Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Matthew Osborne, a prisoner at HMP Lowdham Grange, on 25 November 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, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Matthew Osborne was found hanged in his cell on 25 November 2023 at HMP Lowdham Grange. He was 39 years old. I offer my condolences to Mr Osborne's family and friends.

Mr Osborne was the sixth self-inflicted death at Lowdham Grange since October 2021 and the fifth there during 2023. In February 2023, the management of the prison transferred from Serco to Sodexo and resulted in an exodus of staff alongside higher levels of ingress of drugs, higher levels of violence and self-harm, less time out of cells and a deterioration in staff-prisoner relationships.

In my investigation into the first of the self-inflicted deaths in 2023, I expressed my serious concern about prisoner safety at Lowdham Grange. Unfortunately, my investigation of Mr Osborne's death has only served to prove those concerns fully justified. In the final eight weeks of his life, Mr Osborne was housed in the segregation unit while also being supported through suicide and self-harm monitoring procedures. On the day of his death, officers should have checked him three times every hour, but they failed to make all of the necessary checks and they had not checked him for almost two hours when they found him hanged.

In December 2023, HMPPS took back interim control of the prison and on 1 August 2024, the prison was formally taken back into public sector control. The prison is in transition and now faces a significant challenge to restore order and ensure the safety of the prisoners and staff that live and work there. I make fewer recommendations than I otherwise might have done in recognition of this period of transition.

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 **May 2025**

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Summary

Events

1. On 7 September 2022, Mr Matthew Osborne was remanded to HMP Pentonville charged with robbery and grievous bodily harm. He had left Pentonville only the day before and his latest charges were for offences dating back several years. He was later sentenced to 38 months in prison.

2. After spending time in several different prisons in early 2023, Mr Osborne moved to HMP Lowdham Grange on 20 June.

3. On 29 June, staff started prison suicide and self-harm monitoring procedures (known as ACCT) when Mr Osborne said that he had thoughts of self-harm. In July, Mr Osborne attempted to hang himself, but the ligature snapped. Three days later staff intervened when they saw him with another ligature around his neck and trying to find a fixing point. Mr Osborne remained on ACCT for his remaining time in prison and at times was subject to constant supervision.

4. On 3 October, Mr Osborne moved to the segregation unit after he punched two officers. Mr Osborne was still in the segregation unit on 22 November when he again attempted to assault an officer. From mid-October onwards, staff were required to carry out ACCT checks on Mr Osborne three times an hour.

5. Staff did not comply fully with the required level of ACCT checks during the morning and early afternoon of 25 November and their last check on Mr Osborne was at 2.32pm. When officers went to Mr Osborne's cell at 4.22pm with his evening meal, they found him hanged from a ligature tied to an air vent. The officers radioed a medical emergency code and went into the cell. They cut the ligature and started cardiopulmonary resuscitation (CPR). Nurses arrived four minutes later and continued CPR.

6. Ambulance paramedics arrived at 4.47pm and took charge of Mr Osborne's care. At 5.18pm, the paramedics ceased all efforts and pronounced life extinct.

Findings

7. Mr Osborne's ACCT care plan lacked clear actions for his ongoing support and his family were not included as sources of support.

8. The segregation records provided by Lowdham Grange contained only one review board assessment authorising his continued segregation and there were no mental health safety algorithms.

9. Mr Osborne's ACCT reviews and continued segregation reviews were not aligned as required.

10. Mr Osborne was discussed four times at the Safety Intervention Meeting (SIM), but there were no meaningful actions listed to support either him or the staff dealing with him.

11. Staff did not refer Mr Osborne for a challenge support and intervention plan (CSIP) until 22 November. An earlier referral would have been appropriate.

12. On 25 November, officers failed to check Mr Osborne at the required frequency, and he was not checked for almost two hours before he was found hanged at 4.22pm.

13. The clinical reviewer concluded that the clinical care Mr Osborne received at Lowdham Grange was not equivalent to that which he could have expected to receive in the community. She noted that communication between primary care and mental health staff was not robust. There were also instances where the mental health team did not respond to urgent referrals within the appropriate timescale.

14. During Mr Osborne's time in Lowdham Grange, there was a chronic shortage of operational staff and wing managers. Violence, illegal drugs and debt increased. Dedicated teams such as safer custody staff were cross deployed to help run the basic daily regime.

Recommendations

- The Governor must carefully consider the findings of this report and the early learning review to ensure that the concerns identified are being addressed.

The Investigation Process

15. HMPPS notified us of Mr Osborne's death on 25 November 2023. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

16. The investigator visited Lowdham Grange on 12 December 2023. The prison provided copies of some of the relevant extracts from Mr Osborne's prison and medical records. CCTV, body worn video camera footage and records of telephone calls were also provided and reviewed.

17. The investigator interviewed two members of staff at Lowdham Grange on 18 April and interviewed another member of staff on 4 June by video-link. The investigation was subsequently reallocated to another investigator. He interviewed three additional staff in November and December 2024, all by video-link.

18. NHS England commissioned a clinical reviewer to review Mr Osborne's clinical care at the prison. She and the investigator conducted joint interviews with clinical staff.

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. We contacted Mr Osborne's mother and sister to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Osborne's sister asked:

- Did Lowdham Grange have access to her brother's mental health records from Pentonville and his mental health diagnoses?
- Was Lowdham Grange aware that her brother had attempted suicide in the community?
- When and why was her brother made subject to ACCT monitoring and support?
- How did her brother behave while supported through ACCT and what meaningful support did he receive from staff?
- When was her brother removed from constant supervision, why were his observations lowered and who made that decision?
- Why was her brother in segregation at a time when he was also being supported through ACCT?
- What support did her brother receive apart from being supported through ACCT?
- Why were the family not informed that her brother was being supported through ACCT?
- Why was her brother restrained on 22 November, was he checked by a nurse and was body worn camera footage reviewed?
- Why was her brother not checked for the two hours before his death and how often had there been similar omissions?

21. We have answered these questions in this report and have answered other questions in separate correspondence.

22. We shared our initial report with HMPPS and with Mr Osborne's mother via her solicitor. No factual inaccuracies were identified.

Background Information

HMP Lowdham Grange

23. 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.

24. 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.

25. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

26. HM Inspectorate of Prisons inspected Lowdham Grange in March 2025. The full inspection report had not yet been published at the time of this investigation report. Prior to that, the most recent full inspection 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 specialist staff leaving. HMIP were critical of the use of segregation noting that the unit was often full, and, at the time of the inspection, two prisoners had been in the unit for over 100 days with little done to address their issues or to reintegrate them back into the main population. Inspectors noted that the regime in the segregation unit was poor.

27. Inspectors found that levels of recorded self-harm were high, and prisoners said that self-harm was as a result of uncertainty and changes at the prison as well as bullying, debt and lack of help with basic requests. Inspectors found that there was insufficient analysis of the causes of self-harm with no overarching strategy to address the issue. Inspectors noted that a high number of prisoners were being supported through ACCT, but there was little other support for them apart from the ACCT process.

28. Inspectors found that too little key work was being delivered and that many key work sessions were not adequate. Inspectors also found that about half of adjudication cases (for dealing with prisoners breaking prison rules) were not proceeded with due to administrative errors. Inspectors found that oversight of use of force was very weak, and leaders could not be confident that all use of force was necessary or proportionate. HMIP noted that Challenge, Support and Intervention Plans (CSIP) were not being used effectively to manage perpetrators of violence.

29. Inspectors found that partnership working between the healthcare provider and the prison was poor. Healthcare staff did not feel respected and prison staff did not always take their clinical judgement into consideration.

30. HMIP carried out an independent review of progress at the prison in January 2024. They found that levels of violence had increased by 55% and self-harm by 41% since the 2023 inspection. A high number of staff had resigned leaving the prison desperately short-staffed. Inspectors did not find sufficient progress had been made in respect of any of the concerns raised in the full inspection.

Independent Monitoring Board

31. 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 in early 2023 Lowdham Grange was short of managers and operational staff. Prisoners often experienced a very restricted regime with excessive hours locked-up and restrictions on social visits, access to showers, work and fresh air. The IMB reported that the prison was not safe with increasing numbers of prisoner-on-prisoners assaults and prisoner on staff assaults.

32. The IMB noted the segregation unit had been fully occupied for the majority of the year and too many prisoners had been segregated for long periods without access to a meaningful regime and without an effective reintegration plan. The IMB noted that at the time of reporting, around one-third of the prisoners in the segregation unit were being supported though ACCT. The IMB also noted that prisoners had made video recordings (using illicit mobile phones) of staff in the segregation unit apparently using inappropriate language during use of force incidents.

33. The IMB noted that since HMPPS had stepped in, the Governor had identified various priorities for making the prison safer for both prisoners and staff. Steps included reducing the prison's population by around 10% and deploying additional staff on detached duty to improve the prison regime.

Previous deaths at HMP Lowdham Grange

34. Mr Osborne was the ninth prisoner to die at Lowdham Grange since November 2020. Of the previous deaths, two were from natural causes, one was drug related, and five were self-inflicted. Mr Osborne's death was the fifth of the five self-inflicted deaths at Lowdham Grange 2023. Some of those investigations highlighted the serious issues evident at the prison.

35. Up to the end of January 2025, there had been six further deaths at Lowdham Grange since that of Mr Osborne. Five of these were suspected to be drug related and one was due to natural causes.

Assessment, Care in Custody and Teamwork

36. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

37. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures was, at the time of Mr Osborne's death, set out in Prison Service Instruction (PSI) 64/2011. In January 2025, the new Prison Safety Policy Framework came into effect but the guidance on ACCT remained largely unchanged.

38. Guidance on segregation procedures states that particular care should be given to authorising continued segregation of a prisoner on an open ACCT. The guidance states that continued segregation should occur only in exceptional circumstances and that ACCT case reviews must take place at the same time as segregation reviews.

Key worker scheme

39. The key worker scheme is a key part of HMPPS' 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.

40. Within this allocated time, key workers can vary individual sessions 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.

41. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons were 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

42. In March 2020, Mr Matthew Osborne was remanded to HMP Pentonville charged with harassment and other offences against his ex-partner. In February 2021, he was sentenced to 24 months imprisonment. He was released on licence in July 2021, but was recalled to custody in January 2022 for breaching his licence conditions.

43. At the time, Mr Osborne was using a wheelchair following injuries sustained in a fall from height the previous month. Mr Osborne gave conflicting accounts about the fall: he said at separate times that he had fallen when trying to burgle a property but also said that he had deliberately jumped from height as an act of self-harm. A reception nurse at Pentonville noted that Mr Osborne had no concerns about his mental health and no thoughts of suicide or self-harm.

44. Mr Osborne was released from prison on 6 September but was rearrested on 7 September and remanded to Pentonville charged with offences of robbery and grievous bodily harm that had occurred in 2013. He was found guilty of these offences on 1 November and sentenced to 38 months in prison.

45. Mr Osborne transferred to HMP Highpoint (in Suffolk) on 14 February 2023.

HMP Highpoint

46. On 12 March, Mr Osborne submitted a transfer request. He told an officer that he was struggling as his family lived in London and Highpoint was too far for them to visit. He said that he wanted to transfer back to Pentonville. The officer told Mr Osborne that he would speak to his colleagues about the possibility of a transfer but that it could be a lengthy process.

47. While on the exercise yard on 1 April, Mr Osborne threw some tied bed-sheets over the inner perimeter fence in an apparent escape attempt. Officers placed him in handcuffs and took him to the segregation unit. Mr Osborne was placed on the escape list (E-list.). Prisoners are placed on the E-list when additional security processes are needed to manage an identified risk of escape. E-list prisoners wear brightly coloured clothing, and their movements are closely monitored.

48. On 25 April, Mr Osborne transferred to HMP Chelmsford. Ahead of his transfer, a physiotherapist assessed that Mr Osborne was able to walk without the use of a wheelchair or crutches and a nurse noted that he was medically fit to transfer.

HMP Chelmsford

49. During a reception interview at Chelmsford, Mr Osborne said that he had no past or present thoughts of suicide or self-harm. Mr Osborne was placed in the segregation unit as he had transferred from the segregation unit at Highpoint.

50. On 26 April, a supervising officer told Mr Osborne that she would speak with colleagues to see if a transfer to Pentonville was possible. Mr Osborne said that he did not think moving to a standard wing was a good idea in the meantime as he

thought he might come into conflict with other prisoners. Mr Osborne said that he suffered with stress and anxiety, but he did not want to take any medication.

