Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brett Rogers, a prisoner at HMP Long Lartin, on 7 June 2017.

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 Rogers was murdered in his cell by two prisoners, A and B on 7 June 2017 at HMP Long Lartin. Mr Rogers was 25 years old.

I offer my condolences to Mr Rogers' family and friends and my sincere apology for the very long time it has taken to produce this report. My investigation was delayed first at the request of the police, and then by a delay in obtaining the medical records of the two perpetrators, which led to a further delay in producing a clinical review of their time in Long Lartin.

Prisoner A was not thought to be a risk to other prisoners, but prisoner B's psychopathy and personality disorders meant that he did pose a risk to others. Evidence at their trial showed that prisoner B was the instigator of Mr Rogers' murder and prisoner A was under his influence. Despite initial concerns about moving prisoner B to a standard wing from the segregation unit, he appeared to settle in well without any significant problems and I am satisfied that there was no evidence that he posed a particular threat to Mr Rogers.

The actions of prisoners A and B were sudden and unexpected and it would have been very difficult for prison staff to have predicted or prevented Mr Rogers' murder. I have made no recommendations.

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.

Sue McAllister CB
Prisons and Probation Ombudsman **June 2020**

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Summary

Events

1. Mr Brett Rogers had a history of violent behaviour, attempted suicide and self-harm, mental illness and admissions to secure mental health units. On 27 January 2017, he transferred to HMP Long Lartin and was held on the healthcare centre for assessment because he was not taking his anti-psychotic medication.

2. Mr Rogers became compliant with his medication in early February and his behaviour steadily improved. He completed a phased move to Perrie Blue (a small unit of 42 cells) and moved there permanently on 7 March. He was supported appropriately by a protocol for his management, a violence reduction support plan and regular review by a dedicated mental health nurse and the psychiatrist.

3. Mr Rogers appeared settled on Perrie Blue, mixed with the other prisoners and was given a job as a wing cleaner.

4. Prisoner A had been in Perrie Blue since February 2017. He had a history of mental illness, substance misuse, attempted suicide, methadone dependence, social anxiety disorder and post-traumatic stress disorder. He was not regarded as a risk to other prisoners. He became friends with Mr Rogers and appeared to look after him and advocate for him.

5. Prisoner B, had a history of attention deficit hyperactivity disorder (ADHD), poly-substance misuse, post-traumatic stress disorder, psychosis and emotionally unstable and antisocial personality disorders. In December 2016, he was assessed as possessing the traits of psychopathy. His personality disorder meant that he was a risk to staff and prisoners.

6. Prisoner B, had been kept in the segregation unit for two months when he first arrived at Long Lartin while his risk was assessed. He was moved to Perrie Blue wing in December 2016. His risk was reassessed in February 2017, after he punched another prisoner, but he appeared to settle In Perrie Blue without further problems.

7. The records showed no significant contact between prisoner B and Mr Rogers but he gradually became friendlier with prisoner A.

8. On 7 June 2017, Mr Rogers did not go down for his evening medication. An officer discovered him unresponsive in his cell. A code blue emergency and an ambulance were called and staff and nurses tried to resuscitate Mr Rogers. They stopped when they realised rigor mortis was present and ambulance paramedics confirmed he had died.

9. Mr Rogers had no obvious injuries but CCTV showed prisoners B and A had spent time in his cell that afternoon. Police investigated and charged them with murdering Mr Rogers. They were both found guilty in November 2017.

10. The coroner gave Mr Rogers' cause of death as compression to the neck.

Findings

11. Mr Rogers was appropriately located on Perrie Blue and had good support plans in place to manage his risk. He was well supported by staff and the mental health team and his overall care was good.

12. We found no evidence that prisoner, A posed a risk to Mr Rogers before 7 June 2017. Their relationship appeared positive. After Mr Rogers died, another prisoner said that prisoner A had told him he could "kill Brett" but he did not tell staff at the time.

13. Mr B's personality disorder meant that he posed a risk to others. His risk was assessed in the segregation unit before he was moved to Perrie Blue and he received ongoing support from the mental health team. We are satisfied that the decision to move him to Perrie Blue was not unreasonable. There was nothing to suggest that he posed a particular risk to Mr Rogers before 7 June 2017.

