

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Loch, a prisoner at HMP Lowdham Grange, on 6 April 2025

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO



WHAT WE VALUE



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

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

Mr David Loch died from the effects of synthetic cannabinoids on 6 April 2025 at HMP Lowdham Grange. He was 35 years old. I offer my condolences to Mr Loch's family and friends.

Mr Loch was the sixth drug related death at Lowdham Grange since November 2024.

Mr Loch had been at Lowdham Grange for 10 days before he died. He had a history of illicit drug use in the community and in prison and had been referred to the substance misuse team for assessment. There were no reported concerns about Mr Loch using illicit drugs in the days prior to his death.

The clinical reviewer concluded that the care Mr Loch received at Lowdham Grange was good and at least equivalent to what he could have expected to receive in the community.

In December 2023, HMPPS took back interim control of Lowdham Grange and on 1 August 2024, the prison was formally taken back into public sector control. I commented at that time that the prison was in a period of transition and faced significant challenges. This remains the case, and the recent drug-related deaths are of particular concern. I acknowledge that the prison has developed an action plan to address these issues and is receiving additional support from the national safety team. Following a recent investigation into another of the five suspected drug-related deaths, I recommended the prison ensure there is a programme to educate and communicate the risks of drug use to prisoners. A new Governor has also recently taken up post at Lowdham Grange, with a view to tackling the current issues facing the prison.

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 2025

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Summary

Events

1. On 20 June 2019, Mr David Loch was remanded to prison charged with grievous bodily harm. On 12 February 2020, he was sentenced to 12 years in prison. On 27 March 2025, Mr Loch transferred to Lowdham Grange.
2. Mr Loch had been previously diagnosed with attention deficit hyperactivity disorder (ADHD) and emotionally unstable personality disorder and was prescribed medication for these conditions. He also had a history of substance use.
3. In November 2024, Mr Loch had been monitored under suicide and self-harm monitoring (known as ACCT) after he made superficial cuts to his arm. There were no further acts of self-harm and staff did not raise any concerns about his risk or well-being.
4. While at previous prisons, Mr Loch's behaviour had been problematic and he used illicit drugs, the last time being on 6 and 25 December 2024 at HMP Full Sutton. On 1 April, following his transfer to Lowdham Grange, Mr Loch was placed on the prison's drug and alcohol team list for assessment.
5. At 9.00am on 6 April, staff unlocked Mr Loch's cell and found him lying on his bed, unresponsive. Staff immediately radioed a medical emergency code. On examination, it was clear that Mr Loch was dead and cardiopulmonary resuscitation (CPR) was not considered to be appropriate. At 9.21am, paramedics pronounced Mr Loch's life extinct.
6. The post-mortem examination established that Mr Loch died from the use of synthetic cannabinoids.

Findings

7. Mr Loch was the sixth prisoner to die from the effects of drugs at Lowdham Grange since November 2024. He was able to access illicit drugs (specifically synthetic cannabinoids) with apparent ease, despite having only been at the prison for 10 days.
8. On 5 and 6 April, the officer on night duty failed to check on Mr Loch as part of the mandatory roll checks at 6.45am, 5.25pm and 9.00pm. However, on both occasions, the officer reported the correct number of prisoners, despite not counting them all. The prison is conducting an internal investigation into the officer's actions.
9. The clinical reviewer concluded that the clinical care Mr Loch received at Lowdham Grange was of a good standard and at least equivalent to what he could have expected to receive in the community.
10. In response to the drug related deaths at Lowdham Grange, the National Substance Misuse Group (SMG) carried out a Drug Strategy Support visit on 11-12 September 2024. SMG made six recommendations including photocopying of incoming mail to reduce the ingress of drugs imprinted on paper, reviewing the parcel process, a full

review of visits procedures, ensuring staff better understand those prisoners found under the influence of drugs and actions that should be taken and raising awareness of the substance misuse and drug strategy across the prison. The safety group for the Long Term, High Security Estate (LTHSE) have developed an action plan to address the recommendations.

