

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Lloyd Rodgers a prisoner at HMP Hatfield on 7 January 2017

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Lloyd Rodgers died on 7 January 2016 of multiple head injuries from a road traffic accident while on temporary release from HMP Hatfield. He was 27 years old. I offer my condolences to his family and friends.

The investigation found no evidence that Mr Rodgers had intended to take his life, and his death was the result of a road traffic accident. Toxicology tests found alcohol in his system, which might have impaired his judgement in crossing a dual carriageway.

Although Mr Rodgers breached his licence conditions on the evening he died, staff at Hatfield had appropriately considered and authorised his application for release on licence. I do not believe that prison staff could have anticipated this or prevented Mr Rodgers' death.

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

**Nigel Newcomen**  
**Prisons and Probation Ombudsman**

**September 2017**

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# Summary

## Events

1. On 13 October 2015, Mr Lloyd Rodgers was sentenced to three years and four months in prison for drug offences. He served time in two prisons and in May 2016 he was transferred to HMP Hatfield, an open prison, to prepare for his release in 2017. Mr Rodgers had settled well into prison life. He had no history of substance misuse, mental ill health or attempted suicide or self-harm. He was never identified or monitored as at risk of suicide or self-harm
2. On 28 September, staff reviewed his temporary release risk and assessed that he was at low risk of harm and of re-offending. Mr Rodgers completed seven periods of release on temporary licence without incident or concern.
3. On 6 January 2017, Mr Rodgers was released for four nights on licence to spend time with his family. His conditions included that he should not go to a pub or drink alcohol. His offender manager had arranged to meet him on 9 January. Because of his low risk, compliance with previous temporary release conditions and because there was no security intelligence about him, staff at Hatfield did not consider it necessary to test him for alcohol or illicit substances, telephone or visit him at his place of residence.
4. On 7 January, Mr Rodgers spent time with his family in a pub, where he drank alcohol. Hatfield staff were not aware of this. At around 10.30pm, he left the pub, apparently after a minor argument with his partner, and began walking back to his aunt's house, where he lived while on temporary release. While crossing a dual carriageway, Mr Rodgers was hit by a heavy goods vehicle. He died at the scene.
5. Mr Rodgers' post-mortem examination results indicated a significant amount of alcohol in his system, as well as a trace of cocaine from past use. The clinical reviewer said that his judgement might have been impaired by the level of alcohol in his system.
6. The police took no action against the vehicle driver and found no evidence that Mr Rodgers had intended to walk into the vehicle

## Findings

### Mr Rodgers' death and assessment of his risk

7. Mr Rodgers' death was due to a road traffic accident. There is no evidence that he intended to take his life. It is possible that the amount of alcohol in Mr Rodgers' system might have impaired his judgement when crossing the dual carriageway.

### Monitoring licence conditions while on temporary release

8. Mr Rodgers had been assessed as at low risk of harm and of re-offending, had completed a number of periods of temporary release without incident and there was no security or substance-related intelligence about him. It is reasonable that the prison did not test him for alcohol or illicit drugs or arrange to telephone or

visit him at his place of residence. Although Mr Rodgers breached his licence conditions on the evening he died, prison staff could not have anticipated this or prevented his death.

### **Clinical care**

9. The clinical reviewer concluded that Mr Rodgers' clinical care and treatment while at prison was comparable with that which he would have received in the community.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Hatfield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited Hatfield on 16 January 2016. She obtained copies of relevant extracts from Mr Rodgers' prison and medical records. Due to the nature of Mr Rodgers' death, she did not conduct formal interviews but spoke to the Governor, a Supervising Officer and the Head of Offender Management. She also interviewed a prisoner.
12. NHS England commissioned a clinical reviewer to review Mr Rodgers' clinical care at the prison.
13. We informed HM Coroner for South Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Rodgers' mother, to explain the investigation. She had no specific issues for us to consider.
15. Mr Rodgers' mother received a copy of the initial report. She did not make any comments.

## Background Information

### HMP Hatfield

16. HMP Hatfield is an open resettlement prison which holds up to 338 men who are due to complete their sentence within two years.

