Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ricky Crosher, a prisoner at HMP Lowdham Grange, on 11 October 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 Ricky Crosher died after being found hanged in his cell on 11 October 2023 at HMP Lowdham Grange. He was 40 years old. I offer my condolences to Mr Crosher's family and friends.

Mr Crosher's was the fifth self-inflicted death at Lowdham Grange since October 2021 and the fourth of five self-inflicted deaths 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 drugs, 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 Crosher's death has only served to prove those concerns fully justified. During the relatively short period Mr Crosher was there, the prison was not only unable to keep him safe but failed to recognise, including obvious signs of serious assault, that he needed support. Perhaps the saddest aspect of this case is that Mr Crosher rang the prison's safer custody support line seven times, including four times over the two days before he died and yet nothing appears to have been done in response to his calls.

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 the prison service 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 **January 2025**

Contents

Summary

Events

1. Mr Ricky Crosher had a significant history of alcohol and drug misuse, mental health issues and self-harm by cutting. On 26 August 2015, he was sentenced to 13 years imprisonment for aggravated burglary with intent.

2. Mr Crosher was released on licence on 2 December 2022 and recalled to prison on 4 March 2023 for breaching his licence by using drugs. He moved to HMP Lowdham Grange on 19 July 2023.

3. On arrival, Mr Crosher told the prison's safer custody team that he had last smoked psychoactive substances (PS) a week before and wanted to make a fresh start and work with them. He said he had been in debt for PS and vapes before in prison but either he or his family had managed to pay them off. His prison telephone calls from Lowdham Grange showed he frequently asked for money from his family to pay other prisoners.

4. On 22 August, he told his mother he had been beaten up. His substance misuse nurse noticed he had a black eye two days later and Mr Crosher confided that he had been assaulted by other prisoners. Another nurse submitted a security information report about his injuries.

5. On 25 August, Mr Crosher called the advice line staffed by trusted prisoners and reported a problem with a prisoner on his wing. On 27 August, he was noticed to be under the influence of a substance suspected to be PS.

6. On 12 September, Mr Crosher received treatment for cuts and bruises to his face. On 17 September, he told his mother that he had been assaulted again. The lack of information about this in Mr Crosher's prison records means we do not know whether the injuries relate to the same incident.

7. On 18 September, Mr Crosher called the prisoner advice line and told a prisoner he was under threat, there were a lot of people he did not get on with and he had a black eye and a broken nose. The prisoner advised Mr Crosher to call the safer custody line and leave a message. Mr Crosher's telephone records indicated that he did this.

8. On 7 October, Mr Crosher told staff he had cut himself with a razor blade. He said that he wanted to move wings because he was not safe but would not give the names of the people he was under threat from. Staff began Prison Service suicide and self-harm monitoring procedures (known as ACCT).

9. Shortly after 2.00am on 8 October, Mr Crosher set fire to a pillow in his cell and was moved to the adjacent spur on the same wing as his cell was full of water. He repeated he was under threat and said he would isolate in his cell until he was moved to a different wing. Later the same day, he told a mental health nurse that "his head had gone" and he could not cope.

10. Mr Crosher asked to move to another wing at an ACCT review on 9 October but was advised to try to settle in on his new spur and to ring the safer custody line or

talk to wing staff if he needed to. On 9 and 10 October he rang the prisoner advice line and the safer custody line eight times in total.

11. He left a message on the prisoner advice line on 10 October, that he “desperately” needed to speak to someone. The length of his calls to the safer custody line indicated he left messages but calls to this line were not recorded. There is no evidence as to whether staff listened to the messages he left before or after he died. His telephone calls to his parents indicated that he was very anxious about being in debt to other prisoners.

12. At 2.25am on 11 October, Mr Crosher asked the night patrol officer for a nurse. There are no nurses on duty at night in the prison. He did not say why he wanted to see one. Mr Crosher was last checked and seen to be alive at a routine check at 6.47am. Shortly after 7.00am, an officer completing an ACCT check discovered Mr Crosher had covered his observation panel and could not get a response from him. The officer checked the other prisoners on ACCT on that spur and then returned to Mr Crosher’s cell with a colleague.

13. They opened the inundation point in the cell door and saw Mr Crosher hanging from the toilet door. Officers and nurses gave Mr Crosher cardio-pulmonary resuscitation until paramedics took over, however Mr Crosher was declared dead at 7.41am. Toxicology showed he had taken cannabis and PS at some point before he died.

Findings

14. Throughout the period Mr Crosher 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.

15. These circumstances impacted the ability of staff to identify and support prisoners at risk. The lack of staff and support services had a significant impact on Mr Crosher's care including only one keywork session, almost no 1:1 contact with his allocated substance misuse worker, no evidence of responses to his calls to the prison telephone support services and that no one answered the main switchboard number when Mr Crosher’s parents rang the prison on 7 October.

16. Mr Crosher’s profile (with a history of self-harm, debt, substance misuse, assault victim, under threat) meant that he should have been identified as at risk to himself and from others, discussed at the Safety Intervention Meeting (SIM) and received specialised support. There was no evidence Mr Crosher received any meaningful support or protection from violence.

17. The level of care and support Mr Crosher received at Lowdham Grange was unacceptably low. Some basic actions were not taken that might have made a difference, including:

- Intelligence reports were not submitted consistently by staff who noticed his injuries in August and September and not at all by wing staff.

- The intelligence reports that were submitted were poorly processed and did not take into account Mr Crosher’s long history of being under threat from his peers.

- None of the intelligence concerning the assaults was passed to safer custody.

- There were a number of failings in ACCT procedures, most seriously the lack of a review in response to the cell fire which should have been regarded as an escalation of risk. Other issues included: healthcare staff not attending reviews, checks were sometimes chaotic, poor completion of the ACCT document at times, insufficient management assurance checks and staff being asked to do case reviews with little notice.

18. The first officer to discover Mr Crosher unresponsive should have called for assistance immediately. Staff should not have opened the inundation point before entering Mr Crosher's cell.

19. The clinical reviewer concluded that the healthcare received by Mr Crosher was partially equivalent to that he could have expected to receive in the community. They noted that there were significant restrictions on healthcare input due to the specific circumstances at Lowdham Grange at the time. The clinical reviewer concluded that information sharing between healthcare staff and prison staff was poor, record keeping was variable and no healthcare staff attended Mr Crosher's ACCT reviews.

Recommendations

- The Governor should introduce a standalone comprehensive debt strategy which is communicated to and understood by all staff, including providing appropriate support and intervention to prisoners where there are any concerns about debt.

- The Governor should evidence how the prison will monitor the challenging of blocked observation panels to ensure compliance with local processes.

- The Governor should ensure that prisoner telephone calls to the safer custody line are recorded and monitored in the same way as calls to anyone other than those organisations contained in Annex B of the Authorised Communications Controls and Interception Policy Framework.

The Investigation Process

20. HMPPS notified us of Mr Ricky Crosher's death on 11 October 2023.

21. 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.

22. The investigator visited Lowdham Grange on 26 October. She obtained copies of relevant extracts from Mr Crosher's prison and medical records, CCTV, body-worn video camera (BWVC) footage and radio traffic from 11 October 2023.

23. The investigator interviewed eleven members of staff between March and August 2024.

24. NHS England commissioned a clinical reviewer to review Mr Crosher's clinical care at the prison. The clinical reviewer and the investigator interviewed four healthcare staff together.

