Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Binfield, a prisoner at HMP Lowdham Grange, on 6 March 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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 Anthony Binfield died after being found hanging in his cell on 6 March 2023 at HMP Lowdham Grange. He was 30 years old. I offer my condolences to Mr Binfield's family and friends.

Mr Binfield's death was the first of three self-inflicted death at Lowdham Grange in March 2023. There had been a further two self-inflicted deaths by the end of 2023. Both HM Inspectorate of Prisons and the Independent Monitoring Board expressed concerns about the safety of the prison around the time of Mr Binfield's death. In February 2023, the management of the prison transferred from Serco to Sodexo and resulted in an exodus of staff alongside higher levels of drugs, violence and self-harm, less time out of cells and a deterioration in staff-prisoner relationships. Much data was also lost during the transfer. Given the issues we uncovered during this investigation and the further self-inflicted deaths since, I remain extremely concerned about prisoner safety at Lowdham Grange and I urge HMPPS and Sodexo to consider how they can support meaningful improvements.

Mr Binfield was able to access illicit drugs with apparent ease. He also appeared to be in debt and at risk from other prisoners. Lowdham Grange did not have adequate strategies in place to robustly address these issues, nor did staff consider how to keep him safe other than by him moving wings.

Staff did not check Mr Binfield as they should have done on the day of his death when he was suspected to have been under the influence of drugs. They also falsified records to state that they had. There was also an unacceptable delay of eleven minutes going into his cell when staff could not get a response from Mr Binfield and his observation panel was covered. This reduced Mr Binfield's chances of survival.

The clinical reviewer concluded that Mr Binfield was well supported by the mental health team and his care was equivalent to that he could have expected to receive in the community. I have also concluded that it was reasonable that staff did not consider Mr Binfield to be at heightened risk of suicide when he took his own life.

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 **January 2025**

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Summary

Events

1. On 15 June 2017, Mr Anthony Binfield was sentenced to an extended determinate sentence for wounding with intent to do grievous bodily harm. His custodial period was 12 years with an extended licence period of four years. Mr Binfield had a history of self-harm and psychoactive substance (PS) use in prison. He also had diagnoses of childhood Attention Deficit Hyperactivity Disorder (ADHD) and Emotionally Unstable Personality Disorder.

2. On 24 August 2021, Mr Binfield transferred to HMP Lowdham Grange from HMP Dovegate. Lowdham Grange was the seventh prison Mr Binfield had been in since 2017. On each occasion, he had been transferred at his own request due to being in debt and under threat from other prisoners.

3. Mr Binfield was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) four times in Lowdham Grange between 4 September 2021 and 15 June 2022. He eventually settled on M wing, completed education courses in-cell, was given a trusted job and gained enhanced status on the Incentives and earned Privileges (IEP) Scheme.

4. Mr Binfield was found under the influence of PS five times (including three times on a single day) between 30 August and 22 October 2022. Mr Binfield received mental health support from a nurse and psychiatrist due to his fluctuating moods, depression and self-harm.

5. Mr Binfield made numerous applications to transfer to another prison. Although the prison attempted to move him, he was rejected by several prisons for either not fitting their criteria or because he had been there previously and been moved for his own safety. The prison's ability to move him was also complicated by the reduction in transfers during the COVID-19 pandemic and then by the increase in prison population and lack of available space.

6. Mr Binfield temporarily transferred to HMP Wandsworth on 23 September so that his friends and family could visit him. He returned to Lowdham Grange on 3 November. He initially remained on the induction wing for an extended period due to concerns for his safety elsewhere in the prison. However, in January 2023, Mr Binfield requested a wing move due to being in debt and under threat. In February, he moved to H wing.

7. Staff found Mr Binfield under the influence of PS on 3 December 2022, 14 February, 3 March and 6 March 2023. On each occasion he received harm minimisation advice but declined to work with substance misuse services.

8. On 6 March, Mr Binfield was due to light a candle in the chapel to mark the anniversary of his son's death. The Chaplain tried to find him, but he was at a prison disciplinary hearing. Mr Binfield rearranged the appointment for the following week.

9. Mr Binfield made several phone calls to his girlfriend during the evening of 6 March. They argued and Mr Binfield ended their last call with the words, “I’m gone”. Later, an officer making an Under The Influence Welfare Log welfare check discovered Mr Binfield had covered his observation panel. He was unable to get a response from Mr Binfield but spent 11 minutes attempting to open the inundation point before a colleague removed it and he was able to see Mr Binfield hanging.

10. Officers gave Mr Binfield CPR and paramedics attended but Mr Binfield was pronounced dead. Staff found a suicide note in his waistband indicating that he did not feel able to carry on.

Findings

11. Lowdham Grange’s transfer from Serco to Sodexo was the first time a prison had been handed over from one private provider to another. The impact of the changes had been underestimated, not least the number of managers and staff who resigned when the contract change was announced or left in the early weeks after the transfer. Much data was also lost during the transfer. HMPPS will need to review the lessons learned to ensure smoother transitions between providers in future.

12. Mr Binfield had a number of factors that indicated he was at risk of suicide and self-harm including previous suicide attempts, self-harm, substance misuse, debts and the associated threat from other prisoners. His mental health, especially the personality traits associated with Emotionally Unstable Personality Disorder, meant that this risk fluctuated according to context but was never absent.

13. There were no obvious signs that Mr Binfield was at heightened risk of suicide on 6 March. His actions followed an argument with his girlfriend on the telephone (which prison staff did not know about), as well as it being near to the anniversary of his son’s death.

14. Under the Influence Welfare Log welfare checks were not made as they should have been on 6 March and the record was inaccurate.

15. Staff did not follow the correct procedure when Mr Binfield was found to have covered his observation panel. This led to an unacceptable delay before Mr Binfield’s cell was opened.

