Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Wallace, a prisoner at HMP Lowdham Grange, on 26 January 2025

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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 Raymond Wallace died on 26 January 2025 from the effects of synthetic cannabinoids, while a prisoner at HMP Lowdham Grange. He was 52 years old. I offer my condolences to Mr Wallace's family and friends.

Between 17 November 2024 and 6 April 2025, there were five suspected drug-related deaths at Lowdham Grange, of which Mr Wallace's was the fourth.

The clinical reviewer found that the healthcare that Mr Wallace received was good and equivalent to that which he could have expected to receive in the community.

Prison staff were unclear about when routine roll and welfare checks were meant to be carried out, and what was required with each check. Welfare and roll checks on 26 January, the day Mr Wallace died, were not carried out properly.

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 am pleased that the prison has developed an action plan to address these issues, is receiving additional support from the national safety team and that a new Governor has recently taken up post at Lowdham Grange, with a view to tackling the current issues facing the prison.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **November 2025**

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Summary

Events

1. On 21 March 2022, Mr Raymond Wallace was remanded into custody at HMP Elmley, charged with attempted murder, possession of an offensive weapon and other violent offences. He had been in prison before.

2. Mr Wallace had a history of drug use in the community. Prison intelligence reports from his previous and current sentences suggested Mr Wallace used drugs in prison and was involved in the drug culture.

3. On 29 March 2023, Mr Wallace was transferred to HMP Lowdham Gange. He presented as settled and got on well with staff and peers. Mr Wallace was a trusted prisoner who worked in the prison gardens and supported younger prisoners on his wing.

4. In May 2024, Mr Wallace failed a mandatory drug test and tested positive for cannabis and psychoactive substances (commonly referred to as spice).

5. Mr Wallace was not known to the substance misuse service at Lowdham Grange. Prison staff appeared to be unaware of his drug use, although some prisoners knew he used cannabis.

6. On 26 January 2025, staff unlocked Mr Wallace's cell at 8.45am and again at 2.15pm, but did not check on him as they should have done. He was last seen alive during a roll check at 12.06pm. During an additional roll check at 12.49pm, Mr Wallace was not checked.

7. At 2.56pm on 26 January 2025, two prisoners found Mr Wallace unconscious in his cell. They called staff who immediately responded and radioed a medical emergency code blue (used when a prisoner is not breathing or is unconscious). Nurses began cardiopulmonary resuscitation, and paramedics later assisted. Despite their efforts, at 3.42pm paramedics pronounced life extinct.

Findings

8. Mr Wallace's was one of several drug-related deaths at Lowdham Grange within a short space of time. Mr Wallace was a trusted prisoner who, despite a history of drug use, gave no obvious indications he was using drugs in the months before his death. A pending disciplinary hearing following a failed mandatory drug test in May 2024 was closed without a referral to the substance misuse service. While there was some prison intelligence which suggested Mr Wallace might have been using drugs and was involved in the prison drug culture, there was insufficient evidence to pursue action, other than monitoring at that stage.

9. Lowdham Grange remains in transition following an unstable period which resulted in HMPPS taking back control of the prison. The Substance Misuse Group conducted a diagnostic visit in September 2024, which was followed up in April 2025. Further support has been offered to Lowdham Grange and alongside the appointment of a new Governor in March 2025, the prison is taking steps to address

the ingress and use of drugs but we consider that more can be done to ensure prisoners understand the very real risks of psychoactive substances.

10. On the day of Mr Wallace's death, routine welfare checks and a roll check were not conducted in line with policy. While it is impossible to say whether the outcome would have been different for Mr Wallace had the checks been conducted properly, staff missed two opportunities to identify any concerns between 12.06pm (when he was last seen alive) and 2.56pm when he was found unconscious.

11. Roll checks and welfare checks remain fundamental to the security of the prison and welfare of prisoners. We appreciate Lowdham Grange has begun putting measures in place, but further work is needed to ensure staff are sufficiently trained and there is a quality assurance process in place to monitor progress.

