

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dylan Rose, a prisoner at HMP Hindley, on 6 June 2025

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO



WHAT WE VALUE



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

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

Mr Dylan Rose was found hanged in his cell on 6 June 2025 at HMP Hindley. He was 29 years old. I offer my condolences to Mr Rose's family and friends.

Mr Rose had a history of suicide attempts and self-harm and struggled to manage his emotions. While in prison, he was sometimes assessed as a risk to himself and the investigation found that he was appropriately supported during these times. I am satisfied that staff had no reason to consider him as at imminent risk of suicide when he died.

There was some evidence to suggest that Mr Rose was being bullied and/or in debt, but we have been unable to corroborate this. The investigation found that staff acted reasonably in responding to the information that was available to them.

The clinical reviewer concluded that the healthcare Mr Rose received at Hindley was of a good standard and equivalent to that which he could have expected to receive in the community.

During telephone calls to family on 5 and early on 6 June, Mr Rose said he had attempted to hang himself and insinuated that he would try again. Staff were unaware of this at the time as they were not required to monitor his calls.

I make no recommendations.

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

February 2026

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Summary

Events

1. On 27 June 2023, Mr Dylan Rose was sentenced to 32 months imprisonment for offences of stalking, criminal damage and common assault against a former partner. He had been in prison since February, serving a sentence for another offence. This was not Mr Rose's first time in custody having first been in prison in 2013.
2. Mr Rose was diagnosed with attention deficit hyperactivity disorder (ADHD), but he had not taken medication since 2019. Records note that he struggled with managing his mental health and anger. Mr Rose had a history of attempted suicide and started self-harming in 2004.
3. On 18 September 2024, Mr Rose was released from prison on licence. He was recalled to prison on 7 February 2025 for not complying with his licence conditions. On 14 March, Mr Rose transferred to HMP Hindley which he said he was happy about.
4. Between 7 February and 6 June, Mr Rose was managed under Prison Service suicide and self-harm monitoring procedures, known as ACCT, three times, after he had suicidal thoughts or self-harmed.
5. On 30 April, Mr Rose had a cut to his head and was seen holding his ribs. He told an officer that he had fallen up the stairs. Staff were concerned he may have been assaulted but there was no evidence to corroborate this. On 3 June, Mr Rose was suspected of being in a fight with another prisoner. He told an officer that he had fallen over in the shower. Staff completed a CSIP (challenge, support and intervention plan) referral.
6. On 6 June, Mr Rose made several calls to his partner between 5.52am and 6.40am. He told his partner that he had made a ligature and tried to hang himself. The prison was unaware of this as they were not monitoring Mr Rose's calls.
7. At 7.48am, an officer went to Mr Rose's cell to unlock it. His observation panel was blocked so the officer opened the door. Mr Rose was slumped against the wall at the back of the cell and had tied a bed sheet around his neck secured to the window bars. The officer radioed an emergency code and control room staff immediately called an ambulance. Prison and healthcare staff responded quickly and began cardio-pulmonary resuscitation (CPR). Paramedics arrived at Mr Rose's cell at 8.00am and continued CPR.
8. At 8.35am, paramedics pronounced Mr Rose's life extinct.
9. After Mr Rose's death, his partner told the investigator that he had asked for money from her and for her to pay money into the bank account of another prisoner. We also found a note entitled "vapes owed" in his cell with a list of vapes and the money owed.

Findings

10. Mr Rose's had several risk factors for suicide and self-harm: his previous suicide attempts and self-harm, committing a violent offence against a partner and being a recalled prisoner.
11. Mr Rose's risk to himself was appropriately managed at Hindley. The ACCTs were appropriately closed and all reviews were multidisciplinary. We have concluded that there was no obvious sign to prison staff that Mr Rose was at an imminent risk of suicide in the time before he died.
12. There was some evidence to suggest that Mr Rose was in debt and/or possibly being bullied. Overall, we are satisfied that prison and healthcare staff are aware of appropriate steps to take if they have concerns about violence and vulnerability.
13. The clinical reviewer found that the clinical care that Mr Rose received at Hindley was equivalent to that which he could have expected to receive in the community.
14. We make no recommendations.

