Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alexander Rodgers, a prisoner at HMP Wymott, on 24 October 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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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 Alexander Rodgers was found hanged in his cell on 24 October 2024, at HMP Wymott. He was 49 years old. I offer my condolences to Mr Rodger's family and friends.

Mr Rodger's was the fifth self-inflicted death at Wymott in the past three years. His death came two days after another self-inflicted death at the prison.

Wymott supported Mr Rodgers via suicide and self-harm prevention measures (known as ACCT) between 27 September and 8 October, when he experienced a drug induced psychosis. While we found evidence that the procedures were generally well managed, events in the post-closure period that might have indicated increased risk were not properly considered.

Toxicology showed that Mr Rodgers had used cocaine in the time before he died, and the deterioration in his mental health was brought on by the use of psychoactive substances. Regrettably, as with other prisons, the trading of illicit substances remains an intractable problem that threatens the stability, safety, and security of Wymott. I am satisfied that the prison is committed to tackling this issue and is making considerable efforts to combat drug supply and demand.

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 **June 2025**

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Summary

Events

1. On 28 April 2020, Mr Alexander Rodgers was remanded to prison for aggravated burglary, and later sentenced to eleven years in prison. On 4 February 2021, he transferred to HMP Wymott.

2. Mr Rodgers had a history of anxiety and depression. During his time in prison, he was well supported by the mental health team and engaged with talking therapies. He also had a significant history of substance misuse and was prescribed methadone in the early part of his sentence. In March 2022, Mr Rodgers successfully completed a detoxification programme and until September 2024, there were no recorded incidents of him being under the influence of drugs.

3. On 27 September 2024, staff began suicide and self-harm prevention procedures (known as ACCT) when Mr Rodgers' mental health significantly deteriorated. He moved to the segregation unit for his own protection, initially under constant supervision, and the prison psychiatrist assessed him. Mr Rodgers admitted using a psychoactive substance (through a tampered vape) and the psychiatrist concluded that Mr Rodgers had experienced a drug induced psychosis. On 2 October, Mr Rodgers returned to his own cell and the following week staff closed the ACCT procedures.

4. In the weeks before he died, Mr Rodger's lost his job in the prison when staff saw him trying to obtain vapes from other prisoners.

5. At around 8.12am on 24 October, an officer unlocked Mr Rodgers' cell and found him hanged. At 8.32am, paramedics pronounced life extinct.

Findings

6. Staff appropriately started ACCT procedures when Mr Rodgers showed acute signs of paranoia and began to isolate. We found evidence that staff provided some good, consistent support including from the mental health and substance misuse teams. However, support actions were not reviewed or updated. No one recognised that Mr Rodgers' behaviour in the period before his death might indicate an ongoing risk of harm (including potentially of suicide and self-harm), particularly given the circumstances of his significant deterioration a few weeks earlier.

7. The implementation of Mr Rodgers' CSIP was poor and some staff had a limited understanding of the local process.

8. The early morning roll check on the night that Mr Rodgers died did not comply with local or national policy.

Recommendations

- The Governor should satisfy himself that robust procedures are in place to assess the quality of CSIP procedures, including identifying and correcting practice that is not in line with the Prison Safety Policy Framework.

- The Governor should amend the Local Security Strategy to ensure that it provides clear instructions to night patrol officers on:

  - How to complete a roll check and the circumstances in which a response from the prisoner should be sought.

  - The action to take if a prisoner has blocked their observation panel or they do not have a clear view of them.

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The Investigation Process

9. HMPPS notified us of Mr Rodgers' death on 24 October 2024.

10. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator visited Wymott on 29 October. She obtained copies of relevant extracts from Mr Rodgers' prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Rodgers' clinical care at the prison.

13. The investigator and the clinical reviewer jointly interviewed 15 members of staff at Wymott in November. In addition, the investigator interviewed three prisoners, a workshop instructor, and a substance misuse worker. On 20 March 2025, the investigator interviewed the operational support grade on duty the night Mr Rodgers died.

14. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's office contacted Mr Rodgers' ex-partner to explain the investigation and to ask if she had any matters she wanted us to consider. She asked the following questions, which we have addressed in the report or the clinical review:

    - Did Mr Rodgers ask for help, was this documented and what help was provided?
    - Did Mr Rodgers show signs of distress or suicidal ideation in the time before his death?
    - Why were the ACCT procedures closed?
    - Did staff shortages impact on Mr Rodgers' care?
    - What support was in place for Mr Rodgers' substance misuse?
    - Was Mr Rodgers' cell searched and was he drug tested?
    - Did Mr Rodgers attend any recovery programme or attend support groups in respect to his substance use?
    - Have other prisoners been interviewed about Mr Rodgers' mental state prior to his death?
    - What measures are in place at Wymott to prevent drug use and self-harm?
    - What action has been taken to address drug trafficking at Wymott?

16. Mr Rodgers' ex-partner received a copy of the initial report. She did not identify any factual inaccuracies.

17. The prison also received a copy of the report. In response to their feedback, we have corrected the name of the healthcare provider.

Background Information

HMP Wymott

18. HMP Wymott is a medium security prison in Lancashire for adult men. Most prisoners are serving sentences of four years or longer. Specialist wings include two psychologically informed planned environment (PIPE) units for prisoners with personality disorders. Healthcare services are provided by Practice Plus Group. There is 24-hour nursing cover.

19. HM Inspectorate of Prisons

20. The most recent inspection of Wymott was in December 2023. Inspectors reported that healthcare services were not good enough, particularly the provision of mental health support for the many vulnerable prisoners at Wymott. At the time of the inspection, there were excessive waits of up to 39 weeks for psychological therapies and over a year to get counselling. Inspectors found that neither the health trust nor commissioners were addressing the level of need within the prison.

