Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Cox, a prisoner at HMP Guys Marsh, on 2 December 2023

A report by the Prisons and Probation Ombudsman

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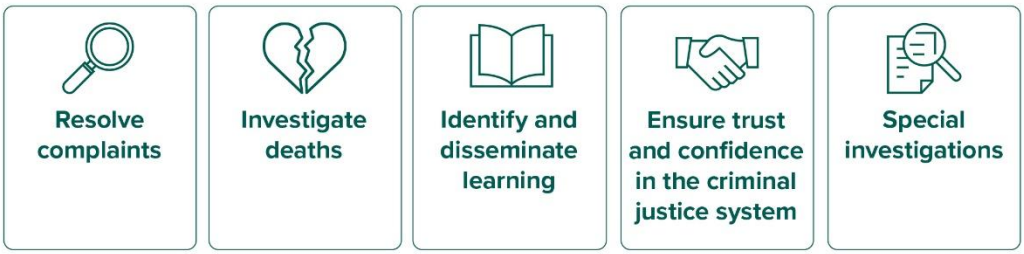
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Andrew Cox died from sudden death associated with polydrug use, on 2 December at HMP Guys Marsh. He was 34 years old. I offer my condolences to Mr Cox's family and friends.

Mr Cox had a history of illicit drug use but declined to engage with substance misuse services while in prison. Intelligence submitted by staff raised concerns about his involvement with the illicit drug supply at Guys Marsh, but no actions were taken. Mr Cox was last seen alive outside his cell at 4.44pm on 1 December. He was not discovered unresponsive until 5.04pm on 2 December, nearly 24 hours later.

The investigation has found that staff failed to conduct the required checks and did not account for Mr Cox or question why he had not been seen or why his observation panel was covered throughout the day. The actions of staff on the wing suggest a culture of either indifference or fear and the Governor will want to take robust action.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

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Summary

Events

1. On 7 February 2017, Mr Andrew Cox was sentenced to eight years and eight months in prison. On 6 May 2021, he was released from prison on conditional licence. He was recalled to prison on 31 December 2021 after he failed to abide by his licence conditions. He was released on licence for a second time on 3 February 2023, but was recalled to prison again on 25 March 2023. Mr Cox had a history of illicit drug use in prison.

2. On 4 May 2023, Mr Cox arrived at HMP Guys Marsh. Shortly after his arrival, a member of the prison's substance misuse team spoke to him, but he denied any issues with illicit drugs and declined their help.

3. Staff submitted at least two intelligence reports within the first few weeks of Mr Cox's arrival at the prison, which indicated that he may be involved in illicit drug use. Staff acted on this information.

4. Between June and September 2023, Mr Cox seriously assaulted two prisoners but for various reasons the charges against him were dismissed.

5. Staff opened a Care, Support and Intervention plan and noted that Mr Cox was being monitored by security staff for his suspected involvement in the illicit drug economy. Staff submitted three intelligence reports between September and November 2023, indicating that Mr Cox had received illicit drugs from a drone, had been overheard discussing payment of large amounts of money for something, and that a prisoner had asked for a transfer as they were under threat from Mr Cox due to debt. There is no evidence that staff took any action.

6. Mr Cox was last seen at 4.44pm on 1 December. CCTV showed him on the wing landing in his dressing gown before being locked in his cell.

7. At 7.30am on 2 December an officer completed a routine check and arrived at Mr Cox's door at 7.33am. Mr Cox's observation panel was covered. The officer said that this was 'normal', and he thought he had heard a response from Mr Cox.

8. At 11.19am, an officer unlocked Mr Cox's door so that he could collect his lunch. The officer did not look in the cell or push the door open. Mr Cox did not collect his lunch and at 12.08pm, an officer locked his cell door. The officer did not confirm whether Mr Cox was in the cell or that he was all right before doing so.

9. At 1.47pm, an officer unlocked Mr Cox's door for association (social time). The officer did not look into the cell and the observation panel was covered. Mr Cox was not seen at any point during the afternoon.

10. At approximately 4.49pm, officers began to lock prisoners in their cells. An officer locking Mr Cox's door was unable to get a response from him and continued to lock the cells along the landing. The officer then returned to Mr Cox's cell and tried to open the door but realised it was wedged from inside. He sought assistance from a colleague. The officers removed the inundation point (used in the event of a cell fire) from the door and removed the obstruction that covered the observation panel.

