Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Metcalfe, a prisoner at HMP Lowdham Grange, on 30 December 2024

A report by the Prisons and Probation Ombudsman

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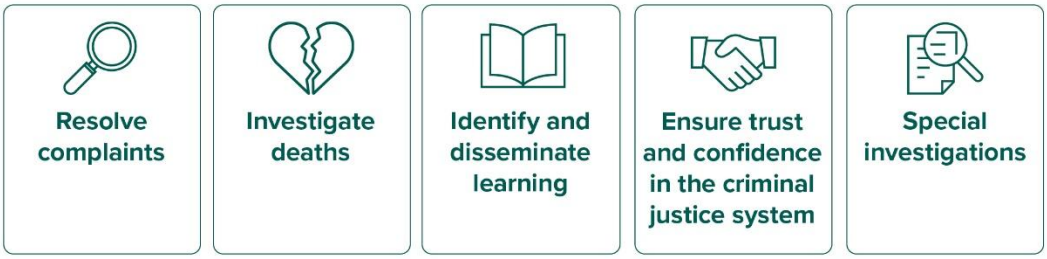
OUR VISION

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 Stephen Metcalfe died from the use of synthetic cannabinoids on 30 December 2024, while a prisoner at HMP Lowdham Grange. He was 47 years old. I offer my condolences to Mr Metcalfe's family and friends.

Mr Metcalfe's was the second drug related death at Lowdham Grange since November 2024. Up to the end of June 2025, there have been four further suspected drug related deaths since Mr Metcalfe's death.

In a previous investigation I noted that 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 the prison has developed an action plan to address these issues and are receiving additional support from the national safety team.

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 **September 2025**

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Summary

Events

1. On 3 May 2004, Mr Stephen Metcalfe was remanded to HMP Winchester charged with manslaughter. On 8 April 2005, he was sentenced to life imprisonment with a tariff (the minimum term of imprisonment to serve) of six years. On 28 November 2023, Mr Metcalfe transferred to HMP Lowdham Grange.

2. Mr Metcalfe had a history of cocaine, cannabis, amphetamine, alcohol use and synthetic cannabinoid use in prison. He had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) for which he was prescribed medication, emotionally unstable personality disorder (EUPD) and anti-social personality disorder with paranoid and histrionic traits. Mr Metcalfe had a history of self-harm but he had not been subject to suicide and self-harm monitoring since November 2020. Mr Metcalfe denied thoughts of suicide and self-harm during his time at Lowdham Grange.

3. Between May and December 2024, Mr Metcalfe was found under the influence of an illicit substance fives times. On one of those occasions he was sent to hospital for treatment. He lost his job in the workshop for being under the influence of drugs while at work. The substance misuse team at Lowdham Grange offered Mr Metcalfe support but he often declined. They continued to support him and gave him harm minimisation advice, particularly about taking illicit drugs alongside prescribed medication. It was later agreed that he would start an opiate substitute treatment (OST) programme. However, Mr Metcalfe continued to use illicit substances while on the programme.

4. At 2.20pm on 30 December, staff approached Mr Metcalfe's cell door and found that the observation panel was covered from the inside. They asked a member of wing staff to open the door. When staff entered the cell they saw Mr Metcalfe sitting on his bed slumped forwards. Staff immediately collected naloxone (a medication which reverses the effects of an opioid overdose) and radioed a medical emergency code.

5. Mr Metcalfe was not breathing and staff started cardiopulmonary resuscitation (CPR). Nursing staff attended and continued with CPR until paramedics arrived at 2.43pm. The paramedics established a pulse, but Mr Metcalfe remained unconscious. At 4.09pm, he was taken to hospital by emergency ambulance.

6. At 9.30pm that evening, Mr Metcalfe died.

7. The post-mortem examination established that Mr Metcalfe died from the use of synthetic cannabinoids.

Findings

8. Mr Metcalfe's was the second death from illicit drug use at Lowdham Grange since November 2024. He was able to obtain illicit drugs, including diverted prescribed medication and psychoactive substances (synthetic cannabinoids) with apparent

ease. Up to the end of June 2025, there were a further four suspected drug related deaths at the prison since Mr Metcalfe's death.