16. Mr Binfield appears to have been in debt and at risk of violence from other prisoners throughout his time in prison. There is no evidence that Lowdham Grange made any efforts to address these issues, apart from moving him from wing to wing. At the time he died, the prison had no specific debt management policy.

17. Mr Binfield was able to access PS with apparent ease. The prison does not have a specific PS reduction strategy and 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 requested.

18. The clinical reviewer found that the care Mr Binfield received in prison was equivalent to that which he could have expected to receive in the community. He

found that Mr Binfield was well supported by the mental health team and was prescribed appropriate medication.

Recommendations

- The Director should outline to the Ombudsman their plan going forward to randomly sample the accuracy of recorded checks until they are satisfied there is not a systemic issue with false entries.
- The Director should evidence how the prison will monitor the challenging of blocked observation panels to ensure compliance with local processes.
- The Director should request HMPPS Substance Misuse Group carry out a support visit to review the prison's drug strategy and identify further measures they can take to reduce supply and demand.
- The Director General of HMPPS should ensure that when contracted prisons are transferred between providers data is not lost.

The Investigation Process

19. HMPPS notified us of Mr Anthony Binfield's death on 6 March 2023.

20. 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. Two prisoners contacted her and were interviewed.

21. The investigator obtained copies of relevant extracts from Mr Binfield's prison and medical records, CCTV and body worn video camera (BWVC) footage, recording of radio transmissions and Mr Binfield's prison telephone calls. She also obtained the HMPPS Early Learning Review, the Sodexo internal investigation report, police scene of crime photographs and East Midlands Ambulance Service records.

22. The investigator interviewed seven members of staff and three prisoners at Lowdham Grange in May and June 2023. She obtained further information from the Head of Security and the Head of Safety, Health and Wellbeing.

23. NHS England commissioned a clinical reviewer to review Mr Binfield's clinical care at the prison. He jointly interviewed healthcare staff with the investigator in May 2023.

24. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology. We have sent the Coroner a copy of this report.

25. The Ombudsman's family liaison officer contacted Mr Binfield's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Binfield's next of kin asked: whether Mr Binfield's medical care had been appropriate, were wing staff aware of his mental health and was he managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) when necessary. These questions are answered in this report and in the clinical review.

Background Information

HMP Lowdham Grange

26. 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.

27. Since my initial report into Mr Binfield's death, the prison was returned to partial public sector control in December 2023 and full public sector control in August 2024.

HM Inspectorate of Prisons

28. 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.

29. 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.

30. 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.

31. 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

32. 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.

33. 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.

34. 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

35. Mr Binfield was the sixth prisoner at Lowdham Grange to die since March 2020. Of the previous deaths, two were from natural causes, two were drug related, and one, in October 2021, was self-inflicted. In our investigation into the self-inflicted death, 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.

36. Mr Binfield's death was the first of three self-inflicted deaths that occurred in March 2023. As a result of these self-inflicted deaths, Lowdham Grange is receiving additional support and monitoring from regional and national safety teams. By the end of 2023, there had been two more self-inflicted deaths at the prison. At the time of writing in January 2025 there had been a further four deaths suspected to be drug related.

Emotionally unstable personality disorder (EUPD)

37. Also known as Borderline Personality Disorder, Emotionally Unstable Personality Disorder (EUPD) is characterised by emotional instability, intense and unstable relationships, impulsive behaviour and negative emotions. It is common for people with EUPD to feel suicidal, impulsively self-harm and engage in reckless activities such as drug misuse.

Psychoactive substances

38. 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.

39. At Lowdham Grange at the time Mr Binfield was there, prisoners found under the influence of PS were placed on an Under The Influence Welfare Log and checked twice every hour for a minimum of four hours and a maximum of 12 hours. Their cell was searched to identify and remove any illicit substances. If more than one welfare log is opened in a 28-day period, the prisoner should be referred for assessment under the challenge, support, intervention plan (CSIP) process.

Key worker scheme

40. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*.

41. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Inundation point

42. Cell doors have inundation points, a removable bung that allows a hose to be used to spray water into a cell in the event of a fire, without opening the door.

Incentives and Earned Privileges (IEP) Scheme

43. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. There are three levels, basic, standard and enhanced.

Key Events

44. Mr Anthony Binfield had a history of substance misuse, depression, anxiety, attempted suicide, self-harm and violence. He had a childhood diagnosis of Attention Hyperactivity Disorder (ADHD – people may seem restless, impulsive and have trouble concentrating) but reported that the symptoms had calmed down in adulthood. He began self-harm by cutting aged 14 to manage stress.

45. On 15 June 2017, Mr Binfield received an extended determinate sentence for wounding with intent to do grievous bodily harm. He was sentenced to 12 years in prison with an extended licence period of four years. He had been in prison before.

46. Mr Binfield regularly self-harmed in prison by cutting his arms and was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT). In January 2018, Mr Binfield sustained serious burns after starting a fire in his cell. He said he was depressed about the length of his sentence, had family issues and had intended to kill himself.

47. Mr Binfield reported first using psychoactive substances (PS) in HMP Aylesbury in 2013 and his prison record (NOMIS) and clinical record showed frequent PS use during his last sentence. Mr Binfield was found unconscious on several occasions. He declined support from substance misuse services.

48. Mr Binfield's prison record indicated that due to issues in the community, he was at risk of harm from other prisoners. His record identified 40 prisoners that Mr Binfield should be kept separate from (known as 'non-associates'). Mr Binfield frequently complained that he did not feel safe in prison and asked for transfers between wings and to different prisons.

HMP Lowdham Grange, 24 August 2021 – 23 September 2022

49. On 24 August 2021, Mr Binfield transferred to HMP Lowdham Grange from HMP Dovegate. Lowdham Grange was the seventh prison Mr Binfield had been in since he was sentenced in 2017. On each occasion, he had been transferred at his own request due to being in debt and under threat from other prisoners.