51. On 3 May, Mr Osborne gave a note to the Duty Director saying that 'the walls were closing in on him' and he wanted help. A mental health nurse tried to speak to Mr Osborne, but he said he would not speak to her with officers present. The nurse noted that the segregation policy prevented her from seeing Mr Osborne alone. She also noted that Mr Osborne had no thoughts of suicide or self-harm.

52. From early May, Mr Osborne began to ask about leaving the segregation unit, but he was told that he could not attend a segregation review on 13 May as he had removed some of his E-list clothing. Mr Osborne said that he did not care, and staff noted that he seemed disinterested.

53. On 14 May, Mr Osborne rang his cell bell and told staff that he had cut his neck with a broken piece of plastic cutlery. Staff started ACCT procedures. At a combined ACCT and segregation review on 15 May, Mr Osborne said that he had cut himself due to stress and anxiety from being in a single cell in segregation. The ACCT chair reminded Mr Osborne of previous discussions with him about reintegration and the need for him to build relationships with staff and prisoners by attending B wing (a standard wing) for short periods ahead of a permanent move.

54. On 18 May, Mr Osborne left segregation and moved to B wing. Staff closed his ACCT on 1 June and removed him from the E-list on 7 June.

55. On 20 June, Mr Osborne moved to HMP Lowdham Grange (in Nottinghamshire).

HMP Lowdham Grange

56. At a reception health screen at Lowdham Grange, Mr Osborne said that he had no thoughts of suicide or self-harm and was glad to have moved. He said that he suffered with anxiety at times but was not feeling anxious at present and he did not need to be seen by the mental health team.

57. A Prison Custody Officer (PCO) from the safer custody team met Mr Osborne in reception. He said that he was 'alright' about being at Lowdham Grange but did not think he would receive any visits as his family lived in London. She told Mr Osborne about the possibility of accumulated visits (where a prisoner can have multiple visits over several days in place of regular visits) or of having video link meetings with his family. Mr Osborne reiterated that he had no thoughts of suicide or self-harm and said he would speak to staff if this changed. Mr Osborne moved to a cell on E wing, a standard residential wing.

58. On 25 June, Mr Osborne had a fight with another prisoner and when staff intervened, he spat blood at them. A nurse examined Mr Osborne and noted that he had a bloody nose and bruising and swelling to his left eye. When staff reviewed CCTV footage of the fight, they deemed Mr Osborne to have been the instigator. He moved to the segregation unit on 26 June and, at a disciplinary hearing, was found guilty of assault and was punished through 14 days' loss of association and privileges and 14 days' reduction in pay.

59. On 29 June, Mr Osborne told a GP during a routine segregation visit that he had thoughts of self-harm. The GP started ACCT procedures. The Business Enterprise Manager chaired an ACCT review with Mr Osborne that afternoon. The mental health Matron and an officer from safer custody also attended. Mr Osborne said that he had been feeling low earlier that day but was okay now. The manager asked Mr Osborne if he wanted to move to a standard wing and he said he did, but he wanted somewhere quiet. She set Mr Osborne's observations at two an hour. On the same day, Mr Osborne moved to A wing, a standard residential wing.

60. At an ACCT review on 6 July, staff reduced Mr Osborne's observations to one an hour.

61. On 12 July, a PCO answered Mr Osborne's cell bell at 11.05am and noted that he had a serious wound to the top of his head and that there was blood on the cell floor. The PCO radioed a medical emergency code red (indicating a prisoner was bleeding seriously) and a nurse responded. Mr Osborne told the nurse that he had attempted to hang himself but had fallen backwards and hit his head on the floor. Mr Osborne was sent to hospital where he was examined and given stiches. He returned to the prison that evening. Staff increased his observations to two an hour.

62. The Business Enterprise manager chaired an ACCT review with Mr Osborne on 13 July. A mental health nurse and an officer who had gone to hospital with Mr Osborne also attended. The manager noted that Mr Osborne appeared very subdued. She asked him why he had tried to hang himself and he said, 'what's the point'. He said that he needed help with his mental health and also said that he had not been able to contact his family as he had no in-cell telephone.

63. The mental health nurse noted that she had found it difficult to assess Mr Osborne's risk as he gave contradictory information: he acknowledged trying to hang himself, but he also spoke about future goals and wanting to telephone his mother. She noted that she encouraged Mr Osborne to engage with the mental health team. The manager asked officers to get Mr Osborne a telephone and increased his observations to four an hour. (Mr Osborne generally rang his mother every few days and also called his sister from time to time.)

64. In the early hours of 15 July, staff saw Mr Osborne with a ligature around his neck and trying to find a suitable ligature point. He had also tied his feet together. At an ACCT review later that day, Mr Osborne said that he had had enough and wanted to end his life. Staff placed Mr Osborne under constant supervision: he was moved to a high observation cell on J wing where staff could see him at all times with staff remaining just outside his door.

65. Mr Osborne remained under constant supervision until 18 July when staff reduced his observations to four an hour and he moved to a standard cell on J wing. An action point in Mr Osborne's ACCT review for that day was for him to be discussed at the safety intervention meeting (SIM) for the multi-disciplinary team to address his behaviours and thinking and for the correct support to be put in place for him.

66. Healthcare staff also discussed Mr Osborne at a multi-disciplinary meeting on 18 July and referred him to a psychiatrist.

67. Mr Osborne was still on four observations an hour when staff found him on 30 July hanging from a ligature (a jumper) tied to his cell door. Staff entered the cell quickly and untied the ligature. A nurse responded and noted that Mr Osborne had bruising to his neck but had no other adverse symptoms and his pulse and respiratory rates were normal. Mr Osborne told officers that he had been in prison a long time and had had enough. (At that point, Mr Osborne had been continuously in prison for 19 months and his earliest potential release date was nine months away.) Staff placed him back under constant supervision in a high observation cell.

68. On 31 July, the Head of Reducing Reoffending chaired an ACCT review for Mr Osborne. She noted that she asked him if he wished to attend the review, but he shook his head and he also shook his head when she asked him if he was willing to talk to her. She noted that Mr Osborne needed to remain under constant supervision as it was not possible to assess his risk due to his lack of engagement. She noted that there would be a further ACCT review the next day.

69. The Head of Reducing Reoffending noted that as she was leaving the segregation unit, Mr Osborne asked to speak to her. He told her that he did not want to be at Lowdham Grange as it was full of sex offenders, and she noted that he 'rolled his eyes' when she told him that that was not correct. She noted that she tried to talk to him about the trigger for him attempting to hang himself the previous day, whether he had plans to harm himself again and what staff could do to help him. She noted that Mr Osborne fluctuated between being engaged to being very vague in his answers. She asked him about his mental health, and he said that he was not engaging with the mental health team as the team were not willing to work with him.

