

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Rogers a prisoner at HMP Dartmoor on 12 December 2018

**A report by the Prisons and Probation Ombudsman**

## 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.

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

Mr David Rogers died after being found hanged in his cell at HMP Dartmoor on 12 December 2018. He was 85 years old. I offer my condolences to Mr Rogers' family and friends.

In July 2017, Mr Rogers had received a 16-year sentence. Although he was shocked by the length of his sentence, he gave no indication to staff, other prisoners or his family that he was at risk of suicide or self-harm. I am satisfied that staff could not have predicted Mr Rogers' actions.

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

**Sue McAllister, CB**  
**Prisons and Probation Ombudsman**

**July 2019**

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# Summary

## Events

1. On 5 June 2017, Mr Rogers was remanded into custody at HMP Exeter, charged with sex offences. On 6 July, he was convicted and sentenced to 16 years in custody, which was significantly longer than he had been expecting.
2. Mr Rogers was 85 years old. He wore leg callipers on his right leg due to an industrial accident some 30 years earlier, but was able to get around easily with the aid of two sticks. He had a heart condition and had been fitted with a pacemaker about five years earlier. He had served three previous custodial sentences, two in 1963 and one in 1969.
3. On 25 May 2018, Mr Rogers transferred to HMP Dartmoor.
4. Mr Rogers had never been known to harm himself while in prison. He settled well at Dartmoor and had regular contact with his offender supervisor and the chaplaincy, and received support from fellow prisoners. He was also in regular telephone contact with his wife and son, who lived in the North East.
5. On 12 December, at 5.43am, a member of staff found Mr Rogers hanged in his cell and requested an ambulance. Officers responded but did not begin cardiopulmonary resuscitation as it was clear that Mr Rogers had been dead for some time. The paramedics arrived at 6.39am and pronounced Mr Rogers dead.

## Findings

### Assessment of risk

6. Although Mr Rogers had been shocked by the length of his sentence, during the six months he spent at Dartmoor, he gave no sign either verbally or in terms of how he presented to staff, other prisoners, or his family that he had thoughts of suicide. We do not consider that prison staff could have predicted his actions.

### Clinical care

7. The investigation identified no concerns with Mr Rogers' treatment while in custody. The clinical review also concluded that the care provided to Mr Rogers was equivalent to that he could have expected to receive in the community.

## Recommendations

8. We have made no recommendations.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Dartmoor on 19 December. He obtained copies of relevant extracts from Mr Rogers' prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Rogers's clinical care at the prison.
12. The investigator interviewed six members of staff and four prisoners at Dartmoor in January 2019.
13. We informed HM Coroner for Exeter and Greater Devon District of the investigation. He gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Rogers' family to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. Mr Rogers' family did not raise any concerns and did not want a copy of this report.

# Background Information

## HMP Dartmoor

15. HMP Dartmoor is a Victorian prison that holds up to 640 adult male prisoners. It has six residential wings and a care and separation unit. Healthcare services are provided by Care UK and mental healthcare is provided by Devon Partnership NHS Trust.

## HM Inspectorate of Prisons

16. The most recent inspection of HMP Dartmoor was carried out in August 2017. Inspectors found staff-prisoner relationships were very good and good support was provided to elderly and disabled prisoners. Inspectors found that levels of violence were very low. The chaplaincy provided excellent pastoral support and made a valuable contribution to prison life. Access to health services was good, nurses ran age-related clinics and appointments with a doctor were readily available and could be arranged on the same day if required.

## 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 annual report, published in January 2019, the IMB commented that the increasing number of elderly prisoners with complex health problems causes difficulties for healthcare and prison staff. Prisoners with mobility issues, including those who are frail and need social care, are allocated cells on the ground floor.

## Previous deaths at HMP Dartmoor

18. Mr Rogers' death was the fifth death at Dartmoor since January 2017. Three of these deaths were from natural causes and one, in February 2017, was self-inflicted. There are no similarities between Mr Roger's death and this earlier self-inflicted death.