9. The clinical reviewer concluded that the clinical care Mr Metcalfe received at Lowdham Grange was of a good standard and 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 Metcalfe's death on 30 December 2024.

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. Three prisoners wrote to Mr Williamson to highlight concerns about illicit drug use at the prison.

13. The investigator obtained copies of relevant extracts from Mr Metcalfe's prison and medical records along with CCTV footage and body worn camera footage (BWVC) relevant to the investigation.

14. The investigator interviewed four members of staff at Lowdham Grange on 4 March 2025.

15. NHS England commissioned a clinical reviewer to review Mr Metcalfe's clinical care at the prison. The clinical reviewer and the investigator interviewed two members of staff by video conference on 28 and 30 January 2025.

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. Mr Metcalfe had no identifiable next of kin.

18. An inquest into Mr Metcalfe's death was concluded on 4 May 2026. The conclusion of the jury was

    '… Misadventure, by way of obtaining and consuming synthetic cannabinoids at HMP Lowdham Grange …'

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. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons inspected Lowdham Grange in March 2025. Inspectors noted the prison was three months into a complex and difficult transition between contractors. They concluded that outcomes for safety, respect and preparation for release were not sufficiently good, and outcomes for purposeful activity were poor. A new governor had recently arrived and had a clear sense of the challenges and seriousness of the concerns identified.

23. The random drug testing positive rate was 40.6% for the previous 10 months and 56% of prisoners at Lowdham Grange said it was easy to get hold of drugs. Staff prisoner relationships were inadequate: prisoners could not rely on staff, who were inexperienced and poorly supervised and key work (one to one sessions with a named officer) barely happened. Time out of cell was inconsistently delivered and inspectors found 43% of prisoners locked in their cells during the working day.

Independent Monitoring Board

24. 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. The Board reported that based on IMB monitoring and other statistical evidence collected from the prison, they concluded that safety in the prison deteriorated throughout the whole reporting period. They also noted that outcomes were being strongly influenced by the ready 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 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 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.

25. 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 misuse 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

26. Mr Metcalfe was the eleventh prisoner to die at Lowdham Grange since January 2022. Of the previous deaths, three were natural causes, five were self-inflicted and two were drug related. Up to the end of June 2025, there have been five deaths at Lowdham Grange since Mr Metcalfe's death. Four were drug related and one was from natural causes.

Assessment, Care in Custody and Teamwork (ACCT)

27. 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.

28. Guidance on ACCT procedures was, at the time of Mr Metcalfe'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.

29. 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 Work Scheme

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

31. 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 worked towards full implementation. Any adaptations, and steps 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

32. On 3 May 2004, Mr Stephen Metcalfe was remanded to HMP Winchester charged with manslaughter. On 8 April 2005, he was sentenced to life imprisonment with a minimum term to serve of six years. Mr Metcalfe's behaviour during the early part of his time in prison was problematic. While on remand, he was sentenced to two and a half years in prison to run concurrently for arson with intent to endanger life. He received a further 16-month sentence for malicious wounding against a member of prison staff.

33. Mr Metcalfe had a history of illicit drug and alcohol use, which were recorded as risk factors in his current and previous offending. Mr Metcalfe had most recently been denied release on parole because his risk had not reduced. He had been to a number of prisons within the high security estate since his conviction.

34. In 2011, Mr Metcalfe was diagnosed with Attention Deficit Hyperactivity Disorder and was prescribed Concerta (a stimulant mainly used to treat ADHD). Mr Metcalfe also had diagnoses of emotionally unstable personality disorder (EUPD) and anti-social personality disorder with paranoid and histrionic traits.