Recommendations

- **The Governor should ensure there is a robust and auditable programme for educating and communicating to prisoners the risks of drug use, and specifically of psychoactive substances.**

- **The Governor should ensure that there is a robust quality assurance process in place to ensure that staff are carrying out roll checks and welfare checks appropriately.**

The Investigation Process

12. HMPPS notified us of Mr Wallace's death on 27 January 2025.

13. 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. One prisoner responded but subsequently declined to be interviewed.

14. The investigator obtained copies of relevant extracts from Mr Wallace's prison and medical records. She watched closed circuit television (CCTV) and body-worn video camera (BWVC) footage, listened to staff radio traffic and obtained prison statements and East Midlands Ambulance Service records.

15. The investigator interviewed three members of staff and two prisoners at Lowdham Grange on 3 March 2025.

16. NHS England commissioned a Clinical Reviewer to review Mr Wallace's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed prison staff, healthcare staff and prisoners on 3 March 2025.

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

18. The Ombudsman's office contacted Mr Wallace's mother and partner to explain the investigation and to ask if they had any matters they wanted us to consider.

19. Mr Wallace's mother wanted to know how and why her son had died. She also asked how long Mr Wallace knew he had heart problems, whether this was treated and with what medication. These questions are addressed in the clinical review.

20. Mr Wallace's partner asked why staff had not checked on Mr Wallace between when his cell was unlocked and when he was found. We have addressed this in this report.

21. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and we have amended this report accordingly.

22. Mr Wallace's mother and partner received a copy of the draft report. They did not make any comments.

Background Information

HMP Lowdham Grange

23. HMP Lowdham Grange is a category B training prison for adult men in Nottingham. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services, including mental health services and substance misuse services.

24. Lowdham Grange was privately managed, first by Serco when the prison opened in 1998 and then Sodexo from February 2023. In December 2023, the government announced 'step in' action to stabilise the prison and took over control on an interim basis. On 1 August 2024, HMPPS took full public sector control of the prison.

HM Inspectorate of Prisons

25. The most recent inspection of Lowdham Grange was 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.

26. Inspectors found that drugs were a very serious problem. The number of prisoners found to be under the influence of illicit substances had continued to rise in 2025. Drones were a particular concern, and many drones were not intercepted. Anti-drone netting in outdoor areas accessible to prisoners was in the process of being renewed, and some other measures were in place or planned. The positive rate of random drug testing for the previous 10 months was 40.6% and 56% of prisoners at Lowdham Grange said it was easy to get hold of drugs.

27. Prevention and detection of staff corruption had improved, especially through much better collaboration with the police, which had resulted in arrests inside and outside the prison. Enhanced gate security was also a useful recent addition, but the very small space available created queues of staff outside the prison and an occasionally rushed searching process, reducing its effectiveness.

Independent Monitoring Board

28. 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 concluded that safety in the prison had deteriorated throughout the whole reporting period. They noted outcomes were strongly influenced by the ready availability of illicit drugs and the associated violence, combined with inexperienced staff who lacked the skills and confidence to manage prisoners with challenging behaviour.

29. By the end of 2023, positive drug test results had gradually increased to over 50% positive, and there were daily incidents of prisoners being under the influence of psychoactive substances and/or alcohol. There was widespread evidence of

psychoactive substances and drones were increasingly being used to drop off drugs and other contraband.

30. The IMB found that since the arrival of HMPPS in December 2023, more thorough staff and visitor searches had taken place, including wing searches and a full lockdown in January 2024. There were plans to install mesh over exercise yards to stop items being dropped by drones.

Psychoactive substances

31. The term psychoactive substances (PS) is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

32. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

HMPPS Substance Misuse Group

33. In September 2024, following a recommendation from the PPO in relation to the death of a prisoner in 2023, the HMPPS Substance Misuse Group (SMG) conducted a drug strategy support visit to understand the scale and nature of substance misuse at Lowdham Grange and the prison's vulnerability to the conveyance of illicit drugs.

34. Their findings included:

- Cannabis and synthetic cannabinoid receptor antagonists (SCRA, a type of PS) were the drugs predominantly used.
- Security and analyst team colleagues had developed a strong understanding of illicit substances in the prison through detailed intelligence reports. This enabled them to produce a detailed and thorough Local Tactical Assessment (LTA) as the basis for further action plans. However, there was further scope for this to be used as one of the primary drivers for both drug strategy and safety teams to work collaboratively.
- There were knowledge gaps among staff about substance misuse.
- There were several vulnerabilities in the visit area, including staff not being given a security briefing before visits, a lack of zonal patrolling and a lack of secure communication means between officers and CCTV operators.