Mental health, self-harm and ACCT procedures

50. On 31 August, a mental health nurse assessed Mr Binfield. He said that his main concerns were depression, fluctuating moods and self-harm. He reported attempting suicide twice in custody, one of which was the cell fire in 2018 (no information about the other attempt was recorded). He said he self-harmed when he found it difficult to manage his emotions and she noted he had significant scarring to his arms and neck. Mr Binfield said he felt that his mood was deteriorating, and this usually led to him fixating on self-harm. He said he was interested in working with the mental health team to support managing his emotions. The nurse discussed Mr Binfield at the mental health allocations meeting the same day and he was added to her caseload.

51. The mental health nurse saw Mr Binfield regularly between September 2021 and September 2022. She said Mr Binfield was good to work with and showed insight

into his issues. He was able to recognise when he was struggling and to ask her and other staff for support. She said his main issue appeared to be his location and she spoke to prison staff when he felt unsafe moving around the prison and when he was frustrated about the lack of progress with his transfer requests.

52. Mr Binfield was monitored under ACCT procedures four times between 8 September 2021 and 15 June 2022 after he made cuts to his arms. On the first occasion, he said he was under threat because of a debt he had incurred at Dovegate. The second time he said he was upset due to a family bereavement, the third because he had tested positive for COVID-19 and the last time because he was worried his application for transfer to a category C prison would be unsuccessful.

53. The mental health nurse regularly attended his ACCT reviews and liaised with the ACCT case manager to make sure that reviews took place on days she was available. She completed a well-being plan to help wing staff recognise when Mr Binfield's mental health was deteriorating. When she was not available, other nurses attended his ACCT reviews and completed welfare checks.

54. One of the psychiatrists working at the prison assessed Mr Binfield on 22 November 2021. She concluded he showed traits of Emotionally Unstable Personality Disorder (EUPD). She prescribed him quetiapine (an anti-psychotic used to treat fluctuating moods) because he said he had found it beneficial in the past. She reviewed Mr Binfield in January, March and August 2022. On the first two occasions, she slightly increased his dose of quetiapine after he reported limited improvement in his mood.

Use of psychoactive substances

55. Mr Binfield declined a referral to the substance misuse team when he first arrived at Lowdham Grange. He was found under the influence of PS on 30 August, 1 September (three times) and 22 October 2021. On each occasion, he was seen by a nurse, given harm minimisation advice, and placed on an Under the Influence Welfare Log.

56. On 31 August, Mr Binfield self-referred to the substance misuse team. The next day, Mr Binfield declined their support. Mr Binfield does not appear to have been referred to the substance misuse team on 22 October and there is no record of a subsequent assessment during this period.

Debt and wing moves

57. When he arrived at Lowdham Grange on 24 August 2021, Mr Binfield said that he had no gang problems or debt issues. On 9 September 2021, he told a Prison Custody Officer (PCO) during a key work session, that a debt had followed him from Dovegate, and he was unable to pay it. The next day staff moved him from E wing to D wing.

58. On 7 October 2021, Mr Binfield told another PCO during a key work session that he did not feel safe on D wing because "repercussions from his offence" had followed him to Lowdham Grange. On 14 October, he told another PCO that he was under threat from two prisoners from Dovegate. The PCOs informed the safer custody department. There is no evidence that staff took any action as a result.

59. The same day, Mr Binfield's security record (Mercury) showed intelligence had been received that he was under pressure to assault a member of staff in order to repay a debt from Dovegate. On 25 October, further intelligence indicated that Mr Binfield was under pressure to put money into various bank accounts in the community. Mr Binfield told staff he would stay in his cell until he was granted a wing move because he thought he would be assaulted if he left it.

60. On 28 October, the mental health nurse spoke to Safer Custody on Mr Binfield's behalf, and he moved to J wing the same day. On 3 November, Mr Binfield told the mental health nurse he was worried his problems had followed him to J wing. On 12 November, Mr Binfield told a PCO that he had spoken to safer custody and wing staff several times and felt his only option was to move to another prison.

61. On 16 November, Mr Binfield told the mental health nurse he was being threatened on J wing. The next day he told a PCO that he was in debt for PS and a mobile phone that his 'associate' had stolen in Dovegate. There is no record of any consideration being given to how else, other than wing moves, Mr Binfield could be supported, or his problems investigated or resolved.

62. On 27 November, Mr Binfield's security record showed he was seen with bruising to his face that had not been there in the morning. He moved to K wing the same day. On 3 December, intelligence showed another prisoner had threatened Mr Binfield with a knife over a debt of £1,500. On 5 December, Mr Binfield said he did not feel safe on K wing but then appeared to settle there.

63. On 4 June 2022, Mr Binfield moved to M wing after the prisoners who had threatened him in October moved to K wing. Mr Binfield did well on M wing. On 15 June, after an ACCT review, staff agreed that he could have in-cell education because of the number of prisoners on his non-association list. He said he was feeling the most settled he had been for two years and was drug-free. A PCO became Mr Binfield's key worker on M wing and they had consistent weekly sessions during June, July and August. At the end of July, staff gave Mr Binfield the trusted job of wing cleaner and on 23 August he gained enhanced status under the incentives and earned privileges (IEP) scheme.

Transfer requests

64. Mr Binfield's prison records included 17 pages of applications relating to transfer requests. We asked Lowdham Grange for evidence of which prisons they had contacted in response to Mr Binfield's transfer requests and when. The Head of the Offender Management Unit (OMU) explained that OMU staff had lost access to their email accounts and other records when the prison transferred operator from Serco to Sodexo so she could not provide this information.

65. Mr Binfield's applications showed he initially asked for a transfer to HMP Swaleside or HMP Woodhill on 20 October 2021 because he said he was under threat. He received a reply explaining that it was currently very difficult to arrange transfers because of restrictions on moves due to the COVID-19 pandemic. Both prisons rejected Mr Binfield's transfer request.