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

26. The Ombudsman's office contacted Mr Crosher's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Crosher's mother said she was concerned that her son had been assaulted by other prisoners, had not seen a doctor about his broken arm and had not received adequate mental health care. She said she and Mr Crosher's father had both telephoned the prison to try to relay their concern for his welfare. She asked why there was so much blood in Mr Crosher's cell when he was found hanged and why he was not in a safer cell (a cell with reduced ligature points). We have covered these issues in this report and in the clinical review.

Background Information

HMP Lowdham Grange

27. 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.

28. 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.

29. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

30. The most recent inspection of HMP Lowdham Grange was in May 2023. Inspectors reported that the prison was not safe, with high levels of drug use and violence. The transfer from Serco to Sodexo had led to uncertainty and anxiety among prisoners and staff, whose numbers were reduced by the loss of significant numbers of key and specialist staff.

31. The availability of drugs had increased. The security department had lost staff and there was a backlog of intelligence reports that had not been acted on. Inspectors were told that the primary source of drugs was staff corruption and smuggling at social visits. Despite this, staff were not searched often enough, there was no enhanced gate security and checks on staff and visitors entering the prison were inadequate. Meaningful strategies to tackle drugs, debts, bullying and gang-related violence had not been developed. Not all violent incidents were investigated, and challenge support and intervention plans (CSIP) were not being used effectively to manage perpetrators of bullying or support victims. Access to work and education was poor and too little keywork was being delivered.

32. HMIP returned to the prison in January 2024 to review progress. Inspectors found that a shortfall of 51 Prisoner Custody Officers (PCOs) meant that the very basic needs of prisoners were often not met. Prisoners were often locked up for very long periods which caused frustration. Violence had increased by 55% and not enough was being done to investigate incidents or challenge perpetrators. Illicit drug use had also increased but very few security reports were submitted about this. Since HMPPS had arrived, the number of searches had increased and therefore so had the number of illicit items found.

33. The relationship between Sodexo and the healthcare provider was strained. Concerns from healthcare staff about their safety had resulted in only minimal and critical health services being delivered.

Independent Monitoring Board

34. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2023, the IMB reported that the safety of the prison had deteriorated. There had been an increase in the number of prisoner-on-prisoner assaults, in self-harm and in weapons finds. Almost 20% of mandatory drug tests were positive and prisoners under the influence of psychoactive substances was an almost daily occurrence. The IMB feared that the prevalence of drugs was likely to increase the negative impact of gang culture and make prisoners feel less safe.

35. The Board considered that relationships between staff and prisoners had deteriorated and there had been a significant reduction in purposeful activity which had led to prisoners spending long periods locked in their cells. Healthcare services continued to be under great pressure and the IMB considered that physical and mental healthcare was at a lower standard to that in the community.

36. The investigator spoke to the Chair of Lowdham Grange IMB in October 2023. The Chair said she was extremely concerned about the safety of staff and prisoners. Nurses were refusing to go on to the wings except for emergency code calls and the education provider NOVUS had also told education staff not to go on to wings. Staffing levels and morale was extremely low. Violence was frequent and a number of prisoners were in debt because of the prevalence of illicit substances.

Previous deaths at HMP Lowdham Grange

37. Mr Crosher was the eighth prisoner at Lowdham Grange to die since October 2020. Of the previous deaths, two were from natural causes, one was drug related, and four were self-inflicted. In our investigation into a drug related death in July 2021, we were concerned that the prisoner had been able to access psychoactive substances (PS) with apparent ease despite the prison being in lockdown due to the COVID-19 pandemic. In our investigation into the self-inflicted death of a prisoner in March 2023, we were concerned that he was able to access PS with apparent ease, was in debt and under threat from other prisoners. We did not consider that the prison had adequately addressed these issues or supported the prisoner.

38. Up to September 2024, there have been three deaths since Mr Crosher's, one self-inflicted, one from natural causes and one drug-related.

Assessment, Care in Custody and Teamwork (ACCT)

39. 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.

40. 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 is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive substances (PS)

41. The term psychoactive substances is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) 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.

42. 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.

Key worker scheme

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

44. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Inundation point

45. Cell doors have inundation points, a removable bung that allows a hose to be used to spray water into a cell in the event of a fire, without opening the door.

Key Events

46. Mr Ricky Crosher had a significant history of alcohol and poly-substance misuse, mental health issues and self-harm by cutting. Mr Crosher's OASys report (a risk assessment completed by the Probation Service) recorded three previous suicide attempts, all by heroin overdose. Mr Crosher had spent a significant part of his life in prison for offences related to his drug use and was frequently managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT). On 26 August 2015, he was sentenced to 13 years imprisonment for aggravated burglary with intent.

47. Mr Crosher was released from HMP High Down on licence on 2 December 2022. He was recalled to prison on 4 March 2023 for breaching his licence by using drugs and arrived at HMP Thameside the same day.

HMP Thameside 4 March 2023 – 18 July 2023

48. Mr Crosher told a nurse during an initial health assessment that he smoked crack cocaine daily and also sometimes used Subutex (buprenorphine - a semi-synthetic opioid used in detoxification from opioid addiction). His urine tested positive for opiates, cocaine, cannabis and Subutex. He was prescribed methadone for opiate withdrawal and venlafaxine for depression and anxiety.

49. Mr Crosher was briefly managed under ACCT procedures twice at Thameside after he self-harmed by cutting. On 18 May, he had an altercation with another prisoner and sustained scratches to his face. He lost his job as a wing cleaner the next day and cut his arm severely enough to need hospital treatment. On 11 June, Mr Crosher fell in his cell while under the influence of psychoactive substances (PS – known in prison as Spice). His methadone was reduced as a precaution due to the danger of mixing opiates and PS. On 29 June, Mr Crosher made superficial cuts to his arms because he was frustrated with the continued reduction in his methadone.

50. On 18 July 2023, Mr Crosher transferred to HMP Bedford for one night before moving to HMP Lowdham Grange the next day.

HMP Lowdham Grange 19 July – 6 October 2023

51. When he arrived at Lowdham Grange Mr Crosher told a prisoner custody officer (PCO) from the prison's safer custody team that he had last smoked PS a week before and wanted to make a fresh start and work with the substance misuse team. He said he had been in debt for PS and vapes before in prison but either he or his family had managed to pay them off.

52. A nurse completed an initial health assessment. Mr Crosher denied any feelings of suicide or self-harm. He said he thought he might need mental health support and the nurse noted that he seemed a little vulnerable. She referred Mr Crosher to the mental health and substance misuse teams. A GP continued his prescriptions for methadone and venlafaxine.

53. Mr Crosher had a keyworker session with another PCO the same day. She noted he seemed well and happy to be at Lowdham Grange for a fresh start.

54. On 24 July, Mr Crosher told the substance misuse team that he did not want to work with them. As a methadone patient, he automatically remained on their caseload and an assessment was re-booked.

55. At 2.53pm on 25 July, Mr Crosher telephoned his mother and asked her if she could give him £10.00 or £15.00. He sounded anxious but did not have enough credit on his account to speak for very long.

56. At 3.19pm, Mr Crosher telephoned the prison's safer custody line (a telephone support service for prisoners to contact the safer custody team direct from their cell telephones). Calls to the line are not recorded. (Most calls a prisoner makes from his prison phone account are recorded and can be listened to later by staff if evidence suggests it necessary.) The safer custody line's recorded message lasted for eight seconds before voicemail connected. Mr Crosher's call lasted ten seconds in total.

57. On 31 July, a nurse completed a mental health triage assessment with Mr Crosher. The nurse noted Mr Crosher appeared in a good mood and was pleasant and co-operative. He said he had no thoughts of suicide or self-harm and did not need any mental health support. He said he usually self-harmed out of frustration with the prison environment. The next day the mental health team allocations meeting discharged Mr Crosher from their caseload.