The Investigation Process

11. HMPPS notified us of Mr Loch's death on 6 April 2025.
12. 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.
13. The investigator visited Lowdham Grange on 15 April. He obtained copies of relevant extracts from Mr Loch's prison and medical records and viewed CCTV and body worn video camera (BWVC) footage relevant to the investigation.
14. The investigator interviewed four members of staff at Lowdham Grange on 13 June 2025.
15. NHS England commissioned a clinical reviewer to review Mr Loch's clinical care at the prison.
16. 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.
17. The Ombudsman's office wrote to Mr Loch's next of kin to explain the investigation and to ask if they had any matters, they wanted us to consider. The family were spoken to on 8 July and confirmed that they had no questions but would like to receive a copy of our report.
18. The family of Mr Loch received a copy of our initial report but made no comments on our findings.

Background Information

HMP Lowdham Grange

19. HMP Lowdham Grange is a category B male adult prison located in Lowdham, Nottinghamshire. The prison was operated by Serco for 25 years until 16 February 2023, when Sodexo Justice Services took over the running of the prison. This was the first time a prison had transferred from one private contract manager to another.
20. In December 2023, HMPPS took back operational management of the prison for an interim period, bringing in an experienced governor and additional HMPPS staff, including officers on detached duty, to improve staffing levels. The interim period of HMPPS control was initially extended from March to September 2024 but in May 2024, HMPPS decided to take back full control of the prison and terminate the contract with Sodexo. On 1 August 2024, the prison was formally taken back into public sector control.
21. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons inspected Lowdham Grange in March 2025. Inspectors noted that since their last inspection in 2023 there had been 10 deaths in custody, four of which were suspected of being attributed to drug misuse. A very high number of medical emergencies were linked to drugs, yet health services were no longer providing round-the-clock care, were not meeting the needs of patients, and in some cases were unsafe.

Independent Monitoring Board

23. 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 January 2024, the IMB reported that the prison was unsafe. They found that safety in the prison deteriorated throughout the whole reporting period. They also noted that outcomes were being strongly influenced by the availability of illegal drugs, along with the associated violence, combined with inexperienced staff who lacked the skills and confidence to successfully manage prisoners with challenging behaviour. There was an increasing number, during the year, of prisoner-on-prisoner assaults and prisoner-on-staff assaults, a rise in prisoner self-harm, the number of 'in-cell fires' set by prisoners, and the significant number of weapons' finds, culminating, in January 2024, in the largest number of weapons' finds ever recorded in one lock down search by HMPPS.
24. The Board noted that by May 2023, 35% of mandatory drug tests (MDTs) carried out were positive. By the year end, this had gradually increased to over 50% positive, and there were daily incidents of prisoners being under the influence of psychoactive substances and/or alcohol. Consequently, the underlying economy of drugs and other substance use increased the negative impact of gang cultures at

the prison, putting more prisoners into debt and making prisoners feel less safe and more likely to self-isolate.

Previous deaths at HMP Lowdham Grange

25. Mr Loch was the 16th prisoner to die at Lowdham Grange since January 2022. Of the previous deaths, five were from natural causes, five were self-inflicted and five were drug related. Up to the end August 2025, there have been no deaths at the prison since Mr Loch's death.

Key Events

26. On 20 June 2019, Mr David Loch was remanded to prison, charged with grievous bodily harm. On 12 February 2020, he was found guilty and sentenced to 12 years in prison.
27. Over the following years, Mr Loch transferred between four different prisons. At times, he was subject to suicide and self-harm monitoring (known as ACCT), the most recent being in November 2024, after he made superficial cuts to his arm. The ACCT was closed on 2 December. There were no further acts of self-harm and staff did not raise any concerns about his risk or well-being.
28. Evidence from the previous prisons indicated that Mr Loch displayed problematic behaviour, including illicit drug use. Mr Loch had also been under the care of the mental health teams due to his diagnoses of attention deficit hyperactivity disorder (ADHD) and emotionally unstable personality disorder. Mr Loch was prescribed quetiapine (antipsychotic) and lisdexamfetamine (ADHD medication).
29. Mr Loch had a history of illicit drug use both in the community and in prison. On 6 and 25 December 2024, he was found under the influence of illicit drugs and was downgraded to the basic incentives level (meaning certain privileges, including in-cell television were removed). His behaviour deteriorated further and he smashed the contents of his cell and threatened staff. As a result, he was relocated to the segregation unit at Full Sutton on 28 December. He remained there for the duration of his stay at Full Sutton.
30. On Thursday 27 March 2025, Mr Loch was transferred to HMP Lowdham Grange.
31. Nurse A completed an initial health screen with Mr Loch and he reported no physical health issues. Nurse A referred him to the substance misuse team, mental health team and the neurodevelopmental/neurodiversity occupational therapist due to his ADHD diagnosis.
32. Mr Loch was located on the first night/induction residential unit. There is no evidence that Mr Loch received a formal induction.
33. On 29 March, Nurse B completed a secondary health screen. It was noted that due to Mr Loch's substance use history he would not be allowed to keep his medication with him in his cell, and this would be dispensed under supervision.
34. On 1 April, Nurse C from the substance misuse team, spoke to Mr Loch about his support needs. It was noted that while at Full Sutton, Mr Loch had regular psychosocial intervention for substance use. Nurse C placed Mr Loch on the waiting list for a Comprehensive Substance Misuse Assessment (CSMA). The initial assessment had been scheduled for 27 March but could not be completed due to staff shortages.
35. On 1 April, Mr Loch moved from the induction wing to M wing, houseblock 4, cell 30, a standard residential wing. There are no entries on Mr Loch's prison record after 1 April, other than a statement which said he had completed the induction.