70. The Head of Reducing Reoffending chaired Mr Osborne's ACCT review on 1 August. Mr Osborne attended along with a mental health nurse, the Head of Security, and a member of the safer custody team. The Head of Reducing Reoffending noted that Mr Osborne engaged in the review to a degree. She noted that he would not say whether he had harmed himself again since 30 July. He said that he was mentally unwell and that while he had no immediate plan of suicide, he would likely kill himself at some point as he had nothing to live for. She kept Mr Osborne under constant supervision and scheduled another ACCT review the next day.

71. The mental health nurse referred Mr Osborne to the mental health team for ongoing support and for future psychology support for childhood trauma.

72. The Head of Reducing Reoffending chaired Mr Osborne's ACCT review on 2 August. Mr Osborne attended, as did the mental health nurse, the Head of Security, and two officers from the segregation unit. The Head of Reducing Reoffending noted that Mr Osborne seemed more hopeful that day although he acknowledged that he could attempt to take his life again. He said that he did not want to do that, but his 'head was not in the right place'. She noted that the nurse provided Mr Osborne with material on the management of self-harm and post-traumatic stress. Staff kept Mr Osbourne under constant supervision.

73. On 3 August, a GP prescribed Mr Osborne an antidepressant, sertraline.

74. Staff discussed Mr Osborne at the SIM meeting on 3 August. Staff noted that Mr Osborne was under constant supervision after being found with a ligature and had

said that he had given up due to being in prison for a long time. The SIM minutes contain no action points for Mr Osborne's support.

75. Mr Osborne remained under constant supervision until 11 August. At an ACCT review that day, the Business Enterprise Manager noted that Mr Osborne was still having thoughts of self-harm from time to time but did not have such thoughts at the moment. She also noted that he was keen to move from the high observation cell so he could have some privacy. She reduced his observations to four an hour and he moved back to a standard cell on E wing.

76. A psychiatrist assessed Mr Osborne on 14 August. Mr Osborne said that he had been feeling suicidal for four months and that his suicidal thoughts were intermittent. He said that he was not able to look after himself, and that he was worried about being homeless on release, although he also said that he did have somewhere to go so he 'should be okay'. The psychiatrist noted that Mr Osborne was a 'vague historian' and despite reporting occasional suicidal thoughts he did not appear to be depressed. He noted that Mr Osborne had recently started taking sertraline and staff should wait to see the effect of the medication.

77. At an ACCT review on 21 August, the Business Enterprise Manager reduced Mr Osborne's observations to three an hour.

78. On 23 August, Mr Osborne punched another prisoner in the face on E wing. Mr Osborne admitted assaulting the other prisoner but gave no explanation for doing so. He was found guilty at a disciplinary hearing and was punished through 14 days' loss of privileges (which can include access to the prison shop, an in-cell television and time out of cell). The following day, he moved to P wing.

79. At another healthcare multi-disciplinary meeting on 4 September, a mental health nurse noted that Mr Osborne had been discharged from the complex caseload, but he would remain under care from her and the psychiatrist.

80. At an ACCT review also on 4 September, staff reduced Mr Osborne's observations to two an hour. (He had weekly ACCT reviews though September into mid-October where he was kept on two observations an hour.)

81. On 7 September, a GP reviewed Mr Osborne. He noted that Mr Osborne had been on sertraline for four weeks and he said the medication was helping. However, the GP noted that Mr Osborne had not collected his medication for the past three days and he told him that the medication only worked if it was taken regularly. Mr Osborne said he would start taking the medication again.

82. On both 9 and 10 September, the mental health nurse noted that she tried to telephone Mr Osborne in his cell but, after picking up the telephone, he put it straight back down again. She told the investigator that she had been assigned as Mr Osborne's mental health worker. However, she had found it very difficult to engage with him as he generally did not want to speak to her. She told the investigator that she considered Mr Osborne had the mental capacity to make decisions about his clinical care.

83. On 18 September, the psychiatrist noted that Mr Osborne had failed to attend a psychiatric appointment and was no longer taking his medication. He noted that he

would not send Mr Osborne a further appointment, but would see him again if needed.

84. On 22 September, a PCO noted that she attempted to have a key work session with Mr Osborne, but he would not talk to her and, as he walked back to his cell, he shouted abuse at other prisoners. (Apart from this, Mr Osborne had only one key work session at Lowdham Grange.)

85. In late September, Mr Osborne was involved in several incidents of inappropriate behaviour. He set fire to a mattress, smashed a television and held a weapon towards two other prisoners who responded by assaulting him. He moved wings several times due to the incidents. Staff submitted intelligence reports about the incidents, but no further action was taken to consider supportive action for Mr Osborne, such as referring him for discussion at the SIM.

86. On 3 October, Mr Osborne punched two officers when they unlocked his cell to give him a toilet roll. He was moved to the segregation unit, where he remained until his death. Staff discussed Mr Osborne's actions at a SIM in October, but the only action noted was for him to remain in segregation.

87. At an ACCT review on 11 October, Mr Osborne asked about the progress with his request to transfer to a prison in the south. An Operational Manager (OM) chaired the review that day and he told Mr Osborne that he would check with segregation managers. He added an action to Mr Osborne's care plan and noted that he had sent an email. (Mr Osborne's records contain no further information on whether he did in fact send an email and what, if any, progress occurred with his request to transfer.)

88. On 17 October, the Business Enterprise Manager noted that she attempted to see Mr Osborne for an ACCT review, but he had covered his observation panel which he refused to remove. She noted that he was shouting aggressively saying that he did not want to talk to anyone. She noted that despite having a good rapport with Mr Osborne, he would not listen to her that day. She increased his observations to three an hour.

89. At an ACCT review on 24 October, the Business Enterprise Manager noted that Mr Osborne was calmer than when she last saw him. He apologised for his behaviour saying that he had been angry with the segregation staff, not with her. He would not answer when she asked him if he had any thoughts of self-harm. Mr Osborne said that he did not want to talk any more as he had had too many ACCT reviews. She maintained his observations at three an hour.

