Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Richards, a prisoner at HMP Lowdham Grange, on 13 March 2023

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

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 then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr David Richards was found hanging in his cell at HMP Lowdham Grange on 13 March 2023. Staff and paramedics tried to resuscitate him but were unsuccessful. Mr Richards was 42 years old. I offer my condolences to his family and friends.

Mr Richards' death was the second of three self-inflicted deaths at Lowdham Grange in March 2023. Both HM Inspectorate of Prisons and the Independent Monitoring Board expressed concerns about the safety of the prison around that time. The transfer of the management of the prison from Serco to Sodexo in February 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.

While Mr Richards had expressed his discontent about being at Lowdham Grange, there was no indication that he was at risk of suicide or self-harm in the two and a half weeks he spent there. I am satisfied that staff could not have foreseen his actions.

Nevertheless, I am concerned about the cluster of deaths that occurred so soon after the management of the prison was transferred from one private provider to another and the uncertainty this created among staff and prisoners. HMPPS must consider how smoother transitions can be achieved in future.

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 **December 2023**

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Summary

Events

1. On 4 April 2022, Mr David Richards was remanded to HMP Chelmsford charged with attempted murder. It was his first time in prison.

2. Mr Richards arrived with a suicide and self-harm warning as he had recently tried to take his own life. Staff started suicide and self-harm prevention procedures (known as ACCT), which remained open until 18 April.

3. Staff supported Mr Richards using ACCT from 6 to 26 May and from 15 to 30 June. Both times he said he had been hearing voices and had been thinking about suicide. He was prescribed antidepressant and antipsychotic medication.

4. On 17 November, Mr Richards was found guilty of attempted murder. Staff reviewed his risk and assessed that he did not need the support of ACCT procedures at that time.

5. On 12 January 2023, Mr Richards was sentenced to 27 years imprisonment. He told staff he had been expecting it, but because of the length of the sentence, staff started ACCT procedures. Mr Richards said that he had no thoughts of self-harm and was aware of the support available. Staff closed the ACCT the next day.

6. On 24 February, Mr Richards was moved to HMP Lowdham Grange. He told staff that he had no thoughts of harming himself.

7. On 6 March, safer custody staff visited Mr Richards for a wellbeing check. Mr Richards told them that he had not asked to be moved to Lowdham Grange and would not be getting any visits from family as they were too far away. He said he had been shocked at the length of his sentence, felt vulnerable and would like to go to a “more mature” wing. Staff noted that he told them that he had no thoughts of harming himself and had never been on ACCT.

8. On the morning of 13 March, Mr Richards telephoned his mother and said that he needed to talk to his solicitor urgently about money. He asked his mother if she could ask the solicitor to arrange a time for him to call them. He spoke to his mother again later who said a call had been arranged for 5.00pm.

9. Mr Richards was due to be moved from the induction wing to a standard wing that day. At around 11.30am, an officer took some bags to him so he could pack. There were no apparent issues. At around 1.15pm, a prisoner who had been unlocked for work, alerted staff that Mr Richards was hanging in his cell. Staff and paramedics tried to resuscitate him but at 2.12pm, paramedics declared that he had died.

Findings

10. The safer custody staff who saw Mr Richards on 6 March, had been unable to access his electronic prison record and were therefore unaware that he had been supported using ACCT several times at Chelmsford. This issue has since been

rectified. Mr Richards did not appear to be at risk of suicide or self-harm at that time.

11. While Mr Richards had some risk factors for suicide and self-harm, he gave no indication that he was at imminent risk of suicide or self-harm during his time at Lowdham Grange. While he expressed that he felt vulnerable, there is no evidence that he was under threat from other prisoners. It is unclear why Mr Richards wanted to speak to his solicitor about money but there is no indication that he was in debt to other prisoners. We are satisfied that staff could not have foreseen Mr Richards' actions.

12. The clinical reviewer found that the care Mr Richards received in prison was equivalent to that which he could have expected to receive in the community. He found that Mr Richards was well supported by the mental health teams and was prescribed appropriate medication.

13. We make no recommendations.

The Investigation Process

14. HMPPS notified us of Mr Richards' death on 13 March 2023.

15. 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 him. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Richards' prison and medical records.

17. The investigator interviewed seven members of staff at Lowdham Grange between May and August 2023.

18. NHS England commissioned two independent clinical reviewers to review Mr Richards' clinical care at the prison. The investigator was joined by a clinical reviewer for some healthcare interviews.