14. We are satisfied that the actions of both, prisoners, A and B were sudden and unexpected and that it would have been very difficult for prison staff to have predicted or prevented Mr Rogers' murder.

15. We make no recommendations.

The Investigation Process

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

17. The investigator obtained copies of relevant extracts from Mr Rogers prison and medical records. At the request of West Mercia police, she did not interview anyone until the completion of the criminal trial of the two men convicted of murdering Mr Rogers. The police provided her with copies of their interviews. The investigator also obtained relevant parts of the prison and medical records of the two men convicted of murdering Mr Rogers through the Caldicott Guardian process.

18. The investigator interviewed nine members of staff at HMP Long Lartin in March 2018.

19. NHS England commissioned a clinical reviewer to review Mr Rogers' clinical care at the prison and the clinical care of the two men convicted of murdering Mr Rogers.

20. We informed HM Coroner for Worcester of the investigation. The Coroner gave us the results of the post-mortem examination. The Coroner decided not to hold an inquest into Mr Rogers' death and we have not sent them a copy of this report.

21. We contacted Mr Rogers' father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Rogers' father said his main concern was the mental healthcare provided to his son. He thought Mr Rogers was a vulnerable prisoner and should have been in the healthcare unit. We have addressed these concerns in this report.

Background Information

HMP Long Lartin

22. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Care UK, with mental healthcare subcontracted to South Staffordshire and Shropshire NHS Foundation Trust Mental Health Team.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that the prison had made very good progress in meeting the Prisons and Probation Ombudsman's recommendations following investigations into three self-inflicted deaths at Long Lartin since 2014. Inspectors noted the management team were competent and effective.

24. Inspectors found relationships between staff and prisoners were confident and respectful. Healthcare was well led and work to support those with mental health needs was responsive and effective; waiting times were short and better than those found in equivalent community services.

Independent Monitoring Board

25. 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 Long Lartin, for the year to 31 January 2018, the IMB noted the normally settled atmosphere at Long Lartin had been disturbed by periods of tension, including raised levels of violence against staff and prisoners.

26. The Board noted that both mental health and general nursing staff were below the agreed service level and there was no psychologist. They were also concerned prison staff had fallen significantly behind with data collection, recording and reporting on NOMIS, the electronic prison record.

Previous deaths at HMP Long Lartin

27. There was a homicide at Long Lartin in June 2015 and another in June 2016. Our investigation into the first, found that it would have been difficult for the prison to have predicted the death. However, our investigation into the second, which took place in the prison's vulnerable prisoner unit, found evidence that the victim was at risk from the perpetrator and the prison could have done more to keep him safe.

28. There have been 10 deaths at Long Lartin since Mr Rogers died. The majority were from natural causes and none were homicides.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level

of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

30. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

31. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody.*

Key Events

Mr Brett Rogers

32. Mr Brett Rogers had a history of violent behaviour, attempted suicide and self-harm, mental illness and admissions to secure mental health units. On 24 July 2015, he was remanded to HMP Chelmsford charged with the murder of his mother and her friend. At the time of the offence he was on licence from a sentence for grievous bodily harm imposed in 2012 after he stamped on his father's head and broke his eye socket. On 13 May 2016, he was sentenced to life imprisonment with a minimum time to serve of 32 years.

33. Mr Rogers was managed as an inpatient in the healthcare unit in Chelmsford. He struggled with communication, was described as almost mute, and was deemed too nervous and "strange" to move to a standard wing. He was assessed as presenting a high risk of serious harm to staff and other prisoners. Intelligence indicated that Mr Rogers was using illicit psychoactive substances (PS) and that this was one underlying cause of his strange behaviour and lack of compliance with his medication.

34. On 24 January 2017, Mr Rogers was transferred to Long Lartin. He was admitted to their inpatient healthcare unit because he had been non-compliant with his anti-psychotic medication at Chelmsford and staff were concerned about his state of mind. Prison Service suicide and self-harm monitoring procedures (known as ACCT), which had been started at Chelmsford, were continued. Mr Rogers was unable to smoke in the healthcare unit and repeatedly asked to move to a standard wing.