The Investigation Process

15. HMPPS notified us of Mr Rose's death on 6 June 2025.
16. The investigator issued notices to staff and prisoners at HMP Hindley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
17. The investigator visited Hindley on 6 August. She obtained copies of relevant extracts from Mr Rose's prison and medical records, CCTV and body-worn video camera (BWVC) footage.
18. The investigator interviewed two members of staff and one prisoner via Microsoft Teams in July. She interviewed a further six members of staff in August at Hindley and in October met the Head of Safety on Microsoft Teams.
19. NHS England commissioned a clinical reviewer to review Mr Rose's clinical care at the prison. The clinical reviewer conducted all interviews with the investigator.
20. We informed HM Coroner for Greater Manchester of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
21. The Ombudsman's office contacted Mr Rose's parents to explain the investigation and to ask if they had any matters that they wanted us to consider. Mr Rose's father asked why Mr Rose had been placed in a single cell that had ligature points when he was known to be suicidal. We have addressed this issue in this report.
22. We shared the initial report with Mr Rose's parents. The solicitor representing Mr Rose's parents wrote to us pointing out some factual inaccuracies. We have amended this report accordingly. Mr Rose's parents also raised a number of questions that do not impact on the factual accuracy of this report and which we have addressed through separate correspondence.
23. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Hindley

24. HMP Hindley is a category C training and resettlement adult male prison near Wigan. It takes prisoners over the age of 18, around a third of whom are under the age of 25. With approximately 60 new arrivals a month, the prison manages a considerable turnover of prisoners. The population also includes a substantial number of prisoners on licence recall.
25. Primary healthcare is provided by Spectrum, mental health services are provided by Greater Manchester Mental Health NHS Foundation Trust and substance misuse services are provided by Change, Grow, Live (CGL).

HM Inspectorate of Prisons (HMIP)

26. The most recent inspection of Hindley was in 2023. Inspectors reported that leaders were committed and working hard to improve the prison. However, the environment was run down, the regime was poor, and the prevalence of drugs was at the heart of much that undermined safety for prisoners. The prison was not safe enough. Mandatory drug testing revealed that over half of the prison population were active drug users and there were high levels of recorded violence and high numbers of self-harm. Staff turnover was high and there was a high proportion of inexperienced staff because of this.
27. HMIP carried out an independent review of progress in August 2024. Inspectors found reasonable progress in some areas but still had some concerns. While there had been some investment to improve the infrastructure, many prisoners continued to live in overcrowded areas. Violence had reduced during the previous six months compared with the same period before the inspection. However, the ingress of illicit items remained a significant concern. Mandatory drug test data indicated that the positive test rate was higher than previously and was the highest of all prisons in England and Wales.
28. Inspectors found that there had been a concerning increase in reported incidents of self-harm. Some of this increase was due to a small number of prolific self-harmers who received good support. Although staff retention remained challenging, staff had grown in confidence.

Independent Monitoring Board

29. 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 December 2024, the IMB reported that it was increasingly concerned about the rising levels of violence affecting both prisoners and staff at Hindley. The IMB reported that drugs continued to be readily available in the prison and noted that positive results from random mandatory drug tests were one of the highest of all adult male prisons in England and Wales. They remained concerned about the lack of security and searching at the main gate.

30. The IMB reported that rates of self-harm continued to be a concern. The national problem of prison overcrowding was also impacting Hindley, who were continuously operating at full or near capacity. Overall, the IMB reported that prisoners are treated with fairness and humanity.

Previous deaths at HMP Hindley

31. Mr Rose was the third prisoner to die at Hindley since June 2022. Of the previous deaths, one was due to natural causes and the other cause of death had not yet been ascertained. Since the death of Mr Rose and up until the end of October 2025, there had been no further deaths at Hindley.

Assessment, Care in Custody and Teamwork (ACCT)

32. 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.
33. 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, the closure has been discussed with the prisoner and a post closure review date has been set. 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. In November 2024, a revised Prison Safety Policy Framework was issued outlining the ACCT process, this was fully implemented on 1 January 2025.

Key work scheme

34. The key work 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 issued in 2018.
35. In recent years, 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.