On doing so, the officers saw Mr Cox lying face down on the floor and called a medical emergency code and colleagues called an ambulance.

11. Staff used special equipment to open the cell door outwards. Officers and nursing staff gained access to the cell at 5.04pm. It quickly became apparent that Mr Cox was dead with extensive rigor mortis present. Staff did not attempt to resuscitate him. At 5.45pm, the paramedics arrived and confirmed that Mr Cox had died.

Findings

12. Mr Cox was able to access illicit drugs with apparent ease at Guys Marsh. However, he was offered appropriate support from the substance misuse team, but he declined.

13. There is no evidence that staff acted upon intelligence which indicated Mr Cox was involved in the illicit drug culture at the prison and staff completed only one intelligence led search of his cell. Although Guys Marsh have attempted to put in place extra measures to reduce illicit drug supply since Mr Cox's death, there are still weaknesses in the processes including the lack of staffing resource.

14. Staff completing the routine and welfare checks on 2 December 2023, should have removed the obstruction from Mr Cox's observation panel. It is shocking that processes in place at Guys Marsh meant that Mr Cox had not been seen alive for 24 hours when he was discovered. We consider that staff actions suggest a culture of either indifference or fear.

15. The clinical reviewer concluded that the clinical care Mr Cox received at Guys Marsh was equivalent to what he could have expected to receive in the community.

Recommendations

- The Director General of Prisons should consider what additional support can be put in place to address staffing at Guys Marsh and consider, as a matter of urgency, how it can be expected to deliver an effective drug strategy and reduce the supply of illicit drugs with the resources currently available.

- The Governor and Head of Security should continue in the efforts to identify and address weaknesses and measures to prevent supply of drugs into Guys Marsh and ensure all intelligence is acted upon and outcomes recorded.

- The Governor should re-issue the operational order from 2021 and a notice to prisoners which informs both staff and prisoners about the process that must be followed when unlocking a cell door and ensure that there are robust quality assurance processes in place to check compliance.

- The Governor should commission a disciplinary investigation into the actions of all staff working on Gwent unit on 2 December and inform the PPO of the outcome.

The Investigation Process

16. HMPPS notified us of Mr Cox's death on 3 December 2023.

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

18. The investigator visited Guys Marsh on 21 December 2023. He obtained copies of relevant extracts from Mr Cox's prison and medical records, along with CCTV and Body Worn Video Camera (BWVC) footage. The investigator also viewed Mr Cox's cell and spoke with prisoners that had known him.

19. The investigator interviewed seven members of staff and one prisoner at Guys Marsh on 30 and 31 January 2024.

20. NHS England commissioned an independent clinical reviewer to review Mr Cox's clinical care at the prison. The independent clinical reviewer and the investigator jointly interviewed nursing staff on 31 January 2024.

21. We informed HM Coroner for Dorset of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

22. The Ombudsman's office wrote Mr Cox's family to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Cox's family asked why Mr Cox had not been discovered until Saturday afternoon and asked for a copy of this report.

23. Mr Cox's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

24. HMPPS responded to the initial report on 1 October and accepted all recommendations made. A copy of the action plan to address these is attached to the final report.

Background Information

HMP Guys Marsh

25. HMP Guys Marsh is a medium security prison that holds male prisoners. Practice Plus Group provides primary and secondary mental healthcare and commissioned EDP to provide integrated substance misuse services. Healthcare services are available on weekdays and at weekends from 8.30am to 6.00pm and there is a doctor on duty on Saturday mornings.

HM Inspectorate of Prisons

26. The most recent full inspection of HMP Guys Marsh was in July 2022. Inspectors identified 14 key concerns, including three priority ones: the high number of violent incidents which were not investigated in sufficient depth to understand the causes, high levels of illicit drugs coming into the prison, despite improved security measures, and not enough being done to reduce the drug supply. Other key concerns included offender management and key work, which lacked focus and frequency.