- Staff were not trained to operate the baggage X-ray machine, yet visitors' equipment was passed through it, which caused further friction between visitors and staff.

- Legal visits presented a risk of drug ingress, notably in the form of paper-based illicit substances. The team suggested the prison adopted a digital approach to minimise the amount of paper coming in.

- The prison highlighted drone incursions as one of its primary routes of ingress.

- Revised monthly drug strategy meetings had started. However, residential staff had little knowledge of the strategy and how their roles contributed to its effective delivery.

- Prisoners raised frustrations at the lack of activities to keep them occupied, resulting in increased levels of boredom and frustration, with some using substances as a coping mechanism.

35. The SMG made six recommendations. These included that:

- Activity should be undertaken to raise awareness of substance misuse and drug strategy across the prison.

- Widespread understanding should be driven across the prison to ensure all staff are aware of what action to take when they find a prisoner under the influence of a substance.

- The Senior Management Team should ensure there is closer strategic alignment between security, safety and drug strategy activity.

- The prison should conduct a full review of existing visits procedures.

- The prison would benefit from conducting a review of its parcel process.

- Social mail should be photocopied.

Previous deaths at HMP Lowdham Grange

36. Mr Wallace was the twelfth prisoner to die at Lowdham Grange since January 2022. Of the previous deaths, two were from natural causes, three were drug-related and five prisoners took their own lives. One cause of death remains unknown and under investigation. There are no similarities between the findings in our previous investigations and those following our investigation into Mr Wallace's death.

37. Since Mr Wallace's death up until 8 August 2025, three prisoners have died. Two died from natural causes and one from an unknown cause. All remain under investigation.

Key Events

38. On 21 March 2022, Mr Raymond Wallace was remanded into custody at HMP Elmley, charged with attempted murder, possession of an offensive weapon and other violent offences. He had been in prison before. On 1 March 2023, Mr Wallace was sentenced to nine years imprisonment.

39. Mr Wallace had a history of drug use in the community and prison. Prison intelligence during previous periods in prison suggested Mr Wallace was involved in the supply and distribution of drugs and used cannabis.

40. On 29 March 2023, Mr Wallace was transferred to HMP Lowdham Grange. He appeared to settle well and told staff he was happy to be there. He raised no concerns and was managed under an enhanced regime (the highest level) as part of the incentives scheme (which rewards good behaviour by increasing access to visits, the prison shop and time out of cell).

41. In June, prison intelligence suggested PS and cannabis were prevalent on F Wing, where Mr Wallace lived, to the extent that staff had become unwell. Mr Wallace was one of several prisoners suspected to have been under the influence but there is no evidence that any further action was taken.

42. In September, Mr Wallace completed a cleaning course. Staff recorded positive behaviour entries in his prison electronic record in September and November.

43. In April 2024, prison intelligence suggested Mr Wallace was involved in the drug culture, acting as a look out when a package was dropped from a drone onto the wing exercise yard.

44. On 21 May, Mr Wallace failed a mandatory drug test. He tested positive for cannabis and PS. He was placed on report pending a disciplinary hearing. Mr Wallace's disciplinary hearing summary recorded that the charge was not proceeded with. Lowdham Grange was unable to provide further documentation, and we therefore do not know the reason for this. There is no evidence that any further action to address Mr Wallace's drug use was taken, including referral to the substance misuse team.

45. On 27 July, Officer A met Mr Wallace for a keywork session. Officer A told Mr Wallace she had noticed he seemed stressed recently and asked how he was. Mr Wallace told her he had been trying to get an inter-prison telephone call (a supervised call between prisoners in different prisons) with his son. Mr Wallace said that he was otherwise settled on the wing. Officer A noted she thought other prisoners saw Mr Wallace as a father figure on the wing and he helped many younger prisoners, often cooking for them.