35. On 26 January, Dr A, a consultant forensic psychiatrist, reviewed Mr Rogers. The doctor recommended that Mr Rogers remain in healthcare on a 'four-man unlock' (four officers were required to be present when his cell was unlocked) because of his unpredictability and high risk of harm to himself and others. Mr Rogers continued to behave bizarrely for the rest of January but in early February he started taking his medication and his mental state improved. His medical record showed he was in a brighter mood and was more communicative.

36. On 21 February, Mr Rogers began a phased move to Perrie wing (a standard wing). He went there every evening for social time and exercise and reported that he enjoyed it. Dr A reviewed him on 2 March and considered that Mr Rogers might have autistic spectrum disorder. He said that Mr Rogers was not psychotic and he agreed he could return to a standard wing with further reviews planned. Nurse A was allocated as Mr Rogers' named mental health nurse.

37. On 7 March 2017, Mr Rogers was moved permanently to Perrie Blue. Perrie wing is divided into two separate wings – Perrie Blue and Perrie Red. Perrie Blue with 42 cells is the smallest standard wing in Long Lartin. The population was regarded as mature and stable and staff said the wing had a "community feel" to it. It was often used as a transitional location for prisoners who had spent significant time in segregation or in healthcare so they could become used to a standard wing. The ratio of staff to prisoners was also higher than on other standard wings.

38. Senior Officer (SO) A said she first spoke to Mr Rogers in healthcare to assess his suitability for Perrie Blue wing. She said that Mr Rogers was "odd" both in his demeanour and mannerisms. She said she was worried that this would make him vulnerable on a standard wing and he might get into debt because of his dependence on tobacco. However, Mr Rogers settled in reasonably well on Perrie Blue. He was still a strange man but did not appear to have problems making the transition from healthcare. The SO said that Mr Rogers showed no evidence that he was struggling or stressed on Perrie Blue.

39. SO A wrote a comprehensive protocol for staff to manage Mr Rogers, which we have seen. The protocol was emailed to all wing staff and a copy was pinned up in the Custodial Manager's (CM's) office. The protocol operated in tandem with a violence reduction support plan because of the concerns he was vulnerable to debt and his history of substance misuse in prison.

40. Mr Rogers' first recorded contact with prisoners, B and A was on 8 March. His prison record showed he had talked to them when they had cut his hair. There are no other entries in Mr Rogers' prison record that refer to contact with prisoner B On 17 March, Officer A noted that Mr Rogers had become friends with prisoner A and they spent a lot of time together. Wing staff made entries on Mr Rogers' prison record almost daily and often made several entries on one day. They reported that he was quiet but said, overall, he appeared settled and relaxed on the wing.

41. On 11 April, SO A reviewed Mr Rogers' violence reduction support plan and decided it should remain open. She noted his mannerisms continued to be strange but he had shown no signs of violent behaviour. Several entries from other staff commented on the positive nature of Mr Rogers' friendship with prisoner A.

42. On 20 April, Dr A reviewed Mr Rogers and found no sign of acute mental illness. Mr Rogers continued to be supported by regular appointments with Nurse A. On 18 May, the doctor reviewed Mr Rogers again. Mr Rogers said he was ok and had spent his time smoking and watching TV. He said he had no difficulties with other prisoners and was eating and sleeping well. The doctor noted that Mr Rogers was well-kempt and appeared well. Mr Rogers asked if he could change his anti-psychotic medication from amisulpride to olanzapine because he felt 'medicated'. He said he had previously taken olanzapine and felt better using it. The doctor explained the side effects and potential risks of changing medication from something he was stable on but agreed to prescribe olanzapine. He planned to review Mr Rogers in two months.

43. On 24 April, Mr Rogers was allocated work in one of the prison workshops but did not attend. Officer B contacted Nurse A and she agreed to assess whether Mr Rogers could cope in a workshop environment. The nurse decided Mr Rogers' mental health meant he was only suitable for wing-based work. Staff gave Mr Rogers responsibility for some cleaning tasks to get him out of his cell and enable him to interact with a small number of prisoners at a time. He remained compliant with his medication and had regular appointments with Nurse A.

44. On 2 May, SO A noted on his prison record that Mr Rogers had settled well and there was no evidence to suggest that anyone was taking advantage of his vulnerability. She said he was tolerated well and supported by the other prisoners. She closed his violence reduction support plan.