Key Events

36. Mr Dylan Rose was diagnosed with attention deficit hyperactivity disorder (ADHD – symptoms can include inattention, hyperactivity and impulsivity). However, he had not taken medication since 2019. Probation records note that he struggled with managing his mental health and anger. Mr Rose had a history of attempted suicide and started self-harming in 2004. He had been in prison several times since 2013 and was regularly managed under suicide and self-harm monitoring procedures, known as ACCT.
37. Mr Rose was sentenced on 27 June 2023, to 32 months imprisonment for offences of stalking, criminal damage and common assault against his former partner. Mr Rose had been in prison since February 2023, serving another sentence and being concurrently held on remand.
38. Between February 2023 and September 2024, prison staff opened ACCTs for Mr Rose five times as they were concerned he was a risk to himself.
39. Intelligence reports from 2024 indicate that Mr Rose was suspected of brewing fermented liquid (hooch), supplying drugs, being involved in the illicit economy and, at times, bullying and threatening others.
40. On 18 September, Mr Rose was released on licence. On 7 February 2025, he was recalled to prison for not complying with his licence conditions and taken to HMP Altcourse. Mr Rose asked for vulnerable prisoner (VP – those considered to be at risk from other prisoners) status. This meant he would only mix with other vulnerable prisoners and would be kept separate from the rest of the prison population. It is not recorded why he asked for this or on what grounds it was granted.
41. On 4 March, Mr Rose transferred to HMP Liverpool. He requested VP status again, the reason for this is not known. His request was declined as Mr Rose had not been convicted of sexual offences. Mr Rose chose to isolate (not engage with the prison regime) and said he would only engage with the regime in a prison outside of Merseyside. He continued to isolate until 10 March, when staff moved him to a different wing.
42. On 10 March, staff opened an ACCT after Mr Rose swallowed bleach tablets. Staff took him to hospital as a precaution, and he was discharged the same day.
43. On 11 March, Supervising Officer (SO) A completed Mr Rose's ACCT review. He asked him why he had swallowed bleach tablets. Mr Rose said he sometimes "gets like that", that his head was "gone", and he was being impulsive, but he wanted to live. He said he had received bad news about his partner having a miscarriage. However, he said he was going to be transferred to HMP Hindley which he was pleased about as it was closer to his partner. SO A set checks at hourly with two conversations a day. Mr Rose said this was appropriate for him as he did not like being checked on by staff and it would end up making his mental health worse.
44. SO B closed Mr Rose's ACCT on 14 March. Mr Rose said he had no thoughts of suicide and self-harm, and he was in a good place mentally.

HMP Hindley 14 March – 6 June 2025

45. Mr Rose transferred to Hindley on 14 March. During his reception screening, Mr Rose told staff he was not vulnerable or at risk from other prisoners. No other concerns were noted. Mr Rose told staff he smoked cannabis in the community and had done in prison before, but he did not want to be referred to the substance misuse team. Staff moved Mr Rose to the induction wing and placed him in a single cell.
46. The same day Nurse A completed a healthcare screening. Mr Rose told her that taking bleach tablets a few days earlier had not been a suicide attempt but was a way to get transferred from Liverpool. The following day, Nurse B completed a secondary healthcare screening and noted no concerns. Nurse B referred Mr Rose to the mental health team for a review due to his ADHD diagnosis.
47. On 17 March, staff moved Mr Rose to single cell on Alpha wing as his cell sharing risk assessment (CSRA) rating was high. (CSRA provides a risk assessment for cell sharing by assessing the risk posed by a prisoner to another in a locked cell.) Mr Rose had markers on the system for violent, racist and homophobic behaviour as well as a history of setting his cell on fire.
48. On 7 April, two prisoners used their cell bells to notify staff that Mr Rose was going to kill himself. Operational Support Grade (OSG) A attended and radioed SO B as Mr Rose had blocked his observation panel. SO B opened an ACCT after entering Mr Rose's cell and speaking with him. Mr Rose had made a ligature and stabbed himself in the hand which had caused a minor cut. A Listener (prisoners trained by Samaritans to provide emotional and confidential support to their peers) spoke with Mr Rose and he appeared to calm down. SO B placed him on four checks per hour overnight.
49. SO C, Mr Rose's ACCT case coordinator, completed the ACCT review the next day. A nurse from the mental health team attended the review, as well as chaplaincy staff. During the review, Mr Rose said he had felt overwhelmed with a few issues, notably a meeting with probation staff being cancelled and arguments with his partner. Mr Rose said he believed a period of no contact with his partner would benefit him as well as being employed. SO C agreed to support him with accessing work and completed a mental health referral. Staff set Mr Rose's ACCT checks at one per hour and two daily conversations.
50. On 9 April, healthcare staff referred Mr Rose to the learning disability nurse for a review of his ADHD. He did not have an appointment with the nurse before he died.
51. On 10 April, staff found a Zanco (small) mobile phone and items suggestive of brewing fermented liquid (known as hooch) in Mr Rose's cell. He received a disciplinary warning.
52. On 15 April, SO C chaired Mr Rose's ACCT review. Mr Rose said he was in a much better place and had been limiting contact with his partner. He was due to start work in the workshop and had been attending the gym. Mr Rose had been referred for anxiety and dysregulation support by the mental health team. SO C