66. Between 11 November and 15 December 2021, Mr Binfield requested transfers to HMP Long Lartin, HMP Hewell, HMP Frankland, HMP Full Sutton, HMP

Chelmsford, HMP Manchester, HMP Garth and HMP Gartree. On 15 December, the prison sent his application to Manchester. On 16 December, they explained to Mr Binfield that he only fitted the criteria for Manchester, Dovegate, Garth, Woodhill and Swaleside. As he had already been rejected by Swaleside and Woodhill and had previously been moved out of Dovegate and Garth due to being under threat, it was increasingly difficult to obtain a transfer for him.

67. On 10 January 2022, Mr Binfield asked for an update on his transfer application to Manchester. He received a reply that there was no news yet and that transfers were very limited due to there being hardly any space left in prisons. Mr Binfield again asked for an update on 24 January and 11 March and each time he was told there had been no response. On 25 April, in response to a further application from Mr Binfield, a PCO in OMU offered to approach other prisons under the accumulated visits scheme (a temporary transfer to a prison closer to home to receive visits there).

68. After a further exchange of applications with Mr Binfield, staff contacted prisons in or near London on 20 May to ask about accumulated visits. On 24 June, they told Mr Binfield that several prisons were not accepting anyone for accumulated visits but that he was on the waiting list at HMP Wandsworth. Mr Binfield's correspondence with the OMU department showed his frustration with the situation but he was also appreciative of the efforts made by the prison to move him at least temporarily.

HMP Wandsworth, 23 September – 3 November

69. On 23 September 2022, Mr Binfield moved to Wandsworth for six weeks accumulated visits. Just before he left, he was assaulted by another prisoner in his cell. There are no entries on Mr Binfield's prison record for his period at Wandsworth.

HMP Lowdham Grange

3 November 2022 – 2 February 2023, E wing

70. Mr Binfield returned to Lowdham Grange on 3 November and was given a cell on E wing, the induction unit. A nurse completed an initial health assessment and he said he was chatty and happy to be back. The nurse referred Mr Binfield for a mental health assessment and on 7 November, he was returned to the mental health nurse's caseload.

71. On 5 November, Mr Binfield told a PCO during a key work session that seeing his family again had helped him think positively about his future and he wanted to focus on being recategorized to category C. He was concerned about where he would be located after E wing and said he would speak to safer custody. Mr Binfield later reported that it had been exceptionally agreed he would stay on E wing because of his concerns about moving.

72. On 8 November, the dedicated search team searched Mr Binfield's cell after intelligence was received that he had illicit substances. The team found nothing.

73. The mental health nurse saw Mr Binfield on 14 November. She said she had spoken to the allocations department about Mr Binfield's transfer application to Manchester. They had told her that Mr Binfield's best chance of moving from Lowdham Grange was for him to be successful in his application for category C. She relayed this to Mr Binfield, and he said his main concern was his location within the prison. He said there was no wing he could safely move to due to being under threat from multiple prisoners.

74. The mental health nurse said Mr Binfield appeared generally bright in mood. As he appeared to be doing well overall, he had not self-harmed for a while and was an enhanced level prisoner. She decided that a monthly check in with the duty mental health nurse would be sufficient contact and he was removed from her caseload.

75. On 26 November, Mr Binfield told a PCO that he felt safe on E wing. She noted that he was an enhanced regime prisoner and was well-behaved. On 30 November, the search team completed another intelligence-led search of Mr Binfield's cell but again found no illicit substances.

76. On 3 December, Mr Binfield was found under the influence of PS in his cell. A nurse assessed him and noted he had a rapid pulse, was unable to speak and was unsteady on his feet. She placed him on an Under the Influence Welfare Log and referred him to the substance misuse team. As a result of being suspected to be under the influence, the next day Mr Binfield was reduced to standard level on the IEP scheme in line with local policy.

77. On 5 December, a drug recovery worker completed a triage assessment. Mr Binfield declined support and said he did not think that his PS use was problematic.

78. Mr Binfield had two dedicated key workers on E wing. He had weekly key work sessions for the rest of December at which he appeared to be in good spirits and reported feeling safe. He continued to apply for a transfer but also said he had decided to focus on applying for category C status.

79. A prison GP reviewed Mr Binfield on 29 December. He reported that his mood still fluctuated, and he felt he was over-thinking things. The GP said she would increase his quetiapine provided an electrocardiogram (ECG) showed no problem with his heart. Mr Binfield said he had thoughts of self-harm but did not want to be subject to ACCT monitoring and so he managed these by distracting himself.

80. On 6 January 2023, the Security Department received intelligence that Mr Binfield had been bullied to add another prisoner's wife to his prison telephone contact list so that prisoner could use his phone credit. There is no evidence that staff took any further action about this.

81. On 12 January, a prison offender manager (POM) told Mr Binfield that he had not been successful in his application for category C. She said this was due to his PS use. She explained that he would be eligible for review again in six months. Mr Binfield said he wanted to transfer to Manchester. He said he was not happy at Lowdham Grange, and he was not happy on E wing because he felt the regime was tighter than on other wings and it was too quiet. She said she would speak to the allocations department about his transfer.

82. On 17 January, further intelligence indicated that Mr Binfield and another prisoner were involved in the drug culture on E wing. The same day Mr Binfield refused an order to come in from the exercise yard and was seen to exchange drugs with the other prisoner through the fence. He was charged with breaking prison rules, but the disciplinary hearing was not proceeded with due to a lack of evidence.

83. On 31 January, Mr Binfield refused an order to transfer to N wing. The charge was dismissed at a disciplinary hearing the next day because it was accepted that Mr Binfield had refused the move because he would not have been safe.

