effective system for gathering, retaining, reviewing and disclosing potentially relevant material so that the issues relevant to death can be identified and learning put in place.

If the process of learning from deaths is obfuscated by failures in the disclosure process, there is a risk that deaths will occur in the future from matters which could and should have been rectified.

Candour

The Healthcare Trust are subject to a statutory duty of candour. HMPPS, Serco and Sodexo failed to embrace the same ethos during these investigations.

Consequently, there was minimal acceptance of the risk factors set out above, all of which may cause or contribute to deaths in the prison in the future. I have shared my concerns previously with those at HMP Lowdham Grange (PFD report relating to Christopher Howard Smith, dated 7 July 2023). I am troubled that unless there is a radical change in culture, and reflective learning from deaths is prioritised, prisoners will continue to die in custody.

	It is most concerning that there is a marked discrepancy between the failings that were admitted in oral evidence by the vast majority of witnesses when faced with irrefutable evidence, against the written statements submitted to the coronial investigations which contained very little, if any, reflection and candour. Even after the evidence had been called, the prison organisations did not respond to my request to advance admissions in order to relieve the jury of the burden of making findings on each and every issue. I would like to understand any action proposed by the Minister, Serco and Sodexo to address the issue of candour.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take action in relation to the above matters. (1) Minister for Prisons and NHSE (2) Minister for Prisons, NHSE, Serco, Sodexo and Nottinghamshire Healthcare NHS Foundation Trust (3) Minister for Prisons (4) Minister for Prisons (5) Minister for Prisons (6) Minister for Prisons (7) Serco Justice Director and Minister for Prisons (8) Minister for Prison, Serco and Sodexo
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4 April 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** In addition to the organisations identified above, I have sent a copy of my report to the Chief Coroner and to the Interested Persons. I am also under a duty to send the Chief Coroner a copy of the responses received from the organisations listed in section 6 above. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	DATE 7 February 2025  Signature Laurinda Bower, HM Area Coroner, **Nottingham City and Nottinghamshire**