36. On 3 April, Ms A, a Neurodiversity Occupational Therapist, saw Mr Loch to complete a detailed assessment of need and social functioning. Mr Loch said he had no thoughts of suicide or self-harm and she found no evidence of any active psychotic symptoms. Ms A confirmed Mr Loch's neurodiversity and indicated that he had ADHD with some obsessive-compulsive disorder traits. Ms A also recorded that Mr Loch had a history of substance use but that he had told her he had not used illicit substances for around 18 months. Records show that this was not the case as he had been found under the influence during his time at Full Sutton in December 2024.
37. On 3 April, Dr A, a Consultant Psychiatrist, completed a desktop review of Mr Loch's notes and Ms A's assessment, to ascertain the risk and the urgency for a face-to-face assessment. Dr A noted that there appeared to be no immediate risk in relation to Mr Loch's well-being and he decided that Mr Loch would not be offered a routine mental health assessment within the standard two-week period.
38. No concerns were raised about Mr Loch the following day.

Events of 5 and 6 April

39. The following account has been taken from documentary evidence provided by Lowdham Grange, CCTV and Body Worn Video Camera (BWVC) footage, medical records and transcripts of interviews with staff.
40. During the morning period from around 10.00am on 5 April, CCTV shows Mr Loch around the entrance to his cell, playing and watching other prisoners playing pool. He was interacting with other prisoners, two of whom staff believed were involved in the illicit drug trade at Lowdham Grange. At approximately 11.57am, after collecting his lunch, staff locked Mr Loch in his cell.
41. At 2.15pm, staff unlocked Mr Loch's cell for social time. Between 2.15pm and 5.05pm, CCTV shows Mr Loch playing pool and going to cells occupied by the two prisoners he had engaged with during the morning. Between 3.43pm and 3.47pm, Mr Loch was in the cell of one of the other prisoners, before returning to his own cell.
42. At 4.03pm, CCTV footage shows Mr Loch at the door of his cell and he appeared unsteady on his feet. When interviewed, prison staff said that they had not been aware of any issues or concerns about Mr Loch at any point during the day.
43. At 5.00pm, staff began locking prisoners back in their cells. CCTV shows Mr Loch on the upper landing, and he appeared to receive items from both prisoners that he had been engaging with throughout the day, before returning to his cell where he was locked in at 5.05pm. Neither of the prisoners referred to wished to engage with the investigation and they were not interviewed by the police.
44. Staff completed a routine roll check (a security check to count prisoners and confirm they are in their correct cells) once prisoners were secured in their cells, and Mr Loch was seen alive in his cell at 5.11pm.
45. Operational Support Grade (OSG) A was on night duty and was assigned to cover M wing. OSG A told the investigator that he arrived for his duty at around 7.30pm.

He received a handover from the outgoing day staff, who reported no concerns, checked on those subject to suicide and self-harm monitoring (ACCT) and then completed a roll check at 9.00pm.