35. On 28 November 2023, Mr Metcalfe transferred from HMP Long Lartin to HMP Lowdham Grange as a progressive move.

36. Long Lartin provided a discharge summary which recorded that Mr Metcalfe had a history of cocaine, cannabis, amphetamine, and alcohol use and a history of psychoactive substance (PS) use in prison and was at risk of overdose. It recorded that Mr Metcalfe was keen to receive help with relapse prevention. It said that Mr Metcalfe had engaged in one-to-one key work sessions for support in managing anxiety and stressors that were thought to be the underlying causes of his relapse into substance use. Some medication seeking behaviour was also noted.

37. During his reception screen at Lowdham Grange, healthcare staff noted Mr Metcalfe's history and referred him for an ADHD review. No other concerns were raised. Although offered, Mr Metcalfe declined to be referred to the substance misuse team.

38. On 8 January 2024, a nurse completed a mental health triage with Mr Metcalfe and discussed his ADHD diagnosis. Mr Metcalfe said that he had been prescribed methylphenidate (a stimulant for the treatment of ADHD). The nurse noted that Mr Metcalfe said that he was hoping to progress toward parole and stay out of trouble. Mr Metcalfe said that he occasionally smoked cannabis, but denied it being a problem. The nurse offered to refer him to the substance misuse team, but he declined.

39. On 15 February a psychiatrist, assessed Mr Metcalfe. The psychiatrist noted that Mr Metcalfe appeared disgruntled about issues in the prison but did not feel that he exhibited any underlying issues with his mental health. The psychiatrist recorded that Mr Metcalfe would benefit from working with the neurodiversity team to understand and manage his ADHD diagnosis. No other concerns were raised.

40. On 29 April, a neurodiversity practitioner, assessed Mr Metcalfe. Mr Metcalfe asked for additional support with his ADHD and said that although he had been prescribed

medication, he was then 'left to his own devices'. Mr Metcalfe denied any issues with illicit drug use or thoughts of suicide and self-harm. Between April and October, the neurodiversity practitioner saw Mr Metcalfe for a further eight sessions to work with him on managing and understanding his diagnosis of ADHD through in-cell workbooks and talking sessions.

41. On 9 May, a member of staff from the programmes team, told Mr Metcalfe that he had been accepted on the Becoming New Me + (BNM+) course. The BNM+ course is for high or very high-risk adult men who have learning disabilities or challenges and have been convicted of a sexual or violent offence. It supports participants to develop skills to strengthen their pro-social identity and plan for an offence-free life.

42. At 10.42am on 29 May, staff found Mr Metcalfe lying on the floor of the wing landing. They radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties) and healthcare staff attended. A nurse recorded that when she arrived, Mr Metcalfe was sitting on the floor against the wall. Staff said that Mr Metcalfe had been unsteady on his feet and he reported that he had fallen over.

43. The nurse recorded that Mr Metcalfe was slightly disorientated but was able to walk back to his cell with assistance, where he was examined. She noted that he had slight redness to his eyes, was able to speak in short sentences and appeared tired. When asked whether he had taken any illicit substances, Mr Metcalfe denied this. He was advised to drink plenty of fluids. She referred Mr Metcalfe to the substance misuse team, and she advised officers to contact the healthcare unit if Mr Metcalfe's condition deteriorated.

44. Staff opened a Psychoactive Substances log (known at Lowdham Grange as a NPS log and designed to monitor a prisoner who is believed to be under the influence of illicit substances), with welfare checks to be completed once an hour.

45. On 30 May, a nurse from the substance misuse team, spoke with Mr Metcalfe, who denied that he had used illicit drugs. The nurse recorded that at that time Mr Metcalfe did not display any signs of intoxication. He was offered support from the substance misuse team, but he declined. The nurse gave Mr Metcalfe information about the risks of mixing prescribed medication and illicit drugs and advised him to contact the substance misuse team if he needed any further help. The NPS log was closed.

46. Over the following four months, there were no other reported issues about Mr Metcalfe and the use of illicit drugs or about his general behaviour.