Independent Monitoring Board

27. 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 November 2022, the IMB reported that with Guys Marsh being a rural establishment with a significant perimeter to patrol, organised crime groups (OCG's) continued to 'bombard' the establishment with throwovers and drone deliveries of drugs and mobile phones. The Board said that there needed to be more sophisticated ways of combatting these destabilising deliveries rather than the current patrols around the establishment and asked HMPPS to provide extra support to the prison in order to tackle OCG activities.

Previous deaths at HMP Guys Marsh

28. Mr Cox was the fourth prisoner to die at Guys Marsh since July 2020. Of the previous deaths, one was self-inflicted and two were drug related. Up to the end of April 2024, there had been one drug-related death since Mr Cox's death, which is still under investigation.

29. We have previously made a recommendation about appropriate checks on prisoners when a cell door is unlocked. In response to this recommendation, HMP Guys Marsh said that an operational order and a notice to prisoners was issued in December 2020 to inform both staff and prisoners about the process that must be followed when unlocking a cell door. It reinforced the message that when unlocking a cell door staff must obtain a verbal response from each prisoner. If a response is not obtained, then staff should access the cell to check on the prisoner's welfare. Following completion of unlock staff must sign the wing diary to state they have undertaken these checks. Both orders were reissued in October 2021 and staff's understanding of the order was to be checked following the reissue.

Incentives and Earned Privileges (IEP) Scheme

30. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

Key Events

31. On 7 February 2017, Mr Andrew Cox was sentenced to eight years and eight months in prison for criminal damage (causing explosions) endangering life. He was initially released from HMP/YOI Portland on conditional licence on 6 May 2021, but his licence was revoked on 31 December 2021 after he failed to abide by his licence conditions, and he was taken to HMP Bristol. On 19 January 2022, Mr Cox was transferred to HMP Erlestoke, and released on licence on 3 February 2023. He again failed to abide by his licence conditions and committed further offences (burglary) leading to his licence being revoked on 25 March 2023. He returned to Bristol. Mr Cox was due for release on 25 August 2025.

HMP Bristol

32. An officer spoke with Mr Cox on his arrival at Bristol as part of the first night reception procedures. She recorded that Mr Cox had previously been at Bristol and said that he was happy and had no concerns. He denied any thoughts or intentions of harming himself.

33. On 28 March 2023, staff at Bristol reported a strong smell of illicit drugs coming from Mr Cox and his cellmate (also his co-defendant) cell and that other prisoners had been seen gathering around and entering the cell.

34. On 4 April, the prison's search team searched Mr Cox's cell and found cannabis, tobacco paper, a lighter and suspicious paper (there is no record as to whether this was tested or whether it was impregnated with illicit substances). Staff placed Mr Cox on report. Staff recorded that he and his cellmate should not share a cell and a note was placed on their prison records. There were no other reported drug incidents involving Mr Cox while at Bristol, but there were entries related to his threatening and abusive behaviour toward staff.

HMP Guys Marsh

35. On 4 May, Mr Cox was transferred to HMP Guys Marsh.

36. Officer A completed the first night documentation with Mr Cox and recorded that healthcare staff had seen him in reception and that he had no physical issues and was not receiving any prescribed medication. The officer recorded that Mr Cox had no self-harm history, made him aware of the dangers of using illicit substances and the consequences of engaging in illicit drug use.

37. Following the first night process, Mr Cox was allocated a cell on Anglia unit, where he would remain for the first 48 hours. Mr Cox was placed in a shared cell with his cellmate despite the marker on his record indicating that they should not share a cell.

38. On 5 May, a member of staff from the prison's substance misuse team (Change, Grow, Live) spoke with Mr Cox. He told her that he did not use illicit drugs or alcohol and declined any further interventions.

39. On 8 May, a member of staff submitted an intelligence report that information had been received that suggested Mr Cox and his cellmate were in possession of two ounces of cannabis and were being visited at their cell window by other prisoners. The report noted that Mr Cox and his cellmate had previously shared a cell at Bristol, and their adjudication history showed they had used cannabis together.

40. The next day, staff submitted a further intelligence report, indicating that Mr Cox and his cellmate's cell was popular with other prisoners and that there had been a strong smell of cannabis coming from the cell, with occupants and visitors constantly appearing 'stoned' when leaving. In response, staff searched their cell. They found a small quantity of tobacco along with tobacco smoking papers. Smoking is prohibited in prisons and tobacco is a contraband substance. There was also information that a phone was being concealed in the cell, but staff recorded that a full search was not conducted for operational reasons.