said he was satisfied that Mr Rose's support actions had been completed. Staff present agreed to close the ACCT.

53. In interview, SO C said Mr Rose did not appear vulnerable on the wing and any vulnerability was linked to his personal relationships. He described Mr Rose as "one of the boys" and said that although he had seen him with a black eye on one occasion, he did not believe Mr Rose was being bullied.
54. Ms A, psychological wellbeing practitioner, saw Mr Rose on 24 April for his anxiety and dysregulation support assessment. Mr Rose told her he had no thoughts of suicide or self-harm and believed his main issues were understanding and managing his anger. Mr Rose highlighted outside stressors such as not being able to see his son and his relationship with his partner. He admitted that he reacted with anger and did not know how to control his outbursts. Mr Rose said he had support on the wing through peers and prison officers. Ms A added Mr Rose to the conflict resolution course waiting list.
55. The same day, staff searched Mr Rose's cell, following prison intelligence that he was in possession of a mobile phone and using it to harass and threaten someone in the community. The intelligence came from an anonymous telephone call made to the prison and suggested that Mr Rose was contacting a former partner. Staff found a mobile phone charger. Mr Rose received a disciplinary warning.
56. On 30 April, Officer A noticed Mr Rose had a cut to his head, and he was holding his ribs. Officer A spoke to Mr Rose who said he had fallen up the stairs during afternoon association. In interview, Officer A said that he was dubious of this account because he could not understand how Mr Rose had managed to injure his ribs. Officer A said he asked staff, but nobody saw anything, and other prisoners confirmed Mr Rose's version of events. Officer A said he did not think Mr Rose was at risk from other prisoners. He said he got on with a lot of people, socialised with other prisoners and seemed to be well liked.
57. Officer A referred Mr Rose to healthcare staff, who offered paracetamol and ibuprofen for the pain. Mr Rose declined. The GP saw Mr Rose later, and prescribed naproxen for the pain and lansoprazole to minimise the stomach problems caused from naproxen. The investigator spoke to the healthcare worker who initially saw Mr Rose but he was unable to recall details of assessing him.
58. Officer A submitted an intelligence report following the alleged fall. The security analyst read this and suggested security staff should watch CCTV to confirm Mr Rose's version of events. This was never done. Details of the intelligence report were emailed to the safer custody team for the incident to be investigated further. This did not happen. Ms B, Head of Safety, told the investigator that a request may have been made to the team, however, due to staffing issues across the prison the safer custody team were often deployed to other areas. Ms B explained that the alleged fall may not have been prioritised given that Mr Rose had already been spoken to about it, other prisoners had confirmed he fell, and no staff witnessed it.
59. On 17 May, Mr Rose spoke with Officer A while he was in the queue for the medication hatch. He told him he had an adjudication hearing for covering the

cameras in the servery and for a weapon being found in there. Officer A told the investigator that Mr Rose said he covered them as he planned to take his own life by hanging himself in there. Mr Rose told Officer A that he was having issues with his son, and his partner had been diagnosed with cancer. Officer A told the investigator that he spent some time with Mr Rose that morning and advised him to tell the senior manager holding the adjudication hearing.