## Key Events

19. On 5 June 2017, Mr David Rogers was remanded into custody at HMP Exeter charged with sex offences. Mr Rogers had been in prison three times before, twice in 1963, and the last time in 1969.
20. Mr Rogers was 85 years old, suffered from a heart condition and had had with a pacemaker since 2012. He wore callipers on his right leg due to a fused ankle which was the result of an industrial accident some 30 years earlier. He walked easily with the aid of sticks.
21. Mr Rogers' prescribed medication in the community was atorvastatin (to lower cholesterol), quinine (for leg cramps), ramipril (for high blood pressure and congestive heart failure), glyceryl trinitrate (GTN) spray (for angina), clopidogrel (to prevent blood clots), lansoprazole (to reduce stomach acid) and co-codamol (for the relief of mild to moderate pain).
22. At his reception screening in Exeter, a prison GP saw Mr Rogers and repeated his prescribed medication. The prison GP recorded that Mr Rogers suffered from ischaemic heart disease and angina, had had a pacemaker fitted, and had a fused right ankle.
23. During reception, Mr Rogers told a Staff nurse that he had taken an overdose because of the pressure his case had put him under. He said he had not had contact with a community mental health team. He denied having any current thoughts of suicide or self-harm.
24. On 6 June, a nurse a member of the mental health team saw Mr Rogers for a mental health assessment. Mr Rogers said it had been a shock when his stepdaughter made allegations about him. He said he had pleaded guilty to lower his sentence and was due in court again at the beginning of July for sentencing. Mr Rogers denied he had any intention or any plans of suicide. He recorded that Mr Rogers presented as being low in mood but was not clinically depressed. He assessed that Mr Rogers was not at risk of self-harm or suicide.
25. On 8 June, a visiting psychiatrist recorded in Mr Rogers' medical record that a mental health team discussion about Mr Rogers' ongoing care had been held following a member of the mental health team's assessment. She recorded that Mr Rogers had no history or evidence of psychosis or mood disorder, and no suicidal ideation or thoughts of self-harm. She referred Mr Rogers to be seen by a doctor to prescribe an antidepressant, and noted that while Mr Rogers was not added to the mental health caseload, he could be re-referred at any time if, and when, necessary.
26. On 13 June, prison GP saw Mr Rogers following the referral made by a visiting psychiatrist. Mr Rogers said he felt low and found it difficult to concentrate. He denied he had any thoughts of self-harm or suicide. The prison GP prescribed sertraline (an anti-depressant) in addition to the rest of Mr Rogers' prescribed medication.
27. On 6 July, Mr Rogers was convicted and sentenced to 16 years in custody. On his return to Exeter from court, a prison GP saw Mr Rogers. Mr Rogers said his

wife and son were supporting him but they lived in the North East. He said he felt the rest of his family were against him. He said he had expected a sentence of about four years which was why he had pleaded guilty. He was shocked to receive such a long sentence but did not intend to appeal. Mr Rogers said he could “get on with things” now that the uncertainty was over. He said he had no plans to harm himself at all and was focused on the future with the support of his wife and son.

28. The prison GP recorded that Mr Rogers had no plans to self-harm but that she believed the enormity of his sentence, combined with his age, had not really sunk in. She prescribed one dose of zopiclone (for insomnia) and arranged a further appointment with a doctor in five days’ time.
29. On 11 July, a prison GP saw Mr Rogers as arranged by another prison GP. Mr Rogers said he felt much better after taking sertraline and had no difficulty reading, concentrating or mobilising around the wing. He recorded that Mr Rogers had no thoughts of self-harm or suicide, and that the treatment plan was to continue with the prescription of sertraline along with the rest of Mr Rogers’ prescribed medication.
30. On 8 August, Mr Rogers asked for clinical support for a move to HMP Durham, in order to be closer to his family. Although the support was agreed, the move was not considered appropriate.
31. Between 21 August and 24 May 2018, Mr Rogers moved from Exeter to HMP High Down, then to HMP Isle of Wight and back to Exeter. Throughout this period Mr Rogers continued to receive his prescribed medication and had regular interventions with healthcare. He consistently denied having any thoughts of suicide or self-harm and at no time was he assessed as being at risk of suicide.