41. However, while a member of staff was conducting an external patrol of the unit during the afternoon, partly smoked 'joints' were found around the outside of Mr Cox and his cellmate's cell. More intelligence reports were submitted on 11 and 27 May, suggesting that Mr Cox and his cellmate were using cannabis, but there is no evidence that staff took any further action.

42. On 15 June, Mr Cox punched and knocked unconscious another prisoner while on the exercise yard. Mr Cox was taken to the segregation unit and placed on report. However, the charge was dismissed because the victim refused to give evidence. (The incident was referred to the police who took no further action.) Mr Cox was placed on the basic level of the incentives and earned privilege scheme (meaning he had reduced access to some in-cell items and other privileges). A challenge, support and intervention plan (CSIP) was also opened on Mr Cox. (A CSIP is used to support and manage prisoners who consistently display challenging and violent behaviour.)

43. On 16 June, Mr Cox was moved to a single cell on Gwent unit.

44. Mr Cox appeared to settle on Gwent unit, and there were positive entries in his wing record about his behaviour and adhering to the regime. He gained employment assisting servery workers and collecting the meal trolley from the kitchens. Following a review of his incentives and earned privileges on 27 June, Mr Cox was moved up to the standard level.

45. Also on 27 June, staff reviewed Mr Cox's CSIP (with some incorrect information recorded). Staff told the investigator that there was no specific monitoring in place and that intelligence reports submitted that named Mr Cox were collated to build a bigger picture.

46. On 3 August, Mr Cox was upgraded to the enhanced incentives level. Staff recorded that he had been doing his job to a good standard.

47. On 16 September, Mr Cox assaulted another prisoner and was placed in his cell pending a disciplinary hearing. The disciplinary hearing was initially heard on 18 September, and Mr Cox pleaded not guilty. The case was adjourned twice. When heard again on 1 December, the charge was dismissed as witnesses were 'unavailable'.

48. Between 27 September and 8 October, staff submitted three intelligence reports. The first noted that two prisoners said that a drone package had been collected that morning and the contents were for Mr Cox. The second report said that a prisoner had overheard a conversation between Mr Cox and another prisoner, who was heard to say to Mr Cox 'I'll pay two grand for it'. The third report indicated that a prisoner had asked for a prison transfer because he said he had 'a lot of money on his head' and was under threat from Mr Cox and two other prisoners. There is no evidence that staff took any further action in response to these intelligence reports.

49. On 25 November, a prison manager asked Officer B to collect Mr Cox from the grounds because he had been seen wandering around after returning the meal trolley. The officer approached Mr Cox and another prisoner, and it was clear that Mr Cox had something concealed under his jumper. When he saw the officer approaching, he walked in a different direction. The officer stopped and searched him and found two packets of crisps, and on searching the area, recovered two multi packets of crisps that had been stolen from the kitchens. Mr Cox was sacked from his job and placed on report. There were no further intelligence reports about Mr Cox's behaviour or his involvement in drugs in the weeks prior to his death.

Events of Friday 1 and Saturday 2 December

50. At around 4.44pm on 1 December, CCTV shows Mr Cox on the landing outside his cell, dressed in a dressing gown. He walked down to the ground floor and returned to his cell with his evening meal. He then went back on the landing and spoke to other prisoners before he and all prisoners on the wing were locked in their cell for the routine count at around 4.55pm. Mr Cox went into his cell and a piece of fabric can be seen at the top of his door. Mr Cox's observation panel remained obscured (later found to be by a dressing gown hung over the back of the cell door) for the remainder of the night and on 2 December.

51. Operational Support Grade (OSG) A was on night duty on Gwent unit on 1 December and conducted a routine check of prisoners when he started his shift. The OSG could not be interviewed during the investigation as he was on long term leave of absence from the prison. However, he made a written statement on 31 January 2024, and said that he was not able to remember details from the night. However, he said that it was normal for prisoners to cover their observation panels and that this made it hard to conduct routine checks. The OSG said that most prisoners would not only cover their observation panels but also the door frame, making it almost impossible for staff to see down the sides of the doors.