58. On 10 August, a nurse completed Mr Crosher's re-arranged substance misuse assessment by telephone after Mr Crosher said he was unwilling to attend in person. The nurse said Mr Crosher appeared guarded and disinterested and did not want to discuss his history of substance misuse or its role in his offences. He said he had taken illicit opiates, Subutex and PS in Thameside to cope with the pain of a broken wrist. The nurse completed a support care plan and planned to visit Mr Crosher once a month.

59. On 21 August, Mr Crosher telephoned his mother and asked her if he could urgently borrow £30.00.

60. A nurse saw Mr Crosher on 22 August at the medication hatch. He said Mr Crosher appeared low in mood. He gave Mr Crosher harm minimisation advice and outlined the risk of using PS with prescribed medication. At 10.22am, Mr Crosher called his mother and asked her if she had £10.00 she could lend him. At 8.18pm, he called his mother back and said he had been in a fight and had a bad nose and eye. He said someone thought he had taken something from their cell and he thought it was a set up. His mother asked him if the prison officers had intervened and Mr Crosher said they had not. There is nothing in Mr Crosher's prison record to indicate that staff had either witnessed the fight, or noticed Mr Crosher's injuries after it.

61. Two days later, on 24 August, the nurse noticed Mr Crosher had bruising on his face and a black eye. Mr Crosher was reluctant to talk about what had happened so the nurse told him he would call him on his cell telephone later in the day. He discussed Mr Crosher in the healthcare lunchtime handover meeting and it was

decided Mr Crosher should be brought to healthcare for assessment. The nurse tried to call Mr Crosher as planned but he did not answer his phone.

62. The same day, Mr Crosher moved from the induction unit to a cell on A Wing. (This was the last entry on his electronic prison record - NOMIS - until 7 October.)

63. Mr Crosher saw the GP about his injuries that afternoon. They also discussed the injury to his wrist and Mr Crosher asked for tramadol (an opioid painkiller) to manage the pain. The GP said he would not consider tramadol unless Mr Crosher first reduced his methadone from 20ml a day to 10ml.

64. The nurse spoke to him after he had seen the GP. Mr Crosher said he was willing to gradually reduce his methadone in order to be prescribed tramadol. He told the nurse that he had been "jumped" on his previous wing two days before and still felt a bit shaken by the experience. Mr Crosher said he thought he had been attacked due to his offence which had involved stabbing a 17 year old female with a screwdriver while under the influence of drugs. He told the nurse that safer custody was aware of him being assaulted and so the nurse did not contact them himself. We have not seen any evidence that Mr Crosher reported the assault to safer custody or that anyone from that team saw him. Mr Crosher said he would "keep his head down". He denied taking any illicit substances or any thoughts of suicide or self-harm.

65. At interview, the nurse said this was the only time he had been able to see Mr Crosher in person in a confidential setting. At the time, healthcare staff had been told not to attend the wings except for emergencies because senior managers considered that there were insufficient prison staff to keep them safe. There were rarely enough staff to escort prisoners to healthcare and limited space there to see people on their own. He was therefore unable to undertake effective psychosocial support sessions. The nurse said he tried to mitigate this by telephoning Mr Crosher in his cell but Mr Crosher did not answer his phone. His work as Mr Crosher's substance misuse keyworker was therefore reduced to brief welfare checks when he saw Mr Crosher at the medication hatch in the presence of other prisoners and staff.

66. Also on 24 August, another nurse completed an intelligence report (IR) after she too noticed Mr Crosher's facial injuries when he attended the healthcare unit to see the GP. She reported that Mr Crosher had a black eye and when she asked him how he had got it, he had replied that someone had got the wrong information. There is no indication in Mr Crosher's records that any actions were taken in response to this IR and it does not appear to have been assessed by the security department. The Head of Safer Custody confirmed that they were unaware of the assault on Mr Crosher.

67. At 1.30pm on 25 August, Mr Crosher telephoned the Lowdham Grange prisoner advice line (PAL - a telephone service staffed by trusted prisoners during the day, regime permitting). The call connected to voicemail after 46 seconds and Mr Crosher left a message:

> "Hello, can someone come over and see me please. You've put someone on the wing, it's a problem for me and, you know, I need someone to come and see me please."

68. At 1.46pm, Mr Crosher called his mother and told her that he had a problem with a prisoner that had moved to the wing. He said his black eye had come out and it was attracting unwanted questions from other prisoners. He asked his mother to put £25.00 into an account in a woman's name, indicating that she had paid money to them before. He said he had to "pay something off" from his previous wing because he "kept bumping into people and it was no good".

69. The next day on 26 August, Mr Crosher told his mother that his father was going to give her £25.00 for him and not to put it in the woman's account he had mentioned because he wanted to "save that one for Monday". He said he would call back with the details of a different account. When he called his mother back she said someone else had rung her with the account details. Mr Crosher called her again to check she had paid the money in and became agitated when she told him that his father had only given her £20.00 and not £25.00. His mother agreed to make up the difference.

70. On 27 August, wing staff noticed Mr Crosher was unsteady on his feet with dilated pupils and slurred speech. A nurse assessed him in his cell and concluded Mr Crosher was under the influence of an illicit substance. He sent a task to the substance misuse team and stopped Mr Crosher's methadone for 24 hours as a precaution. There is no evidence in the clinical records that Mr Crosher was seen by the substance misuse team for a follow up appointment after this incident and no evidence that he was monitored in line with the prison's policy for monitoring prisoners suspected of being under the influence of illicit substances.

71. On 5 September, Mr Crosher applied for employment. He said he was depressed by not working and would work in whatever job came up first. He was placed on the waiting lists for several workshops and the waiting list for wing cleaner.

72. On 12 September, a nurse saw Mr Crosher to assess cuts and bruises to his face. The entry in the clinical record refers to an assault but gives no detail of the incident or what Mr Crosher said about it. At interview the nurse could not recall anything Mr Crosher told him that day. There is no mention of an assault in Mr Crosher's prison records and no evidence that the safer custody team were made aware of the incident or offered Mr Crosher any support.

73. A nurse saw Mr Crosher at the medication hatch on 17 September and noticed he had a black eye. She recorded that he declined an assessment. At 4.49pm, Mr Crosher called his mother and told her he had "had another beating". He told her he was still in debt and needed a job. At the end of the call he asked his mother if she could give him some money. There is no other information in Mr Crosher's prison records about this assault and no IR was completed. We do not therefore know whether this was a separate incident to the one on 12 September.

74. A nurse spoke to Mr Crosher at the medication hatch the next day. He noted that Mr Crosher had a nasty bruise to one eye but, apart from confirming he had been assaulted, he was unwilling to discuss details of the incident. At 1.45pm, another nurse telephoned Mr Crosher to complete an asthma review. He told her he thought he had broken his nose and asked to see a nurse. The nurse recorded that she had tasked the nurse in charge with responding to his request.

75. The same day at 3.19pm, Mr Crosher called the prisoner advice line and spoke to a prisoner. Mr Crosher said he was under threat, there were a lot of people he did not get on with and he had a black eye and a broken nose. He said it was the second time he had "had a kicking" and thought he had some broken ribs. The prisoner advised Mr Crosher to call the safer custody line and leave a message. Mr Crosher called the safer custody line at 3.23pm. The call lasted for 22 seconds indicating that he left a voicemail.

76. The staff member with oversight of the safer custody department at the time told the investigator that messages to the safer custody line are not recorded and monitored in the same way as other prisoner telephone calls because of their sensitive nature. Usual practice was for safer custody staff to listen to messages at the beginning and end of every shift. Messages were deleted after they had been listened to. Although he thought some sort of log of the calls was kept, the prison was unable to provide one. He told us that, at the time, staff shortages meant that safer custody staff were frequently cross-deployed to wings and were unable to perform their roles – including checking the voice messages every day.

