Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adam Rogers, a prisoner at HMP Exeter, on 1 June 2015

A report by the Prisons and Probation Ombudsman
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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*

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.

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

Mr Adam Rogers was found hanged in his cell at HMP Exeter on 1 June 2015. He was 22 years old. I offer my condolences to Mr Rogers' family and friends.

Mr Rogers had a range of risk factors which would have increased his risk of suicide and self-harm, including a relationship breakdown and the loss of contact with his child. He had been involved in a cluster of violent incidents in the weeks before his death, both as a perpetrator and victim and was known to use drugs, including 'spice' - a new psychoactive substance. Prison staff need to be vigilant for these risk factors, but I accept that, immediately before his death, there was little to indicate that Mr Rogers was feeling particularly distressed or that he was at heightened and imminent risk of suicide. He gave no indication to anyone of his intentions or of the extent of his vulnerability. I therefore consider that it would have been difficult for staff at Exeter to have predicted his actions or prevented his death.

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

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Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

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Summary

Events

1. On 25 November 2014, Mr Adam Rogers was remanded to HMP Exeter, charged with conspiracy to supply Class A drugs. It was not his first time in prison. On 9 December, he told a prison GP that he had been using illicit drugs in prison, but did not want to be referred for help with substance misuse problems.

2. On 16 April 2015, Mr Rogers told another GP that his partner had left him, he had no contact with his child and he was facing a long sentence. He said he was not sleeping well, but said he had no thoughts of suicide or self-harm. The doctor prescribed sleeping tablets and antidepressants. Mr Rogers told the GP he had smoked a new psychoactive substance (a synthetic cannabinoid). On 18 May, Mr Rogers missed an appointment to review the antidepressant medication.

3. Mr Rogers was involved in attacks on other prisoners in April and May. In May, one of the prisoners Mr Rogers had previously attacked, assaulted him. Mr Rogers was charged with disciplinary offences in relation to these incidents but the hearings were adjourned. Mr Rogers lost some prison privileges and was moved to another wing. He would not discuss the reasons for the fights. There was some intelligence that Mr Rogers was involved in organised crime in the prison.

4. On 31 May, officers searched his cell and found a homemade mobile phone charger. Mr Rogers and his cellmate were both charged with an offence against Prison Rules and were due to attend a disciplinary hearing the next day.

5. At 7.45am on 1 June, cells were unlocked on the wing. Mr Rogers went to a friend's cell before being locked in his cell again at 9.00am. He was on his own in the cell as his cellmate had a visit with his solicitor. Staff and prisoners who had contact with Mr Rogers that morning had no concerns about him.

6. At around 10.35am, an officer went to collect Mr Rogers for his disciplinary hearing and found he had hanged himself from the window bars by a torn piece of sheet. The officer pressed the personal alarm on his radio and shouted for help. Another officer radioed an emergency code. Staff tried to resuscitate Mr Rogers until paramedics arrived and took over emergency treatment. At 10.55am, the paramedics recorded that Mr Rogers had died.

Findings

7. In retrospect, Mr Rogers had a number of factors, which made him a risk of suicide. He was suffering from depression, he was facing a long sentence, his relationship had broken down and he had no contact with his child. He used drugs and had been involved in a number of violent incidents shortly before his death. We are satisfied that these incidents were dealt appropriately, in line with the prison's violence reduction strategy and there was little to indicate that Mr Rogers was particularly vulnerable. Despite the range of his risks, Mr Rogers appears to have internalised most of his anxieties and we consider it would have been difficult for staff to have identified that he was at imminent risk of suicide and to have prevented his death.

The Investigation Process

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

9. NHS England commissioned a clinical reviewer to review Mr Rogers' clinical care at the prison.

10. The investigator visited the prison on 10 June 2015, and obtained copies of relevant extracts from Mr Rogers' prison and medical records.

11. The investigator interviewed 12 members of staff and three prisoners. The clinical reviewer joined the investigator for some of the interviews with staff.