46. Officer A met Mr Wallace for another keywork session on 4 September. Mr Wallace repeated frustrations with his telephone calls but overall appeared well. Prison electronic records reflected that Mr Wallace continued to comply well with the wing regime, was polite and had a good rapport with staff and prisoners. (We could not establish whether or when Mr Wallace was able to speak to his son but there is no further mention of problems with an inter-prison phone call.)

47. On 9 January 2025, Officer B met Mr Wallace for a keywork session. Mr Wallace told him he was doing well, and his health was good. He said he had lots of friends at Lowdham Grange and kept in touch with his family by telephone. He said he enjoyed his job, working in the prison gardens. During the remainder of January, Mr Wallace appeared settled.

Events of 26 January 2025

48. The investigator watched closed circuit television (CCTV) and body-worn video camera (BWVC) footage, listened to staff radio communications and obtained prison statements and East Midlands Ambulance Service records.

49. At around 8.45am, Mr Wallace's cell door was unlocked. Prison staff did not check on him.

50. At around 10.34am, Mr Wallace left his cell and spent around 90 minutes socialising with other prisoners and cooking food. At around 11.58am, Officer C locked Mr Wallace in his cell.

51. At around 12.06pm, Officer D completed a roll check (a manual check by prison officers of each cell to confirm the presence of prisoners). Officer D observed Mr Wallace through his cell door observation panel.

52. At around 12.49pm, the control room asked staff to complete a standfast roll check (an ad hoc roll check in addition to the routine roll checks which requires officers to carry out a physical headcount of all prisoners). CCTV shows that at around 1.06pm, Officer E checked cells on the bottom landing. He did not check any cells on the top landing, including where Mr Wallace lived.

53. At around 2.15pm, Officer C unlocked prisoners for afternoon activities. He unlocked all cells, including Mr Wallace's, without looking through any observation panels or checking on prisoners' welfare.

54. At around 2.40pm, Prisoner A (a prisoner on the wing) briefly looked through Mr Wallace's observation panel. He returned at 2.56pm and opened Mr Wallace's cell door. At the same time, Prisoner B, a prisoner, was nearby at the end of the landing. Prisoner A beckoned to Prisoner B. Prisoner B told the investigator that Mr Wallace had planned to cook food for prisoners that afternoon and Prisoner A had gone to his cell to ask if he was coming out.

55. Prisoner B told the investigator that Prisoner A shouted to him and said he thought something was wrong with Mr Wallace. At 2.57pm, Prisoner A went back into Mr Wallace's cell, followed by Prisoner B within a minute. Prisoner B told the investigator that the lights in Mr Wallace's cell were off, and his music was playing. He saw Mr Wallace sitting slumped over on the edge of his bed.

56. Prisoner A and Prisoner B immediately went to the staff office and told Officer D and Officer F that something was wrong, and they thought Mr Wallace was dead. Officer F immediately ran to Mr Wallace's cell, followed shortly after by Officer D.

57. Officer F entered Mr Wallace's cell at 2.58pm, followed by Officer D seconds later. In his statement, Officer F said he found Mr Wallace sitting slumped forwards, with

what appeared to be vomit on the floor and coming out of his mouth. He put his hand on his shoulder to try and get a response. Mr Wallace slumped sidewards, and Officer F laid him on his bed.

58. Officer D radioed a medical emergency code blue (used when a prisoner is unconscious or not breathing) at 2.59pm, as Mr Wallace remained unresponsive. The control room log recorded an ambulance was called at 3.00pm. (There may be a discrepancy of one minute between the time shown on CCTV footage and the control room clock. There is no evidence of a delay.)

59. Officer F was unable to find a pulse and began cardiopulmonary resuscitation (CPR). Officer D assisted.

60. At 3.01pm, Officer F, Officer D and Officer G (who had responded to the code blue) carried Mr Wallace onto the landing outside his cell. Officer H ran to collect the defibrillator (a device that can apply an electric charge to the heart to restore a normal heartbeat).

61. At 3.02pm, Nurse A and Nurse B arrived at Mr Wallace's cell, followed seconds later by Nurse I and Nurse J. All carried emergency bags. Officers continued CPR while nurses administered naloxone (a medication that rapidly reverses an opioid overdose) and inserted an airway.