47. On 2 October, Mr Metcalfe approached a member of staff from the substance misuse team and asked for support from the substance misuse team. Mr Metcalfe said that he had been using illicit substances, wanted to stop and was interested in one to one and group work. She referred Mr Metcalfe to the substance misuse team for assessment and told him that he could contact them in the meantime if he needed support.

48. At 9.39am on 4 October, Mr Metcalfe was found under the influence of an illicit substance while in the workshop. Staff radioed a code blue. Control room staff called an ambulance immediately. When nursing staff attended, Mr Metcalfe was

sitting on a chair, and he appeared distressed. The nurses recorded that he appeared 'scared' of the people around him. They tried to reassure him but noted that he seemed confused, unable to communicate and unable to sit unaided. The nurses also tried to complete his observations, but he was too agitated.

49. Due to his presentation, nursing staff administered naloxone but Mr Metcalfe's presentation remained the same. While they were treating him, other prisoners in the workshop became refractory so staff moved Mr Metcalfe into the corridor for his safety. He still appeared agitated and disorientated and he then became unresponsive. Staff laid him onto the floor. His respiratory rate was low and the nurses administered oxygen and more naloxone. A defibrillator was attached to Mr Metcalfe, but it was noted that he was breathing so resuscitation was not required.

50. Mr Metcalfe regained consciousness and engaged with staff. He said that he could not recall anything but he said that he had used 'spice', a form of PS. Nursing staff continued to monitor Mr Metcalfe until the paramedics arrived. He was taken to hospital by ambulance for further observations.

51. At hospital, Mr Metcalfe was assessed but required no further treatment and he returned to Lowdham Grange at around 5.30pm. On his return, a nurse spoke with him. Mr Metcalfe said that he had been told that he had nearly died and the nurse confirmed that this was the case. Mr Metcalfe declined to have his physical observations taken.

52. Mr Metcalfe lost his job due to being under the influence of drugs in the workshop.

53. On 6 October, a member of staff from the substance misuse team, spoke to Mr Metcalfe about his substance misuse needs and the seriousness of his recent drug use. Mr Metcalfe said that he wanted to engage with the substance misuse team and she booked him in for an assessment. She spoke to Mr Metcalfe about the risks associated with spice, including the detrimental impact this could have on both his physical and mental health. She also told him how to contact the substance misuse team should he require any additional support prior to his assessment.

54. On 31 October, a member of staff from substance misuse team, completed an assessment with Mr Metcalfe. Mr Metcalfe disclosed that he was currently using illicit buprenorphine (primarily used to treat opioid addiction as part of a treatment programme). Mr Metcalfe said that he would like to be put on a detoxification programme. Mr Metcalfe took a drug test which was positive for cannabis and buprenorphine. Mr Metcalfe said that he wanted to come off illicit buprenorphine and was keen for a buvidal detox (used to treat dependence on opioids) once he had been maintained on methadone (methadone maintenance treatment is used to treat opioid dependence.) The member of staff referred Mr Metcalfe to the substance misuse prescribing team. (He would later take over as Mr Metcalfe's substance misuse keyworker.)

55. On 4 December, a member of staff saw Mr Metcalfe. Mr Metcalfe said that he wanted to get off everything that he was currently using and said that he was using illicit buprenorphine on a regular basis. The member of staff told Mr Metcalfe that he would need to provide further urine tests and complete a drug diary before a prescriber could see him. Mr Metcalfe agreed.

56. On 6 December, an officer held a keywork session with Mr Metcalfe. This was the first recorded keywork session during Mr Metcalfe's time at Lowdham Grange. Mr Metcalfe said that he was about to begin drug treatment but was required to produce a urine sample. The officer recorded that he was aware that Mr Metcalfe had previously been found under the influence of drugs in the workshop and that this had led to him to lose his job. When he asked him whether he was still using, Mr Metcalfe said that he did not wish to talk about it. The officer talked to him about the effects of losing his job. Mr Metcalfe said that he was struggling for money, and they discussed possible opportunities for wing-based work. Mr Metcalfe did not raise any other issues, and he said that he was settled on the wing.

