REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013	
1.	**CORONER** I am Miss Laurinda Bower, HM Area Coroner, for the coroner area of Nottingham City & Nottinghamshire.
2.	**DATE OF REPORT** 20 May 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. The Governor of HMP Lowdham Grange, Nottingham 2. Head of Healthcare, HMP Lowdham Grange, Northamptonshire Healthcare NHS Foundation Trust (*concern 6 only*) You are under a duty to respond to this report within 56 days of the date of this report, namely by July 16, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** **1. Failure to have in place an appropriately staffed and resourced Safer Custody function**

	2. **Failure to have in place a robust system for managing the safer custody telephone line** 3. **Failure to provide a safe Care and Separation Unit which adhered to expected policy and minimum standards of decency** 4. **Persistent failure to have in place a robust system for learning from deaths** 5. **Failure to retain evidence pertinent to the death** 6. **Failure to ensure a safe and productive working relationship between prison and healthcare staff**
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** This court has been concerned with investigating the circumstances of a series of self-inflicted deaths of prisoners at HMP Lowdham Grange, Nottinghamshire. This is the third prevention of future death report to follow the respective inquests. Ricky Crosher died on 11 October 2023. An investigation into his death was opened on 25 October 2023. The inquest into Ricky's death was held before a jury and concluded on 28 November 2025. Matthew Osborne died on 25 November 2023. An investigation into his death was opened on 7 December 2023. The inquest into Matthew's death was held before a jury and concluded on Ricky's was the fourth self-inflicted death to occur at the prison in the first 9 months of the Prison contract being taken over by Sodexo, following the first private provider to private provider operator contract transfer in England (February 2023). Matthew's was the fifth. HMPPS stepped-in to control the prison in December 2023. The conclusion of the jury at the respective inquests was that: Ricky died as a result of suicide contributed to by neglect, with multiple failings identified as contributing to his death. Matthew died as a result of suicide contributed to by neglect, with multiple failings identified as contributing to his death.
9.	**CIRCUMSTANCES OF DEATH** Ricky Crosher arrived at HMP Lowdham Grange in July 2023. In the months before his death, he was identified as at increased risk of suicide and self-

	harm, therefore an ACCT was opened. The ACCT was not managed in accordance with the policy. Ricky rang the prison's Safer Custody telephone line. This was a voicemail box which could be accessed by prisoners using their in-cell telephony. The system was designed as a way for prisoners to request support from Safer Custody by leaving a message with the name and location, and a Safer Custody trained officer would then listen to the message and respond accordingly. Ricky left multiple messages on that voicemail inbox in the days prior to his self-inflicted death. There is no record of whether these messages were listened to, but certainly no action was taken to see Ricky, despite him being on an ACCT and asking for someone to speak with him urgently. In the hours prior to Ricky being discovered deceased in his cell, ACCT checks were documented as having taken place, but CCTV showed these checks did not occur. Further, Ricky's cell hatch was noted by officers to be covered but no attempts were made to remove the covering despite there being no response from Ricky inside the cell. Matthew arrived at HMP Lowdham Grange on 20 June 2023. He made a number of serious attempts on his life by ligature and was placed on an ACCT. He was detained in the prison's Care and Separation Unit from 3 October 2023 until he died on 25 November 2023. CSU staff were unaware of the previous attempts he had made on his life, and the prison failed to manage his ACCT in accordance with the policy. Again, ACCT checks were recorded in the documentation which simply had not occurred. Matthew's mental health deteriorated significantly while on CSU and his continued detention in segregation was not managed in accordance with prison policy. He had no reintegration plan. There was a lack of input from Safer Custody. He was housed in a cell which did not meet basic standards including a lack of mattress. In the hours before his death, segregation staff who were supposed to be on the landing conducting ACCT and welfare checks were instead using the TV in the adjudication room to keep track of the football reporting. Prior to the inquest, the court was informed that the CCTV footage from the unit had corrupted so that certain time frames from certain cameras was lost. Mid-inquest, some of this footage was discovered embedded within folders marked with different dates/time stamps. Some of the footage was never recovered, in particular the footage from outside Mathew's cell when he was relocated and had been handed fabric item. In each case, there was evidence of a strained relationship between prison and healthcare staff which was to the detriment of prisoner safety.

	Some of these serious failings in care were repeated from previous deaths in custody at the prison, suggesting a sustained failure to learn from previous deaths, and occurred at a time when there were sustained concerns about Sodexo's ability to run a safe, secure and decent prison. Whilst I appreciate these failings in care occurred at a time when Sodexo was responsible for the operation of HMP Lowdham Grange and the prison has now transferred to the public sector, this report is concerned with preventing *future* deaths, and so I alert the current HMPPS Governor of my concerns to ensure that staff, many of whom have TUPED over from Sodexo, do not repeat these mistakes leading to deaths in the future. The same is true in relation to healthcare. The contract has now moved to Northamptonshire Healthcare NHS Foundation Trust, and I would welcome an update from the new provider on steps taken to address the working relationship between the new providers.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: **1. Failure to have in place an appropriately staffed and resourced Safer Custody function** **2. Failure to have in place a robust system for managing the safer custody telephone line** **3. Failure to provide a safe Care and Separation Unit which adhered to expected policy and minimum standards of decency** **4. Persistent failure to have in place a robust system for learning from deaths** **5. Failure to retain evidence pertinent to the death** **6. Failure to ensure a safe and productive working relationship between prison and healthcare staff**
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to:

	[please do not use individual's names, but instead roles/titles] • **Ricky's Family** • **Matthew's Family** • **HMPPS** • **Sodexo** • **Northamptonshire NHS Foundation Trust (the new healthcare provider)** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** **Miss Laurinda Bower** **HM Area Coroner** **Nottingham City and Nottinghamshire**