60. Officer A opened an ACCT. Mr Rose's ACCT review took place later that day. He told staff that he was sick of being in prison and was struggling with family ties. He said he was settled on Alpha wing, he had no thoughts of suicide or self-harm and would speak with prison staff if in a crisis. SO D set Mr Rose's checks at one per hour and one conversation daily.
61. On 24 May, SO E chaired Mr Rose's next ACCT review with Mental Health Nurse C and Mr Rose. SO E told us that Mr Rose appeared settled and spoke of the future. Mr Rose said he had no thoughts of suicide and self-harm and was in a good place. Nurse C told the investigator that she had no concerns around Mr Rose being a risk to himself. She said Mr Rose came across as "jovial" and talked about good relationships with staff and a family member on the wing who he found supportive (it remains unclear if this family member were a direct relation to Mr Rose). Staff agreed to close Mr Rose's ACCT.
62. Officer B carried out Mr Rose's first and only key work session on 29 May. Mr Rose raised no issues. He said he was feeling good and would speak to staff if he needed anything.
63. On 2 June, staff submitted an intelligence report that Mr Rose had sent a letter to an unknown member of the public to discuss cell searches, how he was going to 'nail' a prisoner who had been recalled, and another prisoner who owed him money. There is no evidence that staff spoke to Mr Rose about this or took any further action.
64. On 3 June, Officer C noticed prisoners crowded around on the fourth landing, so he went to investigate. He saw Mr Rose with scratches on his face and his glasses were missing. Another prisoner also had marks on his face. In interview, Officer C said he assumed the two prisoners had been fighting so he locked them both in their cells. Mr Rose told Officer C he had fallen in the shower and lost his glasses.
65. In interview, Officer C said he was unaware of any issues between Mr Rose and the other prisoner. He told the investigator that Mr Rose seemed to get on well with the other prisoners on the wing and that he did not appear vulnerable or targeted by others.
66. Officer C submitted a CSIP (challenge, support and intervention plan – used for those who are a potential risk to others) referral for both prisoners after the alleged fight. Mr Rose's referral progressed to an investigation, but this had not taken place before he died.
67. Nurse D reviewed Mr Rose after the incident. Nurse D noted scratches above his right eye, bruising to both sides of his mouth, bruising to his left eye and scratches to the right side of his upper chest. Unfortunately, Nurse D was not

available for interview as she had left the Prison Service. However, medical notes indicate that Mr Rose told her that he fell in the shower. He declined healthcare intervention. Staff put Mr Rose on the optician's list for replacement glasses.

68. Prisoner A told the investigator that he spoke to Mr Rose daily. He said he was worried about him because Mr Rose was being bullied by three other prisoners, and he regularly had injuries. Prisoner A said the bullying was linked to a mobile phone that Mr Rose had in his possession and because his partner had contact with other prisoners at Hindley. He told the investigator that he and Mr Rose told wing staff about the bullying, and their response was to advise them to deal with it themselves. There are no records of Mr Rose disclosing bullying to staff or any issues with other prisoners. Prisoner A said he could not remember which member of staff he and Mr Rose had talked to.
69. Prisoner A said Mr Rose was well liked and he got on with staff. He said Mr Rose just wanted to go home and be with his family. Prisoner A said that Mr Rose would pretend to be happy when out on the wing but was more honest when it was just the two of them. Prisoner A said he was not surprised that Mr Rose took his life.