52. Mr Cox did not press his emergency cell bell during the night of 1and 2 December and staff had no reason to check him.

53. OSG A said that he completed the morning routine check at around 5.30am on Saturday 2 December, and had struggled to gain responses from several prisoners. He could not recall spending any longer at Mr Cox's cell than any other. CCTV shows the OSG standing outside Mr Cox's cell for longer than he appeared to at other doors. In his statement, the OSG said that if he had spent more time at the door, he did so to try and get a response by banging and shouting. CCTV footage does not show the OSG banging on Mr Cox's door. The OSG said that although he could not definitely recall, he would not have moved on from Mr Cox's cell if he had not got a response.

54. Gwent wing was locked down during the morning period, meaning that all prisoners remained in their cells, unless they were working as wing cleaners or unlocked to collect medication or attend the gym. Officer C, Officer D and Officer E were on duty.

55. Officer C began his duty at 7.30am. As the first officer to arrive, he completed the morning routine check. CCTV shows him arriving at Mr Cox's cell at 7.33am, he appears to open the observation panel cover to an open position, but does not stop to look in. The officer was unavailable for interview due to long term leave of absence but provided a written statement. He said, '…during the count I thought I heard a 'yeah' response from his cell due to him being covered up [his observation panel being obscured] which was normal, but I cannot be sure now that it came from his cell or the next cell along…'

56. During the morning period both Officer D and Officer E can be seen on CCTV outside Mr Cox's cell, either talking to other prisoners or posting canteen sheets and lunch menus. They did not look into Mr Cox's cell. However, Mr Cox's friends had gone to his door that morning but got no response. Mr Cox's friend, told the investigator that the last time that he saw Mr Cox was the previous afternoon when he had collected his meal. CCTV shows him at Mr Cox's door at 9.40am, but he got no response. He said that he called Mr Cox's name, but thought that he must have been asleep, so decided he would speak to him later that day. He said that he had attempted to look into the cell, but the observation panel was covered.

57. CCTV shows at 11.19am, Officer E unlocked Mr Cox's door. She did not push the door or look into the cell at any point. The unlock was to enable prisoners to collect their lunch, which was served at around 11.34am. Between 11.35am and 11.57am, Mr Cox's friends can be seen on CCTV listening at his door. Another one of Mr Cox's friend, told the investigator that he was trying to get a response from Mr Cox along with others and confirmed that the observation panel was covered. Mr Cox did not come out from his cell and did not collect his lunch. Although staff mark off prisoners as they collect meals, the investigator was told that it was not usual for staff to check on or chase up those who failed to collect meals.

58. The physical education instructor, was helping out on Gwent unit at around 11.45am, during the lunch period. He went onto Mr Cox's landing and began locking prisoners in their cells after they had collected their lunch. Officer E was also on the landing with the physical education instructor.

59. The physical education instructor said that he secured one side of the landing, while Officer E did the other. He said that there were doors that had the observation panels covered, so he either knocked on the door or kicked the door and said that he got a verbal response. He said that he did get a response from Mr Cox but could not recall what this was. The physical education instructor said that he was not completing a routine check, and as far as he was concerned, he was 'just locking doors'. The physical education instructor secured Mr Cox's door at 12.08pm and closed the (still obscured) observation panel.

60. That afternoon, all prisoners on Gwent unit were unlocked for social time and exercise. CCTV shows Officer D unlocked Mr Cox's door at 1.47pm. He kicked the door as he unlocked it and then walked away. The officer said that he believed he had received a response from Mr Cox and if he had not, he would have kicked the

door again or shouted, and would not have moved straight on, although he could not recall with any certainty whether he had definitely heard Mr Cox respond. The officer said that he had opened Mr Cox's door enough for the bolt to 'shoot' out which meant the door would remain open, but he did not attempt to look in.

61. Officer E and Officer D can be seen on CCTV walking past Mr Cox's cell. CCTV also shows prisoners gathered outside his cell socialising, and on occasions they can be seen trying to look into the cell down the side of the door or gain a response from Mr Cox. Mr Cox is not seen at any point during the afternoon.

62. At around 4.49pm, officers began to lock prisoners in their cells. CCTV shows Officer D locking Mr Cox's door, and then speaking to Mr Cox's friend, a prisoner, who was in the cell next door. Officer D said that he had not been able to get a response from Mr Cox so he asked the prisoner if he could call to him and see if he had any success, but there was still no response.