62. At 3.15pm the first ambulance with three paramedics arrived at the prison gate. They reached Mr Wallace at 3.17pm. A minute later, staff moved Mr Wallace to the end of the landing, where there was more space.

63. At 3.20pm, a second ambulance arrived at the prison gate. A fourth paramedic arrived on F Wing two minutes later. At 3.22pm, paramedics from the helicopter emergency medical services (HEMS) arrived at the prison. At 3.24pm, two HEMS paramedics arrived on F Wing and assisted with resuscitation efforts.

64. Despite their efforts, at 3.42pm, paramedics pronounced life extinct.

Information received after Mr Wallace's death

65. Prison intelligence received after Mr Wallace's death suggested he had been using illicit drugs.

Contact with Mr Wallace's family

66. At 4.00pm on 26 January, the prison appointed the Offender Management Unit (OMU) Hub Manager as the prison's family liaison officer. An Offender Management Unit administrator was appointed as the deputy family liaison officer. Mr Wallace's next of kin lived far from the prison and the OMU Hub Manager arrived at their address at 10.00pm that night, broke the news of Mr Wallace's death and offered support. Another member of staff took over as the family liaison officer on 27 January.

67. The prison contributed toward the cost of Mr Wallace's funeral in line with national policy.

Support for prisoners and staff

68. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners with support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer support) to identify prisoners most affected by the death.

69. After Mr Wallace's death, the Head of Operations debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

70. The prison posted notices informing other prisoners of Mr Wallace's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Wallace's death.

Post-mortem report

71. The pathologist established that Mr Wallace died from the effects of synthetic cannabinoids (PS). The post-mortem and toxicology reports identified the presence of ketamine and pregabalin (a medication that was not prescribed to Mr Wallace) in Mr Wallace's system which indicated previous use (the post-mortem did not provide any further information on how recently he might have consumed the substances).

72. The pathologist found a significant degree of cardiac disease, the degree of which could cause sudden death. The pathologist concluded the presence of synthetic cannabinoids was the most important acute factor, but the presence of heart disease most likely indirectly contributed to Mr Wallace's death.

73. Mr Wallace's prescribed medication was detected and indicated therapeutic use (in line with his prescribed doses).

Inquest

74. At an inquest held between 29 June and 2 July 2026, the Coroner concluded that Mr Wallace death was drug related.

Findings

Substance use

75. Mr Wallace had some recorded history of substance use both in prison and in the community. However, he was not known to the substance misuse service at Lowdham Grange. In May 2024 (when Sodexo managed the prison), he was placed on report pending a disciplinary hearing after testing positive in a mandatory drugs test. In January 2025, a decision was made not to proceed with the charge (following the management 'step in' of HMPPS). Lowdham Grange was unable to provide full documentation so we could not establish the reason the charge was dropped. However, there is no evidence that Mr Wallace was referred to the substance misuse service in May 2024, or that any other action was taken to assess or address his substance use and we have been unable to establish why not. While we note there are processes already in place at Lowdham Grange which trigger referrals and information sharing with the substance misuse team, we bring to the Governor's attention the importance of sharing intelligence at all stages.

76. After May 2024, there is no record that staff considered Mr Wallace to be under the influence of drugs again although other prisoners reported that he used drugs.

Drug strategy at Lowdham Grange

77. Lowdham Grange's drug strategy dated August 2024 noted significant increases in finds of illicit items. There had been a 24% increase in illicit drugs being found in 2023/2024 compared to 2022/2023. There had also been an increase in reported incidents involving PS and health partners suggested there was significant under-reporting of PS use. Random and mandatory drug testing fell short of the 15% target and there was little evidence of supplementary suspicion, frequency or risk testing. At the time of this investigation, the drug strategy was under review to reflect HMPPS taking management of the prison.

78. In September 2024, the HMPPS Substance Misuse Group (SMG) conducted a drug strategy support visit at the prison to understand the scale and nature of substance misuse problems and the scale of the prison's vulnerability to the conveyance of illicit drugs. They found PS and cannabis were the most commonly used drugs. They identified some knowledge gaps among staff around substance use and physical vulnerabilities, including visits and searching. It was positive that they found that the security and analyst team had developed a strong understanding of illicit substances in the prison through detailed intelligence reports. This enabled them to produce a detailed and thorough Local Tactical Assessment (LTA) which was used as the basis for further action plans at departmental level. Revised monthly drug strategy meetings had also started.