19. 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.

20. The Ombudsman's family liaison officer contacted Mr Richards' mother to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of the report.

21. We shared our initial report with HMPPS. They found no factual inaccuracies.

22. We sent a copy of our initial report to Mr Richards' mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Lowdham Grange

23. 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 in February 2023, Sodexo took over the running of the prison. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

24. 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, whose numbers were reduced by the loss of some key and specialist staff. There were high levels of self-harm. The healthcare department was undermined by significant staff shortages. Access to work and education was poor.

Independent Monitoring Board

25. 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 was 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.

26. 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.

27. 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. There were three deaths in March. The number of prisoners on ACCT more than doubled, from 13 to 32, between the end of February and the end of March. There had been an exodus of staff 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

28. Mr Richards was the seventh prisoner at Lowdham Grange to die since March 2020. Of the previous deaths, two were from natural causes, two were drug related, and two were self-inflicted. Mr Richards' death was the second of three self-inflicted deaths that occurred in March 2023.

Key worker scheme

29. 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*. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

30. 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.

Key Events

31. Mr David Richards was remanded in prison on 4 April 2022, charged with the attempted murder of his former partner. He was sent to HMP Chelmsford. It was his first time in prison.

32. The Person Escort Record (PER) that accompanied Mr Richards noted that he was at high risk of suicide. He told reception staff that he had been struggling with his mental health and had recently tried to take his own life. Staff started suicide and self-harm prevention procedures (known as ACCT). A member of the mental health team saw Mr Richards and noted that he would be monitored through the ACCT process. A GP prescribed sertraline (an antidepressant) and promethazine (to aid sleep).

33. Staff stopped ACCT procedures on 18 April, but reopened them on 6 May, when Mr Richards said that he was struggling with his mental health, hearing voices and thinking about suicide. He said that he did not feel safe on the wing, so staff moved him to the vulnerable prisoners' unit (VPU), where he said he felt safer.

34. Staff stopped ACCT procedures on 26 May. The same day, Mr Richards agreed to start taking olanzapine (an antipsychotic).

35. Staff restarted ACCT procedures on 15 June when Mr Richards said he was under threat from other prisoners and was experiencing auditory and visual hallucinations. He said he was unable to cope and would take his life if he got the chance. A mental health nurse reviewed him and noted that his answers appeared to be purposely vague and generic, and she did not believe that he was experiencing psychotic symptoms. She noted that his court case was approaching and thought he might be trying to use his mental health as mitigation.

36. On 23 June, a prison psychiatrist reviewed Mr Richards and noted no evidence of thought disorder but agreed to increase his prescription of olanzapine. Staff stopped ACCT procedures on 30 June.

37. Mr Richards had regular sessions with his key worker. He talked about his case and discussed his children. He took a course to train as a Listener, which he enjoyed. Mr Richards discussed with his key worker where he might transfer after being sentenced. He also discussed looking into the possibility of contact with his children after his trial.

38. On 21 September, the psychiatrist reviewed Mr Richards. He said that he was happy with his medication, was not suffering from any hallucinations, and expressed no paranoia or delusional beliefs. The psychiatrist noted that Mr Richards was not psychotic, though was anxious and possibly suffering from depression.

39. On 17 November, Mr Richards was found guilty of attempted murder. Staff monitored his mood and whether he needed the support of ACCT procedures but assessed that it was not necessary at that time.

40. On 12 January 2023, Mr Richards was sentenced to 27 years imprisonment. He told staff that he had been expecting this, but due to the length of sentence, staff

started ACCT procedures. At an ACCT review the next day, Mr Richards said that he had been anticipating a sentence in the region of 25 years and had been mentally prepared. He said he had no thoughts of harming himself and felt settled on his medication. Staff stopped ACCT procedures.

41. Mr Richards continued to see his key worker and his emotional support worker and interacted positively. He spoke to his mother daily. His prison record showed good reports from prison staff.

42. At an ACCT post-closure review on 2 February, Mr Richards said that he was feeling positive, with no thoughts of harming himself and no issues to raise. He was awaiting news on a transfer. He saw a prison psychiatrist on 8 February, who noted that he was not acutely mentally unwell, was not psychotic, suicidal or depressed. He also noted that Mr Richards did not appear to have a long-term psychotic disorder. He agreed to reduce Mr Richards' olanzapine dose.