63. Officer D continued along the landing locking doors before he returned to Mr Cox's cell at 4.51pm. He knocked on Mr Cox's door, tried to get a response and tried to open the door but was unable. He then left the landing and returned at 4.53pm with Officer C.

64. Officer F had been assisting on Gwent unit during the afternoon. In her statement she said that at around 4.50pm, she was on the ground floor completing the evening routine check. She was approached by Officer D who said that he had been unable to get a response from Mr Cox. The officer said that she told Officer D to try and enter the cell to check his welfare and that she would follow him upstairs. The officer said that when she arrived, Officer D and Officer C were banging on the door, she looked through the observation panel, but it was blocked. The officer said that it became apparent that the door had been wedged from inside and they were unable to gain access.

65. While Officer D and Officer C continued to kick and push on Mr Cox's door, Officer F went to the landing office and collected the key to remove the inundation point on the cell door. (The inundation point is used in the event of a fire and allows staff to insert a hose.)

66. Once the inundation point was removed, Officer F moved the obstruction covering the inside of the door to one side. Initially she could see that Mr Cox was not on his bed and on looking to the other side, saw him lying face down on the floor. The officer immediately told Officer D to call a code blue (indicating that a prisoner is unconscious or is having breathing difficulties). The call was made at 4.58pm. The officer said that she instructed Officer D to collect the anti-barricade keys, which would allow the staff to remove the lock on the outside of the door and open it outwards allowing entry. However, Officer F said that the screw heads were blocked, and she also needed 'picks' (small metal items used to remove blockages from the anti-barricade screws), before staff could remove them from the door.

67. Officer G responded to the code blue and helped to force the door open. He noted that there was something wedged in the top of the door, and he tried to pull this over the top. The officer said that he tried to look around the sides of the door where there is usually a small gap and through the observation panel, but it remained covered from the inside.

68. By 5.01pm there were around twelve members of staff outside Mr Cox's cell, trying to remove the anti-barricade screws. Healthcare staff were ready to enter the cell once the door was opened. Staff finally gained entry to the cell at 5.04pm.

69. Body Worn Video Camera (BWVC) footage was initiated at the cell and provided to the investigator. Officer G and Officer H were first to enter the cell, closely followed by a nurse and paramedic (the paramedic was an agency member of staff working at Guys Marsh at that time.)

70. Officer G said that when he entered the cell, Mr Cox was lying face down on the floor, he was dressed only in a pair of boxer shorts, his feet were pointed towards the window at the back of the cell and his head towards the door at the front of the cell. Officer G moved Mr Cox onto his back and said that there was a large amount of blood coming from his nose, his body indicated that he had been in this position for a prolonged period of time and that Mr Cox was dark purple in colour.

71. Officer G said that he instinctively started chest compressions and completed about two, before the paramedic entered and indicated CPR should stop.

72. The nurse told the investigator that as soon as she and the paramedic began checking Mr Cox, it was clear that he was in a state of rigor mortis.

73. At 5.45pm, emergency paramedics arrived at Guys Marsh and after completing their own observations they confirmed that Mr Cox had died.

Events following Mr Cox's death.

74. While in the cell, staff noted that the meal Mr Cox had collected the evening before was still on the side and was untouched. An unidentified powder was also noted on the table along with a makeshift tube, usually used for snorting illicit drugs.

75. Intelligence reports submitted following Mr Cox's death detailed information received from a number of prisoners suggesting that Mr Cox had been using illicit drugs during that weekend and he had also received a package from a drone in the days prior to his death.

76. The substance recovered from Mr Cox's cell by the police was tested and identified as cocaine.

Contact with Mr Cox's family.

77. A prisoner at Guys Marsh used an illicit mobile telephone and told Mr Cox's family that he had died before staff were able to make contact.

78. Mr Cox's family contacted the prison and spoke to a prison manager, and asked if she could confirm what they had been told. The prison manager told the investigator that while this was not the way such news should be relayed, she confirmed that Mr Cox had died.

79. On 3 December, the Governor, visited Mr Cox's family at their home and offered his sympathy and explained what was known at that stage and the process that would follow.