77. A PCO who was a regular officer on A Wing said that Mr Crosher was polite and willing to talk to staff when spoken to but did not go out of his way to initiate conversation. She thought Mr Crosher was vulnerable to being put under pressure and acted as a 'runaround' for other prisoners (he would do things for them so they did not get into trouble themselves). She knew he used PS and thought that doing things for other prisoners might be in part how he paid for these. She said that at the time there was a lot of PS on the wings.

78. The PCO said she had noticed Mr Crosher with a bruised eye but said he had told staff he had fallen over in his cell. At the time there was a shortage of houseblock managers and sometimes there was no manager on the houseblock for weeks at a time. Houseblock managers were responsible for creating support plans for prisoners in debt and under threat. She said it was therefore extremely difficult for staff to arrange extra support or wing moves for prisoners vulnerable to being bullied and threatened. There was also no debt strategy in place for supporting prisoners and no keywork took place because there were only just enough staff most days to run the most basic regime.

79. On 21 September, Mr Crosher made another application for a job as he still did not have one. Staff replied the next day that he was on several waiting lists and they would allocate him a job when a space became available. Mr Crosher was not given a job before he died.

80. On 3 October, Mr Crosher saw a nurse in response to his request to see a nurse on 18 September. He said the issue with his ribs had resolved but he had a painful lump on his wrist. The nurse booked Mr Crosher a GP appointment but this did not take place before Mr Crosher died.

81. At 5.46pm on 4 October, Mr Crosher called the safer custody line for 19 seconds (indicating he left a voicemail). He spoke to his mother immediately afterwards but did not give any indication to her that he had called the safer custody team or why he might have needed to.

82. On 5 October, a nurse rang Mr Crosher for a welfare check but he did not answer his cell telephone.

83. On 6 October, Mr Crosher called his mother at 9.53am. He said, “it had all started again” and he wondered whether someone had looked him up on the internet. He said he did not feel paranoid but thought everyone was “plotting” against him. He said nothing particular had happened but he thought that the female members of staff were upset with him and other people were talking about him. After a couple of minutes the conversation reverted to general family news. He called his mother back at 12.52pm and apologised if he had worried her earlier but “his head was in bits” and it “was mad in here”. He said he was worried there were rumours about why he was in prison and his mother tried to reassure him.

84. Mr Crosher spoke to his mother again at 2.05pm. He spoke slowly and sounded confused. He rang back at 10.37pm and told his mother that he was worried a woman in the prison had put a hit out on him. His mother tried to reassure him that his concerns were unfounded.

Events of 7 – 11 October 2023

7 October 2023

85. According to the cell bell record, Mr Crosher pressed his cell bell at 4.12am on Saturday 7 October. A PCO, the night patrol officer for A Wing, answered the bell at 4.14am and discovered that Mr Crosher had made several cuts to his arm with a razor. The PCO radioed a code red emergency (which indicates significant blood loss) and the night orderly officer, a senior prisoner custody officer (SPCO), and two PCOs responded and entered his cell. The control room officer called an ambulance in line with the prison’s emergency code policy, but the SPCO told them to stand it down when it became clear that Mr Crosher’s injuries did not require hospital treatment. (There are no nurses on duty at Lowdham Grange at night.)

86. The investigator watched body worn video camera footage of the incident. The copy provided did not show the time of events and started at the point staff entered Mr Crosher’s cell. There was a significant amount of blood on the floor of the cell just inside the door. Mr Crosher handed the staff a razor blade which he had used to cut himself. Mr Crosher appeared calm and allowed staff to dress his wounds.

87. It is not possible to hear the dialogue between the staff and Mr Crosher but staff reports of the incident said he was under threat on the wing and “had pissed too many people off”. He asked for a wing move and was advised by the SPCO to speak to safer custody.

88. A PCO said Mr Crosher said that he needed to move off the wing because he was not safe there. He would not give the names of the people he was under threat from. She said she was surprised that Mr Crosher had self-harmed. The PCO said all three of the officers that spoke to him that night in his cell were A Wing officers and had a good rapport with Mr Crosher. They told him he could speak to staff if he had issues and did not have to take such extreme measures. She said Mr Crosher calmed down and she reassured him that something would be done to help him the next day.

89. She said she gave a detailed handover to the incoming day manager when she went off shift, but she was not aware at that stage that the prison would run a 'red regime' that weekend. This meant that there were not enough staff to unlock prisoners for any reason. As a result, Mr Crosher was not moved to another cell on 7 October.

90. Staff began ACCT monitoring procedures. A PCO completed the concern and keep safe form at 4.55am. He reported that Mr Crosher said he would self-isolate until he was moved, otherwise he would do something "worse than cutting up". Observations were set at two every hour with three conversations a day.

91. The immediate action plan contained two sets of entries completed by an SPCO at 4.20am and by another SPCO at 3.00pm. The placement of the first SPCO's entries and signature indicated they were added after the other SPCO's. We do not believe the first SPCO completed the immediate action plan at the time stated or within an hour of ACCT procedures being started, as she was required to do.

92. Staff submitted an IR at 5.39am. The author reported that Mr Crosher had cuts to his hands and believed he was under threat. The intelligence assessment section said, "It is likely Mr Crosher is suffering from a previous injury to his wrist and this is causing the pain. He self-harms to distract himself from his personal issues. There isn't any intel to suggest he is under threat."

93. At 8.26am, Mr Crosher told a PCO that he felt under threat. He asked if healthcare staff could check his cuts and put his bedding in the laundry.

94. A nurse attempted to examine Mr Crosher's wounds later that morning, but he refused treatment and asked to be taken to hospital. The nurse explained that he did not need to go to hospital but Mr Crosher would not change his mind. The nurse asked his colleague to help and she persuaded Mr Crosher to let them clean, dress and steri-strip his cuts. The nurse sent an urgent task to the mental health team to review Mr Crosher.

95. At 12.23pm, Mr Crosher rang his mother and told her that he had cut himself. He said that his "head was in tatters". He was tearful and told her that he could not do another five years in prison. She tried to reassure him and asked him if he was taking his venlafaxine. He said there were things going on and everyone had been turned against him. He said he had decided to self-isolate in his cell. Mr Crosher ended the call abruptly when someone appeared to be at his door and told his mother he would call her back.

96. At 12.59pm, Mr Crosher phoned his father. He told his father he had cut himself to get off the wing. He said some men on the wing were getting drunk and were going to take over the wing. Mr Crosher asked his father to call the police and tell them. He said he was not under the influence of drugs. His father asked him if people were coming after him but Mr Crosher ended the call. He made no further calls that day.

97. An SPCO completed the ACCT assessment in Mr Crosher's cell at about 3.00pm. The SPCO said he wanted to take Mr Crosher to a more private location but Mr Crosher had not wanted to leave his cell. A custodial operational manager (COM) joined him part way through the assessment. The COM said it was her day off but

she had been asked to work as the prison was extremely short staffed. She said she agreed to go in for about three or four hours in the afternoon and shortly before she left she was asked to complete Mr Crosher's first ACCT case review. She had not met Mr Crosher before and knew nothing about him other than the information written on his ACCT document.

98. During the assessment Mr Crosher said he was feeling low because he did not feel safe on A Wing. He said he had told staff but nothing had been done to support him and he felt that he was being ignored. He said he had cut himself to get the attention of staff. Mr Crosher said he had good family support, especially from his parents. He said he would like to move to another wing and have support from the mental health team.