### **HMP Dartmoor**

32. On 25 May 2018, Mr Rogers was transferred to HMP Dartmoor. On his arrival at Dartmoor, a nurse saw Mr Rogers in reception. She recorded Mr Rogers’ prescribed medication, that he suffered from ischaemic heart disease, had a pacemaker fitted, walked with the aid of crutches and needed to be allocated a cell on the ground floor. Mr Rogers denied he had any thoughts of suicide or self-harm.
33. On 4 June, a prison GP saw Mr Rogers for a review. Mr Rogers said he felt settled and no longer needed to take an antidepressant. He recorded that he discontinued the prescription of sertraline. He noted that Mr Rogers had a pacemaker and used crutches as his balance was not too good. The remainder of Mr Rogers’ medication remained unchanged.
34. Between 5 June and 11 December, Mr Rogers continued to receive his prescribed medication and attended his appointments with healthcare. Mr Rogers had regular contact with the chaplaincy and with his offender supervisor. He also received support from the ‘Buddies’ system at Dartmoor.
35. Two prisoners were prisoners who worked as part of the ‘Buddies’ system at Dartmoor. The role involves providing help to elderly or disabled prisoners to collect meals, clean cells, take them to visits and appointments if they are in

wheelchairs, and generally helping them with their daily living to make life easier for them. They explained to the investigator there is a strict selection process to become a 'Buddy'. Prisoners must apply for the role and are security screened. Once cleared to do the role, applicants have to undertake, and successfully complete, a three-week training course, at which point they become part of the 'Buddies' team.

36. One of the prisoners said Mr Rogers was "a lovely man with a good sense of humour" who got on well with his peers on the wing. The other prisoner said Mr Rogers would mix with the older prisoners on the wing, he was lively, enjoyed a joke and enjoyed making models from matchsticks.
37. A Reverend told the investigator that Mr Rogers was a regular attendee at the Sunday service. He said Mr Rogers gave no one cause for concern, never appeared to be in crisis, was in contact with his family and seemed to be getting on with his sentence.
38. A Supervising Officer (SO) was Mr Rogers' offender supervisor. He explained that he was responsible for a number of prisoners and his role as offender supervisor was to be was to create a sentence plan with them, liaise with probation services and manage the prisoners through their sentence.
39. The SO said that Mr Rogers had been identified as being suitable to complete a sex offender treatment programme called 'Horizon'. He explained to Mr Rogers that it would involve him transferring to a prison that provided that course and would require him to share a cell. Mr Rogers told him that, at 85 years of age, he was reluctant to begin the course as he did not want the disruption of transferring to another prison. He said that prisoners could not be compelled to undertake courses, but that not doing so could affect their chances of parole.
40. The SO said that Mr Rogers always appeared upbeat. He mixed and got on well with his peers on the wing and said he looked forward to going to live with his son when he was discharged. He said the last time he had seen Mr Rogers was on 3 December, when Mr Rogers was in the library. He asked Mr Rogers whether he had had any further thoughts about the Horizon programme. Mr Rogers said he was too old to bother. He said Mr Rogers seemed fine, appeared his usual self and he was borrowing a CD from the library.
41. One of the prisoners who worked as part of the 'Buddies' system said that Mr Rogers was not bullied and gave no indication he had thoughts of suicide. He said it was part of the role of a 'Buddy' to report to staff any bullying or if a prisoner gave any indication they were going to self-harm.
42. The other prisoner who worked as part of the 'Buddies' system said he last spoke to Mr Rogers on the evening of 11 December, when Mr Rogers told him he had some oranges for him. He told Mr Rogers he would collect them off him in the morning. He said Mr Rogers appeared his usual self and gave no indication that he had thoughts of suicide.
43. Mr Rogers' prison phone records show that he was in regular contact with his wife and his son. The investigator listened to each of the calls Mr Rogers made from 26 October 2018 onwards. At no time did Mr Rogers say, or give any

indication, that he had thoughts of suicide or self-harm. The last call Mr Rogers made was to his son on 8 December. Again, he sounded fine and said nothing that would indicate he had thoughts of suicide or self-harm.