84. On 2 February, Mr Binfield had a keywork session with one of his key workers. He said he was frustrated with his location and still wanted a transfer to a prison where he could settle. This was his last keywork session before he died. Due to staff shortages after the change of operator from Serco to Sodexo, key work sessions were only delivered to prisoners identified as particularly vulnerable such as those isolating in their cells.

3 February – 5 March, H wing

85. On 3 February, Mr Binfield moved to cell 41 on H wing.

86. On 14 February, staff found Mr Binfield under the influence of PS. A nurse gave him oxygen, he recovered, and the nurse opened an Under the Influence Welfare Log.

87. A nurse visited Mr Binfield the next day for a mental health team monthly check in. Mr Binfield admitted that he had taken PS and said he was “fed up” with being at Lowdham Grange. He said he was worried his depression was returning and asked to see a prison GP. (Staff later made an appointment for him for 23 February but this was cancelled on the day due to the needs of another patient. It was rescheduled for 9 March.)

88. About an hour later, wing staff found Mr Binfield swaying with his eyes shut in his cell. The mental health nurse attended and gave him oxygen.

89. On 16 February, a substance misuse nurse attempted to give Mr Binfield harm minimisation advice but there was a strong smell in his cell, suspected to be PS, that meant it was impossible for her to remain in there for long. She added Mr Binfield to the list for a triage assessment.

90. On 22 February, a nurse completed a substance misuse triage assessment. (The nurse no longer worked at the prison; the investigator emailed her but received no reply.) Mr Binfield admitted he used PS and declined support from the substance misuse team. He told her he smoked PS whenever he could get hold of it but did not consider it was a problem. She gave him harm-minimisation advice.

91. On 3 March, a PCO was locking prisoners in their cells for lunchtime when he discovered Mr Binfield apparently under the influence of an unknown substance. He said Mr Binfield was unconscious on his toilet floor. He had vomited and his speech was slurred. A prisoner and friend of Mr Binfield helped him up and they put him on his bed in the recovery position in case he vomited again.

92. A nurse attended and said, when she arrived, Mr Binfield was on his bed with vomit on his floor. He did not respond verbally to her questions at first but allowed her to examine him. Eventually he told her that he did not know what he had smoked. She gave Mr Binfield some harm minimisation advice and told him that his medication would be withheld that evening as a precaution in case it reacted adversely with what he had taken. Wing staff started an under the influence welfare log and she set observations at twice an hour. Wing staff told her that Mr Binfield was supposed to be lighting a candle in the chapel as it was the anniversary of his son's death (we could not find any other information about Mr Binfield's son's death in his records).

93. Two PCOs searched Mr Binfield's cell. They removed some exposed wires (prisoners expose wires from their sockets and use them as an ignition source to smoke PS) and an improvised weapon found in Mr Binfield's pocket.

94. Later that afternoon, the mental health team matron reviewed Mr Binfield at the request of wing staff. They told him that Mr Binfield was upset because it was the anniversary of his son's death and he wanted to light a candle in the chapel. Mr Binfield told the matron that he had used PS that morning but was not intending to use it again. The matron said Mr Binfield did not appear to be in crisis and seemed calm.

95. The matron booked a mental health welfare check for over the weekend and contacted the chaplaincy team. The Roman Catholic Chaplain told him that he understood the anniversary was on Monday 6 March, and he had arranged for Mr Binfield to light a candle then.

96. A nurse completed a welfare check the next day, 4 March. Mr Binfield told her he had coped with the anniversary of his son's death by smoking PS, and he wanted to move to a different wing. He said smoking PS stopped him cutting himself. He was annoyed with wing staff but said he did not want to talk about it as it would make him angry. Mr Binfield asked for a distraction pack, and she posted one under his door about half an hour later. She said wing staff told her that he wanted to move wings because he was in debt on H wing.

Events of 6 March 2023

97. On 6 March, a Custodial Operations Manager (COM), the H wing manager, spoke to Mr Binfield as he walked back to the wing from collecting his morning medication. He asked her to follow up about his transfer request to a different prison. She said she would do this and get back to him.

98. At 10.20am, Mr Binfield attended a prison disciplinary hearing relating to his PS use on 3 March. The hearing was adjourned for Mr Binfield to obtain legal advice. While he was there, the Chaplain tried to find Mr Binfield to take him to the chapel to light a candle. Mr Binfield did not go to the chapel that day, but later sent a message to the Chaplaincy team asking for his visit to be rearranged for 13 March.

99. At about 2.30pm, Mr Binfield approached a nurse on the wing and asked if he could speak to someone from the mental health team. She noticed scratches around his left eye. Mr Binfield told her he had been "play fighting".

100. Between 2.30pm and 4.00pm, a nurse completed a follow up appointment with Mr Binfield. He admitted he had used PS on 3 March and said he had found the anniversary of his son's death difficult to deal with. He said he did not believe he had a problem with PS use. She pointed out that he had also been found under the influence two weeks previously. Mr Binfield said he was a prolific self-harmer and he either smoked PS or cut himself. Mr Binfield said he was not very good at talking and tended to bottle his feelings up and then harm himself. He said he was pleased that he had not cut himself for over six months. He said he had been given an opportunity to light a candle for his son and had another service booked.

101. Mr Binfield said he felt mentally stable, had been to work and felt a lot better when he was off the wing (Mr Binfield did not have a job and had refused to work off the wing due to concerns for his safety). The nurse noted that Mr Binfield showed no sign of anxiety or agitation. He denied any thoughts of suicide or self-harm. He said he did not want to work with the substance misuse team and said he was aware of the referral process if he changed his mind.

102. The investigator watched CCTV footage of H wing from 4.45pm. All the prisoners were out on the landing for social time and to collect their evening meal. Mr Binfield visited other cells, walked about the landing, and spoke to several prisoners. At 4.55pm, he went downstairs and returned to his cell three minutes later carrying his evening meal.