Events of 5 – 6 June

70. The investigator watched CCTV and body worn video camera (BWVC) footage. The clocks on the different sources are not synchronised but are within about one minute of each other. She also obtained information from the North-West Ambulance Service. Unfortunately, we have not been able to access Mr Rose's telephone calls due to a software issue. However, we have taken information about his calls from the prison's internal review. The following account has been taken from these sources, staff statements and interviews.
71. On 5 June at 7.03pm, staff locked Mr Rose in his cell. Mr Rose was allowed out until this time as he was employed.
72. Operational Support Grade (OSG) B completed the evening routine roll check of all prisoners. At 7.16pm, she got to Mr Rose's cell. OSG B told us that she spoke to Mr Rose as his observation panel was blocked. She said he seemed in good spirits, which was unusual because he was often quite down. OSG B said she asked Mr Rose to uncover the panel and he confirmed he would. OSG B did not return to Mr Rose's cell again that evening to check that his observation panel had been unblocked. She told the investigator that this was her usual practice if a panel had been blocked. Staff were not expected to check Mr Rose again during the night and he did not press his emergency cell bell.
73. Between 5.20pm and 11.36pm Mr Rose made 39 calls which was an unusually high number. The majority of these were to his partner and four calls were to unapproved numbers so did not connect. We do not know who he attempted to call.
74. At 8.00pm, Mr Rose called his partner. The call lasted 29 minutes, and the prison's internal review noted that Mr Rose was emotional. He told his partner he was scared of his thoughts, and he had deliberately hurt his hand with a vape. Mr

Rose said he had plans to write to his son and the prison would phone her in the morning. He told her to take care, and that she was better off without him.

75. At 5.25am, OSG B completed the morning roll check. She opened the observation panel and said that as she did this Mr Rose sneezed. OSG B said Mr Rose's curtains were open, meaning he was more visible to her. She said he was lying in bed on his right-hand side, so his legs were visible but not his upper body. He appeared to be asleep.
76. Mr Rose attempted several calls to his partner between 5.52am and 6.40am. The first call that connected was at 6.00am. Mr Rose told his partner that he had made a ligature and tried to hang himself. He also admitted to assaulting a prisoner who his partner had been in contact with. We do not know if this was the same prisoner who Mr Rose had allegedly had a fight with on 3 June.
77. At 6.20am, Mr Rose spoke to his partner again, he asked her to ask his mother to put some money in his account. He said that he wanted to die but also referred to getting out of prison. Mr Rose made a further three calls to his partner in which he was threatening towards her. At 6.40am, Mr Rose made his last call. He ended by saying, "this is because of you". The call then disconnected.
78. At 7.45am, Officers A started unlocking prisoners on the wing. At 7.48am, Officers A got to Mr Rose's cell. He said he opened the observation panel to look through but could not see inside the cell properly because the panel was covered with a small piece of cardboard. Officer A opened the cell door and found Mr Rose slumped against the wall at the back of the cell. He was naked and had tied a bed sheet around his neck and secured it to the window bar. His curtains were closed.
79. Officer A entered the cell, moved items out of the way to get to Mr Rose and radioed a code blue (an emergency code used to indicate when someone is unresponsive or not breathing). Officer A used his anti-ligature knife to cut the ligature from the window and from Mr Rose's neck.
80. Officer D and Officer E arrived to assist. Staff laid Mr Rose on the floor and radioed the control room to confirm that Mr Rose was not breathing. At 7.50am, Officer D began cardio-pulmonary resuscitation (CPR). Officer A placed a towel over Mr Rose to protect his dignity. Officer E then took over CPR from Officer D.
81. Ms C, Head of Healthcare, arrived at 7.51am, and requested officers move Mr Rose into the corridor so that there was more room to work on him. She did not bring the emergency equipment with her as she had been in a nearby office and was not the designated emergency responder. Officer A and Officer D lifted Mr Rose out of the cell. Ms C asked for all prisoners to remain in their cells.
82. Ms C and Officer F continued CPR. More healthcare staff arrived with the emergency bags and a defibrillator. They attached the defibrillator, inserted an airway and administered oxygen.
83. At 7.57am, the ambulance arrived at the prison and paramedics got to Mr Rose's cell at 8.00am. Paramedics and healthcare staff continued CPR. At 8.38am, paramedics pronounced life extinct.

Contact with Mr Rose's family

84. The prison appointed Mr A, managing chaplain, as the family liaison officer. Mr A attended the home address of Mr Rose's parents at 10.00am, with Ms D, deputy family liaison officer, and Mr B, Deputy Governor. They broke the news to Mr Rose's parents and offered their condolences. The prison offered a financial contribution to Mr Rose's funeral in line with national policy.