21. Inspectors found the quality of completed ACCT documentation was reasonable, but case reviews often lacked multidisciplinary input. Care plans were limited, which meant that an individual's triggers were not always addressed. Inspectors found that it was positive that findings from the quality assurance of ACCTs was fed back to the safety meetings, where good practice was highlighted, and the consistency of case management reviewed. However, in the inspector's survey, less than half (42%) of prisoners who had been on an ACCT felt well cared for and those prisoners who inspectors spoke to were also very mixed in their views about the quality of care provided.

22. Inspectors reported that the influx of drugs remained a serious problem. It was a cause of debt that resulted in prisoners self-isolating and self-harming because of their fears of violence. There were limited resources available to keep drugs out of the prison with no scanners, systematic checks on staff or adequate technology to reduce the frequent arrival of contraband-laden drones over the large perimeter fence.

Independent Monitoring Board

23. 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 May 2024, the IMB reported that Wymott had continued to suffer the effects of staffing shortages across both directly and indirectly employed staff, and that this had impacted significantly upon the prisoners' experiences. The rate of absences among uniformed staff remained one of the highest in the region, putting a strain on the prison's ability to maintain a decent regime.

24. The IMB noted that they routinely monitor ACCT documents and have generally been satisfied that these are being completed appropriately.

25. The IMB expressed concern about the spikes in the use of illicit substances, particularly following reported drone drops. They highlighted that the area search team visited regularly and recognised that much was being done to try to reduce the use of illicit drugs, including the work of the drug and alcohol rehabilitation service (DARS) team.

Previous deaths at HMP Wymott

26. Mr Rodgers was the 33rd prisoner to die at Wymott since October 2021. Twenty-six of the previous deaths were due to natural causes, four were self-inflicted, one drug related, and one is awaiting classification. To the end of March 2025, there have been four more natural cause deaths. Our report into the death of a prisoner who died two days before Mr Rodgers found that staff managed his ACCT procedures reasonably well, although a potential trigger in the post-closure period was not properly considered.

Assessment, Care in Custody and Teamwork

27. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

28. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Psychoactive substances (PS)

29. 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 nitazenes) 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.

30. 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 Events

Background

31. On 28 April 2020, Mr Alexander Rodgers was remanded in custody for an offence of aggravated burglary and taken to HMP Preston. On 29 October, he was sentenced to 11 years in prison. He had been to prison before. On 4 February 2021, Mr Rodgers transferred to HMP Wymott.

Mental health

32. Mr Rodgers was known to community mental health services from childhood and had recorded diagnoses of mild anxiety and depression. Mental health services in prison supported Mr Rodgers and he had regular sessions with a psychotherapist and counsellor. During 2017 to 2019, Mr Rodgers reported periods of low mood and mental health nurses met him regularly.

33. In October 2020, the mental health team referred Mr Rodgers to IAPT (Improving Access to Psychological Therapies – NHS Talking Therapies, evidence-based psychological therapies for depression and anxiety disorders). In January 2021, following assessment, the IAPT team diagnosed Mr Rodgers with moderate anxiety and severe depression. Mr Rodgers attended three follow-up IAPT sessions before he transferred to Wymott. On arrival at Wymott, staff referred Mr Rodgers to the mental health team and the substance misuse team provided ongoing psychosocial support. During 2023, the mental health team did not have contact with Mr Rodgers as they did not assess that there was any clinical reason to do so. He was not prescribed any regular medication for his mental health at the time of his death.

34. There is no record that Mr Rodgers ever expressed thoughts of suicide or self-harm, or that he had harmed himself.

35. Mr Rodgers had no contact with his family. However, he told staff that he felt well supported by his friends on the wing and he had a good relationship with prison staff.

Substance misuse

36. Mr Rodgers had a significant history of substance misuse and while in custody substance misuse services provided him both clinical and psychosocial support. Mr Rodgers engaged with drug recovery wings, which provide a safer, calmer drug free environment and access to a range of evidence-based recovery focussed interventions.

37. In 2016, during a previous sentence, Mr Rodgers started methadone (an opiate substitute) as part of a maintenance programme. In 2020, while at Preston, with the support of substance misuse services, Mr Rodgers began a reduction plan with the aim of gradually reducing the dose of methadone. When he transferred to Wymott, the reduction plan continued. On 9 March 2022, Mr Rodgers successfully completed his methadone programme. In April, substance misuse services reviewed Mr Rodgers, who reported no issues, and in June they discharged him

from their services. Mr Rodgers had no further recorded incidents relating to substance misuse.

Events from 27 September 2024

38. On 27 September 2024, wing officers observed that Mr Rodgers had begun to isolate himself, had barricaded his door and appeared paranoid saying that people talked about him. An officer referred him to the mental health team. Later, a mental health nurse went to Mr Rodgers' cell and wing staff persuaded him to open his door so she could speak to him. Mr Rodgers appeared very paranoid and said that he would go on hunger strike "so the truth can come out". The nurse asked Mr Rodgers if he had taken any illicit substances, which he denied. She could not properly assess Mr Rodgers' mental state due to his minimal interaction and refusal to let her into his cell. She observed that his cell was chaotic and untidy, his speech was at a normal rate and rhythm, but the content of what he said seemed paranoid. She knew Mr Rodgers well and said that his behaviour was very out of character.