80. The prison contributed to funeral expenses in line with national policy.

Support for prisoners and staff

81. After Mr Cox's death, the prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. However, it does not appear that Guys Marsh followed the principles of the HMPPS postvention process in providing support to staff and prisoners following a death in custody.

82. The prison posted notices informing other prisoners of Mr Cox's 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 the death.

Post-mortem report

83. The post-mortem report gave Mr Cox's cause of death as sudden death associated with polydrug use (Cocaine, MDMB-4en-PINACA & pregabalin). Toxicology tests indicated that Mr Cox had used a large amount of cocaine prior to his death, and the levels found in his system were associated with cocaine toxicity. Mr Cox had also used cannabis, synthetic cannabis, and pregabalin (used to treat anxiety but often illicitly used). Mr Cox was not prescribed pregabalin in prison.

Inquest

84. An inquest into Mr Cox's death was concluded on 16 July 2026 and a jury returned a verdict of misadventure.

Findings

Drugs strategy at HMP Guys Marsh

85. Mr Cox was able to access illicit drugs with apparent ease; however, he was offered appropriate support from the substance misuse team, but he declined. While there was intelligence around Mr Cox's involvement with the use and supply of illicit drugs, he was never reported as being under the influence of drugs while at Guys Marsh.

86. We acknowledge the huge challenges inherent in preventing drugs entering Guys Marsh. The prison has a large perimeter and is situated in an open and accessible rural area vulnerable to throwovers and drones. The illicit drugs market in prison is controlled by organised crime gangs and the scale of the problem requires a co-ordinated approach. The threat from drugs is constantly evolving and more can always be done.

87. Temporary Deputy Governor at Guys Marsh told us that the demand for illicit drugs at Guys Marsh was high, and there were various means for them to be conveyed into the prison due to its rural location, which also made it more difficult to effectively challenge attempts. She said that deterrents were often hindered by a lack of resources. She said that the high number of prisoners linked to organised crime groups and gangs from around the Southwest area were also drivers for the high demand for illicit drugs in the prison. She said that Guys Marsh also had a problem with prisoners' access to mobile phones, which were often used to direct both throwovers and drones. Nevertheless, several important measures have been introduced including:

- trees and hedges were cut back to improve coverage of CCTV.
- additional portable fences were used to fence off areas where 'throwovers' were coming in, so prisoners were unable to retrieve items.
- a Code Orange radio call was introduced, to be used by communications officers or others if someone was seen attempting to throw an item over the wall. (When a Code Orange is called, staff will stand at fixed post points around the perimeter and should be able to see if anything is thrown over and challenge and stop any prisoner that attempts to collect any package.)
- The prison plans to introduce a clear bag policy, to limit items brought in by staff and visitors.
- Robust measures were in place for checking post and parcels.

88. However, many of the initiatives to reduce drug supply and demand at Guys Marsh are undermined by staff shortages. Around 60% of staff in post at Guys Marsh have under two years' experience, and there are no experienced officers to offer support and guidance. This was evident during interviews or in statements where staff spoke about prisoners using illicit drugs, covering observations panels, and wedging cell doors to prevent staff entry as normal occurrences which went unchallenged.

89. The investigator also raised these concerns with the Governor. The Governor said that while he was aware that the prison had faced issues with the ingress of illicit drugs for a variety of reasons and that staffing had been a particular issue, since taking up his post at Guys Marsh he had focused on ways to tackle the illicit drug problem.

90. The Governor said that several measures had already been put in place to increase activity levels in the establishment, including the core day being revised to allow for people attending activity to have adequate domestic and association time, new workshops introduced to offer more varied work and more activity spaces, and the reintroduction of unemployment pay so that those that have been removed from employment have some financial support until they can gain new employment, so that they do not resort to debt creating behaviour.

91. The Governor said that he had decided to not conduct Mandatory Drug Testing (MDT, routine testing of a proportion of prisoners) and use other methods to track and address the issues in the establishment around illicit substances, such as voluntary testing and suspicion testing. He said that resources would focus on reducing the supply and demand of illicit substances. In addition, he said that he was introducing units offering enhanced living conditions and regime for those willing to adhere to substance free living. A new full Body-Scanner had been located in the reception area for testing those under suspicion and new arrivals to the establishment, and all mail is now photocopied, to prevent the ingress of psychotic substances. The Governor cited other interventions being introduced at Guys Marsh to tackle the issues with the illicit economy.