99. The COM and SPCO then held the first case review immediately afterwards. The COM said there was no opportunity to make the review multi-disciplinary because no one from the mental health team was available at that time.

100. The COM noted that Mr Crosher said he had no current thoughts of self-harm. He told her that other prisoners were making threats towards him because of his offence and that he believed there was a price on his head. He said he wanted to remain in his cell until he could move to a different part of the prison. Mr Crosher said he had support from his parents and had spoken to them that morning. She decided to maintain the level of observations at two an hour and scheduled another review for Monday 9 October so someone from the mental health team could attend. She added "wing move" as a single action to the care plan and wrote that it was "required" and should be actioned by the houseblock manager.

101. The COM said that normally a wing move required some consideration with safer custody about which location would be safest to move the prisoner to. She said that if they had known the bigger picture and there had been space it might have been possible to move Mr Crosher immediately, however she considered that Mr Crosher would be safe over the weekend because the red regime meant that he would be locked in his cell.

102. At about 3.10pm, Mr Crosher told a PCO during the afternoon conversation required by his ACCT management that his "head was a mess" but he felt okay.

103. At 3.40pm, staff submitted a second IR about Mr Crosher. It was titled "self-harmed" but gave no further details. The security assessment stated, "Crosher self-harms when frustrated, may also be an avenue to get what he wants." There is no evidence that this was analysed or any further actions to be taken identified.

104. At about 5.50pm, Mr Crosher told a PCO that he felt okay and just needed some hot water, which she got for him.

8 October 2023

105. According to the cell bell record, Mr Crosher pressed his cell bell at 2.03am on 8 October. The operational cell fire report recorded that the fire alarm system activated automatically at 2.06am. An operational support officer (OSO) answered the cell bell at 2.12am and found that Mr Crosher had set fire to a pillow on the floor of the cell near the door. An SPCO, two PCOs and other night staff attended and

the fire service was called. BWVC from two cameras showed that staff had difficulty opening the inundation point as the Houseblock 1 inundation key was bent and, when a different key was obtained, the inundation point was too stiff to open. There was a delay of around six minutes before the Hydramist unit (a machine that uses high-pressure water mist to extinguish fires) was turned on and the fire extinguished.

106. The SPCO said in a written statement provided by the prison to the investigator that Mr Crosher was happy to stay in his cell but she moved him to cell B-02 because his cell was full of water. B Wing is next to A Wing and is also on Houseblock 1. She gave him his TV, telephone, kettle, cutlery and washing bag from his old cell and he was provided with clean bedding. Mr Crosher told her he would ask to move from B Wing at his next ACCT review. The fire service arrived after the fire was put out. The inundation key was replaced after the incident. No ignition source was found in a subsequent search of Mr Crosher's cell. The SPCO did not complete a defensible decision log as required after every cell move for a prisoner subject to ACCT procedures.

107. A PCO noted in the ACCT record that Mr Crosher had set the fire due to being under threat on A Wing. There is no evidence that staff considered whether this change in behaviour with inherent risk involved meant that they should hold an ACCT review and increase Mr Crosher's ACCT observations.

108. A PCO told the investigator that there had been a problem with prisoners setting fires at the time because there were a number of prisoners in debt and cell fires were seen as a way of forcing a wing move rather than waiting for managers to be on duty to arrange one. To try to discourage this and prevent bad behaviour being rewarded, the prison tried to move prisoners setting fires to a different cell on the same wing or houseblock.

109. At about 8.00am, Mr Crosher told a PCO that he had set the fire in order to move to another wing. He asked to go to the segregation unit or be moved to a different prison. He asked the PCO if he had done anything to annoy the staff and she reassured him that he had not. The daily management check of Mr Crosher's ACCT recorded at 9.40am (signature illegible) noted "no increased risk". There is no mention that Mr Crosher set a fire during the night. This was the only daily management check recorded on Mr Crosher's ACCT over the four full days it was open.

110. Later that morning and again that afternoon, Mr Crosher asked for a phone (as his new cell did not have one) so he could call his family to reassure them he was okay and "clear the air".

111. A mental health nurse completed a welfare check on Mr Crosher in his cell in response to the urgent task sent by a nurse. Due to the red regime they spoke in the open doorway of Mr Crosher's cell. The mental health nurse said Mr Crosher was polite, calm, pleasant and engaged well. He said "his head had gone" over the last few weeks and the day before he had felt like he could not cope. He said he had a variety of stressors in prison but had self-harmed due to being in pain since his methadone was reduced. Mr Crosher said he had asked for tramadol and Subutex which he found better for pain management. The mental health nurse advised him to speak to the GP about pain management and to the substance

misuse team about the reduction of his methadone. She explained that Subutex was a highly tradeable drug in prison and was only usually prescribed closer to release. She sent a task to the healthcare administrator to book Mr Crosher a GP appointment. Mr Crosher denied feeling suicidal or like harming himself further.

112. Mr Crosher called his mother at 4.28pm and said he had just been given a phone. She was extremely relieved to hear from him and told him that everyone had been in a state of panic since his calls the day before. He told her he had set fire to his cell because he needed to move to a different location. He said he was being treated as if he was a "grass" and he did not know why. Mr Crosher said there were people on the wing with a lot of money encouraging other prisoners to get into debt. He said he was falling apart physically and was too old to fight. He said the wing had been locked down for a couple of days and some prisoners whose birthdays it was had brewed illicit alcohol (known as hooch) which had led to "madness". There were hardly any staff on duty and it would be easy for the prisoners to take over. He said something had been due to happen to him which is why he had to set fire to his cell to get a move. He said he had wanted to move to the segregation unit but had been moved to a different spur on the same houseblock. They discussed some family news and he reassured her that he was safe and was staying in his cell.

113. Mr Crosher called his father at 6.10pm and repeated what he had told his mother. His father asked him if he could speak to someone about his problems and Mr Crosher said he had been trying to. Mr Crosher's father said he had tried to ring the prison the day before but no one had answered the phone. He advised Mr Crosher to speak to staff the next morning (Monday) when there would be more of them on duty. He emphasised to Mr Crosher that he needed to explain that he really needed to move and should also try to speak to healthcare to have a mental health assessment.

9 October 2023

114. A PCO noted in the ACCT record that Mr Crosher had slept throughout the night and woken up at 5.00am.

115. At 8.00am on 9 October, Mr Crosher told a wing officer that he wanted to remain locked in his cell as he was under threat on the wing. The officer wrote on Mr Crosher's ACCT, "he is not as no one knows who he is".

116. Mr Crosher called his mother at 9.33am. He repeated that he had not been moved to a different houseblock despite cutting himself badly and then setting a fire. He said he had not had a shower since the fire and had been coughing up soot. They discussed family news for the rest of the call.

117. Mr Crosher was charged with breaking prison rules by setting a fire in his cell and attended a prison disciplinary hearing (known as an adjudication) in the segregation unit that morning. He asked for legal advice and the hearing was suspended for seven days to allow him to receive this.

118. At 10.23am, Mr Crosher telephoned the safer custody line. His call lasted 11 seconds.

119. At about 2.00pm, the Industries COM chaired an ACCT review with Mr Crosher and a wing officer in the doorway of Mr Crosher's cell. The Industries COM said she was not Mr Crosher's ACCT case manager but had been asked to cover his review that day due to a lack of staff. She said she tried to get someone from the mental health team to attend the review but no one was available. Prior to the review, she looked at Mr Crosher's electronic prison record but there were no recent entries so she went to B Wing and read his ACCT document and spoke to staff. None of the staff knew Mr Crosher well because he had only just moved there. She said she remembered that Mr Crosher had recently moved from A Wing because he was under threat.