### HM Inspectorate of Prisons

17. The most recent inspection of Hatfield was in August 2015. Inspectors reported that Hatfield had achieved the highest scores across the prison estate for the four areas inspected: safety, respect, purposeful activity and resettlement. They said that Hatfield's approach to resettlement would have benefitted from better co-ordination, with greater attention given to offender management work, but all prisoners had an allocated offender supervisor and most Offender Assessment System (OASys) risk assessments were of good quality. Sentence planning focused on release on temporary licence, work and education, with temporary release used extensively to support progress and resettlement priorities. Prisoners were positive about the resettlement support they received

### Independent Monitoring Board

18. 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 29 February 2016, the IMB reported that Hatfield had achieved excellent results across the prison estate.

### Previous deaths at HMP Hatfield

19. Mr Rodgers' was the third prisoner to die at HMP Hatfield since January 2015. There are no significant similarities between Mr Rodgers' death and that of the other two prisoners.

### Monitoring requirements for release on temporary licence

20. Prisoners may be released on a temporary licence for compassionate reasons or to help them improve their chances of resettlement after their release. Release on temporary licence is designed so that prisoners released must undertake defined and specific activities, which cannot be provided in prison. To ensure public safety and maintain public confidence in the system, prisoners released on temporary licence are rigorously assessed and a senior manager must authorise their suitability.
21. PSI 13/2015 on release on temporary licence, says that Governors must have in place a system of spot checks to ensure offenders released on temporary licence are complying with their licence conditions. It says that an individual risk assessment must address the type and frequency of monitoring required such as a telephone call or visit from staff.
22. Hatfield's local procedures require that staff check on 50% of prisoners released on temporary licence by telephone each week and that they visit 20% of those prisoners at their place of residence. Prisoners must also meet their offender manager in the community while on release. Hatfield said that they tested 10%

of prisoners for substances on a random basis. They said they would also test for alcohol or illicit substances:

- if there was reasonable security intelligence or direct observation that a prisoner had used a substance; or
- if an offender manager recommended that they should test a prisoner based on his behaviour or history of substance misuse which might increase his risk of harm or reoffending.

23. In such circumstances, Hatfield said they would suspend a prisoner's temporary release until they received the test results.

# Key Events

## Background

24. On 8 September 2015, Mr Lloyd Rodgers was convicted of possession and supply of class A drugs. He was sentenced to three years and four months in prison. It was his first time in custody.
25. There were no concerns during his time in prison about his physical or mental health. He had no known history of substance misuse, mental ill health or attempted suicide or self-harm. He settled well into prison life.

## HMP Hatfield

26. Mr Rodgers served time in two prisons before he was transferred to HMP Hatfield, an open prison, on 5 May 2016 to plan for his release in 2017. Staff at Hatfield described him as hard working.
27. Mr Rodgers settled well at Hatfield and to plan for his impending release on 30 January 2017, he was released on temporary licence a number of times. At the review of his temporary release risk on 28 September 2016, his offender manager assessed him as at low risk of serious harm and of re-offending as he had no previous convictions. This risk assessment was due to expire on 22 March 2017. The Head of Offender Management noted that Mr Rodgers was polite and well-mannered, there was no security intelligence about him and he was an enhanced prisoner under the Incentives and Earned Privileges scheme, with no recent adjudications or negative comments from staff. He said that there was no evidence of any substance misuse since he arrived at prison and his behaviour and work performance was very positive.
28. Mr Rodgers completed seven periods of temporary release without incident or concern from staff. Mr Rodgers was not tested for alcohol or illicit substances. Tests are conducted at random or intelligence-led, and there was no information to suggest that he had misused substances or breached his licence conditions.
29. On 28 December 2016, a Supervising Officer assessed and authorised Mr Rodgers' eighth period of release on temporary licence.
30. On 6 January, Mr Rodgers was released on temporary licence for four nights to maintain family ties. His licence conditions included that he must reside at his aunt's house and must not go into a pub or drink alcohol. While on temporary release, Mr Rodgers had planned to visit members of his family, spend time with his children and look for a job for when he was released. His community offender supervisor had arranged to meet him on 9 January 2017. Prison staff never considered that any other monitoring measures (such as staff visits or telephone calls) were necessary as Mr Rodgers was a low risk prisoner and there was no intelligence that he would breach the terms of his licence.