### **Events of 12 December 2018**

44. On 12 December, at 5.43am, an operational support grade (OSG) was undertaking the early morning roll check when he arrived at Mr Rogers' cell. The OSG looked through the observation panel in the cell door and saw Mr Rogers hanging from the window bars with a ligature made from bedding. He immediately radioed a code blue emergency, which indicates a prisoner is unable to, or having difficulty breathing and an ambulance was called immediately.
45. A Custodial Manager (CM) and an Officer arrived in less than 60 seconds. They, and an OSG entered the cell, cut the ligature and lowered Mr Rogers to the floor but did not start cardiopulmonary resuscitation (CPR). The CM told the investigator that they did not start CPR as rigor mortis was clearly evident, which indicated that Mr Rogers had been dead for some time and to start CPR would have been futile and undignified. At 5.45am, the CM informed the ambulance service by telephone that staff had not started CPR as rigor mortis indicated that Mr Rogers had been dead for some time. Paramedics arrived at 6.39am and at 6.55am and pronounced Mr Rogers dead.

### **Post-mortem report**

46. A post-mortem examination conducted by a Home Office Forensic Pathologist confirmed that the cause of Mr Rogers's death was hanging. She noted that the toxicology results showed that Mr Rogers was not under the influence of any illicit drugs or alcohol at the time of his death.

### **Contact with Mr Rogers' family**

47. As Mr Rogers' wife lived in the North East, Dartmoor asked HMP Durham for assistance in breaking the news of Mr Rogers' death to his wife. Two family liaison officers from HMP Durham visited Mr Rogers' wife at her home address at 9.50am to break the news of her husband's death and offer condolences.
48. In the days that followed, a Reverend stayed in touch with Mr Rogers' wife and son in line with Prison Service instructions. The prison offered to contribute to the costs of the funeral. Mr Rogers' family declined this offer as Mr Rogers already had a pre-paid funeral plan with a funeral director in Plymouth.

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

49. The Deputy Governor held a debrief for staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
50. The prison posted notices informing staff and prisoners of Mr Rogers' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Rogers' death.

# Findings

## Assessment of risk

51. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include a prisoner's first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
52. Mr Rogers had some risk factors for suicide and self-harm in that he suffered from depression and low mood, to varying degrees, from the time of his remand into custody in 2017, and had received an unexpectedly long sentence which, given his age, probably meant he would die in prison. In addition, his wife and son, although supportive, lived a long distance away and his only contact with them was by telephone. There may, therefore, have been a case for opening suicide and self-harm monitoring procedures when he was sentenced in July 2017.
53. However, we are satisfied that during the six months he spent at Dartmoor, Mr Rogers gave no indication to anyone that he had any suicidal thoughts. After his transfer to Dartmoor, his mood had improved, and he chose to stop his antidepressant medication in June 2018, and appeared to have accepted his sentence and to be getting on with it.
54. The Reverend, a SO and two prisoners who worked as part of the 'Buddies' system each told the investigator that Mr Rogers had given no indication that he had any thoughts of self-harm or of taking his own life.
55. Although the 72-hour incident report completed by Care UK following Mr Rogers' death found that Mr Rogers had wounds on his arms that were consistent with self-harm, there was nothing in his medical records or details of his contacts with clinicians, that gave them cause to consider that he might be at risk of suicide.
56. We do not consider that staff at Dartmoor could have predicted that Mr Rogers intended to take his life.

## Clinical Care

57. The clinical reviewer is satisfied that Mr Rogers received care that was at least equivalent to the care that he would have received in the wider community.

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