Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Stephens, a prisoner at HMP Guys Marsh, on 15 April 2024

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 Christopher Stephens died from mixed drug intoxication on 15 April 2024 at HMP Guys Marsh. He was 33 years old. I offer my condolences to Mr Stephens' family and friends.

Mr Stephens had a history of illicit drug use but declined to engage with substance misuse services at Guys Marsh. Staff suspected he used drugs, which was corroborated by prisoners, but he was never discovered under the influence. However, there was substantial evidence that he was involved in the illicit economy and little action was taken to address this.

Mr Stephens was last seen alive, in his cell, at 4.34pm on 14 April. He was deeply asleep and snoring heavily but staff did not recognise this was a potential indication that he was unconscious.

Mr Stephens was discovered unresponsive by prisoners at around 9.00am the following day. The investigation found that staff failed to conduct the required routine unlock and welfare checks. The actions of staff on the wing suggest a culture of apathy and complacency, an issue that had been raised in previous investigations and which we understand the Governor is addressing.

I also found that Mr Stephens self-isolated shortly before he died but the prison did not follow their local guidance adequately.

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 **March 2025**

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Summary

Events

1. Mr Christopher Stephens was sentenced to nine and a half years imprisonment in June 2017. He was released from prison in April 2022 but was recalled in December, for alleged offences against his partner. Mr Stephens had a history of substance misuse.

2. Mr Stephens transferred to HMP Guys Marsh on 10 August 2023. When he arrived, he denied that he had any issues with drugs or alcohol.

3. While at Guys Marsh, although some prison staff suspected that Mr Stephens used drugs, he had never been found under the influence and it was likely that any drug use was in his cell and he was known to often keep to himself. However, over the six months he was at Guys Marsh, there was significant evidence that Mr Stephens was involved in the illicit economy: he was found with mobile phones and accessories, he had paper which tested positive for drugs in his cell, visitors were intercepted trying to pass him suspected drugs and a mobile phone signal was detected coming from his cell.

4. In March 2024, Mr Stephens told staff that he wanted to self-isolate because he was under threat. There was no evidence that he was under threat and staff later reported that he only self-isolated for one day, though records are unclear.

5. On 14 April, at 3.38pm, Mr Stephens used his prison phone to call his partner. In their conversation, he referred to taking drugs. At 4.43pm, during a routine welfare check, an officer found Mr Stephens' in his cell, deeply asleep and snoring loudly with an iPhone on his stomach. The officer removed the mobile phone but did not wake Mr Stephens before she left and locked his cell door. Mr Stephens had not left his cell at any point during that day. An officer checked Mr Stephens at 7.00pm and said while he could not see Mr Stephens, he received a verbal response. Staff also checked him at 8.41pm, and 5.24am and 7.29am the next morning and raised no concerns.

6. At 8.23am on 15 April, an officer unlocked prisoners on the wing. He did not check Mr Stephens. A prisoner, who had left his cell, saw that Mr Stephens' observation panel was covered.

7. At 9.03am, at the request of a prisoner, an officer unlocked Mr Stephens' cell but did not check Mr Stephens. (The cell had not apparently been unlocked correctly earlier that morning.) At 9.06am, prisoners entered Mr Stephens' cell and found him in bed, unresponsive. They alerted staff immediately. Staff responded and radioed an emergency code. An officer started cardio-pulmonary resuscitation (CPR) but it quickly became apparent that Mr Stephens was dead and staff stopped CPR. The GP arrived at 9.20am and pronounced life extinct at 9.25am.

Findings

8. Mr Stephens was able to access illicit drugs with apparent ease at Guys Marsh.

9. There was substantial evidence that Mr Stephens was involved in the illicit economy yet staff did little to address this.

10. Staff completing the routine unlock and welfare checks on 14 and 15 April did not carry out their duties appropriately: they did not challenge him about his blocked observation panel or conduct checks with sufficient rigour to realise he was not responding. That staff had made no attempt to challenge him about the mobile phone found on his stomach on the afternoon of 14 April by 9.00am the following morning suggests a culture of apathy, complacency or fear. They also did not recognise that Mr Stephens being in a deep sleep and snoring loudly was a potential sign that he was suffering the effects of a drug overdose or slipping into unconsciousness.

11. Records surrounding Mr Stephens' self-isolation are unclear and staff did not follow local guidance appropriately.

12. The clinical reviewer concluded that the clinical care Mr Stephens' received at Guys Marsh was equivalent to that he could have expected to receive in the community.

Recommendations

- The Governor should ensure that staff are aware that heavy snoring and/or being in a deep sleep can be a sign of unconsciousness and drug overdose and conduct appropriate checks on the prisoner.

- The Governor should introduce a robust quality assurance process to ensure that staff record significant contact with prisoners and follow the self-isolation policy.

The Investigation Process

13. HMPPS notified us of Mr Stephens' death on 15 April 2024.

14. 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.

15. The investigator visited Guys Marsh on 23 April. He obtained copies of relevant extracts from Mr Stephens' prison and medical records, along with CCTV and Body Worn Video Camera (BWVC) footage. He also viewed Mr Stephen's cell and interviewed prisoners that had known him.

16. The investigator interviewed seven members of staff and prisoners at Guys Marsh in June 2024.

17. NHS England commissioned a clinical reviewer to review Mr Stephens' clinical care at the prison. He and the investigator jointly interviewed staff.