Support for prisoners and staff

85. 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
86. After Mr Rose's death, a senior manager 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 and all staff interviewed confirmed they had received adequate support.
87. The prison posted notices informing other prisoners of Mr Rose'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 Rose's death. Listeners were deployed to the wing to support prisoners.
88. A prisoner told us he did not receive adequate support after Mr Rose's death. We informed the prison so that he could be offered further support.

Information received after Mr Rose's death

89. After Mr Rose's death, his partner gave some information to the investigator. This included a video taken from Snapchat which showed Mr Rose apologising to another male in prison. It is not known who he was apologising to or why. Mr Rose's partner said she had received several requests for money and provided a text message from Mr Rose (presumably from an illicit mobile phone he had access to) asking her to pay money into a woman's bank account.
90. We found a note in Mr Rose's cell titled, "vapes owed" with a list of names and details of money owed. We do not know if this is what Mr Rose owed or what others owed him. There was also evidence in the text messages provided by Mr Rose's partner of Mr Rose wanting vapes.
91. Mr Rose's partner also provided details of other text messages from Mr Rose that he sent her. The messages were not date and time stamped but referred to Mr Rose having thoughts of suicide and self-harm.

Post-mortem report

92. The pathologist concluded Mr Rose's cause of death was hanging.
93. The toxicology report indicated that Mr Rose had used cannabis at some point before he died. The pathologist concluded that this was unlikely to have contributed to his death.

Findings

Assessment and management of Mr Rose's risk of suicide and self-harm

94. The Prison Safety Framework lists risks factors and potential triggers for suicide and self-harm. It requires all staff to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.
95. Mr Rose had several risk factors for suicide and self-harm including his previous suicide attempts and self-harm incidents, committing a violent offence against a partner and being a recalled prisoner. Between February 2025 and his death in June, staff appropriately opened an ACCT three times because they had concerns that he may take his own life. Staff noted that Mr Rose struggled with managing his emotions and he admitted on several occasions that he was impulsive and would "lose it". This was often followed by a calmer period and Mr Rose acknowledged that he was feeling better with no thoughts of suicide or self-harm. It is clear that his relationship and personal matters impacted on his ability to manage his emotions.
96. We are satisfied that each ACCT opened at Hindley was managed and closed appropriately based on the level of risk at the time. Each review was multidisciplinary. There was nothing to indicate to prison staff that Mr Rose was at an increased or imminent risk of suicide in the period immediately before he died. His actions appeared to follow a night of emotional instability based on the nature of the telephone calls that he had in the hours before his death. The prison was not required to monitor Mr Rose's telephone calls so would not have known this information at the time. We consider that Mr Rose received appropriate support. We make no recommendation.

Bullying and debt

97. Debt in prison is complex and is known to increase the risk of self-harm and violence. Hindley's Debt Policy was reviewed in July 2025, although an earlier version was in place at the time of Mr Rose's death. It says that debt can often be linked to many of the negative behaviours that happen in prison and there can be some signs and symptoms of debt.
98. During our investigation we were provided information from Mr Rose's family to suggest that Mr Rose might have been in debt and was being bullied. We have investigated this and cannot confirm with certainty either way. Mr Rose sought vulnerable prisoner status at Liverpool and Altcourse suggesting he was concerned for his safety. However, he said he felt safe at Hindley and would discuss any issues with members of staff. There is nothing to confirm that Mr Rose shared any concerns with prison staff regarding potential issues with other prisoners.
99. Prisoner A, who was friends with Mr Rose told the investigator that Mr Rose was being bullied. There is some evidence to suggest that Mr Rose was involved in

violence as he appeared with injuries on 30 April and 3 June. We do not know enough about the nature of the incidents to conclude whether Mr Rose was the victim, the perpetrator or both. There are no records of Mr Rose sharing any concerns for his safety at Hindley with staff. On 6 June, Mr Rose disclosed to his partner that he had assaulted a prisoner.