43. On 22 February, Mr Richards told his key worker that he was fine, with no concerns or issues to raise. He had applied for a mediation course. The following day he had a session with his emotional support worker. He was in a good mood, and was keeping busy to avoid focusing on his long sentence. He said that he struggled most with not seeing his children but had no thoughts of harming himself and was aware of support available. He said he had no hallucinations, and wanted to come off all his medication as he felt that he no longer needed it.

HMP Lowdham Grange

44. On 24 February, Mr Richards was moved to HMP Lowdham Grange. The PER that accompanied him noted that he had previously made attempts on his own life, had recently been under ACCT management, had VP status, and was on medication for his mental health. The PER noted that he was at a high risk of suicide.

45. A nurse carried out Mr Richards' initial health screen. He said that he was happy to be at Lowdham Grange and looking forward to settling on the wing. He said that he had no thoughts of harming himself but as he had been under the care of the mental health team at Chelmsford, the nurse referred him for a mental health assessment. Staff carried out four standard new-arrival checks on Mr Richards through the night. He was sleeping at each check and there were no concerns.

46. On 26 February, staff prescribed Mr Richards' medication and he was allowed to hold seven days' worth in possession.

47. On 1 March, a nurse carried out a mental health assessment. Mr Richards said that he felt like he had a mental breakdown at the time of his offence and felt a lot of shame and guilt around it. He said that he struggled with prison life, where he did not feel safe, and had a long sentence. He mentioned a childhood trauma, but did not disclose any details. He said that his mental state now felt stable. He was trying to think positively and wanted to engage with any interventions that would help him. He would like to establish some contact with his children when he was able to. He was reducing his olanzapine, and wanted to stop all his medication. The nurse said that stopping medication while adjusting to a new prison was not desirable and suggested reducing the dose after four weeks when he had settled. He said that he

had no thoughts of harming himself and that his future relationship with his children was a big protective factor. The nurse referred him for a psychological assessment.

48. On 6 March, two prison custody officers (PCOs) from the safer custody department went to see Mr Richards for a new arrival wellbeing check. Mr Richards said that he had not asked to come to Lowdham Grange and would not be having any visits from his family as they lived too far away. He said it was his first sentence, he felt vulnerable among other prisoners, and would like to go to a "more mature" wing. He said that he had not been under ACCT management, had no thoughts of harming himself, and would tell staff if he felt low. The safer custody staff were unaware that Mr Richards had been on several ACCTs at Chelmsford as they had not checked his electronic prison record. When interviewed, they said that their team of five used to have a computer each but it had recently reduced to only two, so they had not been able to access a computer to check Mr Richards' record.

49. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to the calls Mr Richards made in the week before he died. There was nothing in those calls that suggested Mr Richards was at imminent risk of suicide or self-harm.

Events of 13 March

50. On the morning of 13 March, Mr Richards telephoned his mother. He said that he needed to talk to his solicitor urgently about money, and asked his mother if she could ask the solicitor to arrange a time for him to call. They spoke again, and a call had been arranged for 5.00pm that afternoon.

51. Mr Richards was due to move wings that afternoon. Staff explained to him that he had to move from the induction wing, but as he was a Listener and someone wing staff trusted, they would look to bring him back within a matter of weeks. Although Mr Richards would have preferred not to move, he accepted that he had to and seemed pleased that he had earned the opportunity to return.

52. Prisoners were locked into their cells for lunch at approximately 11.30am, and a PCO went to provide Mr Richards with bags to pack his belongings. He opened the cell door and handed them over. At interview, the PCO said that there was nothing out of the ordinary in the interaction, and he had no concerns about Mr Richards at the time. Another PCO completed a routine check at 11.45am, and again had no cause for concern about Mr Richards.

53. Prisoners who were due to attend work were unlocked from 1.00pm. At 1.17pm, a prisoner told a PCO that he was concerned about Mr Richards. The PCO went to the cell, looked through the observation panel, and saw Mr Richards hanging by a bedsheet attached to the bed. He radioed a code blue emergency (used when a prisoner is unconscious or having difficulty breathing) and the control room called an ambulance. The PCO opened the cell door. He used his anti-ligature knife to cut the ligature and lowered Mr Richards to the floor. He was not breathing and had no pulse, so the PCO began CPR. Other staff arrived in response to the code blue and a PCO applied a defibrillator (an electronic device that gives an electric shock to try to restart the heart) but the battery was flat. The PCO used his radio to request another defibrillator and the prison officers continued with CPR. More staff arrived,

one of them with a defibrillator, and a PCO applied it to Mr Richards. The machine advised them not to give a shock and to continue with CPR, which they did.