103. CCTV showed staff locked Mr Binfield in his cell at 5.01pm. At 5.30pm, the COM went to see him to tell him that he could move to F wing. She said Mr Binfield was slurring his words and his eyes were glazed so she opened an under the influence welfare log.

104. At 5.39pm, a nurse examined Mr Binfield and noted that his speech was slow and slurred, but he had not vomited, he knew where he was and could understand instructions. She said there was a strong smell of PS in the cell. She set welfare checks at twice every hour. She decided that it was safe for Mr Binfield to remain in his cell.

105. There are no records that Mr Binfield's cell was searched as it should have been. However, the COM said the plug socket in Mr Binfield's cell had been damaged, so the wires and plug were removed from his cell. Staff locked Mr Binfield's door at 5.44pm. At 6.16pm, a member of maintenance staff turned off the electricity to the damaged socket at the panel outside Mr Binfield's door. This did not affect the electricity to the rest of the cell.

106. All prisoner telephone calls are recorded but they are only monitored in certain circumstances for example as part of public protection measures. Live monitoring of prisoner telephone calls only takes place exceptionally if there is reason to believe the prisoner is engaged in criminal activity. Mr Binfield's telephone calls were not being monitored. At 5.55pm, Mr Binfield spoke to his girlfriend for almost nine minutes on the phone. His speech sounded slurred. They discussed her health, her driving test and what he had for dinner. CCTV showed that a PCO checked Mr Binfield at 6.00pm. Mr Binfield rang his girlfriend at 6.18pm and again they discussed her driving test. Mr Binfield rang a third time at 6.53pm. The conversation began very affectionately but they argued about her health, and she ended the call abruptly.

107. CCTV showed a PCO A checked Mr Binfield at 7.08pm. Another PCO completed a routine count of prisoners on the landing at 7.34pm. PCO B checked Mr Binfield at 7.42pm, when he checked all the doors were secure at the start of his night duty, and at 8.37pm. The entry immediately after the 8.37pm check was scribbled out and is illegible. The written record also indicated that PCO A had checked Mr Binfield at 6.30pm and 7.25pm, and PCO B had checked him at 8.10pm. CCTV showed none of these checks took place.

108. PCO B said he was also checking a number of prisoners subject to ACCT procedures and had made the 8.10pm entry on Mr Binfield's record in error. (According to the findings of Sodexo's internal investigation, safer custody records showed there was one prisoner on hourly ACCT checks on H wing, and he was not checked at this time.) The PCO said he scribbled out the entry after 8.37pm because he realised at the time that he had made an entry about a check on another prisoner on Mr Binfield's record in error.

109. At 7.19pm, a prisoner appeared to pass something under Mr Binfield's door. The prisoner said Mr Binfield had asked him to light a wick for him because he thought he had no electricity in his cell. He said he told Mr Binfield he could not light the wick but had given him a battery and a vape capsule for the night. He said Mr Binfield put his thumb up and said, "Nice one bro, I'll see you in the morning."

110. Mr Binfield called his girlfriend again at 7.33pm. She told him she did not want him to call her anymore and ended the call. Mr Binfield rang back four minutes later, and they spoke for one hour 42 minutes. Initially they argued, but the conversation then calmed down. At the end of the conversation Mr Binfield tried unsuccessfully to turn the conversation to one of an intimate nature. He ended the conversation with the words "you upset me I'm gone". The call ended at 9.19pm.

111. CCTV showed that PCO B looked through Mr Binfield's observation panel at 9.23pm. He shone his torch at the door for about 30 seconds and then walked downstairs. He returned to Mr Binfield's cell at 9.25pm and tried unsuccessfully to remove the bung from the inundation point in the cell door. At 9.27pm, PCO C joined him and also unsuccessfully tried to remove the bung before they both left.

112. PCO B said Mr Binfield had covered his observation panel with toilet paper and he could not see into the cell. He said he knocked on the door and called to Mr Binfield but got no response. He said he decided to get the key for the inundation point bung from the houseblock central office because his priority was to see into Mr Binfield's cell. He said this was neither official procedure nor accepted practice at Lowdham Grange. He said he was not worried Mr Binfield might have been under the influence of PS as he had not appeared to be under the influence when he had seen him at previous checks.

113. When PCO C could not open the inundation point either, PCO B said he went to the houseblock central office and telephoned the control room officer to send a member of security to the wing. He said with hindsight he could have entered Mr Binfield's cell with PCO C, but his priority had been to open the inundation point to make a visual check. He had a radio with him but did not consider using this to summon help. He said he was mindful that he had been told at handover that Mr Binfield had threatened to "play up" all night.

114. At 9.32pm, PCO D arrived in response to PCO B's request. He said PCO B told him that Mr Binfield had been under the influence earlier in the evening and had threatened to "play up" all night. PCO D said prisoners sometimes covered their observation panels and then refused to respond to staff, which was why he thought PCO B had wanted to open the inundation point.

115. PCO D successfully removed the inundation bung and PCO B looked through the hole in the door and used a pen to move the toilet paper aside. PCO B said that he could immediately see Mr Binfield hanging from the toilet door. PCO D radioed the control room and said he was entering the cell because a prisoner had a ligature and was hanging.

116. PCO B broke the sealed pouch containing his cell key and, at 9.34pm, he and PCO D entered the cell followed soon after by PCO E. PCO E radioed for an ambulance to be requested "straightaway". Between them, the three officers cut Mr Binfield down and laid him on the floor. PCO B started cardiopulmonary resuscitation (CPR).

117. Ambulance service records showed a PCO in the control room called for an ambulance at 9.35pm. The PCO quickly established via radio to the officers in the cell that Mr Binfield was not breathing, and the 999 operator dispatched an ambulance.