45. Officer C was Mr Rogers' personal officer. He described Mr Rogers as "very quiet and difficult to talk to" at first. The officer said that after a while, Mr Rogers opened up a bit and started to trust him and talk to him regularly. Mr Rogers said he was happy on Perrie Blue – Officer C thought this was primarily because he was allowed to smoke. Mr Rogers spent a lot of time in bed in his cell and would not really talk to other staff. He seemed to get on fine with the other prisoners and the officer did not think Mr Rogers was vulnerable. There were good relationships between the staff and the prisoners and he thought that if there had been any indication of a threat to Mr Rogers someone would have said something to staff.

Prisoner A

46. Prisoner A had a history of mental illness, substance misuse, attempted suicide, methadone dependence, social anxiety disorder and post-traumatic stress disorder from a career in the army. He was sentenced to life imprisonment for murder in 2007. In 2012 and 2015 he spent periods in secure mental hospitals for assessment. He had diagnoses of antisocial, borderline and paranoid personality disorders. He said that he had three different personalities: himself; a suicidal depressive; and a confident and aggressive personality called 'Gadget'. He had a history of impulsive and aggressive behaviour to others that he blamed on his split personalities. Medical opinion was that his behaviour was driven by his personality disorders and substance misuse and he did not have a diagnosis of dissociative identity disorder (split personality).

47. On 7 February 2017, prisoner, A, was transferred to Long Lartin after getting onto a roof at HMP Woodhill. He was held in the segregation unit for a period of assessment because of his behaviour at Woodhill. He was also managed under ACCT procedures after he told a nurse that he felt suicidal. He was prescribed a methadone maintenance programme to help him detoxify from an addiction to illicit buprenorphine (Subutex, an opioid substitute) acquired in his previous prison. He was allocated a nurse from the integrated misuse service who reviewed him regularly.

48. On 14 February, Nurse B discussed a potential move to Perrie Blue with him and prisoner, A, started a phased move by visiting the wing for social time. On 22 February, ACCT monitoring was stopped and he was moved permanently to Perrie Blue. He settled well on the wing and became a wing cleaner (a trusted job). He was not involved in any acts of violence on Perrie Blue. On 10 April, he tested positive for cannabis but was negative in another test on 15 May.

49. SO A said prisoner A told her about his multiple personalities and that a different personality came to the surface when he got stressed. The SO said she had never seen signs of these different personalities and that prisoner, A, had always seemed "switched on and together". She got to know him quite well and described him as hard-working and said he had a good relationship with staff.

She did not remember anyone from the mental health team ever saying anything specific to her about prisoner, A, being a risk to others.

50. SO, A, said prisoner, A, took Mr Rogers under his wing and appeared to be a nurturing and caring friend to him. He helped Mr Rogers clean his cell and sounded genuinely well disposed towards Mr Rogers. She did not think he manipulated Mr Rogers or had a negative influence on him. Officer C said prisoner, A, used to clean Mr Rogers' cell for him and looked out for Mr Rogers. Prisoner, A, got on well with staff and had a good sense of humour. Officer C had no anxieties about their friendship.

Prisoner B

51. Prisoner, B, had a history of attention deficit hyperactivity disorder (ADHD), poly-substance misuse, post-traumatic stress disorder, psychosis and diagnoses of emotionally unstable and antisocial personality disorders. In 2016, he was sentenced to life imprisonment for murder.

52. On 20 October 2016, prisoner, B, was transferred to the segregation unit at HMP Long Lartin from the segregation unit at HMP Belmarsh. Records from Belmarsh showed that prisoner, B, said he had violent thoughts and fantasies of killing a person and had tortured and killed a pigeon instead. He had been referred to a Dangerous and Severe Personality Disorder (DSPD) unit and was awaiting an assessment.

53. Prisoner, B, was assigned a community psychiatric nurse (CPN), who visited him regularly, and he was added to the waiting list for the psychiatrist, Dr A. He was managed under the Care Programme Approach (CPA – a package of care for people with severe mental health problems). A weekly multi-disciplinary segregation review board decided he should remain in segregation until the doctor reviewed him. Prisoner, B, complied with the rules of the segregation unit and engaged well with his CPN. On 28 November 2016, prisoner, B, told a prison GP that he had a different personality called 'Michael' who spoke in an Irish accent and was very unpredictable.

