

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Benjamin Walter, a prisoner at HMP Lowdham Grange, on 20 August 2021**

**A report by the Prisons and Probation Ombudsman**

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## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Benjamin Walter died from synthetic cannabinoid (psychoactive substances) toxicity on 20 August 2021 at HMP Lowdham Grange. He was 31 years old. I offer my condolences to Mr Walter's family and friends.

Mr Walter was able to access drugs at Lowdham Grange with apparent ease. However, he was consistently reminded of the risks of using illicit substances but was generally unwilling to accept support from the substance misuse service. His death appears to have been an accidental result of drug use.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**April 2024**

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## Summary

### Events

1. Mr Benjamin Walter was serving an 18 year sentence for murder. He had been in prison since June 2012 and had been at HMP Lowdham Grange since March 2014.
2. Mr Walter had a long history of substance misuse, including psychoactive substances (PS) and was generally unreceptive to offers of support from the substance misuse team. Mr Walter did try to limit his PS use during the early part of 2021, but on 9 June, he told his substance misuse worker that he no longer wished to curtail his use.
3. During a standard welfare check at 2.07am on 20 August, Mr Walter was seen lying on his bed in a strange position. Staff radioed a medical emergency code and went into the cell and commenced resuscitation. A nurse responded quickly and after noting that Mr Walter had clear signs of death, decided that further efforts to try to resuscitate him should cease.
4. The post-mortem examination found that Mr Walter died from synthetic cannabinoid toxicity.

### Findings

5. Mr Walter was able to access illicit drugs with apparent ease at Lowdham Grange. However, he was offered appropriate support from the substance misuse team but was generally unwilling to accept advice about his PS use.
6. Although Lowdham Grange has put in place extra measures to reduce illicit drug supply since Mr Walter's death, there are still weaknesses in the processes. The prison does not have a specific PS reduction strategy and many of the initiatives to reduce drug supply and demand are undermined by staff shortages. Staff searching at the gate is not always completed and the prison is not running intelligence led drug testing or completing the number of suspicion cell searches requested.
7. The clinical reviewer concluded that the clinical care Mr Walter received at Lowdham Grange was equivalent to what he could have expected to receive in the community.

## The Investigation Process

8. HMPPS informed us of Mr Walter's death on 20 August 2021.
9. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Walter's prison and medical records.
11. The investigator interviewed two members of staff at HMP Lowdham Grange on 20 June 2023. The interviews were conducted via video-link. The investigation was then transferred to one of the investigator's colleagues.
12. NHS England commissioned a clinical reviewer to review Mr Walter's clinical care at the prison.
13. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Walter's father to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Walter's father did not raise any matters.
15. We shared our initial report with HMPPS and with Mr Walter's father. HMPPS pointed out a factual inaccuracy with the name of the prison's Head of Safety, Health and Wellbeing, and this report has been amended accordingly. Mr Walter's father did not make any comments.

## Background Information

### HMP Lowdham Grange

16. HMP Lowdham Grange is a Category B male adult prison located in Lowdham, Nottinghamshire, and accommodates up to 888 prisoners. The prison was operated by Serco for 25 years but on 16 February 2023, Sodexo took over the running of the prison. This was the first time a prison had transferred from one private contract manager to another. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

### HM Inspectorate of Prisons

17. The most recent inspection of HMP Lowdham Grange was in May 2023. Inspectors reported that the prison was not safe, with high levels of drug use and violence. The transfer from Serco to Sodexo had led to uncertainty and anxiety among prisoners and staff, with significant numbers of key and specialist staff leaving.
18. The availability of drugs had increased. The security department had lost staff and there was a backlog of intelligence reports that had not been acted on. Inspectors were told that the primary source of drugs was staff corruption and smuggling at social visits. Despite this, staff were not searched often enough, there was no enhanced gate security and checks on staff and visitors entering the prison were inadequate.
19. Data, including that on violence and self-harm predating the transfer, was lost which made it hard for the new leaders to understand the scale of the problems. Meaningful strategies to tackle drugs, debts, bullying and gang-related violence had not been developed. Not all violent incidents were investigated, and challenge support and intervention plans (CSIP) were not being used effectively to manage perpetrators of bullying or support victims.
20. The restricted regime put in place during the COVID-19 pandemic had continued for too long and although the new Director had quickly implemented a new regime, too many prisoners had too little time out of their cell. Access to work and education was poor and too little keywork was being delivered.

### Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2023, the IMB reported that the safety of the prison had deteriorated. There had been an increase in the number of prisoner-on-prisoner assaults, in self-harm and in weapons finds. Almost 20% of mandatory drug tests were positive and prisoners under the influence of psychoactive substances were an almost daily occurrence. The IMB feared that the prevalence of drugs was likely to increase the negative impact of gang culture and make prisoners feel less safe.

22. The Board considered that relationships between staff and prisoners had deteriorated and there had been a significant reduction in purposeful activity which had led to prisoners spending long periods locked in their cells. Healthcare services continued to be under great pressure and the IMB considered that physical and mental healthcare was at a lower standard to that in the community.
23. The Board issued an addendum to their annual report covering the period 1 February to 31 March 2023. The management and operation of the prison passed from Serco to Sodexo on 16 February 2023. The Board noted serious concerns relating to the operation of the prison and implications for safety over the next six to seven weeks. The number of prisoners on ACCTs more than doubled, from 13 to 32, between the end of February and the end of March. A significant number of staff had left since the change in contract was announced in August 2022. IMB members had noticed low staffing levels on all wings.

### **Previous deaths at HMP Lowdham Grange**

24. Mr Walter was the ninth prisoner to die at Lowdham Grange since June 2018. Of the previous deaths, three were drug related, two were self-inflicted and three were from natural causes. In our investigation into one of the self-inflicted deaths, we were concerned about the apparent ease with which the prisoner had been able to access alcohol, which contributed to but did not cause his death. In our investigation into a drug related death in July 2021, we were concerned that the prisoner had been able to access psychoactive substances (PS) with apparent ease despite the prison being in lockdown due to the COVID-19 pandemic.
25. Up to the end of 2023, there had been six self-inflicted deaths at Lowdham Grange since Mr Walter's death, and two deaths from natural causes. In one of the self-inflicted deaths, we considered the availability of illicit drugs at the prison.

### **Psychoactive substances (PS)**

26. PS (formerly known as 'legal highs') continue to be a serious problem across the prison estate. They can be difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

## Key Events

27. On 15 June 2012, Mr Benjamin Walter was remanded to HMP Exeter charged with murder. He was convicted on 3 April 2013 and sentenced to life imprisonment with a minimum term of 18 years.
28. Following his conviction, Mr Walter spent time at HMP Winchester and HMP Garth before he was transferred to HMP Lowdham Grange on 27 March 2014.
29. At the end of 2014, Mr Walter was referred to the mental health team and assessed for an autism spectrum disorder (ASD). He was found not to have ASD and he was discharged from mental health services.
30. Mr Walter's records show that he was regularly seen under the influence of drugs, usually believed to be PS. In addition, he was regularly found in possession of fermenting liquid (home-made alcohol, known as hooch), and was sometimes believed to be under the influence of alcohol. Mr Walter's records suggested that he held hooch for other prisoners to help pay debts (or for payment) and he also often cleaned other prisoners' cells, also for payment. His records indicated that there were instances when Mr Walter was either subject to violence or had had threats made against him. These instances appear to have been debt related, but Mr Walter declined to move wings and indicated that his debts were manageable.
31. Each time Mr Walter was found under the influence, he was monitored until he had recovered, and he was also seen by the substance misuse team who would advise him about the dangers associated with drug use. Mr Walter was not generally receptive to the advice he was given by the substance misuse team so on 5 November 2020, he was referred to mental health services for support for his substance misuse and for issues relating to his family experiences. Following an initial assessment, Mr Walter was seen regularly: every three weeks by a mental health nurse and at two-month intervals by a psychiatrist.
32. Mr Walter's notes suggested he was experiencing some delusional thoughts. As there were no other signs of psychosis, his delusional thoughts were considered to be linked to his PS use and he was advised to reduce his usage.
33. Mr Walter was seen under the influence of drugs on 12 January 2021, and a member of the substance misuse team went to see him on 19 January. This time, Mr Walter responded positively and said that he would like to stop using PS completely before his misuse became a problem again. He said that he had managed to remain abstinent for two years from 2016 to 2017 when he had been supported by a friend who was a non-user and a positive influence on him. He told her that he was presently using PS twice a week. She discussed the various problems associated with drug misuse and gave Mr Walter a 'mini target' to remain drug free for the remainder of the week.
34. On 15 February, the member of the substance misuse team saw Mr Walter again when he said that he had reduced his PS to once a week. He said that there were no set days when he would use PS, but it would be when prisoners offered it to him as payment to clean their cell. He said that he would use PS at night after lock-up

and said he would only use enough PS to 'pass out'. Mr Walter said his goal was to attain abstinence in a month's time and to then become debt free.