57. On 18 December, a member of staff completed the drug screening which indicated that Mr Metcalfe was negative for all illicit substances except for buprenorphine. He sent a task to the substance misuse prescriber for Mr Metcalfe to be seen, with a view to starting him on a drug treatment programme.

58. At around 10.15am on 19 December, Mr Metcalfe attended a BNM+ session. The course facilitators found him in the toilet area under the influence of illicit substances. Staff radioed a code blue. A nurse attended and noted that Mr Metcalfe was slightly confused and disorientated, but he slowly improved. Mr Metcalfe said that he had taken spice. Mr Metcalfe walked unaided back to the wing.

59. On 20 December, an interventions facilitator and a treatment manager, went to speak to Mr Metcalfe about his recent illicit drug use and to encourage him to recommit to the drug treatment programme. Mr Metcalfe was very apologetic and promised to continue to engage.

60. That day, a member of staff spoke with Mr Metcalfe after he attended the medication hatch to have his ADHD medication reviewed. She noted that he was able to talk in full sentences, no slurred speech, steady on his feet and his pupils were normal. When she asked him about his recent episode of being under the influence of drugs, Mr Metcalfe laughed and would not confirm or deny that he had taken an illicit substance. Mr Metcalfe confirmed that he was aware that he had an appointment with the substance misuse prescriber and said that he did not require any other support. She gave Mr Metcalfe advice on drug addiction and harm reduction including the current significant risk of overdose with spice due to the uncertainty of what this was mixed with (intelligence suggested that fentanyl (a potent synthetic opioid drug used for pain relief and anaesthetic) was possibly being mixed with spice).

61. On 23 December, a nurse who was a substance misuse non-medical prescriber, completed an assessment with Mr Metcalfe. The nurse said that he discussed with Mr Metcalfe the dangers of spice, particularly the things that it could potentially be mixed with. The nurse said that the decision was taken to start Mr Metcalfe on 15mg of methadone, which had minimum risk with regards to interactions with illicit and prescribed medications. The nurse said that Mr Metcalfe was keen to be prescribed buprenorphine rather than methadone, but this was not an option as it was the drug that he had been using illicitly.

62. At approximately 3.30pm on 26 December, Mr Metcalfe was seen being helped back to his cell by other prisoners. An officer went to check on him and Mr Metcalfe

seemed under the influence of drugs. The officer requested a nurse to attend the wing and a nurse attended.

63. When the nurse arrived, Mr Metcalfe was sitting on his bed, appeared drowsy and intoxicated, and he was unable to sit straight. Mr Metcalfe agreed to be examined and his observations were within a normal range. While being examined, prison staff removed what appeared to be several tampered vapes from the cell. The nurse concluded that Mr Metcalfe was under the influence of PS, updated the wing observation book, asked officers to monitor Mr Metcalfe and to report any concerning changes to the healthcare team. The nurse sent a task to the substance misuse team to update them.

64. The following day, a member of the substance misuse team spoke with Mr Metcalfe on the wing about his most recent episode of drug misuse. Mr Metcalfe said that he had used illicit substances as he had expected to be on a higher dose of methadone. He said that the 15ml dose was not 'holding him' and he still needed to use illicit buprenorphine to top himself up and avoid withdrawal. Mr Metcalfe accepted that his methadone could be stopped for safer prescribing reasons if he continued to use illicit substances. Mr Metcalfe asked Ms Rai if the methadone could be increased. She said that she would pass on the request to the prescriber, and this could be discussed at his next review. Ms Rai advised Mr Metcalfe about harm reduction and noted that he understood the increased risk of overdose due to polysubstance use and contraindication with his prescribed medication and illicit use.

Events of 30 December

65. 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.