90. Staff also discussed Mr Osborne at the SIM on 24 October. The minutes only recorded that Mr Osborne was in segregation for assaulting staff and that he was to remain in segregation. There was no reference to the fact that Mr Osborne was also on an ACCT. This was the fourth and last time that Mr Osborne was discussed at the SIM. On no occasion was there any action point about whether there should be any further support either for him, or for the Business Enterprise Manager as his ACCT case co-ordinator.

91. The records supplied to the investigator contain only one continued segregation review (a periodic review to consider whether the prisoner should remain in

segregation). A unit manager chaired the one retained review on 25 October. He told the investigator that he was a residential manager for Sodexo at HMP Forest Bank and was seconded to Lowdham Grange in October 2023 to stabilise the segregation unit. He said that segregation reviews were routinely set at two week intervals and the practice at Lowdham Grange was for an administrative assistant to record the reviews. He said that he was disappointed at the lack of detail in the record for the review on 25 October and he could not say where the other reviews might have been stored. Similarly, the records supplied to the investigator contained no safety screen algorithms (completed by healthcare staff) to confirm that Mr Osborne was mentally well enough to be segregated.

92. He was aware that prison service instructions say that for prisoners on ACCT, their ACCT reviews and segregation reviews should be arranged for the same day. However, he could not explain why this did not happen with Mr Osborne. The Business Enterprise Manager told the investigator that she was unaware at the time of this requirement.

93. While the investigator was unable to check any other segregation reviews for Mr Osborne, he was able review some of the daily reviews completed by the Duty Director. In general, these concluded that segregation was the most appropriate location for Mr Osborne due to the difficulty he presented in trying to manage him on a standard wing.

94. On 2 November, the Business Enterprise Manager chaired Mr Osborne's next ACCT review. A segregation officer also attended. The officer told the manager that Mr Osborne had been disruptive during the morning. However, she noted that Mr Osborne was calm and polite at the review but said that he was having constant thoughts of self-harm. The manager noted that she contacted the mental health team before the review to ask if they wished to attend, but they said that he was no longer on their caseload due to his continued refusal to engage with them. She maintained Mr Osborne's observations at three an hour.

95. At a standard segregation visit on 5 November, the duty chaplain noted that Mr Osborne was visibly frustrated, and he described the unit as being 'the weirdest it's ever been'.

96. The Business Enterprise Manager chaired Mr Osborne's next ACCT review on 9 November. She noted that the segregation unit was very noisy at the time which was hampering Mr Osborne's engagement. He said that he had not self-harmed recently but still had thoughts of self-harm at times. She maintained Mr Osborne's observations at three an hour. Mr Osborne also said that he was 'a bit fed up' at being in the segregation unit and she told him that he had a scheduled segregation review set for the following day. At just after 5.00pm, a unit manager noted that Mr Osborne appeared to be coping well.

97. As already noted, Lowdham Grange was only able to locate one of Mr Osborne's segregation reviews, however the Duty Director separately noted on 10 November that the segregation unit was the most suitable location for Mr Osborne.

98. On 16 November, the Business Enterprise Manager chaired an ACCT review with Mr Osborne and noted that he was polite and engaged well. He said that he still had thoughts of self-harm but was managing the thoughts. Mr Osborne said that he

wanted to return to a standard prison wing. She maintained his observations at three an hour and arranged his next review for 23 November. There is no evidence that staff had devised a plan for his reintegration to a normal wing or that staff had properly explained to Mr Osborne what was required of him if he was to progress to standard location.

99. On 17 November a nurse from the mental health in-reach team telephoned Mr Osborne to ask if he needed further support from the team. The nurse noted that Mr Osborne was hostile from the outset, he rebuffed her efforts to speak about his mental health and he ended by saying that he had better things to do than speak to her and he put down the telephone.

100. The investigator listened to all of the telephone calls Mr Osborne made in November. All of his calls were to either his mother or his sister. In one call to his mother, he told her that he was due for release on 7 April 2024. The investigator's assessment was that Mr Osborne generally sounded cheerful in his calls, although he did sound a little more subdued in some calls, including in his last call. His last call was to his mother in the early afternoon of 18 November. He said that he was feeling a 'little down' that day and his mother responded by saying that he had aways been a person who would have days when he was 'down'. The call ended with each saying they would speak again soon.

101. On the morning of 22 November, Mr Osborne asked for a shower so a PCO, along with two colleagues, unlocked his cell. The PCO noted that Mr Osborne had damaged his desk and thrown food around his cell the previous day, so he suspected he would not be in a good mood. He noted that one of his colleagues searched Mr Osborne in preparation for escorting him to the showers and at that point Mr Osborne attempted to punch his colleague. Body worn camera (BWVC) footage shows that officers restrained Mr Osborne to the ground on the landing and once they had controlled him they took him back into his cell. Officers swept debris from Mr Osborne's cell and, once they had done that, they left the cell and relocked the door. The investigator did not notice anything untoward in his observation of the BWVC and staff noted that only minimal force had been needed. A nurse saw Mr Osborne and noted that he had no visible injuries. Mr Osborne said he was uninjured and did not need treatment. In response to the incident a member of staff referred Mr Osborne for consideration for support through a CSIP (CSIPs are used to identify actions to deal with perpetrators of violence). The referral had not been progressed by the time of Mr Osborne's death.

102. Also on 23 November, the Business Enterprise Manager held an ACCT review with Mr Osborne in his cell. Two segregation officers also attended the review. She asked Mr Osborne if he had any thoughts of self-harm and he said he did not and he asked her why she kept asking him that question. She noted that Mr Osborne became aggressive, so she ended the review. She maintained his observations at three an hour and arranged his next review for 27 November.

103. Following a routine visit by an IMB member to the segregation unit on 24 November, the member reported that there were only two staff on duty that day (there were 22 prisoners on the unit that day, its total capacity was 25). Both of the officers reported being assaulted more than once and one officer reported that being assaulted was considered 'part of the job'. The IMB member spoke to prisoners who reported that they were only able to shower once every four or five

days and they said that formal complaints to the prison were not being actioned. The IMB member noted that she did not speak to Mr Osborne that day as she planned to speak to the prisoners on his side of the unit the following Monday.

Events of 25 November

104. The investigator watched CCTV footage, BWVC footage and listened to staff radio communications. The investigator also obtained further information from East Midlands Ambulance Service including a recording of the emergency call received from Lowdham Grange. The following account has been taken from all sources.