39. The nurse and a Custodial Manager (CM) discussed their concerns about Mr Rodgers' presentation and, at 2.45pm, the nurse started ACCT procedures. Observations were set at twice hourly until Mr Rodgers had been fully assessed. In addition, an officer referred Mr Rodgers for a Challenge Support Intervention Plan (CSIP – used to manage perpetrators of violence and, in some prisons, to support victims of violence) because Mr Rodgers had been isolating and said there were threats against him. The CM endorsed the CSIP referral for an investigation.

40. On 28 September, an officer completed Mr Rodgers' ACCT assessment. She described Mr Rodgers' behaviour as erratic and that he believed staff and prisoners were talking about him and that there was a camera in his cell. Mr Rodgers did not want to discuss his situation further but requested vulnerable prisoner status as he felt threatened. (Vulnerable prisoners live on a separate unit from the general population, usually due to the nature of their offence or because they are under threat from others.)

41. Immediately after the ACCT assessment, the case co-ordinator chaired the first ACCT case review with a mental health nurse. Initially Mr Rodgers blocked his cell door with a cupboard and chair. Staff persuaded him to leave his cell and they decided to take him to the segregation unit for his own safety. Because of his high level of paranoia, Mr Rodgers walked with staff via an end door off the wing, so he did not see other prisoners.

42. The ACCT review continued in the segregation unit. Mr Rodgers told the review panel that he would be murdered on the wing, that he had been documenting his trauma and abuse and that this information had been shared by a particular officer and other prisoners knew. Mr Rodgers said this officer had implemented "monitoring" on him, via his Xbox and television. (Mr Rodgers named the officer, but prison staff identified that he was not on duty when Mr Rodgers said these incidents had occurred. Prison and healthcare staff suggested that Mr Rodgers' views were indicative of paranoia he was experiencing at the time. We found no evidence of staff sharing any inappropriate information about Mr Rodgers.)

43. Mr Rodgers also told the review that prisoners thought he was a "grass". The nurse asked Mr Rodgers if he thought it could be his mental health rather than actual

events, suggesting a psychotic episode to him, but he said his mental health was fine. Mr Rodgers disclosed that he had used Subutex recently (medication used to prevent withdrawals from opioids – which he must have obtained illicitly) but denied using or smoking any other illicit substances.

44. The review panel discussed Mr Rodgers' risk and intent. Although Mr Rodgers said that he had not considered harming himself, he believed he was under threat. He said that all officers and prisoners were involved and so he had little trust in others protecting him. The nurse noted that Mr Rodgers presented with psychotic features with a high degree of paranoia and lack of trust. The panel concluded that Mr Rodgers posed a high risk of harm to himself. They decided to place him under constant supervision (meaning that an officer observed him at all times) while he remained so paranoid.

45. The review panel set two support actions; for Mr Rodgers to be placed under constant supervision and to engage with the psychiatrist. The case co-ordinator marked both support actions as complete. (Mr Rodgers had not yet seen the psychiatrist and was not referred at this time.)

46. A residential manager authorised Mr Rodgers' segregation under Prison Rule 45 - Own Interest (when there are good and sufficient reasons for believing that the prisoner's safety and wellbeing cannot reasonably be assured by other means). He completed the Defensible Decision Log to explain the reasons for segregating a prisoner on an ACCT, placing him in the constant supervision cell. (Segregation is known to increase the risk of suicide and self-harm and so staff must detail their decision making process to ensure that all factors have been appropriately considered.)

47. A mental health nurse completed the Initial Segregation Healthscreen. She recorded that although ACCT procedures were in place to support Mr Rodgers, segregation was unlikely to cause a significant further deterioration in his mental health. She noted that constant supervision was necessary and that Mr Rodgers would be assessed by a psychiatrist. The case co-ordinator referred Mr Rodgers for discussion at the Safety Intervention Meeting (SIM). (The SIM is a meeting to discuss managing risks to prisoners and the prison. It is attended by managers responsible for residential units, safety, and the mental health team. Mr Rodgers' progress was discussed at weekly meetings from 2 October.)

48. On 29 September, the case co-ordinator chaired a case review attended by a mental health nurse, the residential manager and Mr Rodgers. They recorded that Mr Rodgers appeared more subdued than the previous day and he told the review panel that he had not slept. Mr Rodgers said that he was "going to be killed in minutes" and throughout the review became distracted by the door, appearing hypervigilant to movement outside on the landing. Mr Rodgers denied using illicit substances and said he had not borrowed any vapes, but then told the review panel he could not remember. The panel agreed that Mr Rodgers appeared to be experiencing an acute psychotic episode. Mr Rodgers remained under constant supervision. No additional support actions were added, but the panel referred him to the substance misuse team and mental health team for a psychiatric review.

49. On 30 September, the case co-ordinator chaired an ACCT review attended by a mental health nurse, the residential manager and Mr Rodgers. The review panel

noted that Mr Rodgers looked very gaunt, and he said that he had not eaten since Friday (27 September). Mr Rodgers said that he did not intend to eat or drink because the food and water had a bad smell. The nurse contacted the healthcare team to complete clinical observations and blood tests, and the review panel organised for Mr Rodgers to have sealed meals.

50. A nurse completed physical health checks. A malnutrition universal screening tool (MUST) indicated Mr Rodgers was a risk of malnutrition. Mr Rodgers weighed 53.7kg, a loss of 4.3kg since 2 September. A GP at Wymott reviewed Mr Rodgers and prescribed Ensure Plus (a supplement drink). Mr Rodgers remained under constant supervision. No additional support actions were added.

51. A CM reviewed the CSIP and agreed that a support plan should be in place. Three support actions were added to the CSIP plan: attend an appointment with the psychiatrist; engage in the regime as a means of distraction; and engage with ACCT reviews. The CM recorded that Mr Rodgers would continue to be monitored and the CSIP reviewed once he had progressed off constant supervision. Nobody reviewed the CSIP support plan.

