

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Rogers, a prisoner at HMP Preston, on 8 October 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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1. 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.
2. 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.
3. In January 2024, Mr William Rogers was sentenced to a 24 month Suspended Sentence Order (SSO) for a sexual offence. (A SSO is a custodial sentence served in the community, unless the person breaches the conditions, in which case the court can activate the sentence and send them to prison.) In July 2025, Mr Rogers was remanded to prison, charged with breaching his Sexual Harm Prevention Order. He remained unsentenced at the time of his death. He died in hospital of lung cancer, on 8 October, while a prisoner at HMP Preston. Ischaemic heart disease, atrial fibrillation (irregular heart rhythm) and chronic obstructive pulmonary disease (COPD – a lung disease) also contributed to his death. He was 74 years old. We offer our condolences to Mr Rogers' family and friends.
4. The Ombudsman's office wrote to Mr Rogers' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
5. NHS England commissioned an independent clinical reviewer, to review Mr Rogers' clinical care at Preston.
6. The clinical reviewer concluded that the clinical care Mr Rogers received at Preston was of a good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Rogers had appropriate care plans in place for his coronary heart disease and COPD, with regular and timely reviews by healthcare staff. The clinical reviewer noted evidence of good multi-disciplinary working, with weekly meetings and responsive involvement from the healthcare team. She also acknowledged compassionate interactions by healthcare and prison staff. The clinical reviewer made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Rogers' care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

May 2026

Inquest

10. At the inquest held on 1 May 2026, the Coroner concluded that Mr Rogers died from natural causes.



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