12. We informed HM Coroner for Exeter and Greater Devon of the investigation who gave us the results of the post–mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Rogers' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Rogers' mother did not identify any specific matters for the investigation to take into account. Mr Rogers' mother received a copy of this report. She did not make any comments.

Background Information

HM Exeter

14. HMP Exeter is a local prison holding about 500 men. The prison primarily serves the courts of the South West. Dorset NHS University Foundation Trust provides health services.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of HMP Exeter was in July and August 2013. Inspectors reported a positive culture at the prison. They considered that staff paid attention to safety and vulnerability issues and initial identification of risk of self-harm and suicide was very good. A small group of staff was responsible for safer custody and was properly focused on risk factors. The safeguarding policy was clear and concise, but had not yet been fully implemented.

16. Inspectors found that levels of violence and reported victimisation at the prison were high, but most prisoners said that they felt safe. Investigations into allegations of violent or antisocial behaviour were good and perpetrators had an initial two-week demotion to the basic regime, sometimes in addition to disciplinary action. When there was insufficient evidence to take formal action, prisoners signed a violence reduction compact but this process was not well managed; targets were not specific to the behaviour improvement that was required and monitoring was not properly focused.

Independent Monitoring Board

17. 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 most recent published annual report, for the year to December 2013, the IMB reported good relationships between staff and prisoners despite the overcrowding in the prison. In a recent safer custody questionnaire, most prisoners said they had not experienced any antisocial behaviour in the prison.

Previous deaths at HMP Exeter

18. Mr Rogers' was the fifth self-inflicted death at Exeter since 2012. There were no significant similarities with the circumstances of the other deaths.

Key Events

19. On 25 November 2014, Mr Adam Rogers appeared in court charged with conspiracy to supply Class A drugs and was remanded to HMP Exeter. This was not his first time in prison. Court custody staff did not identify any concerns about risk of suicide and self-harm but noted that Mr Rogers had previously been convicted of violent offences.

20. At an initial health screen, Nurse A recorded that Mr Rogers had no thoughts of suicide or self-harm and had not previously self-harmed in prison. He was not on any prescribed medication. Officer A, the reception officer, also noted that Mr Rogers had no history of self-harm and said he had no thoughts of harming himself.

21. On 27 November, as part of his induction, the wing violence reduction representative saw Mr Roger. He noted that Mr Rogers did not raise any concerns about his safety and did not appear vulnerable. Mr Rogers moved from the first night centre to a shared cell on A Wing, a standard prison wing.

22. On 9 December, Dr A, a prison GP, prescribed Mr Rogers pain relief medication for an old hip injury. Mr Rogers told the doctor that, since arriving at Exeter, he had taken illicitly obtained subutex (a drug used to treat heroin addiction) and was having some withdrawal symptoms. Mr Rogers declined to be referred to substance misuse services. According to the records, the following four months were uneventful.

23. On 16 April, Mr Rogers told Dr B, another prison GP, that his partner had left him, and he had no contact with his child. He said that he was facing a longer than anticipated sentence. Mr Rogers said he had no plans to harm himself or others. The doctor recorded that Mr Rogers was due in court on the 11 May. He said he was not sleeping and would like to be prescribed sleeping tablets. The doctor recorded that Mr Rogers looked pale, but did not seem distracted, made good eye contact and seemed generally relaxed. The doctor diagnosed depression and prescribed antidepressants (citalopram), which she explained might not take effect for a couple of weeks. She also prescribed a three day course of sleeping tablets (zopiclone) to take before his court appearance. Mr Rogers said he had smoked spice (a new psychoactive substance and a synthetic cannabinoid) on his wing. The doctor did not record whether she had considered referring Mr Rogers to the substance misuse services. She did not think that he needed to be referred to the mental health team.

24. On 21 April, Dr A recorded that Mr Rogers had mistakenly been given his zopiclone early. The doctor prescribed another three days' worth of zopiclone, to be issued on 9 May.