52. On 1 October, a consultant forensic psychiatrist and a nurse met Mr Rodgers. The psychiatrist recorded that Mr Rodgers had no history of psychotic disorder but had recently been acting bizarrely. He noted that Mr Rodgers had started eating and drinking and appeared less paranoid than on previous days. Mr Rodgers said that he had not slept properly and asked for medication to help. The psychiatrist concluded that Mr Rodgers did not display any paranoid thoughts, that there were no disturbing perceptual abnormalities and concluded that recent events were because of a drug induced psychosis. He prescribed a sleep aid for three nights.

53. A nurse from the substance misuse team tested Mr Rodgers' urine, which was positive for buprenorphine (Subutex). Mr Rodgers told her that he believed his vapes had been tampered with and that he had consumed PS (Psychoactive Substances, also known as 'Spice') which had contributed to his recent mental health issues.

54. A recovery worker from the substance misuse team met Mr Rodgers. He told her that he did not need help with his mental health but did for his substance misuse. Mr Rodgers disclosed that he had been using Subutex (illicitly obtained) and thought his vapes had been spiked with PS. She recorded that Mr Rodgers had no thoughts of suicide or self-harm and referred him for a full substance misuse assessment. She explained that the waiting list for this assessment could be up to 20 working days. She provided Mr Rodgers with information around the signs and symptoms of a drug overdose, harm reduction advice, and they discussed the risks of using other people's vapes. She also explained to Mr Rodgers that when someone has been abstinent for long periods, their tolerance levels decrease. She told Mr Rodgers to make an application to the substance misuse team if he needed support before his assessment date.

55. The case co-ordinator chaired an ACCT review attended by a mental health nurse, the residential manager and Mr Rodgers. Mr Rodgers interacted well during the review and admitted using Subutex and smoking PS for the past few weeks. He apologised about his actions and understood the effect this had on his mental health. The review panel noted there was no evidence of the paranoia observed

over the previous few days. Mr Rodgers did not express any thoughts of harming himself and asked to be taken off the constant supervision. The review panel agreed that he would remain under constant supervision until the next review, scheduled for the following day. No additional support actions were identified.

56. On 2 October, a CM chaired an ACCT review attended by a nurse, the residential manager and Mr Rodgers. They noted Mr Rodgers showed no signs of paranoia and there was no evidence that he presented a risk to himself. Mr Rodgers said he did not recall much of the previous few days. The review panel discussed their concerns about Mr Rodgers' substance misuse and potentially using tampered vapes. The panel agreed that Mr Rodgers could return to his cell on E Wing, which pleased him. Mr Rodgers said he did not have any concerns about other prisoners and his only concern was lack of sleep. Observations were reduced to hourly. No additional support actions were noted. Mr Rodgers returned to E Wing later that day.

57. On 3 October, the case co-ordinator chaired an ACCT review attended by a mental health nurse and Mr Rodgers. He reported that he had settled back on the wing and had a good network of supportive friends. Mr Rodgers reported sleeping better and although he still struggled to eat, no longer required Ensure drinks. The case co-ordinator agreed that Mr Rodgers could return to his wing cleaner job. Although Mr Rodgers asked for the ACCT to be closed, the review panel agreed to keep it open to provide ongoing support and monitoring. No support actions were noted. Observations were reduced to one each morning, afternoon, and evening, and three during the night. Staff scheduled a review for 8 October.

58. Over the next few days, healthcare staff checked on Mr Rodgers. He appeared more settled but told nurses that although he was eating better, he wanted to continue with supplement drinks.

59. On 5 October, a nurse met Mr Rodgers, who said he felt better and that the voices he heard were quieter. They discussed whether he should consider an assessment for methadone, but Mr Rodgers said he wanted to remain abstinent. Later, a nurse weighed Mr Rodgers and recorded that he had put on weight (58kg).

60. On 8 October, the case co-ordinator chaired an ACCT review attended by a nurse and Mr Rodgers. The review panel noted that Mr Rodgers said he still struggled to eat and sleep, and that the recent sleep aid prescribed did not work. He said he found his job as a wing cleaner therapeutic. Mr Rodgers expressed concern that he had not had the opportunity to submit a canteen request for vapes while segregated. The case co-ordinator assured him that the wing manager would assist him. Although there remained some mild paranoia, Mr Rodgers reflected that his recent mental health issues were linked to an illicit substance in his vapes. Mr Rodgers told the review that he would like to start on methadone and move to the PIPE unit (psychologically informed planned environment – a progression unit for offenders with personality disorders who have recently completed offending behaviour and treatment programs). Mr Rodgers asked for Ensure drinks as he wanted to increase his weight (they were prescribed). The review panel agreed that the ACCT procedures could be closed and scheduled a post-closure review for 15 October.

61. On 9 October, a nurse met Mr Rodgers, who said he had not used any illicit substances and now did not want to be assessed for methadone. Mr Rodgers said he had eaten, but still struggled to sleep. The nurse discussed good sleep hygiene with Mr Rodgers and referred him to the GP to discuss a short course of sleeping tablets.

62. At 3.49pm, an officer recorded (under a CSIP header on Mr Rodgers prison record) that Mr Rodgers was returning to his usual self. He noted that Mr Rodgers had spent time cleaning and socialising with staff and prisoners. This is the only entry in Mr Rodgers prison record relating to his CSIP.

