HM Prison & Probation Service

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Director General of Prisons
HM Prison and Probation Service
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Miss Laurinda Bower,
Area Coroner for Nottingham City & Nottinghamshire
The Council House
Old Market Square
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16 July 2026

Dear Miss Bower,

Thank you for your Regulation 28 report of 20 May 2026 following the inquests into the deaths of Mr Ricky Crosher on 11 October 2023 and Mr Matthew Osborne on 25 November 2023 at HMP Lowdham Grange. I am responding on behalf of the Governor of HMP Lowdham Grange as the Interim Director General of Prisons.

I know that you will share a copy of this response with the families of Mr Crosher and Mr Osborne, and I would first 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.

Following evidence heard at the inquest you have raised concerns in relation to the operation of both the Safer Custody and Care and Separation Unit functions, as well as the working relationship between prison and healthcare staff.

Your first concern is around staffing and resource within the Safer Custody function at HMP Lowdham Grange. As of March 2026, the Safety team now has a full complement of staff, and to enable the team to be consistently visible across the establishment, the resource has been ringfenced, meaning that staff cannot be redeployed to carry out alternative routine duties. This ensures the staff in the team have the opportunity to actively engage with the most vulnerable prisoners and ensure that appropriate care and support is consistently provided.

The Safety team are also responsible for the management of the Safer Custody telephone line, which prisoners can call if they need some support. This telephone system was upgraded in March 2026 so that it no longer operates as a standalone system, and calls are now routed to a telephone located within the team's office, with a designated member of the team responsible for checking messages multiple times throughout the day. All calls are recorded in a logbook which is regularly reviewed by Safety officers, and appropriate action

is taken in response to any concerns or queries raised. The improved system allows voicemail messages to be retained for a period of 60 days, and the system has the capacity to store up to 100 messages at any one time.

Your third concern relates to the Care and Separation Unit (CSU) provision, which is used to manage and support more complex prisoners. Since August 2024 the running of the CSU has been overseen by a Governor supported by a Custodial Manager, a Supervising Officer, and a team of Band 3 officers.

In addition to the above CSU staffing structure the Duty Governor also completes weekly assurance checks to ensure oversight at senior management level. This weekly assurance visit allows for engagement with staff and prisoners and ensures that the unit is being managed as expected, and in line with HMPPS policy.

All members of operational staff assigned to work within the CSU are subject to a formal selection process where they must demonstrate their ability to deal with complex behaviours, whilst building and maintaining constructive and professional relationships with prisoners. Successful staff receive additional operational training to further develop their skills in recognising and responding to the diverse needs of the CSU population. CSU staff are rotated from the unit after a maximum of three years to maintain effectiveness and wellbeing.

The Governor has assured me that, in line with policy, any prisoner who is located in the CSU while subject to the Assessment, Care in Custody and Teamwork (ACCT) process will have undergone a thorough assessment to determine whether segregation is an appropriate environment for the individual and has determined that no other location is suitable. Should a move from segregation be deemed necessary but no suitable alternative location is available at that time ACCT observation levels are increased, and the prisoner's status reviewed at the earliest opportunity.

A member of the mental health team now attends ACCT reviews on a daily basis, contributing to the review process and helping to identify prisoners who may require additional support. Furthermore, there are clear and effective referral pathways in place for mental health, primary healthcare, and substance misuse services, ensuring that prisoners can access appropriate support in a timely manner.

Your fourth concern is in relation to lessons learnt from deaths in custody at HMP Lowdham Grange. In October 2024 the Governor of HMP Lowdham Grange introduced a Prevention of Future Deaths (PFD) meeting where recommendations arising from Early Learning Reviews, Prisons and Probation Ombudsman (PPO) investigations and Regulation 28 reports are regularly reviewed and actions raised. Assurance checks are conducted on all actions once completed to ensure that recommendations have been fully embedded and are operating effectively within the establishment.

Additionally, in April 2026 HMP Lowdham Grange appointed an Inquest and PFD Lead who is responsible for coordinating the prison's response to PFD matters and for providing oversight and assurance that learning is implemented and sustained across the establishment.

Your fifth concern relates to the retention of evidence pertinent to a death in custody. In November 2024 a system was introduced whereby all prisoner records are stored electronically and the database acts as a central repository for all relevant documentation, enabling the establishment to collate, manage and securely share documentation with external stakeholders. The introduction of this approach ensures that all documentation is

held in a single, controlled, location and access permissions are stringently managed. This system allows for information to be uploaded, tracked, and retrieved with ease, significantly reducing the risk of documents being misplaced or inadvertently destroyed.

Access to CCTV footage for Death in Custody purposes is managed by the Safety Team who are responsible for the identification, downloading and secure retention of relevant footage to ensure it is not overwritten. All footage is obtained, and retained, in line with a local protocol.

Your sixth concern is in relation to collaborative working between HMP Lowdham Grange and healthcare. In July 2025 Northamptonshire Healthcare NHS Foundation Trust assumed responsibility of HMP Lowdham Grange's healthcare provider. Since this change in provider communication and working relationships between parties has improved significantly. Healthcare representatives attend the daily morning briefing and provide updates on any issues arising from the previous day. In addition, a structured daily handover takes place between healthcare and prison staff to ensure continuity of care and effective information sharing.

HMP Lowdham Grange also detail a minimum of two operational members of staff every day to be designated Healthcare Officers. These officers move around the establishment facilitating the movement of prisoners who are attending healthcare appointments in line with the individual wing regime, supporting the efficient delivery of healthcare services and improving prisoner access to care. There has also been an increase in healthcare staffing levels, enhancing the provision of care within the establishment.

I hope the measures outlined above taken by HMP Lowdham Grange provide you with reassurance that learning and appropriate action has been taken from the circumstances of Mr Crosher and Mr Osborne's deaths.

Yours sincerely

Interim Director General Prisons