100. Overall, we are satisfied that prison and healthcare staff are aware of the appropriate steps to take should there be concerns around violence and vulnerability. Staff highlighted that they can only act on what they see or what they are told. In the case of Mr Rose, this appeared to be very little. Officer A appropriately submitted an intelligence report in relation to the incident on 30 April, and Officer C appropriately completed a CSIP referral on 3 June. Unfortunately, there was not time to complete this investigation before Mr Rose took his own life.

Cannabis use

101. Mr Rose's toxicology indicated that at some point prior to his death he had taken cannabis. Mr Rose had been offered a referral to the substance misuse team during his reception screening which he declined. Mr Rose never appeared under the influence of drugs to the knowledge of staff and during our investigation there was no evidence to suggest that drugs were an issue for him.
102. Hindley's drug strategy is due to be renewed in January 2026 as part of national guidance. The current strategy says that cannabis is one of the main drugs of use at Hindley and that for prisoners willing to engage there is specialist intervention work carried out by the substance misuse service. A core component of the strategy is to ensure that as many men as possible are provided with opportunities to be involved in work, education and physical activities. However, due to limited space some of the men can only be offered part time work. Another aspect of the strategy focuses on stopping drugs entering the prison. Hindley have introduced a specialist barcode scanner for legal post and it is searched by specialist drug dogs. They are also pursuing obtaining advanced drone detection technology.

Clinical care

103. The clinical reviewer found that the clinical care Mr Rose received was equivalent to that which he could have expected to receive in the community. They noted that the records and interviews reflected respectful and compassionate care towards Mr Rose. The clinical reviewer made no recommendations.

Governor of HMP Liverpool to note

ACCT

104. Mr Rose's first ACCT since being recalled back to prison was opened while he was a prisoner at Liverpool on 10 March and closed on 14 March, the day of his transfer to Hindley. The Prison Safety Framework states that an ACCT should not be closed to facilitate a transfer to another prison or within 72 hours of a planned transfer. The Governor at Liverpool will want to ensure that staff understand this guidance and that this is not a systemic issue.

Governor of HMP Hindley to note

Mercury intelligence reports

105. The intelligence report submitted on 30 April was not investigated properly by security and safer custody. Security staff did not watch the CCTV as advised to by the security analyst. Ms B also told the investigator that it would have been appropriate for the officer submitting the intelligence report to also submit a CSIP referral. She said this might have meant the incident investigation was prioritised. The Governor will want to ensure that staff in safer custody are sufficiently resourced to follow up on any relevant prison intelligence and that security staff review CCTV as required.

Blocked observation panels

106. The Management of Internal Security Procedures Policy Framework, issued in August 2024 and implemented in January 2025, replaced the Prison Service Instruction (PSI) 24/2011, and dictates that when observation panels are covered the night orderly officer (staff member in charge overnight) must be informed and staff deployed to the cell. Hindley also has a local instruction for night procedures issued in March 2025 which reiterates these instructions and says the blockage must be removed.
107. When Mr Rose had blocked his observation panel on the night of the 5 June, the OSG asked him to remove it but left the cell before he had. They also did not inform the night orderly officer. While this had no bearing on Mr Rose's death, the Governor will want to ensure that staff understand their responsibilities when they discover blocked observation panels.

Key working

108. Neurodiversity support manager, Ms D, told the investigator that Hindley have designed a priority key work register due to staff resources which prevent them from offering weekly key work sessions. This went live in March and had an implementation period which ran until the end of April. Staff use several factors to determine a score, and prisoners are placed in groups from A to D, with A taking highest priority. Those who fall in group A should receive a monthly key work session and, if time permits, then staff will move on to those in group B and then group C and D.
109. Mr Rose was not placed in a priority group for March as the register for each month does not include men who are new to the prison that month. In April, he was placed in group C. However, it would have been unlikely that he would have received a key work session due to the order of priority. Mr Rose was moved to group B in May, and he received a keywork session towards the end of the month. Hindley have told us that in June, Mr Rose was moved to group A meaning he was highest priority. Unfortunately, he was not offered a keywork session before he died. The Governor will want to ensure that prisoners are appropriately prioritised for key working and that the prison continues to make efforts to move towards compliance with the key working model.

Inquest

110. The inquest into Mr Rose's death ended on 6 October 2026 and concluded that Mr Rose died as a result of suicide.



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