118. PCO E collected a defibrillator from the houseblock central office and returned to Mr Binfield's cell at 9.36pm. Body worn video camera footage (BWVC) showed PCO B put the pads onto Mr Binfield's chest. The defibrillator advised "no shock at this time, begin CPR". PCO B removed the pads and began CPR. After two cycles of chest compressions and breaths, he paused. After a short delay, he replaced the pads, and the defibrillator again advised no shock and to continue CPR. PCO B said he realised that he should not have removed the pads but in the heat of the moment he was not thinking straight, and he had been concerned to put the pads on the correct part of Mr Binfield's body.

119. Staff took turns to administer chest compressions. BWVC showed staff completing rounds of chest compressions in between automated defibrillator assessments. At one point the defibrillator indicated it would deliver a shock but then almost immediately said no shock was advised. BWVC showed an envelope sticking out of Mr Binfield's waistband.

120. Paramedics arrived at Mr Binfield's cell at 9.56pm. They took over CPR but at 10.19pm they confirmed that Mr Binfield had died.

121. The envelope in Mr Binfield's waistband contained a final letter written to one of his stepsisters. Mr Binfield said prison had finally got the better of him and he felt the whole system had failed him. He said he had felt trapped all his life and been tormented by his thoughts but would now be free. He left personal messages for other members of his family and instructions for his funeral service.

Contact with Mr Binfield's family

122. The prison initially appointed a family liaison officer (FLO). Given the time of Mr Binfield's death and the distance from the prison to Mr Binfield's next of kin's house,

the FLO and the duty governor agreed that local police would inform his next of kin of his death. Another FLO was appointed and telephoned Mr Binfield's family the next morning.

123. The prison made a financial contribution to Mr Binfield's funeral in line with national policy.

Support for prisoners and staff

124. After Mr Binfield's death, the duty governor 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.

125. The prison posted notices informing other prisoners of Mr Binfield'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 Binfield's death.

Post-mortem report

126. The pathologist gave the cause of death as hanging. Toxicology showed that Mr Binfield had used PS before he died.

Sodexo investigation

127. As a result of the Sodexo internal investigation, the actions of PCO B and PCO D on 6 March were investigated under the disciplinary process, and both received final written warnings.

Inquest

128. An inquest into Mr Binfield's death concluded on 7 February 2025 that his death was suicide due to self-inflicted ligature asphyxiation.

Findings

Assessment of risk

129. Mr Binfield had a number of factors that indicated he was at risk of suicide and self-harm including previous suicide attempts, self-harm, substance misuse, his debts and the associated threat from other prisoners. His mental health, especially the personality traits associated with EUPD, meant that this risk fluctuated according to context but was never absent.

130. Mr Binfield's actions followed an argument with his girlfriend on the telephone. Staff were not monitoring his calls and would have been unaware of the content of them. He had taken PS in late afternoon and the effects of these are unpredictable. We also note that it was the anniversary of the death of one of Mr Binfield's children either that day or on 3 March. Although there is no evidence in his telephone calls or in his suicide note that this was a particular trigger that day, we know that this was upsetting him as he had told staff. However, he had also told staff that he had no thoughts of suicide or self-harm and felt mentally stable. We are satisfied there were no obvious signs that Mr Binfield was at heightened risk of suicide on 6 March.

Falsifying records

131. PCO D and PCO B both falsely recorded checks that they had done on Mr Binfield on the evening of 6 March due to him having been found under the influence of PS earlier that day. As a result, both were subject to disciplinary investigations and received final written warnings.

132. However, we have not seen any evidence that the prison has investigated whether the falsifying of records is more widespread. The fact that two different officers falsified Mr Binfield's records suggests that this might be part of a wider cultural issue. We make the following recommendation:

The Director should outline to the Ombudsman their plan going forward to randomly sample the accuracy of recorded checks until they are satisfied there is not a systemic issue with false entries.

Blocked observation panels and entering cells

133. In February 2018, HMPPS issued a Safety Bulletin on observation panels. This said that if a prisoner does not comply with instructions to remove a blockage, staff must take immediate action to remove the obstruction and check the prisoner's welfare. In line with Prison Service Instruction (PSI) 24/2011, *Management and security of prisons at night*, Lowdham Grange has a local policy on night duties, issued in February 2023. This instructs staff, who find a covered observation panel and an unresponsive prisoner, to radio the communications room and ask the night orderly officer (the officer in charge) to attend.

134. Removing the inundation bung to see into a cell with a covered observation panel and an unresponsive prisoner has never formed part of policy or guidance to staff at Lowdham Grange under Serco or Sodexo. In our investigation into the self-inflicted

death of a prisoner there in October 2018, staff delayed entering the cell of a prisoner being monitored on ACCT procedures to remove the inundation bung to see past an obstruction. Exactly the same thing happened in the self-inflicted death of a prisoner on ACCT in October 2023. The delay in those cases was comparatively short. However, as the key to the inundation bungs is kept in the central office on every houseblock there will necessarily always be some delay caused by retrieving it and consequently in entering the cell and summoning help if necessary.

135. In Mr Binfield's case, 11 minutes elapsed before staff entered his cell. We know from Mr Binfield's telephone records that he was still alive four minutes before PCO B discovered he had blocked his observation panel. While we cannot say for certain that the outcome would have been different had he followed the correct process, the chances of saving Mr Binfield's life would certainly have been increased.

136. We do not think PCO B had reason to be concerned that Mr Binfield had attempted to kill himself. Nevertheless, the dangers of PS use are reflected in the need for the under the influence welfare log. Mr Binfield's cell had not been searched after he had been found under the influence and, even if it had been, there remained the possibility that he had access to more PS and might come to harm from using it. PCO B did not take this into account. He did not adequately assess the situation or consider going into the cell immediately, despite having another officer on duty with him, access to a radio and keys.

137. On 13 April 2023, the Director issued a notice to staff on unresponsive prisoners. This instructed that staff faced with an unresponsive prisoner or a covered observation panel and a prisoner not responding, must stay at the cell door, radio a code blue emergency and make a dynamic risk assessment of whether it is safe to enter the cell. The notice said staff should enter the cell without waiting for colleagues unless there is a risk to personal safety.