120. The Industries COM said Mr Crosher would not come out of his cell to complete the review in a more private setting because he said he was still under threat and had "pissed a lot of people off". He would not go into detail about this. He said his move to B Wing had not made much difference as he was still on Houseblock 1. He said his mood was up and down. She said Mr Crosher was very polite and respectful and gave her no cause for concern. He told her he had seen someone from the mental health team the day before. She said she would invite safer custody and mental health staff to his next review. Mr Crosher said he had 'annoyed' a lot of people in the prison so he would remain self-isolating in his cell for now. She planned to hold the next review on 16 October. She advised Mr Crosher that he should use his cell bell, speak to wing staff or call safer custody for support.

121. Mr Crosher telephoned the prisoner advice line three times between 2.00pm and 2.30pm. No prisoners were on duty answering the line that day. At 2.05pm, Mr Crosher hung up three seconds after being connected. At 2.07pm, Mr Crosher left a voicemail:

> "Hello there, it's Ricky Crosher, can you please come and see me on A Spur please, cell 2, thank you bye."

On the third call Mr Crosher rang off before the call went to voicemail.

122. At 2.29pm, in between his second and third calls to the prisoner advice line, Mr Crosher called the safer custody line. The call lasted 24 seconds.

123. At 2.30pm, a PCO noted on his ACCT document that Mr Crosher was out on the landing and that he told her he felt okay. At 2.59pm, Mr Crosher rang the safer custody line again but the call only lasted three seconds indicating he did not listen to the eight second recorded message in full before hanging up.

124. At 5.00pm, Mr Crosher asked another member of wing staff for some clean dressings for his cuts. There is nothing on the record to indicate that Mr Crosher was seen by healthcare staff in response to this.

125. At 7.34pm, Mr Crosher called the safer custody line again for 17 seconds.

126. A PCO was the night patrol officer for B wing that week. At the end of his night shift on 9/10 October, he noted on Mr Crosher's ACCT record that Mr Crosher had slept during the night and he had not had any interaction with him.

10-11 October 2023

127. Mr Crosher called his mother at 10.30am on 10 October. He said he was fine and they discussed the dogs and what his mother had been up to. He called her back at 11.15am and asked her for £20.00 to buy some canteen items from another prisoner. He said that some prisoners keep a stock of canteen items and sell them at higher prices to other prisoners. He said he needed things because all of his items were still in his previous cell. Mr Crosher's mother said she would send him what money she could, and he told her he would ring her back and give her the account details of who to pay. He rang back at 11.27am and gave her the account details of a woman. Mr Crosher's mother said she would make the payment later and Mr Crosher asked her to do it "now" because they were due to be locked up soon. He rang his mother back at 11.34am and she said she would not being able to pay the money until 1.30pm.

128. A PCO completed a significant number of Mr Crosher's ACCT observations on 10 October. Mr Crosher asked her if she had a problem with him and she reassured him she did not. Later she noted that Mr Crosher was calmer and interacted with another prisoner when out of his cell. Staff gave Mr Crosher his clothes from his previous cell that afternoon. He asked the PCO for a new bandage and she advised him to ask at the medication hatch.

129. At 1.01pm, Mr Crosher called the safer custody line. The call lasted 24 seconds.

130. At 1.03pm, Mr Crosher rang the prisoner advice line and left a voicemail:

> "Hello this is Ricky Crosher. I really desperately need to speak to someone, can you please ring me up or come see me. Thank you."

The message was not listened to until after Mr Crosher died.

131. At 1.26pm, Mr Crosher called his mother again. She told him that she had sent the money he had asked her to send. She asked who the recipient was and Mr Crosher said it was the girlfriend of the man in cell number nine. Mr Crosher told her that if he worked with other prisoners and bought things from them, he thought it offered him a bit of protection. He said there were a lot of rumours about what people were in prison for. They had a general conversation about what she was doing. Mr Crosher said he would call his mother again later that day or the next day. This was the last phone call he made before he died.

132. At 6.01pm, Mr Crosher was locked into his cell for the night. At about 7.00pm, a PCO and an OSO started their night shift on Houseblock 1. In total there were seven prisoners on the houseblock subject to ACCT procedures including Mr Crosher, the prisoner next door but one to him and two prisoners in cells on the landing above him.

133. The investigator watched the CCTV from 9.00pm that evening. Mr Crosher's ACCT checks were completed by the PCO or the OSO. Between them they completed at least two checks every hour except for the period between 11.00pm and midnight when a second check was not completed. Between midnight and 6.00am, they checked Mr Crosher three times every hour. The recorded times on the ACCT document do not accord with the actual time the checks were made. The PCO told

the investigator that the ACCT documents are kept in the houseblock office situated in a central point with the different wings radiating from it known as the 'bubble'. His practice was to make the checks and then complete the different records when he returned to the office. The times of the checks were therefore estimated.

134. The PCO said that Mr Crosher moved around his cell a lot during the night. He said his cell light was on, his TV was on and his observation panel was open which meant it was easy to see him as he passed his cell.

135. CCTV showed that Mr Crosher pressed his cell bell at 2.25am on 11 October and the PCO answered it within a minute at 2.26am. Mr Crosher asked to see a nurse. The PCO said he asked Mr Crosher why he needed a nurse. He said Mr Crosher became agitated, he would not explain what his issue was and asked again to see a nurse. The PCO said prisoners were often unwilling to say exactly what they wanted because it was quiet at night and other prisoners might hear them. He explained that there were no nurses on duty at night and Mr Crosher appeared to accept this and seemed calmer, although low in mood. The PCO said he reminded Mr Crosher he could contact The Samaritans on his cell telephone because it was the only option available to him until morning. He said Mr Crosher did not give him any further cause for concern that night. CCTV showed the PCO last checked Mr Crosher at 5.34am, although he did not record this on the ACCT record.

136. At 5.58am, the OSO completed Mr Crosher's ACCT check. In a written statement she noted that Mr Crosher appeared to be in bed asleep and his observation panel was uncovered. The OSO completed the ACCT document to say that she had checked Mr Crosher at 6.00am and 6.10am. CCTV showed neither the OSO nor the PCO checked Mr Crosher at 6.10am. At 6.16am, the OSO checked the prisoner next door to Mr Crosher but did not check Mr Crosher.

137. Two PCOs took over from night staff on Houseblock 1. They both said they were told that all the required ACCT checks had been completed for the period 6.00am - 7.00am. (This was not correct as no one had checked Mr Crosher since 5.58am.) Together they completed a routine check of every prisoner on the houseblock (known as the early morning roll count). CCTV showed that one PCO got to Mr Crosher's cell at 6.47am and looked through the observation panel before closing the flap and moving to the next cell. The PCO said that he could not remember what Mr Crosher was doing when he checked him during roll count.

138. At 7.02am, the PCO returned to Mr Crosher's cell to complete an ACCT check. CCTV showed the PCO opened the observation panel, then knocked on the door and tried to see into the cell via the cracks at each side of the door. At 7.03am, he left the cell and checked the cell next door before moving out of picture. The PCO said Mr Crosher's observation panel was covered so he knocked on the door and turned the cell light on and off. He decided to check the three other B Wing prisoners on ACCTs and then went to the houseblock office and told the other PCO that he could not get a response from Mr Crosher and his observation panel was covered. He told the investigator that on finding an unresponsive prisoner with a blocked observation panel procedure was to call for assistance to enter the cell. He did not know why he did not call for assistance immediately but remembered thinking that the other B Wing prisoners on ACCT needed to be checked.