54. CM, A, was in charge of the segregation unit when prisoner, B, was there. He said his first impression of him was that he was quite likeable. There was no repeat of his cruelty to pigeons at Long Lartin. Prisoner A's alter ego, used to come out when things were not going his way.

55. CM A said prisoner, B, was kept in the segregation unit so they could find out a bit more about him and see how to progress him to a standard wing. He was subject to Rule 45 which meant he had regular multi-disciplinary review meetings with input from the mental health team and psychologist. CM, A, said it was clear that there were complexities with his mental health and that it was appropriate for him to be in a high security prison, but he did not appear to be any more or less of a risk to others than many of the prison's population.

56. CM, A, said the prison had to justify why they kept each prisoner in segregation and they were required to follow a plan to reintegrate them to the standard wings. It had been recognised that segregating prisoners with personality disorders could make them worse, so the prison was keen that no one spent more time in

segregation than necessary. The multi-disciplinary review board decided to move, prisoner, A, to Perrie Blue because it was a small, stable unit next to the segregation unit with a more mature population.

57. On 13 December, Dr A, reviewed prisoner B and concluded that his presentation was consistent with psychopathy (a personality disorder characterised by anti-social behaviour and lack of empathy and remorse). He recommended further investigation and supported his referral to a DSPD unit with a planned review in six months. At the same time, prisoner, B began a phased reintegration from the segregation unit to Perrie Blue.

58. A forensic psychologist at Long Lartin, said she met prisoner B once briefly in the segregation unit to discuss his suitability for the Long Lartin pre-PIPE (psychologically informed planned environment) unit (a unit for prisoners with a severe personality disorder). She was initially concerned that he was to be moved to Perrie Blue without a proper management plan in place to manage his risk. She raised her concerns by email on 16 December.

59. On 20 December, a risk assessment was completed for moving prisoner B from segregation to a wing. This outlined his risks to others and his mental health. The assessment noted that he fully understood that if he wanted to meet the criteria for admission to a DSPD unit, he needed to spend at least six months on a standard wing. CM B, the Perrie wing manager, was made aware of prisoner B's history and he briefed the Perrie Blue staff. His integration was monitored by wing staff and they were told to report any concerns to the wing managers and through the security reporting process.

60. SO A said she did not know much about prisoner B when he arrived on Perrie Blue but what she had seen of his record had alarmed and worried her. She said the he seemed to revel in being a psychopath. The SO thought that he should have remained in the segregation unit but if he had to be on a wing she thought Perrie Blue was the most appropriate because it was small and had a relatively high number of staff. The SO said she raised questions about his location on a standard wing when he first arrived on Perrie Blue, but felt her concerns were dismissed at the time.

61. On 5 January 2017, prisoner B, told a nurse that he wanted to stop taking his anti-psychotic medication. In response, officers were asked to watch him and note any behaviour changes and Dr A reviewed him earlier than planned, on 19 January. He concluded that prisoner B, had no current mental health issues that required medication but that he continued to pose a high risk of harm to others because of his impulsivity, lack of empathy and conviction that he had to use violence to resolve conflict.

62. On 2 February, prisoner B, punched another prisoner in his cell, bruising his nose. He was charged with a disciplinary offence and monitored under the violence reduction strategy. CM B, said the safer custody team also reassessed his suitability for Perrie Blue and he was confined to his cell while this happened. CM B said he had seen the risk reassessment and it had been very thorough with input from the mental health team. He said prisoner B, was someone who "put you on edge" but he had appeared to settle well on the unit.

63. On 14 February, prisoner B, resumed his medication but took it only intermittently. He was reviewed regularly by the mental health team who reported that he appeared mentally stable and attended education and work.

64. On 16 March, he did not attend a review with Dr B because he was at work. The doctor reviewed prisoner B's medication and decided to discontinue his prescription because he was erratic in taking it and he considered the risks of suddenly stopping and starting it were too great. On 26 May, the prison received intelligence that prisoner B, was involved in taking PS.

65. Prisoner B, missed another review with Dr A on 6 April. The doctor discussed him with his regular mental health nurse who reported no concerns about him. The doctor decided to offer him one further appointment, with a view to discharging him from his caseload.