54. Two nurses responded to the code blue. A nurse tried to insert an airway but was unable to due to the presence of vomit. She used a suction device to try clear the vomit. She reinserted an airway device, however, there was still vomit present and she was unable to administer oxygen. She queried whether the suction device was working properly. Ambulance paramedics arrived at the cell at 1.37pm and took over. They continued resuscitation attempts, but at 2.12pm, confirmed that Mr Richards had died.

Contact with Mr Richards' family

55. Lowdham Grange appointed two PCOs as family liaison officers. They went to Mr Richards' mother's address to notify her of her son's death. In line with HMPPS guidance, Lowdham Grange contributed to the costs of Mr Richards' funeral.

Support for prisoners and staff

56. After Mr Richards' death, a custodial operations manager (COM) 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.

57. The prison posted notices informing other prisoners of Mr Richards' 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 Richards' death.

Post-mortem report

58. The post-mortem report concluded that Mr Richards died from hanging. No illicit substances were found in his system.

Findings

Management of Mr Richards' risk of suicide and self-harm

59. Mr Richards had some important risk factors for suicide. He had been convicted of the attempted murder of his former partner, had received a long sentence, it was his first time in prison, he had previously attempted suicide and he suffered with mental health issues.

60. Mr Richards was managed under ACCT procedures on several occasions at Chelmsford but had appeared fairly settled in the month or so before his transfer to Lowdham Grange. After his transfer, he said he felt vulnerable. However, there were no indications that he had any specific problems with other prisoners. It is unclear why Mr Richards wanted to speak to his solicitor about money but there is no evidence that he was being bulled or was under threat. He was not managed under ACCT procedures at Lowdham Grange and we are satisfied that there was no indication that Mr Richards was at imminent risk of suicide in the days before his death.

61. When safer custody staff saw Mr Richards on 6 March, he told them that he had not been under ACCT management. This was not the case, but the staff said in interview that they had been unable to access Mr Richards' electronic record before seeing him due to a reduction in the number of computers available. This has since been rectified. Both members of staff said in interview that in the meeting, they found no reason to be concerned about Mr Richards' wellbeing.

62. Mr Richards' death was the second of three self-inflicted deaths that occurred within the same month at Lowdham Grange. There were no obvious connections between the circumstances of Mr Richards' death and the other deaths. However, we are aware that the prison was particularly unsettled at that time, due to the transfer of the management of the prison from Serco to Sodexo in February. Both HM Inspectorate of Prisons and the Independent Monitoring Board reported that the prison was not safe. There was a high incidence of drug use, self-harm and violence. Staffing levels were low which resulted in limited time out of cell and a deterioration in prisoner-staff relationships. We cannot say how these factors affected Mr Richards but it is possible that they contributed to his feelings of vulnerability.

63. 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. HMPPS will need to review the lessons learned to ensure smoother transitions between providers in future.

Clinical care

64. The clinical reviewer concluded that the care Mr Richards received in prison was of a good standard and equivalent to that which he could have expected to receive in the community. He found that Mr Richards was well supported by the mental health teams, and seen by mental health professionals on a regular basis. He was

prescribed antipsychotic medication when required, saw a psychiatrist regularly and his medication was closely monitored.

Key worker scheme

65. All prisoners in the closed male estate should be allocated a key worker. They should have an average of 45 minutes a week with their key worker to build rapport and have meaningful conversations.

66. Mr Richards' records show that he saw his key worker regularly at Chelmsford and was open in key work sessions. However, he was not allocated a key worker at Lowdham Grange. We were told that Lowdham Grange was providing key work only to vulnerable prisoners due to operational and staffing pressures. Mr Richards was not classed as a vulnerable prisoner while at Lowdham Grange.

Governor and Head of Healthcare to note

67. The first defibrillator applied to Mr Richards gave a low battery warning and staff had to fetch another one. A nurse also expressed concerns that the suction equipment was not working correctly. It is unlikely that these issues affected the outcome in this case, but we bring them to the attention of the Governor and Head of Healthcare.

Inquest

An inquest into Mr Richards' death concluded on 7 February 2025 that his death was accidental due to self-inflicted ligature asphyxiation.

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