Emergency response

139. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio communications from 13 October. She also obtained information from the East Midlands Ambulance Service. The following account has been taken from these sources and staff interviews and statements.

140. At 7.05am, the PCO returned to Mr Crosher's cell with the other PCO on duty. One PCO said she took the key for the inundation bung with her as it was her practice to remove the bung to observe unresponsive prisoners before calling for assistance. She knocked on Mr Crosher's door and then used the key to remove the inundation bung in the cell door. She looked through the inundation point and saw Mr Crosher standing looking at her in an odd way so she asked the other PCO to look as well. He said he realised something was wrong and radioed a code blue emergency to signify a prisoner in breathing difficulty. The control room called 999 immediately and an ambulance was dispatched with the highest priority.

141. One PCO opened Mr Crosher's door at 7.06am and he and the other PCO went in. He said Mr Crosher was suspended from the frame of his toilet door by a sheet. He used his anti-ligature knife to cut the ligature, laid Mr Crosher on the floor and started cardio-pulmonary resuscitation (CPR). The other PCO said Mr Crosher let out a groaning sound as the PCO cut him down and had foam coming from his mouth. Mr Crosher had used more material to tie his hands to the toilet. She said Mr Crosher fell heavily to the floor but she did not remember seeing any blood in his cell when she first went in. The other PCO said he remembered that Mr Crosher had blood on his chest when he did CPR but he could not remember where this had come from. He did not think Mr Crosher hit his head as he cut him down.

142. Another PCO arrived within seconds and left immediately returning at 7.07am with a defibrillator. One PCO attached the defibrillator as another PCO continued CPR. The defibrillator advised to continue with CPR and two other PCOs took over.

143. At 7.11am, a COM arrived with the green emergency bag followed at 7.12am by two nurses. One nurse said she and the other nurse had only just arrived at the prison for the start of their shift and were still in the gate when they heard the radio call for healthcare staff. She said when she arrived staff were giving Mr Crosher CPR and the defibrillator had been attached to him. Mr Crosher showed no signs of life but was warm to the touch. There was some stiffness in Mr Crosher's jaw but she inserted an airway and gave Mr Crosher oxygen. The defibrillator advised no shock. She noticed that Mr Crosher had tied material around his ankles.

144. At 7.30am, the Helicopter Emergency Medical Service (HEMS) arrived and asked staff to move Mr Crosher to the landing outside his cell. BWVC footage showed that he had bled from his nose. The emergency services took over CPR. They gave Mr Crosher adrenaline and fluids and attached a Lucas machine (a mechanical chest compression machine). At 7.41am, they confirmed that Mr Crosher had died.

145. The staff member with oversight of the safer custody department told the investigator that after Mr Crosher died safer custody staff listened to the safer custody line voicemail and that Mr Crosher had left no messages.

Information received after Mr Crosher's death

146. On 11 October, a prisoner asked a member of staff who had "done" Mr Crosher and asked whether he had been stabbed. He said that other prisoners had been "after" Mr Crosher and that it was "down to Spice". He would not say who the other prisoners were.

147. We received an anonymous letter from a prisoner naming another prisoner on A Wing. The anonymous source said that this prisoner had bullied Mr Crosher physically and mentally and referred to him as a "lackey", "joey", "bitch" and "minion". We passed this information on to the prison.

Contact with Mr Crosher's family

148. The prison appointed two family liaison officers immediately after it was confirmed that Mr Crosher had died. Mr Crosher did not give a next of kin on arrival at Lowdham Grange so they listened to his most recent prison telephone calls and identified his mother from his contact list. At 8.30am, the family liaison officers left the prison to drive to Mr Crosher's mother's address. On arrival, they discovered that Mr Crosher's mother had moved and the new occupants of the house did not know her current address. They rang Mr Crosher's mother and arranged to meet her at her new address where they broke the news of his death in person and offered their condolences. The prison offered a financial contribution to Mr Crosher's funeral in line with national guidance.

Support for prisoners and staff

149. After Mr Crosher's death, the Deputy Director 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. One member of staff interviewed said she had not received a satisfactory level of support after Mr Crosher's death.

150. 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 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.

151. The prison posted notices informing other prisoners of Mr Crosher'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 Crosher'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

152. The pathologist concluded Mr Crosher's cause of death was hanging. They also found that synthetic cannabinoid and cannabis use had contributed to but not caused Mr Crosher's death as he tested positive for these drugs.

Coroner's Inquest

153. The Coroner's inquest concluded on 28 November 2025. The inquest concluded that the medical cause of Mr Crosher's death was ligature compression of the neck. The verdict was suicide contributed to by neglect. The jury gave a narrative verdict.

Findings

Staff shortages and risk management

154. 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 and this might have exacerbated the loss of staff.

155. Throughout the period Mr Crosher 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. There was often not enough staff to bring prisoners to healthcare appointments and not enough rooms in healthcare to see prisoners in confidential settings. Substance misuse support workers and education staff were told by their employers not to go on the wings at all. In October, the 'red regime' was introduced because weekend staff numbers were so low that prisoners had to be left locked in their cells.

156. These circumstances impacted the ability of staff to identify and support prisoners at risk. If the prison was not deemed safe enough for healthcare staff and drug workers to go on the wings it was certainly not safe for vulnerable men like Mr Crosher, with a long history of using illicit substances in prison, getting into debt and coming under threat. The lack of staff and support services had a significant impact on his care including:

- Mr Crosher only had a single keywork session at Lowdham Grange in July.
- Mr Crosher received very limited psychosocial support from his allocated substance misuse worker and almost no 1:1 contact.
- Prison telephone support services that he was advised to use if he felt he needed help were not operating as they should and there is no evidence of any response to his voicemails.
- No one answered the main switchboard number when Mr Crosher's parents rang the prison on 7 October.

157. Additionally, we know from our investigation into a self-inflicted death in March 2023, that a debt strategy, introduced in June 2023, was not embedded and the Safety Intervention Meeting (SIM) was underdeveloped and poorly used. The shortage of wing managers reduced violence reduction care planning (the challenge, support and intervention plan process known as CSIP). Mr Crosher's profile (self-harmer, debtor, substance misuser, assault victim, under threat) meant that he should have been identified as at risk to himself and from others and meant he should have been discussed at the SIM and received specialised support.

158. Our own research over the years has shown there are strong links between bullying and violence and self-inflicted deaths of prisoners of all ages. National guidance for prisons on violence reduction is contained in PSI 64/2011. This contains a commitment to zero tolerance of violence in all prisons and affirms a commitment to the support and protection of victims. There is no evidence Mr Crosher received any meaningful support or protection from violence.

159. While the circumstances in which the prison was operating provide important context, this does not diminish the fact that the level of care and support Mr Crosher received at Lowdham Grange was unacceptably low. Some basic actions were not taken that might have made a difference, including:

- Intelligence reports were not submitted consistently by staff who noticed his injuries in August and September and, damningly, not at all by wing staff.
- The intelligence reports that were submitted were badly processed and did not take into account Mr Crosher's long history of being under threat from his peers.
- None of the intelligence concerning the assaults was passed to safer custody.
- There were a number of failings in ACCT procedures, most seriously the lack of a review in response to the cell fire which should have been regarded as an escalation of risk and proper consideration of the appropriate frequency of checks and removing Mr Crosher to either a safer cell or to a different houseblock. Other issues included: healthcare staff not attending reviews, checks were sometimes chaotic, poor completion of the ACCT document at times, insufficient management assurance checks and staff being asked to do case reviews with little notice.

160. 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.