63. Between 6 and 9 October, the last time Mr Rodgers used his telephone, eight calls were made to a number listed as a friend on his approved telephone list; five of these calls were not answered, but three calls connected and totalled around eight minutes. The investigator listened to these calls, but the people making and receiving the calls did not speak in English. (All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. They did not listen to Mr Rodgers' calls until after his death.) The investigator requested translated transcripts of the calls. Wymott responded that the person was speaking Spanish (the investigator thought the language was Eastern European), but they could not decipher what was said. There is no record that Mr Rodgers spoke any other languages and it is possible that he allowed another prisoner to use his telephone.

64. Staff made daily entries between 9 October and 15 October as part of the ACCT post-closure process. Apart from one day when they noted that Mr Rodgers appeared on edge, all other entries noted that he was like his old self and no other issues were recorded.

65. On 12 October, an officer recorded that while litter picking, Mr Rodgers had asked prisoners on another wing for vapes. He told Mr Rodgers that his behaviour was unacceptable and removed him from his job. (Mr Rodgers had money in his prison account and last ordered vapes on 21 October.)

66. On 16 October, the case co-ordinator completed Mr Rodgers' ACCT post-closure review. Mr Rodgers said that he felt much better, although still had problems eating. Mr Rodgers said he was upset that he had been removed from his cleaning job because it kept him busy. The case co-ordinator recorded that they had a long conversation about Mr Rodgers gaining employment and he advised him to submit a request and complaint form. There is no evidence that he considered the recent negative entry about Mr Rodgers seeking vapes form other prisoners, including whether this increased his risk (of smoking unknown substances again, of the potential for a deterioration in his mental health or of suicide and self-harm).

Events of 23 October

67. The investigator watched closed circuit television (CCTV), body worn video camera footage (BWVC) and listened to staff radio communications from 23-24 October. She also obtained information from North West Ambulance Service. The following account has been taken from all sources.

68. On 23 October, there were no specific issues of concern about Mr Rodgers recorded during the day. However, the observation book for E Wing shows that there were five medical emergencies related to prisoners using illicit substances on the wing (three incidents related to one prisoner). Staff conducted intelligence led searches of the wing and recovered drugs, as well as other illicit substances. Staff submitted an intelligence report and made a note in the wing observation book that the strength of drugs being used was stronger than they had seen. There is no record that Mr Rodgers' cell was searched or that he was found in possession of drugs.

69. A GP at Wymott met Mr Rodgers, who said that he still struggled eating and sleeping. He prescribed a nutritional supplement and a sleeping tablet for three nights (zopiclone). At around 5.15pm, Mr Rodgers collected one sleeping tablet from the medications hatch and a nurse observed him taking it.

70. Mr Rodgers' friends said that during the evening he had a shower and then spent the rest of the association time chatting and laughing with his friends. They all described Mr Rodgers as his usual self and that there were no signs that he was in crisis or struggling with his mental health. CCTV shows Mr Rodgers on the wing in his dressing gown, talking to other prisoners and vaping.

71. At 7.04pm, an officer locked Mr Rodgers into his cell for the night. She had no concerns.

72. At 9.20pm, an Operational Support Grade (OSG) started a count of prisoners. When she arrived at Mr Rodgers cell, she used her torch to look through the observation panel before moving on to complete her count.

73. At 10.42pm, Mr Rodgers activated his emergency cell bell and a minute later the OSG responded. She stood at his door for just under a minute talking. She said that she struggled to understand Mr Rodgers due to his Scottish accent and that he kept talking over her. She said that Mr Rodgers did not appear distressed.

74. At 10.50pm, Mr Rodgers pressed his emergency cell bell again and the OSG responded around three minutes later. CCTV shows she stood outside Mr Rodgers cell, appearing to talk to him for around one minute, before she returned to the wing office. She said that she could still not understand what Mr Rodgers said, and because she had no access to electronic prison records, went to the segregation unit where her colleague worked to ask for advice. She said this officer usually worked on E Wing and knew Mr Rodgers. He checked his prison record for the previous few days and did not identify anything of concern. The officer reassured her and said that Mr Rodgers worked as a cleaner on E Wing and was known to be a good prisoner. She did not know Mr Rodgers had recently been supported via ACCT procedures and she did not record anything in the wing observation book as she did not consider his behaviour to be concerning.

75. Prisoners who lived in the cells near to Mr Rodgers said during the night around 2.00am to 3.00am they heard him shouting. Mr Rodgers did not press his cell bell. The OSG said she completed regular checks walking around the wing and she did not hear Mr Rodgers shouting.

Events 24 October

76. At 5.02am, the OSG arrived at Mr Rodgers' cell during her routine count of prisoners. She used her torch and looked through the observation panel. This check was brief, lasting no more than a couple of seconds before she moved on to the next cell. She said she had a clear view of Mr Rodgers during her roll check. She saw him in bed and had no concerns.

77. At 5.30am, the OSG wrote in the wing observation book, "Unable to get a clear view of a number of cells due to lockers clothes at end of bed". She did not specify which cells, and there is no evidence that she asked for assistance from the night operational manager. She said that roll checks were often started early, because prisoners often covered or blocked the view and so it took longer to complete the checks. She said staff were frustrated by how frequently this happened and always encouraged prisoners to keep the line of sight from their observation panel to their bed clear to avoid them being unnecessarily disturbed during the early morning roll check.

78. At 7.30am, an officer started his shift. At 8.12am, he unlocked Mr Rodgers' cell door so he could collect his medication. Initially he struggled to open the door as furniture had been used to make a barricade and so he activated his BWVC. He saw Mr Rodgers hanging, shouted for help and radioed a code blue medical emergency (used to indicate when someone is not breathing or unconscious). Officers responded quickly to assist the officer, and control room staff requested an ambulance.