46. OSG A said that before starting a roll check, he would be aware of how many prisoners were on the wing and how many he needed to account for. CCTV from the evening of 5 April shows OSG A going around the wing completing the count. However, he did not go to Mr Loch's cell. When asked why he had not gone to Mr Loch's cell, OSG A told the investigation that he was unfamiliar with the layout of M wing and that he did not know there was a cell where Mr Loch was located. The cell occupied by Mr Loch was the end cell, on the ground floor and by the wing office.
47. Despite the number of prisoners he had counted not tallying with the number of prisoners he had been told were held on the wing that day, OSG A reported the correct roll.
48. At 5.30am on 6 April, OSG A began completing a morning roll check. CCTV shows that again, OSG A missed Mr Loch's cell but again he reported the correct numbers. The investigator asked OSG A how he could have accounted for the right number of prisoners, even though he had not counted Mr Loch. OSG A said that he thought he had counted everyone and must have miscounted. OSG A handed over to the day staff and reported no concerns.
49. At 9.00am on 6 April, Custodial Manager (CM) A was assisting with unlocking prisoners on M wing. He started at Mr Loch's cell. When he looked in through the observation panel, he saw Mr Loch lying on his bed, in what CM A described as a 'precarious' position. CM A said that his first thought was that Mr Loch was under the influence of drugs. He entered the cell and spoke to Mr Loch but received no response. CM A said that he shook Mr Loch on the shoulder, and it was at this point he realised that, in his opinion, Mr Loch was dead. CM A described Mr Loch as rigid, with no natural movement in his body and he observed blood pooling on the left-hand side of Mr Loch's body.
50. CM A radioed a medical code blue at 9.01am (indicating a prisoner is unconscious or is having breathing difficulties). CM A said that he was unable to give cardiopulmonary resuscitation (CPR) as Mr Loch had rigor mortis.
51. Nurse B responded immediately. Nurse B said that when she entered Mr Loch's cell at approximately 9.02am, she observed Mr Loch lying on his bed and on examination there were clear signs of rigor mortis. She concluded that CPR would be futile. Nurse B told staff that an ambulance would still be required to pronounce life extinct.
52. At 9.15am, paramedics arrived at the cell and after completing their own checks, pronounced Mr Loch's life extinct at 9.21am.

Contact with Mr Loch's family

53. The prison appointed Supervising Officer (SO) A to act as family liaison officer. Initially the next of kin details recorded were for Mr Loch's probation officer. However, the prison identified an address for Mr Loch's father and requested their colleagues at HMP Frankland (which was closer to the address) to visit the address

and inform the family, which they did later that day. SO A and his colleague Ms A remained in contact with the family.

54. The prison contributed towards funeral expenses in line with national policy.

Support for prisoners and staff

55. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners to identify prisoners most affected by the death.
56. After Mr Loch's death, Ms B, Head of Security, 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. Samaritans were also notified in line with postvention procedures.
57. The prison posted notices informing other prisoners of Mr Loch'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 the death.

Post-mortem report

58. A post-mortem report gave Mr Loch's cause of death as use of synthetic cannabinoids.

Inquest

59. An inquest with a jury was completed on 10 August 2026. The jury found that Mr Loch died as a result of misadventure involving the use of synthetic cannabinoids.

Findings

Clinical care

60. The clinical reviewer concluded that the clinical care Mr Loch received at Lowdham Grange was of a good standard and at least equivalent to what he could have expected to receive in the community.
61. Mr Loch was appropriately referred to the substance misuse team and was on the waiting list for a detailed assessment, which was expected to take place on 1 April. The clinical reviewer noted that Mr Loch received structured psychosocial intervention for substance misuse at his previous prison as part of his substance use treatment, which suggested he may have engaged with the service at Lowdham Grange. The clinical reviewer concluded that the care Mr Loch received for his substance use was equivalent to what he could have expected to receive in the community.
62. The clinical reviewer has made some recommendations that are not related directly to Mr Loch's death, but which the Head of Healthcare will wish to address.

Drug strategy at Lowdham Grange

63. Mr Loch was the sixth drug related death at Lowdham Grange since January 2022. He was able to access illicit drugs with apparent ease, despite having only been at the prison for 10 days.
64. Lowdham Grange's drug strategy dated August 2024 noted significant increases in finds of illicit items. There had been a 24% increase in illicit drugs being found in 2023/2024 compared to 2022/2023. There had also been an increase in reported incidents involving PS and health partners suggested there was significant under-reporting of PS use. Random and mandatory drug testing fell short of the 15% target and there was little evidence of supplementary suspicion, frequency or risk testing. At the time of this investigation, the drug strategy was under review to reflect HMPPS taking management of the prison.
65. In September 2024, the HMPPS Substance Misuse Group (SMG) conducted a drug strategy support visit at the prison to understand the scale and nature of substance misuse problems and the scale of the prison's vulnerability to the conveyance of illicit drugs. They found PS and cannabis were the most commonly used drugs. They identified some knowledge gaps among staff around substance use and physical vulnerabilities, including visits and searching. It was positive that they found that the security and analyst team had developed a strong understanding of illicit substances in the prison through detailed intelligence reports. This enabled them to produce a detailed and thorough Local Tactical Assessment (LTA) which was used as the basis for further action plans at departmental level. Revised monthly drug strategy meetings had also started.
66. The SMG made six recommendations, including that activity should be undertaken to raise awareness of substance use and the drug strategy across the prison, drive understanding of the prison's policy on managing prisoners under the influence of a substance, closer strategic alignment between security, safety and drug strategy