105. The segregation unit at Lowdham Grange is a two-corridor unit in an L shape. The staff office and the adjudication room are at the corner of the L. Mr Osborne's corridor contained 17 cells. At the time, the overall capacity of the unit was 25 and on 25 November, there were 24 prisoners in the unit.

106. CCTV shows that the night officers generally maintained a good frequency of checks on Mr Osborne through the night of 24/25 November, although there was a 55-minute gap between a check at 5.33am and the next check at 6.28am. However, when day staff came on duty, they failed to maintain the required level of checks. They recorded ACCT checks at 8.44am and 9.00am but CCTV shows that no checks were made at these times. Mr Osborne rang his cell bell at 9.02am and when an officer responded at 9.10am he asked for hot water. (His records show that he rang his cell bell four further times that day, the last time at 12.15pm, but there is no record of his reasons.)

107. At around 10.00am, the Duty Manager checked all the prisoners in the segregation unit. He noted that Mr Osborne said that he was fine and had no concerns to raise.

108. CCTV shows that officers made four ACCT checks between 9.49am and 11.14am. Officers recorded making these checks although the timings differed to those as shown on CCTV. In addition, officers noted that they made four further ACCT checks at 10.17am, 11.00am, 11.50am and 12.05pm but CCTV confirms that they did not make checks on or around these times. Staff noted a summary of the morning for Mr Osborne to say that he had remained in his bed for most of the morning and had not spoken much to staff.

109. Officers were compliant with ACCT checks during the early afternoon (from 12.29pm to 2.31pm). PCO A checked Mr Osborne at 2.31pm as he was escorting a nurse, who was making a routine daily check on all the segregated prisoners. The nurse noted that when she asked Mr Osborne if he was alright, he answered that he was 'fine', he said he did not have any concerns and he had no thoughts of suicide or self-harm. The nurse also noted that after completing her visit, officers briefly discussed some of the prisoners on the unit. With Mr Osborne, they said that they were concerned that he was sometimes low in mood and was also unpredictable and that he continued to pose a risk to staff. The nurse noted that she would raise the concerns with the healthcare team on the following Monday.

110. CCTV shows that PCO B then checked Mr Osborne at 2.32pm. This was the last check until 4.22pm (one hour and 50 minutes later). CCTV shows that in the period 2.32pm to 4.22pm, officers continued to visit Mr Osborne's corridor dealing with

other prisoners and were often just a few metres away from Mr Osborne's cell but did not look into his cell.

111. At 4.22pm, PCOs A and B went to Mr Osborne's cell with his evening meal. They could not see Mr Osborne, so they unlocked the door and went into the cell. They then saw Mr Osborne hanged from a ligature tied to an air vent. The officers radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties) and cut the ligature. Officers also cut a binding Mr Osborne had used to tie his hands together. After placing Mr Osborne on the floor, the officers started CPR. Nurses arrived at 4.26pm and staff moved Mr Osborne from his cell to the landing where there was more room. The officers continued giving CPR while the nurses gave him oxygen. They also checked him periodically with a defibrillator.

112. Control room staff immediately called an ambulance when the code blue call was made, and paramedics arrived at 4.47pm. The paramedics took charge of Mr Osborne's care but at 5.18pm they ceased efforts to resuscitate him and declared life extinct.

Contact with Mr Osborne's family

113. A family liaison officer (PCO) was appointed. Along with a colleague, the FLO drove to Mr Osborne's mother's home and broke the news of his death to her at 10.30pm.

114. Lowdham Grange contributed to the cost of Mr Osborne's funeral in line with national instructions.

Support for prisoners and staff

115. 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.

116. After Mr Osborne's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising. A staff care team member also attended to offer support.

117. The prison posted notices informing other prisoners of Mr Osborne'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 Osborne's death. Listeners (prisoners trained by The Samaritans to provide confidential peer support) were not deployed to the wing in line with postvention procedures because the prison did not have any trained Listeners operating at the time.

Post-mortem report

118. The pathologist gave Mr Osborne's cause of death as hanging. In addition to the ligature mark, the pathologist also listed a number of older and more recent injuries

to Mr Osborne's body. The more recent injuries comprised scratches, abrasions and bruises. The pathologist did not speculate on the origin of these injuries. Toxicological examination had no significant findings.

Action taken by Sodexo Justice Services following Mr Osborne's death

119. Following Mr Osborne's death, the Director commissioned an investigation into the events of 25 November. Several officers were suspended from duty pending the investigation. The investigation found that throughout the day, officers failed to check Mr Osborne at the required frequency including a failure to check him at all during the final two hours before he was found hanged. Sodexo dismissed PCO A and PCO B. A third officer who falsified checks on the morning of 25 November left the Service before the investigation was undertaken.

Findings

Assessment of Mr Osborne's risk of suicide and self-harm

120. In place at the time of Mr Osborne's imprisonment, Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. (In January 2025 this was replaced by the *Prison Safety Policy Framework*.) The PSI says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

121. Staff opened an ACCT nine days after Mr Osborne arrived at Lowdham Grange which remained in place until his death five months later. Over the course of the five months, Mr Osborne spoke about his thoughts of suicide or self-harm. Staff also found him with ligatures around his neck twice and with a head injury after he said he had tried to hang himself, but the ligature had snapped. Mr Osborne also engaged in various other risky behaviours: he set fire to a mattress, he was involved in altercations with other prisoners, he assaulted or attempted to assault officers and he damaged prison property. In addition, he failed to engage with mental health staff.

122. Staff constantly supervised Mr Osborne twice: first for three days in mid-July, and then between 30 July to 11 August. He was on four observations an hour in the immediate periods either side of his periods of constant supervision, but he was more usually on between two and three observations an hour and had been on three observations an hour during the final six weeks of his life.

123. Up to October, mental health nurses usually attended Mr Osborne's ACCT reviews. However, they only attended one of his final nine reviews during October and November. The Business Enterprise Manager noted on 2 November that she had contacted the mental health team prior to the review that day who told her that Mr Osborne was no longer on their caseload due to his refusal to engage with them.

124. We note that Mr Osborne had a total of nine different ACCT case managers across his 35 ACCT reviews. The Business Enterprise Manager chaired 19 of the reviews, while other of his reviews were chaired by alternative and more senior case managers at times when Mr Osborne was subject to constant supervision, and we recognise that other of Mr Osborne's reviews would have taken place at times that the manager was on leave. Instructions make it clear that consistency in case management should be maintained where possible, but it is unclear whether any more could have been done to maintain consistency in Mr Osborne's case. It is apparent that the Business Enterprise Manager established a reasonably good relationship with Mr Osborne, although there were also occasions when it was clear that he was not interested in engaging with her or indeed any staff.