25. On 26 April, Mr Rogers punched a prisoner who was already being assaulted by other prisoners on the exercise yard. In line with the prison's violence reduction policy, staff demoted him to basic regime on the Incentives and Earned Privileges scheme until 3 May, when he returned to standard regime. Mr Rogers attended a disciplinary hearing (known as an adjudication) on 27 April, and was found guilty of assault. His punishment was to lose his television, the opportunity to mix with

other prisoners during association periods, access to his private cash account and to the prison shop for 28 days.

26. On 11 May, Mr Rogers went to court and was again remanded to Exeter.

27. On 18 May, Mr Rogers did not attend a GP appointment to review his antidepressant prescription. We do not know why he missed the appointment, but doctors continued to prescribe citalopram.

28. On the morning of 22 May, officers intervened when Mr Rogers assaulted another prisoner. Mr Rogers told Nurse B that he did not want to be checked for injuries, but she noted that his knuckles were pink and he had no other visible injuries. That afternoon, staff demoted Mr Rogers to basic regime again.

29. On 23 May, the prisoner Mr Rogers had assaulted the day before, attacked Mr Rogers. Nurse B treated two one inch lacerations behind Mr Rogers' right ear and a small graze on his left temple. Mr Rogers told staff he did not want the matter referred to the police.

30. On the afternoon of 23 May, Mr Rogers attended a disciplinary hearing. The Head of Residence adjourned the hearing for seven days for Mr Rogers to seek legal advice. The Head of Residence said that Mr Rogers seemed fine and did not appear vulnerable. He said that there was some intelligence to suggest that Mr Rogers was involved in bullying other prisoners, but none that he was being bullied himself. He said that he had asked Mr Rogers about the reason for the fights, but Mr Rogers did not want to discuss them.

31. Around 10.50am on 24 May, Mr Rogers and another prisoner were seen on CCTV kicking a prisoner who was on the ground. Staff intervened and stopped them and charged them with an offence of assault under Prison Rules. Later the same day, the prisoner Mr Rogers had attacked on 22 May, assaulted him again. Once more, Mr Rogers said that he did not want the police involved. Nurse C examined Mr Rogers and recorded that he needed no treatment.

32. On 25 May, the Head of Security began an adjudication in relation to the assault charge the previous day and adjourned the hearing for seven days, again to allow Mr Rogers to seek legal advice. The Head of Security told the investigator that intelligence reports had linked Mr Rogers with organised crime groups in the prison who were trying control access to drugs. The Head of Security said there was information indicating that the two men had been fighting about a mobile phone, but Mr Rogers would not tell him the reason for the fights.

33. The Head of Security decided to move Mr Rogers from A Wing to C Wing (another standard wing) to separate him from the other prisoner. Mr Rogers moved to a double cell with prisoner, A, on C3 landing. Both prisoners were on basic regime, with reduced privileges. The Head of Security said that acts of violence and antisocial behaviour were recorded in the duty governor's daily briefing and in wing observation books so that all staff were aware. He considered that, in the short term at least, the problem between Mr Rogers and the other prisoner had been resolved by moving Mr Rogers.

34. On 27 May, a recovery support worker, from the substance misuse team, visited Mr Rogers in his cell, because he had received a self-referral form. Mr Rogers told the

recovery support worker that he had not self-referred and suggested that a friend had made the application as a joke. The recovery support worker gave Mr Rogers a brief overview of the substance misuse service, but as he raised no concerns, the referral was closed.

35. On 31 May, after receiving information, officers searched Mr Rogers' and prisoner, A's cell and found a homemade telephone charger in the ventilation vent. Both prisoners were charged under Prison Rules with an offence of possessing an unauthorised article. They were due to attend a disciplinary hearing the next day.

1 June 2015

36. Around 7.50am on 1 June, officers unlocked the cells on C Wing and Mr Rogers and prisoner, A, went to see prisoner B and prisoner C, in their cell. Prisoner B and prisoner C told the investigator that there was nothing about how Mr Rogers appeared, which led them to have any concerns about him. Officers who saw Mr Rogers that morning also had no concerns about him. At around 9.00am, Officer C and Officer D locked Mr Rogers back in his cell. Prisoner A was not in the cell at the time as he had a visit with his solicitor.