161. At the time of writing, in August 2024, the current Head of Safety said he had a team of two custodial managers, three officers and an analyst and was recruiting second analyst. This helped ensure messages on the safer custody telephone line were picked up and acted on. The SIM was running regularly. The team looked at the prison daily briefing sheet for reports of prisoners with evidence of assault in case they had not been informed by wing officers or the security department. Regular keywork had restarted for prisoners identified as being vulnerable. The prison had trained 14 Listeners but the scheme had not yet been launched. The addition of extra HMPPS staff from December meant there was a regular regime and therefore the Prisoner Advice Line ran more consistently. Mental health nurses are made available for ACCT reviews to be booked in advance.

162. We note that despite these early signs of improvement, safer custody staff are still not ring fenced from cross deployment to fill shortages of wing staff and the debt

strategy is due for review and is still not embedded. We make the following recommendation:

The Governor should introduce a standalone comprehensive debt strategy which is communicated to and understood by all staff, including providing appropriate support and intervention to prisoners where there are any concerns about debt.

Blocked observation panels and entering cells

163. In February 2018, HMPPS issued a Safety Bulletin on observation panels. This said that if a prisoner does not comply with instructions to remove a blockage, staff must take immediate action to remove the obstruction and check the prisoner's welfare. In line with Prison Service Instruction (PSI) 24/2011, *Management and security of prisons at night*, at the time Mr Crosher died Lowdham Grange had a local policy on night duties, issued in February 2023. This instructs staff who find a covered observation panel and an unresponsive prisoner, to radio the communications room and ask the night orderly officer (the officer in charge) to attend.

164. On 13 April 2023, the then Director issued a notice to staff on unresponsive prisoners. This instructed that staff faced with an unresponsive prisoner or a covered observation panel and a prisoner not responding, must stay at the cell door, radio a code blue emergency and make a dynamic risk assessment of whether it is safe to enter the cell. The notice said staff should enter the cell without waiting for colleagues unless there is a risk to personal safety.

165. On 1 June 2023, the Director issued an information bulletin on how to deal with covered observation panels and items hindering visibility into cells. This too instructed staff that if a prisoner who had covered his observation panel did not respond then they should enter the cell if it was safe to do so and remove the obstruction. In night state, unless it was an emergency, two staff should be present before the cell is entered and the night orderly officer must be informed.

166. On 13 February 2024, the Governor issued a Governor's Order instructing staff to adopt a zero tolerance approach to any covered observation panel whatever time of day or night they discovered one. For prisoner's subject to ACCT monitoring, staff were instructed to raise the alarm and enter the cell unless they judged it unsafe to do so, in which case they should wait for assistance.

167. Removing the inundation bung to see into a cell with a covered observation panel and an unresponsive prisoner has never formed part of policy or guidance to staff at Lowdham Grange under Serco or Sodexo. In our investigation into the self-inflicted death of a prisoner there in October 2018, staff delayed entering the cell of a prisoner being monitored on ACCT procedures to remove the inundation bung to see past an obstruction. In March 2023, staff delayed entering the cell of a prisoner on welfare observations after being found under the influence of PS to remove the inundation bung to see past an obstruction.

168. The PCO should have immediately radioed for assistance when he discovered Mr Crosher had blocked his observation panel and did not respond to him. Given his lack of knowledge of Mr Crosher we consider it was reasonable for him to decide

not to open and enter the cell alone. We accept he was concerned to check the other B wing prisoners on ACCT but urgently summoning other staff in line with the local guidance in place at the time would also have allowed this to be done in a timely way. The combination of this and the other PCO on duty opening the inundation point first, meant there was an unnecessary delay in entering Mr Crosher's cell of four minutes. We cannot say whether this affected the outcome for Mr Crosher but in cases of hanging, urgent intervention is crucial to survival.

169. Despite the guidance issued to staff in April and June 2023, it is clear from this investigation that there remained a culture among staff of removing the inundation bung instead of following local procedures at the time of Mr Crosher's death. In January 2024, we recommended that the prison should evidence how they will monitor the challenging of blocked observation panels to ensure compliance with local processes. We acknowledge the further guidance issued to staff in February 2024. However, at the time of writing we have not received HMPPS' response to our previous recommendation. Until we receive this we remain concerned that this issue has not been robustly or adequately addressed. Therefore, given this and the change in management of the prison, we repeat our previous recommendation:

The Governor should evidence how the prison will monitor the challenging of blocked observation panels to ensure compliance with local processes.

Drug strategy

170. In our investigation into the self-inflicted death of a prisoner at Lowdham Grange in March 2023, we were concerned that he was able to access PS with apparent ease, had got into debt and was under threat from his peers. We remain concerned about the easy availability of illicit substances at the prison. In our previous investigation, we spoke to the then Head of Drug Strategy under Sodexo who told us that he had developed a drug reduction action plan but some key elements such as searching and testing were underdeveloped due to staff shortages.

171. In May 2024, the investigator spoke to the Head of Regime Services who was given responsibility for drug strategy following the HMPPS step in. He told us that mandatory testing had recently begun and suspicion testing was due to start imminently. Positive drug tests had reduced from 54% in December 2023 to 34% in February 2024 and he anticipated further reductions. Searching had increased and the influx of extra staff from HMPSS meant that they were able to respond more quickly to intelligence received. Substance misuse groupwork had just resumed.

172. A diagnostic support visit from HMPPS Substance Misuse Group due in May 2024 had been postponed due to the need for them to divert to a prison where a high number of drug related deaths had occurred in a very short space of time. This was now due to take place in September 2024. Given the comprehensive nature of diagnostic support visits which produce a detailed analysis of the individual prison's substance misuse issues and an action plan of necessary actions, we make no recommendation.

Recording of prisoner calls to the safer custody telephone line

173. All calls made on the prisoner telephone system are recorded by default. Exceptions to this are listed in Annex B of the Authorised Communications Controls and Interception Policy Framework and include calls to the prisoner's legal adviser and organisations with confidential access, such as the PPO, the IMB and The Samaritans. The list rightly does not include calls to internal safer custody lines run by individual prisons. However, Mr Crosher's calls to the safer custody line were not recorded. We do not consider that such lines have or should have the same status as independent organisations and the prisoner's legal representative. Furthermore, when needed, reviewing such calls might provide valuable evidence about a prisoner's risks.

174. While we were told that calls to the safer custody line were logged, the prison was unable to supply the investigator with a copy of the log. Self-evidently, maintaining a log of calls allows for identification of repeat callers, repeat issues and serious concerns. We therefore recommend that:

The Governor should ensure that prisoner telephone calls to the safer custody line are recorded and monitored in the same way as calls to anyone other than those organisations contained in Annex B of the Authorised Communications Controls and Interception Policy Framework.

Clinical care

175. The clinical reviewer concluded it was difficult to draw parallels with community-based care, due to the unique circumstances at Lowdham Grange when Mr Crosher died. This led to significant restrictions on healthcare staff's input and ability to provide clinical care. The clinical reviewer concluded that the healthcare received by Mr Crosher was partially equivalent to that he should have expected to receive in the community. They found that information sharing between healthcare staff and prison staff was poor, record keeping was variable and no healthcare staff attended Mr Crosher's ACCT reviews.

176. The clinical reviewer noted that there should be robust safeguarding processes at Lowdham Grange to keep prisoners safe and protect them from abuse and neglect. She said that when prisoners tell healthcare staff they have been assaulted, staff should record this in the clinical record and ensure that a referral is made to the safeguarding link in the prison and Nottingham Healthcare NHS Foundation. There is no evidence that this took place for Mr Crosher. The Head of Healthcare will want to ensure that these safeguarding processes are embedded, understood by all staff and routinely followed.

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