125. We also note that Mr Osborne's ACCT reviews were generally set at regular weekly intervals rather than set at a frequency reflective of the prisoner's level of risk as required in instructions.

126. Mr Osborne made comments at times to suggest that his decision to take his life at some stage was inevitable. All of this said, we consider that the decisions to maintain his observations at three an hour during the final weeks of his life were reasonable based on the apparent risk he presented at those times.

ACCT care plan

127. By the time of his death, Mr Osborne had had a total of 35 case reviews. There were eight actions in his care plan, the majority of which were entered at an early stage, and which related to practical issues such as applying for work and arranging his finances and prison phone accounts. Four of the actions related to administrative health related actions such as arranging an appointment with the psychiatrist. Staff added the final action on 8 October, which was about Mr Osborne's wish to move to a prison in the south. Other than a member of staff sending an email about Mr Osborne's request to move, there is no further information on any progress with his request. Overall, Mr Osborne's care plan lacked clear targets that might have helped him through what was clearly a difficult period for him. In addition, it was clear to the investigator that Mr Osborne's sister, and his mother in particular, were very supportive of him but they were not included as sources of support in his care plan.

128. We spoke to the acting Governor in February 2025. She told the investigator that when HMPPS took over management of the prison they recognised several shortcomings with the way ACCT was being managed. She said that future ACCT reviews were often booked for days when key staff were on leave which resulted in changes to the ACCT case co-ordinator. In addition, ACCT documentation was not kept together which caused difficulty with case management. She said that all ACCT case co-ordinators are now operational staff, unlike when Sodexo managed the prison. She said that three HMPPS supervising officers joined the prison on detached duty and were temporarily promoted to custodial manager grade to act as ACCT case co-ordinators and to train staff in ACCT. She said that ACCT case co-ordinators now ensure that a multi-disciplinary team is assembled for ACCT reviews.

129. However, the acting Governor acknowledged that while skill levels have improved, managers are still finding omissions with aspects of ACCT management processes.

Decision to continue Mr Osborne's segregation

130. Prison Service Order (PSO) 1700, *Segregation*, states that segregation should be used only as a last resort while maintaining a balance to ensure it remains an option for disruptive prisoners. The PSO acknowledges that prisoners whose behaviour is most difficult, are often the most vulnerable and while prisoners on ACCT might need to be segregated, this should only occur when other options are considered inappropriate. The reasons for initial and continuing segregation decisions should be regularly monitored so that prisoners do not spend longer in segregation than is necessary.

131. Mr Osborne was in segregation for three days at the end of June 2023, when he had a fight with another prisoner and spat blood at officers who intervened. Mr Osborne had another fight in August and in September was involved in further conflict with other prisoners and also set fire to his mattress. After punching two officers on 3 October, Mr Osborne was segregated again, and he remained in segregation until his death. In November, Mr Osborne spoke about being 'a bit fed-up' about being in segregation, but on 22 November he had to be restrained when he attempted to assault an officer.

132. We agree that the decisions to move Mr Osborne to segregation in June and then again at the beginning of October were reasonable. Unfortunately, Lowdham Grange were only able to locate one of Mr Osborne's continued segregation reviews (the review on 25 October), so it is impossible to properly determine what considerations were given to try to move Mr Osborne back to a standard wing and what advice staff gave him about what was expected of him in terms of improved and consistent behaviour.

133. Guidance on segregation procedures states that particular care should be given to authorising continued segregation of a prisoner on an open ACCT. The guidance states that continued segregation should occur only in exceptional circumstances and that ACCT case reviews must take place at the same time as segregation reviews. While the timings of Mr Osborne's segregation reviews are unclear, there is nothing to suggest that they coincided with his ACCT reviews; indeed, the Business Enterprise Manager told the investigator that she was unaware of this requirement.

134. The acting Governor said that segregation processes are much improved since the time of Mr Osborne's death. She said that record keeping and retention has improved and she was unaware of any recent instances where documents have not been completed or retained.

Safety intervention meeting (SIM)

135. PSI 64/2011 sets out that the Safety Intervention Meeting (SIM) is a multi-disciplinary safety risk management meeting, chaired by the senior management team, to provide further support and guidance to case review teams for prisoners with particularly challenging needs or a significant level of risk. Prisoners placed on constant supervision are a mandatory referral to the SIM.

136. Mr Osborne was discussed four times at the SIM between late June and late October. The minutes of the meetings merely record factual information such as that at various times he had attempted suicide or self-harm, was on an ACCT and had assaulted staff. There was no specific reference to Mr Osborne being simultaneously on an ACCT while also in segregation and, most importantly, there are no action points on what might be done to support Mr Osborne and the staff most directly involved in trying to keep him safe.

137. The acting Governor said that SIMs at Lowdham Grange have changed beyond recognition since Mr Osborne's death. She said that SIMs now run for two and a half hours with full discussion on prisoners referred to the SIM and support plans put in place. In addition, particularly difficult prisoners are also discussed at a separate multi-disciplinary meeting (MDM). She said that she did not have any real

knowledge of Mr Osborne, but as a prisoner who had a history of violence and who was in segregation while on ACCT, it seemed likely that he would have been referred for discussion at the MDM.

Challenge support intervention plans (CSIP)

138. CSIPs are used to help manage violent prisoners. Staff referred Mr Osborne for consideration for a CSIP on 22 November after he attempted to assault an officer. The referral had not been progressed by the time of his death. Mr Osborne was both vulnerable and had a history of violence so he should have been considered for a CSIP much earlier in his time at Lowdham Grange. In their inspection of Lowdham Grange in 2023, HMIP found that CSIP was not being used effectively to manage perpetrators of violence or to support victims.

139. The acting Governor acknowledged that Lowdham Grange's use of CSIP had not progressed as much as in other areas since HMPPS took charge of the prison. The reason for this was due in part to staff access to both legacy and new computer programmes. She said, however, that the prison had now employed a senior officer with a specific responsibility for violence reduction.