37. Around 10.35am, Officer E went to collect Mr Rogers for the adjudication and noticed that the cell door observation hatch was covered with toilet paper. He knocked on the door and asked Mr Rogers to take down the tissue. When Mr Rogers did not respond, the officer opened the door and found that Mr Rogers had hanged himself by a ligature made from a bed sheet, tied to the window bars. The officer pressed the personal alarm on his radio (in fact the alarm was not activated) and shouted for help. He cut the ligature and lowered Mr Rogers onto his back on the floor.

38. Supervising Officer (SO) A was in the staff office on C4 landing when he heard someone call for help and went down to C3 landing. Officer C and Officer D were on C3 landing but could see no problem and checked C2 landing. As SO A went back up to C3 landing, a prisoner pointed towards Mr Rogers' cell and Officer E came out of the cell shouting for help.

39. SO A went into the cell followed by Officer C. According to prison logs, at 10.36am, the officer radioed a code blue medical emergency, which indicates a prisoner is unconscious, not breathing or is having breathing difficulties, alerts other staff to attend and the control room to call an ambulance. Nurse D and Healthcare Officer A arrived shortly afterwards.

40. Mr Rogers was white and cold and had deep ligature marks around his neck. Healthcare officer, A, started cardiopulmonary resuscitation and attached a defibrillator (a life saving device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest). The defibrillator found no shockable rhythm and the staff continued to try to resuscitate him. Dr B arrived to help.

41. The control room log shows that staff called at ambulance at 10.37am. (The ambulance service records indicate the call was received at 10.40am.) The ambulance arrived at the prison gate at 10.45am, and the paramedics reached Mr Rogers' cell at 10.47am. At 10.55am, the paramedics recorded that Mr Rogers had died.

Contact with Mr Rogers' family

42. Mr Rogers' mother lived in Manchester and staff at Exeter asked HMP Manchester to visit her. Shortly before midday, Mr Rogers' brother and mother phoned Exeter and spoke to the Governor because they had heard that something had happened to Mr Rogers. The Governor said that officers from Manchester were on their way, but told them that Mr Rogers had died.

43. Around 1.00pm, Officer F and Officer G, from HMP Manchester, arrived at Mr Rogers' mother's home. Officer H was appointed as Exeter's prison family liaison officer and phoned Mr Rogers' mother the next day. Officer H kept in contact with Mr Rogers' family. The prison contributed to the funeral, in line with Prison Service instructions.

Support for prisoners and staff

44. At 2.10pm, the Head of Offender Management debriefed the staff involved in the emergency response, and the prison's care team offered support. The Governor issued notices to staff and prisoners informing them of Mr Rogers' death, and officers and members of the chaplaincy team supported prisoners. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Rogers' death.

Post-mortem report

45. A post-mortem examination recorded Mr Rogers' cause of death as suspension by ligature around the neck (hanging). The toxicological examinations found the presence of citalopram (his prescribed antidepressant) in Mr Rogers' body at therapeutic levels, consistent with his prescribed medication. No other drugs were detected.

Findings

Violence reduction

46. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody) gives instructions and guidance on dealing with prisoners who are violent and who are the victims of violence. The PSI states that prisoners should be encouraged to address the causes of their violent behaviour. Victims of violence should be provided with appropriate support, according to the hurt or injury they suffer.

47. Between 26 April and 24 May, Mr Rogers was involved in three attacks on other prisoners and was twice assaulted himself (by a prisoner he had attacked). According to the prison's local violence reduction strategy at the time, prisoners involved in violence were demoted to basic regime and referred for a disciplinary hearing. Mr Rogers had been placed on basic regime and two disciplinary hearings had been adjourned for him to seek legal advice. During the hearings, senior staff asked Mr Rogers about the incidents but he did not want to discuss what had happened and did not raise any specific concerns with them. Because several of the incidents involved the same prisoner, staff moved Mr Rogers from A Wing to C Wing to limit their contact with each other.