79. The SMG made six recommendations, including that activity should be undertaken to raise awareness of substance use and the drug strategy across the prison, drive understanding of the prison's policy on managing prisoners under the influence of a substance, closer strategic alignment between security, safety and drug strategy activity, a review of existing visits procedures, review of the parcel process and photocopying social mail.

80. In January 2025, the Head of Drug Strategy and the Head of Security told the investigator that since October 2024, the prison had experienced a sharp increase in the number of medical emergencies related to prisoners suspected of being under the influence of drugs. Cannabis and PS remained the predominant drugs used. However, prison intelligence suggested that a variety of other substances, including fentanyl, ketamine and opiates were being used.

81. The Head of Security and the Head of Drug Strategy said that they worked closely with the police and had a good relationship with them. However, both said they felt the approach to managing drones was reactive rather than proactive. Drones were a significant issue, with attempted drops of packages every other night. There were examples of collaborative work taking place, particularly in sharing information about vehicles. This had resulted in arrests. Searching and risk drug testing remained challenging due to lack of resources.

82. In response to SMG recommendations, the prison is reviewing their drug strategy and have introduced measures to combat drugs coming into the prison, including securing funding for netting and window grill replacements and delivering corruption prevention training, with a recent focus on civilian staff.

Actions taken by Lowdham Grange since Mr Wallace's death

83. The Head of Security said the gate area was a concern as the prison experiences a high number of people and vehicles coming through. Enhanced gate security and other measures have been introduced, including a limit on paper permitted into the prison and the photocopying of mail. The prison is also exploring the development of a dedicated wing for incentivised substance free living.

84. The SMG scheduled a review for April 2025. Before it could take place, the SMG reconfigured to the Drug and Alcohol Group (DAG), with a new focus on capability and training. Direct prison support, including visits, stopped. Recruitment is underway to employ regional drug and alcohol leads to undertake this role.

85. On 9 April, the regional safety group undertook a safety visit and agreed with the DAG to look at some of SMG's key recommendations from September 2024. They found evidence of enhanced searching and additional training to support this. Progress had been made to raise awareness of substance use and the prison's drug strategy. However, it was unclear how many staff had completed training through an email link.

86. The SMG suggested that a tripartite meeting linking safety, security and drug strategy may be beneficial. They also found there were no courses being delivered to prisoners in relation to substance use. The prison is exploring alternatives which may be delivered through the education provider. In May 2025, Lowdham Grange accepted an offer from the Regional Safety Team and DAG to become a pilot site to undertake a training needs analysis and develop bespoke staff training.

87. We fully recognise the significant challenges inherent in preventing drugs coming into Lowdham Grange. The illicit drugs market in prison is controlled by organised crime gangs and Lowdham Grange recognises that the scale of the problem needs a co-ordinated approach which they have been implementing.

88. Lowdham Grange has experienced a turbulent two years and the demand for drugs and ingress into the prison is one of many significant problems they need to address. In March 2025, a new Governor was appointed of Lowdham Grange. Although some good work is being done at Lowdham Grange, including limiting paper coming into the prison and enhanced gate security, the threat from drugs is constantly evolving and more can always be done.

89. We welcome the work underway at Lowdham Grange to tackle the availability of drugs. However, we consider that work to educate and warn prisoners about the known dangers of using drugs, particularly synthetic cannabinoids and opioids, is vitally important. We make the following recommendation:

The Governor should ensure there is a robust and auditable programme for educating and communicating to prisoners the risks of drug use, and specifically of psychoactive substances.

Security - roll checks

90. The Management of Internal Security Procedures Policy Framework requires at least four routine roll checks in every 24 hours. An officer's signature in the wing residential diary confirms all doors have been checked as locked and secured and the presence of prisoners in their correct cells. This requires officers to assure themselves that prisoners are in their cells by obtaining a clear view of their face and, as far as reasonably possible, that prisoners are alive and well. The same requirements apply to standfast roll checks.