Events of 25 November

140. By 25 November, Mr Osborne's frequency of ACCT checks had been established for some time at three an hour. During the morning and early afternoon of 25 November, officers failed to complete all of the necessary ACCT checks on him: he should have been checked 18 times between 8.29am (when staff delivered his breakfast) and 2.31pm (when he received a routine check), but CCTV shows that they made only 13 checks in this period. After 2.31pm, staff made no checks on Mr Osborne for almost two hours before finding him hanged at 4.22pm. We informed the police of these omissions, but they did not take any further action.

141. During his staff disciplinary interview, PCO A said that the usual staffing level on the unit was four, but on 25 November there were only two officers on duty. He said that he had previously raised the issue of staffing levels with the Orderly Officer (the senior officer on duty) but he could not recall if he had done so on this day. He also said that throughout the afternoon he had heard Mr Osborne shouting and arguing with another prisoner (which would have indicated he was alive). He acknowledged however that he should have made visual checks on Mr Osborne during this period. We note from our observation of the CCTV that officers were frequently close to Mr Osborne's cell during the afternoon, and it would only have taken a few seconds to make a visual check on him.

142. Mr Osborne's cell bell records also show that he rang his bell five times that day, the last time at 12.15pm. The expectation is that officers should respond to cell bells within five minutes. CCTV shows that one of the calls was answered immediately, but the other four times it took officers between eight and 26 minutes to respond. An officer noted that the reason Mr Osborne rang his bell at 9.02am was to ask for hot water, but there is no record of his reasons for ringing his bell on the other occasions.

143. Following Mr Osborne's death, the then Director arranged an investigation into the omissions with the ACCT checks. The investigation took account of CCTV evidence which showed that the officers made frequent visits to the adjudication room which contained a television. Officers said that they were visiting the room to make telephone calls, but the officers also acknowledged that BBC news or sports had been played on the television in the past, although they could not recall if that was the case on 25 November (a Saturday). The investigation also noted that at one stage, two of the officers appeared to be kicking a toilet roll back and forth and that they did not appear to be under operational pressure. At the conclusion of the investigation, PCO A and PCO B were dismissed from service. A third officer, who was also included in the internal investigation, but who we considered played no significant part in events for Mr Osborne, resigned before the investigation commenced.

144. The acting Governor said that managers now make assurance checks on correct completion of ACCT checks. She said that ACCT documents are selected at random, and CCTV checked to ensure that staff have made the checks signed for. Disciplinary investigations are conducted if staff omissions are identified. We are pleased to learn of the robust quality assurance process now in place at Lowdham Grange.

Staff shortages and risk management

145. Lowdham Grange's transfer from Serco to Sodexo in February 2023 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. The transfer to Sodexo coincided with Serco's successful bid to operate HMP Fosse Way, around 30 miles from Lowdham Grange, and this might have exacerbated the loss of staff.

146. Throughout the period Mr Osborne was in Lowdham Grange there was a chronic shortage of operational staff and wing managers. Violence, illegal drugs and debt increased. Dedicated teams such as safer custody staff were cross deployed to help run the basic daily regime. The intelligence manager and all but one of the security department analysts left and the department had to be rebuilt. From June 2023, healthcare staff were told not to go on to the wings while prisoners were unlocked, except in emergencies.

147. These circumstances impacted the ability of staff to identify and support prisoners at risk. Mr Osborne was involved in altercations with other prisoners on several of the wings where he was housed, and he also suffered with anxiety and regular thoughts of suicide or self-harm. The lack of staff and support services would have had an impact on Mr Osborne's care, including that he had only one proper key work session while at Lowdham Grange. In addition, improved staffing levels across the prison might have allowed staff to attempt to move Mr Osborne to a standard wing with enhanced support rather that keeping him in segregation (on an ACCT) which staff believed was the only safe option for good order and discipline. We also note the evidence of one of the segregation officers that on the day of Mr Osborne's death there were only two officers on duty on the segregation unit instead of the correct staffing level of four.

148. Mr Osborne was the fifth self-inflicted death at the prison in 2023. As we have identified in our investigations following these other deaths, the two private companies that ran the contract must bear significant responsibility for these failings, rather than individual staff working in extremely difficult circumstances. Serco, for the manner in which they left the prison, and Sodexo for hugely underestimating the requirements of running a safe and secure establishment in those circumstances.

149. The acting Governor said that when HMPPS formally took charge of Lowdham Grange all staff were security re-vetted and that led to the loss of 20 staff that did not meet vetting requitements. She said that further staff were lost through resignations. She said that the prison has since recruited additional staff and now have 179 band C officers (of which 30 are on detached duty), against the overall staffing profile of 208 band C officers. She said that there are further officers presently undergoing training, but recruitment difficulties include that Lowdham Grange is not on a bus route, so all staff must travel to the prison by car.

Recommendation

150. Although HMPPS took over interim management of Lowdham Grange in December 2023, they did not take permanent control until August 2024. The acting Governor said that this was when they were able to start effectively tackling staffing and other operational issues at the prison. We recognise that many working practices have changed at Lowdham Grange since HMPPS took full operational charge of the prison. We also note the Governor's evidence of the changes made since Mr Osborne's death and also her acknowledgment that there was still more work to do. We make the following recommendation:

The Governor must carefully consider the findings of this report and the early learning review to ensure that the concerns identified are being addressed.

Postvention

151. In compliance with the aims of postvention, Listeners should have been deployed to provide support to prisoners most affected by Mr Osborne's death - following a death in custody incidents of self-harm often increase. At the time of Mr Osborne's death Lowdham Grange did not have any Listeners operating.

152. The acting Governor said that Lowdham Grange now has trained Listeners including Listeners working in reception, on the induction wing and to help with postvention. She said that there are Listener suites across the prison wings and that there is a weekly Listeners meeting.

Clinical care

153. The clinical reviewer found that the clinical care Mr Osborne received at Lowdham Grange was not equivalent to the care which he could have expected to receive in the community. She noted that communication between primary care and mental health staff was not robust and there were instances where the mental health team did not respond to urgent referrals within the appropriate timescale. The clinical

reviewer was also critical of the record keeping following the emergency response when Mr Osborne was found hanging.

154. However, the clinical reviewer also acknowledged that delivery of care to Mr Osborne was hampered in part for reasons outside of healthcare staff control, in particular the problems with officer staffing levels which made for an unsafe working environment for staff and prisoners.

Inquest

155. An inquest into Mr Osborne's death held between 16 December 2025 and 4 February 2026 concluded that his cause of death was suicide contributed to by neglect. The inquest jury found multiple instances of prison and healthcare failings that affected Mr Osborne's death.

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