66. On the morning of 30 December, Mr Metcalfe attended a BNM+ group session. Two members of staff were facilitating. The topic of the session was about 'feelings' and participants were encouraged to explore this. A member of staff told the investigator that it was clear Mr Metcalfe was struggling with the topic so they offered to talk it through with him on the wing later that day, and they agreed they would see him at around 3.00pm.

67. At around 11.15am, Mr Metcalfe returned to the wing from the group session. A Supervising Officer (SO) said that he spoke to Mr Metcalfe on the landing. Mr Metcalfe talked about wanting to get a job in the kitchens or the staff bistro. Mr Metcalfe said that he had not been using illicit substances for a week or so and that he wanted to progress towards being released. After collecting his lunch, Mr Metcalfe was locked in his cell. Staff raised no concerns.

68. The two members of staff who were facilitating went to see Mr Metcalfe earlier than planned and arrived at his cell at around 2.20pm. A member of staff said that she knocked on the cell door and called to Mr Metcalfe, before opening the observation panel which was covered from the inside. At this point a member of staff said that she asked an officer, who was on the landing, to open the door. When the door was opened they saw Mr Metcalfe sitting on the edge of his bed, slumped forwards with his arms hanging down. The officer called to the SO and they entered the cell. At

2.23pm, they radioed a code blue. The SO exited the cell and ran to the wing office to collect naloxone, before returning. The SO administered naloxone and checked for a pulse but could not feel one so they started CPR.

69. A Senior Practice Nurse attended along with two other nurses. They instructed the staff to move Mr Metcalfe out onto the landing where there was more space to work. The nursing staff took over managing the treatment and cycles of CPR with the assistance of prison staff. They administered more naloxone.

70. At 2.43pm, paramedics arrived and took over treatment. Mr Metcalfe was still unconscious, and a Lucas machine (a mechanical CPR device designed to deliver high-quality chest compressions to patients in cardiac arrest) was attached to continue CPR. A pulse was established but Mr Metcalfe did not regain consciousness. At 4.09pm, he was taken to hospital by emergency ambulance.

71. At 9.30pm that evening, Mr Metcalfe died.

Contact with Mr Metcalfe's family

72. Mr Metcalfe had listed his grandmother as his next of kin, but when Lowdham Grange attempted to make contact, she was no longer at the address provided. The prison made further attempts to trace a next of kin for Mr Metcalfe and consulted the police and Mr Metcalfe's solicitor, but no next of kin could be traced.

73. Lowdham Grange arranged and paid for the funeral in line with national policy.

Support for prisoners and staff

74. 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.

75. After Mr Metcalfe was taken to hospital, the Deputy Governor, and a senior 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.

76. Following Mr Metcalfe's death, the prison posted notices informing other prisoners of his 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 Metcalfe's death. Listeners (prisoners trained by The Samaritans to provide confidential peer support) were not deployed to the wing in line with postvention procedures. Postvention was not carried out by the Samaritans following the death of Mr Metcalfe due to them having withdrawn their service at Lowdham Grange at the time of Mr Metcalfe's death. The Samaritans re-introduced their services in January 2025.

Post-mortem report

77. A post-mortem report gave Mr Metcalfe's cause of death as the use of synthetic cannabinoids. Coronary artery atheroma was listed as a contributory factor.

Findings

Clinical care

Drug strategy at Lowdham Grange

78. Mr Metcalfe was able to access illicit drugs including diverted prescribed medication and PS with apparent ease. His was the second drug related death at Lowdham Grange since November 2024, and up to the end of June 2025, there have been a further four suspected drug related deaths since Mr Metcalfe's death.

79. Lowdham Grange has recently seen many changes, from being managed by the private sector since 1998 to coming back under the control of HMPPS in August 2024. The investigator was told that this change had caused significant issues with staffing and some uncertainty and unrest amongst prisoners.

80. There is significant evidence, including the recent drug related deaths, to indicate that Lowdham Grange is experiencing significant problems in dealing with the supply and ingress of illicit drugs. Several factors have emerged from this and other investigations including staff inexperience and common routes of ingress, including staff and vehicles entering the prison.