91. On 26 January, Officer D conducted the lunchtime roll check at 12.06pm. This was the last time Mr Wallace was seen alive.

92. Following a request from the control room at 12.49pm for a standfast roll check, Officer E failed to check any cells on the first floor, where Mr Wallace lived. Officer E's conduct was subject to an internal prison investigation and progressed to a disciplinary hearing. The hearing has not yet taken place.

93. The primary purpose of a roll check is to confirm that all prisoners are present and accounted for. Not completing a roll check of any kind is therefore a serious breach of security. Roll checks are also an opportunity to check on a prisoner's welfare and identify any serious concerns. While it is impossible to say whether the outcome would have been different for Mr Wallace if he had been checked in line with policy during the standfast roll check, this was a missed opportunity to identify any concerns.

Welfare checks

94. Prison Service Instruction 75/2011 on residential services requires staff to ensure prisoners are supported and their daily needs met. Staff should assure themselves of the wellbeing of prisoners during or shortly after unlock, even when prisoners are not expected to leave their cell.

95. During unlock and welfare checks in the morning and afternoon of 26 January, prisoners on F Wing, including Mr Wallace, were unlocked but not checked. Officer C failed to look through cell door observation panels before unlocking cells and did not check on the welfare of any prisoners. The failure to check on Mr Wallace when

he was unlocked at 2.15pm was a second missed opportunity to identify any concerns. Failure to look through observation panels before unlocking cell doors also presents a risk to officers.

96. The Deputy Governor told the investigator that both Officer C and Officer E (who failed to complete the standfast roll check) were employed by Sodexo. Before March 2025, all staff were trained by Sodexo. HMPPS have no access to their training records. We cannot be certain that Officer C and Officer E (and other staff trained by Sodexo) received sufficient training to enable them to undertake their roles effectively.

97. Lowdham Grange considered investigating the actions of Officer C. However, due to the lack of evidence that he had received sufficient training and support to undertake his role, an investigation was not deemed appropriate.

98. On 14 April, a Governor's Order was issued to all staff which detailed expectations to check on prisoners when they are unlocked and how to manage challenges with this (for example, if an observation panel is blocked).

99. On 28 May, Lowdham Grange held a whole prison training day which focused on safety. Training on welfare checks and roll checks was also delivered.

100. The senior leadership team is now conducting ad hoc wing visits to monitor that checks are being completed correctly and the Governor is reinforcing expectations to wing managers in the morning briefing. However, there is no formal quality assurance process in place to monitor progress. We therefore make the following recommendation:

The Governor should ensure that there is a robust quality assurance process in place to ensure that staff are carrying out roll checks and welfare checks appropriately.

Clinical review

101. The clinical reviewer concluded that the care Mr Wallace received was of a good standard and equivalent to that which he could have expected to receive in the community.

102. The clinical reviewer found some good evidence of information sharing between healthcare and prison staff. In particular, communication between prison and healthcare staff during the resuscitation attempt was excellent. There was nothing in Mr Wallace's clinical record to suggest he had been using illicit drugs, and he had been offered harm reduction advice in April 2023 at Lowdham Grange. The clinical reviewer made two recommendations about moving unresponsive patients and sharing information with substance misuse services which the Head of Healthcare will need to address.

Governor to note

Keywork

103. The investigator found that Mr Wallace had positive relationships with staff and peers. Staff described him as polite, compliant and settled. Staff to whom we spoke said they had never seen him under the influence of substances and appeared unaware of his drug use. Mr Wallace's prison electronic record detailed 17 entries in 2024: three of these were related to keywork sessions and others were about Mr Wallace's behaviour.

104. Although there is evidence that staff and prisoners knew Mr Wallace well, there is limited evidence that staff had meaningful and in-depth contact with him. In the 22 months that Mr Wallace lived at Lowdham Grange, there are only four recorded key work sessions, out of a possible 95 that should have been offered. Three of these took place with different keyworkers.

105. While we recognise the significant challenges Lowdham Grange faced during this period, regular sessions with a consistent keyworker might have offered Mr Wallace the support he needed and further opportunities for staff to be professionally curious and engage him in a more meaningful way.

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