48. The day before he died, officers found a homemade mobile phone charger in Mr Rogers' shared cell. It is possible that Mr Rogers was under pressure to hold this for other prisoners, but there is no evidence of this.

49. A PPO publication of October 2011, 'Violence reduction, bullying and safety' noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages and in a Learning Lessons Bulletin about the self-inflicted deaths of young adult prisoners, published in July 2014, we found that 20% of 18-24 year olds who killed themselves had experienced bullying in the previous month, compared to 13% of other prisoners. However, we found no hard evidence that indicated that Mr Rogers was being bullied or coerced by other prisoners and no direct link between the violent incidents and Mr Rogers' death. We are satisfied that Exeter dealt with Mr Rogers in line with the prison's local violence reduction strategy.

Mr Rogers' risk of suicide and self-harm

50. When Mr Rogers arrived at Exeter in November 2014, he said that he had never harmed himself or attempted suicide before. There was no history of self-harm recorded in his prison or medical records. In April 2015, Mr Rogers told a prison doctor that he felt depressed and the doctor prescribed antidepressants, which Mr Rogers continued to take until his death. He said that he had no thoughts of suicide or self-harm at the time. Mr Rogers was young, his relationship had broken down, he had no contact with his child and he thought he was facing a longer than expected sentence. All of these factors increased his risk of suicide. However, no one had any concerns that Mr Rogers was at risk of suicide and self-harm or considered that he needed to be monitored under Prison Service suicide and self-harm prevention procedures.

51. As we have discussed, Mr Rogers was also involved in five incidents of violence, four of them occurring just over a week before he died. Staff moved Mr Rogers to

another wing to try to prevent further incidents and, when asked, he raised no concerns about his safety. Staff had no concerns about Mr Rogers' vulnerability. In the period after the fights and during the morning of 1 June, Mr Rogers gave staff and other prisoners no reason to consider that he needed closer monitoring. His friends said that he had seemed in good spirits on the morning of 1 June.

52. However, his cellmate told us that Mr Rogers had not slept well the night before his death. He said that he was upset that his former partner had told him that she was taking his name off his baby's birth certificate and naming another man as the father. He noted that, the night before Mr Rogers killed himself, he had placed some photos of his baby son and his father on his stereo; he thought that Mr Rogers had been sitting looking at them during the night. He said that Mr Rogers particularly missed his father. His cellmate said that Mr Rogers found the regime on C Wing difficult as staff applied the basic regime more strictly than on A Wing and they were locked in their cells for 22.5 hours every day. Although his cellmate and others knew that Mr Rogers had things that were causing him stress, they saw no indication that he was suicidal. In retrospect, they believed that he had bottled things up and would have been embarrassed to ask for help.

53. Again, we identified a number of these themes in our Learning Lessons Bulletin about deaths of young adults. In particular, we highlighted how the break-up of relationships and separation from their families can disproportionately affect young adults because of their limited life experience. We also recognised the impact of relocation within the prison and that 16% of 18-24 year olds were on the basic regime at the time of their death compared to 6% of older prisoners. Prison staff need to be vigilant in identifying these risks, but we recognise that it would have been very difficult to have anticipated Mr Rogers' actions or to have identified that he was at imminent risk of suicide. We do not consider that staff could have reasonably been expected to predict his actions and prevent his death.

Emergency response

54. When Officer E discovered that Mr Rogers had hanged himself, he did not immediately radio a code blue emergency. He shouted for help and pressed the personal alarm button on his radio. However, the alarm button did not work and, initially, staff on the wing were not sure where help was needed. However, Officer C radioed a code blue when she arrived at the cell, very shortly afterwards – about one minute after Officer E had gone into the cell.

55. Officer E said that he knew he should have radioed a code blue and we understand that he was probably in shock. He cut the ligature from around Mr Rogers' neck immediately. We accept that there was only a slight delay in calling the emergency code and that this would not have affected the outcome for Mr Rogers. Staff appropriately tried to resuscitate Mr Rogers, but sadly this was not possible.