81. In response to the drug related deaths, the National Substance Misuse Group (SMG) carried out a drug strategy support visit on 11-12 September 2024. In summarising their findings SMG said:

- Lowdham Grange has many staff dedicated to their roles across a range of functions and are clearly committed to delivering a safe, secure and stable environment, and contributing to the delivery of drug strategy,
- closer strategic alignment between the security, safety and healthcare departments is needed to foster greater understanding of how drugs are impacting the levels of violence and self-harm across the establishment,
- the management of visits and reception are areas of vulnerability,
- the prison would benefit from an analytical link to health-related incidents (Under the influence (UTIs) and code blues) and finds data. The number of health-related incidents, including UTIs is placing additional pressure on the healthcare department and the management of those UTI is an area of vulnerability.

82. As part of the current PPO investigations taking place at Lowdham Grange, The, Head of Drug Strategy and Head of Security were interviewed in January. They said that at that time of interview there was no mandatory or random drug testing taking place, but suspicion testing was being re-embedded, although there had been a large number of refusals. However, of those tested, 75% tested positive for PS.

83. Cell searching was intelligence led and aside from daily cell fabric checks, cells were not being searched. Although staff were able to conduct suspicion searches The Head of Drug Strategy and Head of Security said that staff needed upskilling to

develop the necessary skills to know what they were looking for and search effectively.

84. The Head of Security said that the prison had been experiencing a high number of prisoners under the influence of drugs, and the intelligence picture was suggesting that illicit material was being conveyed each week by drones, through mail and parcels into the prison, through staff corruption and vehicles entering the prison.

85. The Head of Security said that the prison had taken a number of steps to improve the overall security of the gate and deter those who would attempt to traffic items. These included:

- A strict limit to the amount of paper staff were permitted to bring into the prison about their person (to combat the risk of spice-soaked paper)
- The requirement for staff to remove footwear for X-Ray, limiting what is known to be a possible smuggling method.
- Secondary searching of staff beyond the gate area using prison drug dogs.
- Secondary searching of vehicles beyond the gate area using prison drug dogs and dedicated search team (DST) staff.

86. SMG also made six recommendations including the photocopying of incoming mail, reviewing the parcel process, a full review of visits procedures, ensuring better understanding by staff of those found under the influence and actions that should be taken, and raising awareness of the substance misuse and drug strategy across the prison.

87. A group safety lead (LTHSE) told the investigator that the SMG action plan had been developed and further assurance visits were already planned to review how Lowdham Grange were progressing with the recommendations from their report.

88. A new Governor has also recently taken over at Lowdham Grange and actions were being taken to address the findings of the SMG visit along with other initiatives as mentioned. It is clear that there is much to be done at Lowdham Grange, but it is evident that the prison is being proactive in attempting to turn the current issues around. At this time, we make no further recommendations.

Substance misuse support

89. The clinical reviewer concluded that the clinical care Mr Metcalfe received at Lowdham Grange was of a good standard and equivalent to what he could have expected to receive in the community. Mr Metcalfe was offered the support from the substance misuse services on several occasions but he often declined. When he asked for help, this was provided quickly and when he had been found under the influence of drugs, the substance misuse team gave him regular advice and education about the risks of using illicit substances and gave specific harm reduction advice.

90. The clinical reviewer made recommendations not directly related to Mr Metcalfe's death, which the head of healthcare will wish to address.

Governor to note

Keyworker Scheme

91. Mr Metcalfe had been at Lowdham Grange since November 2023, however, he only received two recorded keywork contacts during his time at the prison. Key work is a key part of HMPPS' response to self-inflicted deaths, self-harm, and violence in prisons, and is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison.

92. It is clear that this was not operating as it should at Lowdham Grange and was another area that had fallen victim to the changes that had taken place at the prison and shortages in the staffing group. The Governor will want to ensure that delivery of the keyworker scheme is improved, and that staff are sufficiently trained and given the time to deliver this crucial area of work.

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