138. On 1 June 2023, the Director issued an information bulletin on how to deal with covered observation panels and items hindering visibility into cells. This too instructed staff that if a prisoner who had covered his observation panel did not respond then they should enter the cell if it was safe to do so and remove the obstruction. In night state, unless it was an emergency, two staff should be present before the cell is entered and the night orderly officer must be informed.

139. Despite the guidance issued to staff in April and June 2023, it is clear from our investigation into the death of a prisoner in October 2023 that there remains a culture among staff of removing the inundation bung instead of following local procedures. We therefore remain concerned that this issue has not been robustly or adequately addressed. We make the following recommendation:

The Director should evidence how the prison will monitor the challenging of blocked observation panels to ensure compliance with local processes.

140. The prison also held a disciplinary investigation into the actions of PCO B that night. Had they not done so we would have recommended that they did. We are satisfied that the matter has been dealt with via the disciplinary process and make no further recommendation.

Violence reduction and debt support

141. A PPO publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013 - 2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly.

142. National guidance for prisons on violence reduction is contained in PSI 64/2011. This contains a commitment to zero tolerance of violence in all prisons and affirms a commitment to the support and protection of victims. For the majority of Mr Binfield's time at Lowdham Grange the prison was operated by Serco. Their violence reduction policy included measures to monitor, review and support victims, although they had no separate debt management policy.

143. Mr Binfield appears to have been in debt and at risk of violence from other prisoners throughout his time in prison. Between 2017 and 2021, he moved prisons seven times, eventually remaining at Lowdham Grange largely because he had run out of options to move on. His record at Lowdham Grange showed evidence that he was bullied and had been assaulted on more than one occasion, most recently in January 2023.

144. Mr Binfield had a very positive period on M wing from June to September 2022 when he had a job, was allowed to complete education in-cell, had a consistent key worker, regular mental health support and attained enhanced level on the IEP scheme. However, his cycle of getting into debt and coming under threat resumed on return from Wandsworth in November 2022. There is no evidence that the prison made any specific efforts to break this cycle, apart from moving him from wing to wing. Moving prisoners is not a long-term solution to supporting behavioural change and resolving the underlying issues behind debt.

145. Overall, and despite the good work of some staff, notably the mental health nurse, it is easy to see why Mr Binfield felt that the prison system had not sufficiently supported or protected him.

146. Both HMIP and the IMB identified high levels of violence at Lowdham Grange, and the prison is clearly not sufficiently safe. The prison re-wrote and updated their violence reduction strategy in February 2023. The new post of Head of Safety Health and Wellbeing was created in May 2023, and it was quickly identified that the prison had no debt management strategy. A new policy was published in June 2023. We recognise that there have been significant challenges at the prison and that new policies and procedures will take time to embed and on that basis, we make no recommendation.

Drug strategy

147. We are concerned that Mr Binfield 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.

148. 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.

149. 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 consider that the prison needs expert support to build on the measures they have already taken to reduce supply and demand for drugs in the prison.

The Director should request HMPPS Substance Misuse Group carry out a support visit to review the prison's drug strategy and identify further measures they can take to reduce supply and demand.

Emergency response

150. PSI 03/2013, *Medical Emergency Response Codes*, requires governors to have a two-code medical emergency response system. As is usual, Lowdham Grange use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

151. PCO D did not radio an emergency code when Mr Binfield was discovered hanging. However, he clearly communicated the nature of the emergency to the control room and the officer immediately called an ambulance. The control room officer was in radio contact with staff at the scene which allowed the call handler to correctly triage the call and dispatch a priority one ambulance.

152. An emergency code was not used in the response to one of the two other self-inflicted deaths at Lowdham Grange in March 2023. On 2 April, the Director issued a notice to staff reminding them to use emergency codes. A code blue was used in

both deaths of prisoners in October and November 2023. We are satisfied that this is not a systemic issue at the prison, and we make no recommendation.

153. PCO B attached the defibrillator pads to Mr Binfield's chest, waited for the machine to make its assessment and then incorrectly removed the pads to continue CPR. He replaced the pads after two cycles of chest compressions and breaths. We understand that these situations are highly stressful and that mistakes are easily made. We do not consider that this made a difference to the outcome for Mr Binfield and make no recommendation.

Electricity in Mr Binfield's cell

154. Two prisoners told the investigator they thought Mr Binfield had no electricity in his cell on the evening he died. BWVC showed PCO D, PCO B and PCO E initially used torches when they entered Mr Binfield's cell, however his cell light is subsequently turned on. Mr Binfield did not refer to having no electricity during his several telephone calls that evening.

Clinical care

155. The clinical reviewer concluded that the healthcare Mr Binfield received in prison was equivalent to that which he could have expected to receive in the community. He found that Mr Binfield received comprehensive support from the mental health team and engaged well. He was prescribed appropriate medication which was regularly reviewed by the psychiatrist.

Transfer from Serco to Sodexo

156. Lowdham Grange's transfer from Serco to Sodexo was the first time a prison had been handed over from one private provider to another. The impact of the changes had been underestimated, not least the number of managers and staff who resigned when the contract change was announced or left in the early weeks after the transfer. Despite data being transferred to a cloud service in preparation for the transfer, a significant amount of information including emails and other records were lost. The removal of all branded Serco policies meant everything, including the local security strategy, had to be re-written.

157. The transfer to Sodexo coincided with Serco's successful bid to operate HMP Fosse Way and it is likely that this exacerbated the loss of staff, many of whom went to work for Serco there. Nevertheless, HMPPS will need to review the lessons learned to ensure smoother transitions between providers in future. We make the following recommendation:

The Director General of HMPPS should ensure that when contracted prisons are transferred between providers data is not lost.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100