35. On the evening of 7 March, Mr Walter was again seen under the influence. The member of the substance misuse team saw him the following day when he said that he had not been heavily intoxicated, and he was still only using once a week. When She saw Mr Walter again on 22 March, he said that he had not used PS for a full week.
36. Mr Walter continued to limit his PS use over the following weeks however, when the member of the substance misuse team saw him on 9 June, he said that he had resumed using around twice a week when alone in his cell. He said using PS made time pass more quickly. He said that he had no intention of stopping use of PS and did not consider the drug a problem: he said the only problem was when he could not afford to buy it. She reminded Mr Walter about the various risks associated with drug misuse, including the unknown strength of the supply and the dangers of using drugs when alone. Despite the advice, Mr Walter said repeatedly that he was fine and did not need any support. She noted that she encouraged Mr Walter to reduce his use of PS and reminded him about harm reduction. She noted that based on Mr Walter's responses, he would be taken off the substance misuse team caseload, but he could contact her again if he changed his mind and decided he needed support.
37. On 11 June, Mr Walter attended an adjudication hearing in relation to him having been found under the influence of drugs the previous month. A prison manager chaired the hearing and when she asked him if he had used a substance, he said that he had. He said he was a PS user, that he intended to continue using PS, and that the prison could not stop him. She told Mr Walter that he would die if he continued to use PS and he answered that he would not die. After telling Mr Walter that he was being selfish and that he should imagine his mother being told that he had died, she imposed a punishment of 14 days' loss of privileges. (Mr Walter had also been found guilty and punished at previous adjudication hearings.)
38. On 21 June, the member of the substance misuse team saw Mr Walter again after he was suspected to be under the influence. Mr Walter said that he had used an illicit substance, and said "I'm going to use it, I like to use it, it's not a problem". Mr Walter again declined further help from the substance misuse team and she again warned him about the various risks involved, including risks associated with mixing substances and the strength of substances.
39. There were no recorded instances of Mr Walter being seen under the influence during the following two months, although he was found in possession of smoking paraphernalia on 10 August.
40. Mr Walter's keyworker saw him for the last time on 11 August. She noted that Mr Walter appeared settled and he raised no concerns. She noted, however, that Mr Walter's hygiene was poor, and she encouraged him to improve.

## Events of 20 August

41. At around 2.00am on 20 August, two PCOs began making a standard welfare check of prisoners on houseblock 2 (where Mr Walter was located). PCO A reached Mr

Walter's cell at 2.07am and saw Mr Walter lying on his bed in a strange position. PCO B was checking cells on the opposite side of the landing and PCO A called to her for assistance. PCO A switched on the in-cell light and then radioed a code blue emergency (to indicate a prisoner is unconscious or having breathing difficulties). He also radioed the night orderly officer (the senior officer on duty) for permission to enter the cell. Permission was given immediately, and the two PCOs went into the cell. PCO A noted that Mr Walter's body was cold, stiff, and that he had no pulse. The PCOs then moved Mr Walter to the floor and PCO A began cardio-pulmonary resuscitation (CPR).

42. A nurse responded to the code blue call and arrived at Mr Walter's cell at 2.13am. While PCO A continued with CPR, the nurse checked Mr Walter with a defibrillator. The nurse noted that Mr Walter's clinical observations all indicated that there were no signs of life, and that rigor mortis was present in his jaws, neck, arms and legs. The nurse also noted that Mr Walter's eyes were open, and his pupils were fixed and dilated. After four cycles of checks with the defibrillator without success, the nurse told PCO A to stop further efforts to resuscitate Mr Walter as he was dead.
43. Ambulance paramedics were called when the code blue call was made and a first responder paramedic arrived at 2.32am. The nurse noted that on observing Mr Walter, the paramedic agreed that the nurse had made the correct decision to cease resuscitation.