## 7 January 2017

31. A Detective Sergeant from the Serious Collisions Unit at South Yorkshire Police said that on the evening of 7 January, Mr Rodgers spent time with his family, partner and their two children at a local public house, where he drank cider. Mr

Rodgers' family said that he had a minor argument with his partner and left the public house at around 10.30pm to walk back to his aunt's house.

32. Mr Rodgers was crossing a dual carriageway when he was involved in a road traffic accident. Although there was a pedestrian crossing nearby, Mr Rodgers did not use it.
33. An independent witness told the police that Mr Rodgers seemed to walk into the front nearside of a heavy good vehicle, and was then pulled underneath it. According to the witness, the heavy goods vehicle had just set off from traffic lights and was travelling at around 10 to 15 miles per hour. The driver noticed a bump on the rear wheels and stopped the vehicle. She had not felt anything at the front of the vehicle. The police said that this was a blind spot for drivers of heavy goods vehicles.
34. Once the driver realised that she had knocked someone over, she contacted the police and emergency services. The draft police investigation report said that no one had been charged with any offences and there was no indication that Mr Rodgers walked into the path of the vehicle, with a view to kill himself.
35. The police had not known at the time that Mr Rodgers was a serving prisoner. A police constable and police family liaison officer notified Mr Rodgers' family of his death.
36. Around 10.40am on 8 January, a prisoner at Hatfield told an officer that he believed a prisoner had died while on temporary release. Another officer had also heard that Mr Rodgers had been killed in a road traffic accident the previous night. Neither officer knew anything more so they contacted an SO to tell her what they had heard. She called Mr Rodgers' aunt, who confirmed that he had been killed in a road accident at 10.40pm the previous night.
37. A prisoner and friend of Mr Rodgers told the investigator that Mr Rodgers had never given him the impression that he would take his own life. He said that Mr Rodgers had been looking forward to getting a job and spending more time with his children on release.

#### **Contact with Mr Rodgers' family**

38. At 2.44pm on 8 January, an SO, acting as the prison family liaison officer, telephoned Mr Rodgers' mother and arranged to meet her the next day.
39. On 9 January, at 10.50am, the SO and a prison manager visited Mr Rodgers' mother at her home. The prison contributed to the cost of Mr Rodgers' funeral in line with national instructions, and arranged a memorial service at the prison which the family attended.

#### **Support for prisoners and staff**

40. After Mr Rodgers' death had been confirmed on 8 January, a manager debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

41. The prison posted notices, informing other prisoners of Mr Rodgers' death, and offering support. Staff spoke to all prisoners in case they had been adversely affected by his death.

#### **Post-mortem examination**

42. Mr Rodgers' post-mortem examination results revealed that he died from multiple traumatic head injuries caused by the road traffic accident. Toxicology reports indicated that his blood contained a significant amount of alcohol and a trace of cocaine. The clinical reviewer said that it was possible that the level of alcohol in Mr Rodgers' system might have impaired his judgement.

# Findings

## Mr Rodgers' death and assessment of his risk

43. There is no evidence to indicate that Mr Rodgers intended to take his life on the evening he died. During his time in prison he was never identified as at risk of suicide or self-harm, and staff and a prisoner whom the investigator spoke to said that Mr Rodgers was happy and settled. He had no history of attempted suicide or self-harm, substance misuse or mental ill health, and he had previously been temporarily released a number of times, without incident or concern.
44. Mr Rodgers' death was due to a road traffic accident. The draft police investigation report said that no one had been charged with any offences and there was no indication that Mr Rodgers had walked into the path of the vehicle, with a view to kill himself.
45. Mr Rodgers' toxicology results found a trace of cocaine from past use and a significant amount of alcohol in his blood. We agree with the clinical reviewer that the level of alcohol in Mr Rodgers' system might have impaired his judgement when crossing the dual carriageway.

## Monitoring licence conditions while on temporary release

46. Mr Rodgers had been assessed at low risk of harm and of re-offending, had completed a number of periods of temporary release and there was no security or substance-related intelligence about him. It is reasonable that the prison did not test him for alcohol or illicit drugs or arrange to telephone or visit him at his place of residence. He was scheduled to meet his offender manager on 9 January in line with prison policy. Mr Rodgers breached his licence conditions on the evening he died, but prison staff could not have anticipated this or prevented his death.

## Clinical care

47. The clinical reviewer found that Mr Rodgers' clinical care and treatment while in prison was comparable to that which he would have received in the community.

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