79. The staff found Mr Rodgers hanged by a dressing gown cord from the window in his cell. They cut the ligature and placed Mr Rodgers on the floor and found clear signs of rigor mortis in his arms and body (the stiffening of the body after death). Healthcare staff responded quickly, including two nurses. They did not start CPR as it was evident Mr Rodgers had died.

80. At 8.27am, paramedics arrived at Mr Rodgers' cell and, at 8.32am, pronounced life extinct. Paramedics recorded that Mr Rodgers had rigor mortis, was cyanosed (when the skin turns a bluish colour due to lack of oxygen), had signs of blood pooling and that his eyes were fixed and dilated. These were all signs that Mr Rodgers had been dead for some time.

Contact with Mr Rodgers' family

81. Mr Rodgers listed his solicitor as his next of kin. The acting Governor telephoned his solicitor to break the news of his death, who later informed Mr Rodgers' ex-partner. In line with Prison Service Instructions, the prison contributed towards the costs of Mr Rodgers's funeral, which was held on 25 November.

Support for prisoners and staff

82. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners 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.

83. After Mr Rodgers' death, the Governor debriefed the prison 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 and TRiM Team (trauma informed management) also offered support. Healthcare staff were invited to attend the prison debrief but were debriefed by their manager. Wymott contacted the Cumbria & Lancashire Group Safety Team who together with the North West Wellbeing Team visited the prison on 19 December. They undertook a floor walking exercise with staff, offering support and advice.

84. The prison posted notices informing other prisoners of Mr Rodgers' 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. Samaritans and Listeners were quickly notified of the death and provided support to prisoners. On 3 November, the prison held a memorial service in the chapel which Mr Rodgers' friends attended.

Post-mortem report

85. The pathologist concluded that the cause of Mr Rodgers' death was due to hanging. Toxicology results showed evidence that Mr Rodgers had cocaine in his blood and that zopiclone had been taken in the hours before he died. The toxicologist recorded that their results indicated that Mr Rodgers died soon after he had taken cocaine.

86. We do not know when or how Mr Rodgers obtained cocaine.

Findings

Identifying the risk of suicide or self-harm

87. At the time of Mr Rodgers' death, Prison Service Instruction (PSI) 64/2011, governed ACCT suicide and self-harm prevention procedures, which required all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. (This has now been superseded by the Prison Safety Policy Framework implemented on 1 January 2025 – the principles of how an ACCT is managed are largely unchanged.) Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Wymott appropriately managed Mr Rodgers' ACCT procedures and whether they should have re-started them in the time before his death.

88. Mr Rodgers had no history of suicidal ideation or self-harm. On 27 September, prison and healthcare staff recognised that he was at increased risk when he experienced a psychotic episode and appropriately started ACCT procedures.

89. We found there was consistent case management of Mr Rodgers' ACCT procedures and a mental health nurse attended every case review. There was evidence that staff supported Mr Rodgers, including a swift response from the substance misuse team and prison psychiatrist. However, we identified some issues with how the ACCT procedures were managed.

90. Support actions were identified at the first case review, but these were not reviewed or updated, and some were signed as completed before this was the case. On 8 October, despite Mr Rodgers saying he still had issues with sleeping, that he was not eating properly and was concerned about his canteen order and his vapes, the ACCT was closed. There was never any reference in the ACCT to Mr Rodgers' CSIP. During the post-closure period, Mr Rodgers lost his job due to seeking vapes from prisoners on another wing. Despite the strong link between this and the psychosis that led to starting ACCT procedures, there is no evidence that this was considered at the post-closure review. However, we found no other evidence that Mr Rodgers was at increased risk of suicide in the time before he died.

91. There was no quality assurance of Mr Rodgers' ACCT before his death, which meant that these issues were not identified at the time. After Mr Rodgers' death, Wymott identified issues with the management his ACCT procedures. The Head of Safety said having reviewed Mr Rodgers' ACCT he was satisfied that a lot of support had been in place for him, and that staff had completed actions, but these were not updated or recorded on the ACCT document. On 27 November, the prison addressed the issues by providing the case co-ordinator with advice, guidance, and training.

92. The Head of Safety said Wymott had had difficulty undertaking quality assurance of ACCTs due to the lack of a dedicated member of staff. He confirmed that, having identified the need to ensure quality assurance was completed, all SOs and CMs who have case management responsibility have now been trained in the process. He confirmed that, from 3 February 2025, an ACCT quality assurance process has been introduced at Wymott and that 100% of the first 72-hour checks are

completed, 50% of ACCTs are checked weekly, and 100% of post closure reviews. A database has been designed to track the QA process to ensure they are completed. In addition, Wymott invited the National Safety Team to review the processes, which was completed on 10 March, and they will be delivering additional training to all case managers on 31 March.

93. Given the steps already taken, we do not make a separate recommendation.

Challenge, Support and Intervention Plan (CSIP)

94. Challenge, Support and Intervention Plans (CSIP) are a violence reduction case management model used to support and manage prisoners who are considered to pose a risk to other prisoners and staff. In some prisons, including Wymott, CSIPs are also used to provide support to victims or suspected victims of bullying, intimidation, and those who self-isolate. Following another death, Wymott had already introduced a single case manager approach to CSIPs at the time of Mr Rodgers' death whereby each prisoner is designated a CSIP manager who will continue to be responsible for the management of their CSIP. Introducing the single case manager, similar to how an ACCT is managed, is designed to place more accountability on individual case managers and minimise the likelihood of actions being missed. This is supported by a quality assurance process in which spot checks are completed to ensure that staff and managers are following the procedures to the required standards.