### **Contact with Mr Walter's family**

44. Lowdham Grange appointed a family liaison officer (FLO). She telephoned Mr Walter's father at around 7.40am on 20 August to break the news of his son's death. In a follow-up conversation later that day, Mr Walter's father told her that he had adopted Mr Walter when he was a young child, and he gave her the first name of Mr Walter's birth mother. She obtained full contact details of Mr Walter's birth mother and telephoned her to break the news.
45. The prison contributed to the cost of Mr Walter's funeral in line with national policy.

### **Support for prisoners and staff**

46. One of the prison's senior managers debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
47. The prison posted notices informing other prisoners of Mr Walter's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Walter's death.

### **Post-mortem report**

48. The post-mortem report gave Mr Walter's cause of death as synthetic cannabinoid toxicity. Toxicology tests showed that Mr Walter had taken PS before he died. The pathologist noted that post-mortem examinations confirmed there was no anatomic (natural) cause for Mr Walter's death.

## Findings

### Drug strategy at HMP Lowdham Grange

49. We are concerned that Mr Walter was able to access PS with apparent ease. We acknowledge the huge challenges inherent in preventing drugs entering Lowdham Grange. The prison has a large perimeter and is situated in an open and accessible rural area vulnerable to 'throw-overs' and drones. The illicit drugs market in prison is controlled by organised crime gangs and the scale of the problem requires a co-ordinated approach. The threat from drugs is constantly evolving and more can always be done.
50. HMIP and the IMB both raised concerns in their most recent reports that it is easy for prisoners to access drugs in the prison. Following the transfer to Sodexo, the security department lost some experienced staff and some important statistical data. Nevertheless, several important measures have been introduced or are pending, including:
- A dedicated drug strategy manager was appointed in February 2023.
  - 100% staff search was introduced in October 2023.
  - Funding has been obtained to replace the netting covering all the exercise yards.
  - The outward opening windows on Houseblocks One and Two are being replaced with vented windows with meshes in January 2024.
  - Since March 2023, six members of staff have been dismissed or resigned for involvement in bringing drugs or mobile phones into the prison.
51. We note, however, that the prison does not have a specific PS reduction strategy. Additionally, many of the initiatives to reduce drug supply and demand at Lowdham Grange are undermined by staff shortages. Staff search at the gate is not always completed and the prison is not running intelligence led drug testing or completing the number of suspicion cell searches required. We raised concerns about these issues in a recently issued self-inflicted death investigation at Lowdham Grange and recommended that the Director should request support from HMPPS. As we are awaiting a response to that recommendation, we make no further recommendation in this case.

### Mr Walter's substance misuse

52. Mr Walter had a long history of using illicit substances in prison. Each time he was identified as being under the influence he was monitored until he had recovered and was then seen by the substance misuse team. Mr Walter was generally dismissive of offers of support, although in January 2021, he said that he would like to stop using PS. Mr Walter continued to limit his PS use over the next several months, although he said that he continued to use PS to some extent. However, when Mr Walter was seen by his substance misuse worker on 9 June, he said that he had resumed using PS twice a week and said that he had no intention of stopping. The

substance misuse worker reminded him of the risks with PS use, including the unknown strength of the supply.

53. Mr Walter reiterated his attitude to continued PS use at an adjudication hearing on 11 June when he said that the prison could not stop him, and he was dismissive of the suggestion that he would die if he did not stop.
54. We are satisfied that Mr Walter knew the dangers of PS use and consider he was offered appropriate support and guidance from the substance misuse team. We have found no evidence that Mr Walter intended to die on 20 August, but it is clear that his intention was to continue to use PS.

### **Clinical care**

55. The clinical reviewer concluded that the healthcare Mr Walter received at Lowdham Grange was equivalent to what he could have expected to receive in the community.
56. The clinical reviewer has made two recommendations that are not directly linked to Mr Walter's death but which the Head of Healthcare will need to address.

### **Governor to note**

57. While Mr Walter was offered ongoing support by the substance misuse team, the problem with Mr Walter's substance misuse was not discussed with him during his periodic key-worker meetings. It is clear that Mr Walter was generally unreceptive to advice about substance misuse. However, we consider that his keyworkers should have included discussion about his drug use during their meetings, including his responses. The Director might wish to consider how key-workers structure meetings with prisoners to focus on specific areas of concern.

### **Inquest**

58. An inquest into Mr Walter's death that was held on 26 June 2023 concluded that his cause of his death was synthetic cannabinoid toxicity.

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