92. Clearly, there is targeted activity to address the problem of drugs at Guys Marsh, which we welcome. However, we consider the prison's response to intelligence about Mr Cox's involvement in illicit drug use and supply at Guys Marsh was insufficient. Mr Cox was only ever subject to one cell search. He was allowed to share a cell with his cellmate, despite intelligence that they should not do so. We make the following recommendations:

The Director General of Prisons should consider what additional support can be put in place to address staffing at Guys Marsh and consider, as a matter of urgency, how it can be expected to deliver an effective drug strategy and reduce the supply of illicit drugs with the resources currently available.

The Governor and Head of Security should continue in the efforts to identify and address weaknesses and measures to prevent the supply of drugs into Guys Marsh and ensure all intelligence is acted upon and outcomes recorded.

Blocked observation panels

93. An HMPPS Safety Briefing on Observation Panels, issued in February 2018, says that local safety measures should explain what staff should do if the occupant of a cell cannot be seen due to the panel being covered or blocked. It goes on to say that when staff discover that a panel has been blocked, and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare.

94. We consider that the actions of multiple staff on 1 and 2 December suggest that there is a systemic issue in the tackling of blocked observation panels at Guys Marsh. CCTV and officer accounts indicate that Mr Cox's observation panel was blocked from late afternoon on 1 December until he was discovered unresponsive 24 hours later.

95. The Governor told the investigator that following Mr Cox's death the Notice to Staff regarding obscured observation panels re-issued in 2021 had been reissued again. In addition senior managers had been tasked with monitoring compliance during wing visits. We welcome the actions already taken but given the severity of the problem evident at Guys Marsh.

96. We are not making a recommendation whilst the new process beds in at Guys Marsh, but have brought he issue to the attention of His Majesty's Inspectorate of Prisons (HMIP) to consider at their next inspection.

Routine checks and welfare checks

97. Routine checks are primarily a visual security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoner's safety to be identified and managed. HMPPS' National Security Framework expects welfare checks to take place at routine checks including that staff are able to see the prisoner's face and satisfy themselves that they are alive and well.

98. Daily cell fabric checks (to ensure a cell's physical condition is up to standard) are a security measure and should be completed daily. No checks took place on 2 December.

99. Mr Cox was not seen alive after he went into his cell at around 4.55pm on 1 December. Despite several staff conducting routine checks, locking or unlocking the door, he was not checked at any point. As noted earlier, staff were aware that his observation panel was covered, but this did not raise concerns. Staff said that they had received a verbal response when checking Mr Cox's cell, although when interviewed they said that they could not be certain that the response had in fact come from Mr Cox.

100. It is not possible to say when Mr Cox became unwell or died but evidence (including the presence of rigor mortis) would suggest it was a significant period. Staff on duty on Gwent unit on 1 and 2 December failed in their duty of care towards Mr Cox to a shocking extent. The evidence suggests that there was a staff culture of either indifference about what prisoners were up to on the unit and whether they were safe, or fear (specifically of Mr Cox, or more generally of prisoners on the unit). Either way, staff made no efforts to challenge Mr Cox for his blocked observation panel or conduct more than rudimentary checks on him. We consider it likely that Mr Cox died at some point in the evening of 1 December. We make the following recommendations:

The Governor should re-issue the operational order from 2021 and a notice to prisoners which informs both staff and prisoners about the process that must be followed when unlocking a cell door and ensure that there are robust quality assurance processes in place to check compliance.

The Governor should commission a disciplinary investigation into the actions of all staff working on Gwent unit on 2 December and inform the PPO of the outcome.

Clinical care

101. The clinical reviewer concluded that the clinical care Mr Cox received at Guys Marsh was of a good standard and was equivalent to what he could have expected to receive in the community.

102. Mr Cox denied using any illicit substance and declined support or input from drug services. Mr Cox was provided with the necessary information to refer himself to mental health and drug and alcohol services.

103. The clinical reviewer also noted that during the emergency response the situation was assessed accurately and was managed with dignity and respect.

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