95. A CSIP referral for Mr Rodgers was submitted to the safer custody department on 27 September, after he began isolating in his cell and said he was under threat. On 30 September, a CM reviewed the CSIP referral, agreed that a CSIP should be implemented, and set three targets as part of Mr Rodgers' support plan. The CSIP was never reviewed. There is no evidence that staff considered the CSIP alongside the ACCT, and there was not a single case co-ordinator responsible for both processes as national instructions require.

96. The CM said that he had not been allocated as the single case co-ordinator and did not know who the CSIP case manager was. He said he entered his name at the top of the form as the system would not allow him to progress the CSIP referral without doing so. Another CM had been designated as the CSIP manager for all those identified as isolating at Wymott, but we found no evidence that he had any contact with Mr Rodgers. The CSIP procedures remained open when Mr Rodgers died, without having had any further review.

97. Staff appropriately referred Mr Rodgers to the Safety Intervention Meeting (SIM) and he was discussed at four of the weekly meetings. However, the information recorded did not change (even when Mr Rodgers' circumstances had changed) and appear to have been simply copied from the previous minutes. The minutes showed that a CSIP review was scheduled for 30 October, over a month after the procedures were implemented. It is not apparent that meaningful and accurate information was discussed or recorded.

98. We found that the implementation of Mr Rodgers' CSIP was poor. While it could have been used to support Mr Rodgers beyond when his ACCT closed, no review took place and therefore there was a missed opportunity in identifying if he continued to struggle, particularly after he lost his employment and was observed

seeking vapes from other prisoners. At interview, some staff demonstrated that their understanding of the CSIP process was very limited in comparison to the ACCT process, which appeared to take priority.

99. The Head of Safety accepted that staff understanding of the CSIP process was not as developed as that of ACCT procedures, that staffing issues at Wymott impacted on their ability to deliver training and that they had to prioritise mandatory training such as ACCT. He said that although Wymott had delivered CSIP awareness training they recognised more needed to be done, to ensure it was effectively implemented. He said that Wymott planned to add additional CSIP training alongside ACCT refresher training. We make the following recommendation:

The Governor should satisfy himself that robust procedures are in place to assess the quality of CSIP procedures, including identifying and correcting practice that is not in line with the Prison Safety Policy Framework.

Clinical care

100. The clinical reviewer concluded that Mr Rodgers received a good standard of clinical care. The mental health team supported Mr Rodgers through a period of drug induced psychosis and contributed to the ACCT process.

101. Substance misuse teams worked with Mr Rodgers to support him when detoxing from methadone, and he went a considerable time without needing support from the service. When Mr Rodgers experienced the drug induced psychosis in September 2024, they quickly assessed and supported him over the following weeks.

Early morning roll check

102. Wymott's Local Security Strategy (LSS), dated 5 January 2021, states that the early morning roll count must take place between 5.30am and 6.00am and that the purpose of this check is to confirm the number of prisoners and obtain a response if required to do so. (There is no reference to ensuring the wellbeing of prisoners, or what to do if there is no clear view of them. It also does not detail the circumstances in which staff might be "required" to obtain a response from a prisoner.) We were told that the LSS is in the process of being updated. The OSG said that on those wings where long-term category C prisoners are held, they often start the roll count early as there are more incidents of prisoners obscuring their observation panel.

103. The Management of Internal Security Procedures Policy Framework, issued in September 2024, sets out that, when checking the roll, staff must assure themselves that prisoners are in their cells by obtaining a clear view of their face, if necessary by waking them. It says that staff must assure themselves that prisoners are alive and well during roll checks.

104. At 5.02am, on 24 October, the OSG conducted the early morning roll check (28 minutes earlier than the LSS stipulates). CCTV shows the check was extremely brief. She said she was familiar with how Mr Rodgers slept and had a clear view of him, hence the brief check.

105. The OSG recorded that she could not get a clear view of all prisoners on the wing, which meant her roll check was inadequate. Although she said that Mr Rodgers was not one of those prisoners who she could not clearly see, we note that he was found hanged with rigor mortis and a barricaded cell door a little over three hours later. Given the brief nature of her roll check and the events shortly afterwards, on balance we are not satisfied that she completed a roll check in line with expectations. The Governor may wish to investigate these events internally. We make the following recommendation:

The Governor should amend the Local Security Strategy to ensure that it provides clear instructions to night patrol officers on:

- **How to complete a roll check and the circumstances in which a response from the prisoner should be sought.**
- **The action to take if a prisoner has blocked their observation panel or they do not have a clear view of them.**

Drug supply and demand at Wymott

106. A psychiatrist diagnosed that Mr Rodgers had experienced a drug induced psychosis, and Mr Rodgers accepted that he had used PS through tampered vapes.

107. Wymott’s drug strategy for the years 2023-2025 notes that PS continues to be the most popular drug. When incidents of PS use spike, there is a correlation with a spike in violence, self-harm and other debt related issues, causing real concerns for safety and stability within the prison.

108. In another recent investigation following a suspected drugs death, the investigator spoke to the Head of Drug Strategy about drug supply and demand at Wymott. He reiterated that PS continues to be the most popular drug at Wymott due to how cheap, readily available, and undetectable it is. He said that PS-soaked paper burnt in a vape is still the most popular method of ingesting PS. Drug ingress routes into the prison include packages being thrown over the wall, being delivered via drones or through the external post. They also enter the prison via families and friends on visits or through members of staff.

Restricting Supply

109. Wymott takes a zero-tolerance approach to anyone they identify as supplying drugs into the prison or those trafficking drugs within the prison. They use a variety of methods to prevent drugs entering the prison which include:

- Ensuring that staff working with incoming mail are well trained, follow procedures and utilise all tools available to them to detect drugs coming into the prison via post. All domestic mail is routinely photocopied and the validity of legal mail is checked via the use of a Rapiscan machine (which detects the presence of drugs). Property parcels are not permitted to be sent in directly from family, and additional property can only be obtained via one of the prison’s authorised catalogues.