66. Prisoner B, met Dr A and his mental health nurse on 25 April. He said he was well, attended the gym, enjoyed work and was due to take a Maths GCSE. He said he ate well, slept well and had no hallucinations or thoughts of harming himself or others. The doctor discharged him from psychiatric follow up but noted that he remained a risk to others. Prisoner B, remained on the caseload of the mental health team.

67. SO B said prisoner B was always polite but was 'workshy' so needed encouragement to do things. The SO said prisoner B, did not come across as aggressive and appeared to just want to be left alone. He did not have any particular concerns about him.

68. Officer D said prisoner B was quite an odd person. One day he would present as normal and the next day he would refer to himself as 'Michael' and speak in an Irish accent. The officer thought he was mostly stable after he moved to Perrie Blue and only noticed him speaking in an Irish accent once or twice. He said there was always a degree of danger with a prisoner like prisoner B but staff were aware of it and it was not possible to keep prisoners in the segregation unit permanently. There was a higher staff to prisoner ratio on Perrie Blue which made it easier to keep an eye on people.

Evidence of risk to Mr Rogers from Prisoner A and Prisoner B

69. Prisoner C, said he became friends with Mr Rogers on Perrie Blue. He thought Mr Rogers had learning difficulties because of how he looked and behaved and the fact that he hardly spoke when out on the wing. He said he often played cards with Mr Rogers in his cell and he was more talkative in one to one situations.

70. Prisoner C said a couple of days before Mr Rogers died, prisoner A had told him that he could "kill Brett". Prisoner C asked him what he meant and prisoner A said that Mr Rogers was "really evil" and he could kill him and take his canteen. Prisoner C also said he heard prisoner B tell Mr Rogers, "You have got evil in your eyes and it takes evil to know evil." Prisoner C said prisoner B and prisoner A talked about things they had learned in the army such as how it was possible to kill someone without leaving a mark. Prisoner C did not report this to staff.

71. There is no other evidence or intelligence that prisoner B or prisoner C were a threat to Mr Rogers.

7 June 2017

72. On 7 June 2017, at 2.30pm, Officer B said she saw Mr Rogers collect his cleaning equipment. He appeared fine but was not wearing his work boots so she sent him back to his cell to put them on.

73. Prisoner C said he returned from work at about 3.00pm and went to visit prisoner B in his cell. Prisoner A was there too but they both left and said they were going see Mr Rogers. At about 3.45pm, prisoner C also went to see Mr Rogers but found his door shut and locked. (Prisoners have a privacy lock that allows them to lock their cell so other prisoners cannot come in, although staff can still open the door with a cell key.) He looked through the observation panel and saw Mr Rogers sitting in his chair, prisoner B sitting on the bed and prisoner A sitting on the pipes at the back of the cell. Prisoner A was rolling a 'joint'.

74. At about 4.10pm, prisoner C spoke to prisoners, B and A in the kitchen where they were making garlic bread. Prisoner A said Mr Rogers had gone to bed and that was why his door was shut. All three men then went into the yard for exercise. At dinner time the medication round was called and prisoner C went to wake Mr Rogers up because he knew he was on medication. He banged on the door but got no response. He looked through the observation panel but said it was too dark to see anything clearly. He said he went to ask prisoner A to try to wake Mr Rogers up but he ignored him. He then saw an officer go to Mr Rogers' door.

75. Officer E said that he returned to the wing from collecting a prisoner and someone told him Mr Rogers had not come down for his medication. He said Mr Rogers usually came for his medication but when he did not it was usually because he was asleep. He went to Mr Rogers' cell and opened the door. Mr Rogers was lying on his back on his bed with the covers pulled up. Officer E could see his work boots were still on his feet. He was unable to get a verbal response from Mr Rogers.

76. Officers in Long Lartin must enter cells in pairs, so Officer E called Officer D and they went into the cell together. Mr Rogers looked very pale and did not respond when they shook him. Officer D said, "He doesn't look right, call a code blue." Officer E radioed the code blue and Officer C and Officer B came immediately. The control room log showed the code blue was called at 5.58pm and control room phoned for an ambulance as soon as it was received, in line with national guidance. Officer E and Officer C lifted Mr Rogers on to the floor and Officer C started cardio-pulmonary resuscitation (CPR) until nurses arrived. He said he could see no injuries around Mr Rogers' neck and could see no sign of struggle in the cell.