activity, a review of existing visits procedures, review of the parcel process and photocopying social mail.

67. In January 2025, the Head of Drug Strategy and the Head of Security told the investigator of one of the other drug related deaths at the prison that since October 2024, the prison had experienced a sharp increase in the number of medical emergencies related to prisoners suspected of being under the influence of drugs. Cannabis and PS remained the predominant drugs used. However, prison intelligence suggested that a variety of other substances, including fentanyl, ketamine and opiates were being used.
68. The Head of Security and the Head of Drug Strategy said that they worked closely with the police and had a good relationship with them. However, both said they felt the approach to managing drones was reactive rather than proactive. Drones were a significant issue, with attempted drops of packages every other night. There were examples of collaborative work taking place, particularly in sharing information about vehicles. This had resulted in arrests. Searching and risk drug testing remained challenging due to lack of resources.
69. In response to SMG recommendations, the prison is reviewing their drug strategy and have introduced measures to combat drugs coming into the prison, including securing funding for netting and window grill replacements and delivering corruption prevention training, with a recent focus on civilian staff.

Actions taken by Lowdham Grange in response to the drug-related deaths

70. The Head of Security said the gate area was a concern as the prison experiences a high number of people and vehicles coming through. Enhanced gate security and other measures have been introduced, including a limit on paper permitted into the prison and the photocopying of mail. The prison is also exploring the development of a dedicated wing for incentivised substance free living.
71. The SMG scheduled a review for April 2025. Before it could take place, the SMG reconfigured to the Drug and Alcohol Group (DAG), with a new focus on capability and training. Direct prison support, including visits, stopped. Recruitment is underway to employ regional drug and alcohol leads to undertake this role.
72. On 9 April, the regional safety group undertook a safety visit and agreed with the DAG to look at some of SMG's key recommendations from September 2024. They found evidence of enhanced searching and additional training to support this. Progress had been made to raise awareness of substance use and the prison's drug strategy. However, it was unclear how many staff had completed training through an email link.
73. The SMG suggested that a tripartite meeting linking safety, security and drug strategy may be beneficial. They also found there were no courses being delivered to prisoners in relation to substance use. The prison is exploring alternatives which may be delivered through the education provider. In May 2025, Lowdham Grange accepted an offer from the Regional Safety Team and DAG to become a pilot site to undertake a training needs analysis and develop bespoke staff training.

74. We fully recognise the significant challenges inherent in preventing drugs coming into Lowdham Grange. The illicit drugs market in prison is controlled by organised crime gangs and Lowdham Grange recognises that the scale of the problem needs a co-ordinated approach which they have been implementing.
75. Lowdham Grange has experienced a turbulent two years and the demand for drugs and ingress into the prison is one of many significant problems they need to address. In March 2025, Ms C was appointed as the new Governor of Lowdham Grange. Although some good work is being done at Lowdham Grange, including limiting paper coming into the prison and enhanced gate security, the threat from drugs is constantly evolving and more can always be done.

Roll checks

76. Routine roll checks are primarily a visual security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoner's safety to be identified and managed. HMPPS' National Security Framework expects welfare checks to take place at routine checks including that staff are able to see the prisoner's face and satisfy themselves that they are alive and well.
77. During the investigation, it became apparent that Mr Loch had not been seen since the last check by day staff at 5.11pm on 5 April. Lowdham Grange's local security strategy (LSS) indicates that mandatory roll checks should take place at 6.45am, 5.25pm and 9.00pm daily.
78. Despite OSG A not being able to reconcile the figures for the counts he undertook against the number of prisoners he knew to be held on M wing, he twice reported the correct number of prisoners. The prison is conducting an internal investigation into OSG A's actions on 5 and 6 April. As a result, we make no recommendation at this time.



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