- The use of enhanced measures to detect drugs on any individual entering the prison. Body scanners are used on new receptions entering Wymott to detect for secreted items. If the scanner detects a secreted item, the prisoner is located in the segregation until he produces a negative scan, preventing the drugs being circulated within the prison. For social visits, the officer in charge receives a daily intelligence brief and area drugs dogs are used to support the staff carrying out the searches of the visitors.

- The installation of window grills to act as physical barriers to prevent passing between windows and restrict drone access. The Head of Drug Strategy told us that currently, most of the cell windows on the outer side of the prison have window grills, however most of the inward facing windows do not. He said that although they have manufactured the grills to cover the inner windows, they are waiting for funding to have them installed.

- The possibility of borrowing specialist drone detection equipment. The Head of Drug Strategy explained that Wymott rely solely on human sightings and reviewing CCTV to detect drone activity at Wymott, meaning that they have no means of tracking drone activity unless physically spotted. As drone detection equipment is very expensive and predominantly reserved for use in the high security estate, Wymott are currently in negotiations with HMP Garth (situated next door to Wymott) and the local police to fund the borrowing of the police' drone detection equipment, which will be shared between the two prisons. This will enable the early detection of drone activity and provide a more accurate intelligence picture on the use of drones in the trafficking of illicit items into Wymott.

- The use of external wall checks and patrols prior to unlock and prisoner movement to ensure the fence and external wall is undamaged, and to look for any potential throw overs.

- The use of external CCTV monitoring of the perimeter and other vulnerable areas within the prison with bids submitted for additional CCTV for evidential purposes and the detection of offences.

- A clear searching strategy to proactively disrupt the trade of drugs within Wymott. This includes the use of intelligence led, targeted searches supported by drugs dogs, when available.

- Effective use of mandatory drug tests with new drug testing processes implemented.

- A focus on improving the quality of intelligence to create a more accurate intelligence picture of drug supply and demand at Wymott. Wymott holds a variety of weekly and monthly security meetings to discuss responses to emerging drug trends and agree on actions to combat the risks associated with these. The Tactical Tasking and Coordination Group uses intelligence to establish areas of conveyance and identify (and close) any gaps.

- An established relationship with all key stakeholders to effectively work together using intelligence strands to respond to emerging drug threats. This includes working with the serious organised crime unit to identify key

organised crime nominals as well as the sharing of intelligence between the local police force to determine and disrupt local supply routes.

Reducing Demand

110. Wymott aims to reduce the demand for drugs by actively supporting and encouraging prisoners into sustainable recovery through a wide range of clinical services and non-clinical interventions. Programmes, such as the Therapeutic Community, offer an intensive structured programme in which staff encourage prisoners to participate in a wide range of enrichment activities and services designed to alleviate boredom and promote recovery. Substance misuse recovery peers, recovery focus groups, and mutual aid support groups (such as Narcotics Anonymous) are used to support and enhance the substance misuse services. Therapeutic activities such as art, drama, music and ‘recovery gym’ exercise sessions are promoted, and prisoners are encouraged to attend educational courses to support their resettlement.

111. Wymott also aim to reduce demand by balancing supporting prisoners found under the influence of drugs with more punitive measures for those persistently using. On the first occasion a prisoner is found under the influence, a DARS practitioner will see them to offer harm reduction advice, warn them about the risks associated with drug misuse, and signpost them to the appropriate avenues of support. Those prisoners refusing to engage with support or persistently using however will be subject to prison disciplinary procedures.

112. Overall, we recognise the significant challenges inherent in preventing drugs entering Wymott. PS is especially prevalent in category C prisons because their lower security measures and stable population allows for the maintenance of distribution networks. In addition, Wymott has a substantial and diverse population, a large perimeter and is situated in an open and accessible semi-rural area making it vulnerable to throwovers and drones. The illicit drugs market in prison is controlled by organised crime gangs and the scale of the problem requires a co-ordinated approach. We found that Wymott fully recognises the above challenges and has taken considerable steps to address them. The prison has both clinical and operational staff dedicated to roles involving drug rehabilitation, strategy and security, and those we spoke to were clearly passionate about their work and were committed to delivering a safe, secure, and stable environment.

113. Given the proactive steps that Wymott are taking, we make no recommendation.

Governor to Note

Access to prisoner records

114. The OSG said that she did not have access to prisoners’ records (NOMIS) since her return from maternity leave in 2020, which all operational staff should. This meant that if there was an incident with a prisoner during the night, when she was alone on the wing, she would not be able to consider their history when deciding what action to take. On the night that Mr Rodgers died, she had to ask a colleague to look up information about him.

ACCT training

115. We identified that only around one third of healthcare staff had received mandatory Suicide and Self-harm Awareness training (commonly referred to as ACCT training). While we know that both the Governor and Head of Healthcare are aware of this issue, they should ensure all staff are trained as soon as possible.

Immediate debrief

116. There was no collective debrief with all the staff involved after Mr Rodgers' death. The Governor and duty governor debriefed the prison staff involved in the emergency response and healthcare staff were invited to attend. During interview we were told healthcare staff were encouraged to return to the healthcare centre for a separate debrief. The Head of Healthcare said that if staff had wanted to attend the prison led debrief, they could have. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed.

Inquest

The inquest into Mr Rodger's death concluded on 14 May 2026. Mr Rodger's death was due to suicide.

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