77. Nurse C, responded to the code blue. He said Mr Rogers was unresponsive, not breathing, cold, with no pulse and fixed and dilated pupils. He was quickly joined by four colleagues. They gave Mr Rogers oxygen using a bag and mask and connected a defibrillator. The defibrillator indicated no electric shock and that CPR should continue. After ten minutes the nurses decided to stop CPR

because signs of rigor mortis were present. Paramedics arrived at 6.24pm and confirmed Mr Rogers had died.

78. There was no evidence of physical injury to Mr Rogers and nurses initially speculated that he might have died from the effects of psychoactive substances.

79. Security officers reviewed CCTV which showed that Prisoners B and A had entered Mr Rogers' cell that afternoon with him and had left without him some time later. Staff took both the prisoners to the segregation unit and contacted West Mercia police. Both men were subsequently charged with murdering Mr Rogers.

80. In November 2017, both prisoners B and A were found guilty of murder and received further life sentences. Prisoner B received a whole life tariff which means he will never be released from prison.

Contact with Mr Rogers' family

81. SO C and senior prison manager, A, drove to Mr Rogers' father's house the evening Mr Rogers died and broke the news of his son's death.

82. The prison contributed to the cost of Mr Rogers' funeral in line with national guidance.

Support for prisoners and staff

83. After Mr Rogers' death, senior manager, B, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising. The staff care team also offered support.

84. The prison posted notices informing other prisoners of Mr Rogers' death and staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected.

Post-mortem report

85. The forensic pathology report showed Mr Rogers died from compression to the neck. Toxicology showed Mr Rogers was not under the influence of any substance when he died.

Findings

Management of risk

86. Mr Rogers had a long history of mental illness and his personality and mannerisms meant a number of staff were concerned that he would be vulnerable to manipulation and bullying by other prisoners on a standard wing. Mr Rogers stayed in the healthcare unit for a long period of assessment before he was moved to Perrie Blue with a protocol for his management, support under violence reduction procedures and with the ongoing support of the mental health team.

87. We have found no evidence that Mr Rogers was vulnerable on Perrie Blue and we are satisfied that appropriate risk assessments and management plans were put in place.

88. Prisoner A had a history of impulsive and aggressive behaviour but was not considered a threat to the safety of others. He had a higher number of risk factors for suicide and self-harm. He appeared to be a good friend and advocate for Mr Rogers. His involvement in Mr Rogers' murder came as a great shock to all the staff who knew him.

89. We are satisfied that there was no evidence that should have led staff to suspect that prisoner A's friendship with prisoner B was dangerous or would result in such tragic consequences.

90. Prisoner B had been diagnosed with psychopathy and emotionally unstable and antisocial personality disorders, which meant he lacked empathy and remorse. He claimed to fantasise about killing someone and there is evidence he tortured animals. His personality disorders meant that he posed a high risk to others. We consider it was appropriate to hold him in the segregation unit while his risk was assessed.

91. Prisoner B's personality and behaviour indicated that he would benefit from management in a DSPD or PIPE unit. These units are designed for prisoners with a severe personality disorder who pose a high risk of harm to others. The criteria for acceptance in these units is that a prisoner must spend a minimum of six months on a standard wing and comply with mental health treatment (in order to demonstrate that they will comply with and, therefore, benefit from, the regime in the units). Segregation units are not appropriate for long-term residence and there is evidence that it is especially harmful to prisoners with personality disorders.

92. Prisoner B's behaviour in prison was not sufficiently dangerous for him to be considered for a Close Supervision Centre (a very high security unit for the most dangerous prisoners with a high ratio of staff to prisoners) and we are satisfied that Long Lartin had no other option than to test him on a standard wing in order to progress him to a DSPD or PIPE unit. Given the nature of Perrie Blue and its small size and higher staffing level, we consider this was the most sensible option. He also remained under regular review by the mental health team and his risk was reassessed after he hit a prisoner in early February.

93. We are satisfied that the staff on Perrie Blue were aware of prisoner B's risk and he was properly monitored. The only evidence that he was a threat to Mr Rogers came after Mr Rogers had died, from another prisoner who did not tell staff what he had heard at the time.

94. We are satisfied that the actions of prisoners A and B were sudden and unexpected and it would have been very difficult for prison staff to have predicted or prevented Mr Rogers' murder.

95. We make no recommendations.

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