18. 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.

19. The Ombudsman's office wrote to Mr Stephens' family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Stephens' family asked what healthcare Mr Stephens had received at Guys Marsh, in particular for his kidney failure. The clinical review covers this issue.

20. Mr Stephens' family received a copy of the initial report. They did not make any comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Guys Marsh

22. HMP Guys Marsh is a medium security prison that holds male prisoners. At the time of Mr Stephens' death, Practice Plus Group provided primary and secondary healthcare and commissioned EDP Drug & Alcohol Services to provide integrated substance misuse services. Since June 2024, Oxleas NHS Foundation Trust has provided healthcare 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

23. 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

24. 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 2023, the IMB reported that with Guys Marsh being a rural prison with a significant perimeter to patrol, organised crime groups (OCGs) threatened the security of the prison with throwovers and drone deliveries of drugs and mobile phones. The Board had concerns about the effects of persistent drug and alcohol use as drivers of debt and increasing violence.

25. During the reporting period, the prison made significant interceptions (153 drug parcels, 149 cell phones and attachments and 57 weapons) due to intelligence, alert officers and public co-operation. Security windows had been fitted to ground floor wings to hamper the sharing of items (such as condiments but also illicit items) passed via cell windows. Paper soaked in psychoactive substances (PS) was still an issue though detection equipment was successful in intercepting much of the material. There were also attempts to pass illicit goods during visits.

Previous deaths at HMP Guys Marsh

26. Mr Stephens was the fourth prisoner to die at Guys Marsh since April 2021. Of the previous deaths, one was self-inflicted and two were drug related.

27. We have made repeated recommendations following previous deaths about staff appropriately checking prisoners when they unlock cells. In December 2020, Guys Marsh issued an operational order and notice to prisoners stating that when

unlocking a cell door staff must obtain a verbal response from each prisoner and sign the wing diary to confirm 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. We made a repeated recommendation about this following the death of a prisoner in December 2023. From December 2024, HMPPS agreed that they would re-issue the operational order and notice to prisoners twice a year.

Incentives Scheme

28. Each prison has an incentives 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 worker scheme

29. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm, and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

30. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

31. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons were delivering adapted versions of the key work scheme while they worked towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

32. In June 2017, Mr Christopher Stephens was sentenced to nine and a half years imprisonment for assault and robbery and sent to HMP Cardiff. This was not his first time in prison. He was released in April 2022, but was recalled to prison in December 2022 for alleged offences against his partner. He was sent to HMP Bristol and transferred to HMP Erlestoke in January 2023.

33. When he arrived at Erlestoke, his reception screen noted that he had a kidney disorder. Mr Stephens was wearing an ankle boot due to a fracture. He denied that he had any history of attempted suicide or self-harm or mental health problems and, although he had a history of substance misuse, refused to be referred to the substance misuse team.

34. Mr Stephens' prison records show that he had a history of being found in possession of hooch (illicitly brewed alcohol), illicit prescribed drugs, mobile phones and phone accessories. He was known to be a supplier of illicit items to other prisoners on the wings. Records also showed that Mr Stephens often self-isolated, for reasons sometimes unknown.

HMP Guys Marsh

35. On 10 August 2023, Mr Stephens transferred to HMP Guys Marsh. The reception nurse noted that Mr Stephens had no thoughts of suicide or self-harm and had no mental health concerns. Although Mr Stephens had a history of substance misuse, he denied that he had any issues with drugs or alcohol. The nurse noted Mr Stephens' kidney failure and referred him to the GP.

36. An officer completed Mr Stephens' first night induction interview. They discussed the dangers of using drugs, but Mr Stephens said that he had no history of substance misuse in prison and no debts.

37. On 11 August, a prison GP reviewed Mr Stephens' medical records. She noted his history of kidney failure. The same day, a prison offender manager (POM) wrote an introductory letter to Mr Stephens. She explained that, as a licence recall prisoner, Mr Stephens' community offender manager maintained responsibility for him. However, while in prison, she would support him through his prison sentence which included sentence planning, addressing his offending behaviour and reducing risk and progressing to open conditions. While she recorded her contact with Mr Stephens on his probation records, she did not record this, or subsequent contacts she had with him, on his prison records.

38. On the same day. The POM met with Mr Stephens. He engaged well. On 16 August, at his key worker session, an officer noted that Mr Stephens had settled well and had no concerns.

39. On 30 August, the POM met with Mr Stephens again. He had an upcoming oral hearing (held by the Parole Board to decide whether a prisoner should be released or moved to open conditions) and she explained the process. She said that she was

aware that Mr Stephens had a history of substance misuse. Mr Stephens talked about his recall, which he disagreed with, his alleged offence and his kidney failure.

40. On 11 September, staff submitted an intelligence report based on information from a prisoner that Mr Stephens was involved in making and distributing PS. No further action was taken. On 16 September, an intelligence report noted that a mobile phone signal had been detected coming from Mr Stephens' cell. Mr Stephens' cell was not searched and no further action was taken. On 30 September, during a visit, staff searched Mr Stephens and his visitors due to suspicious behaviour. They did not find anything.

41. On 8 October, intelligence reports noted that Mr Stephens was subject to closed visits (prevented from having any form of physical contact) after two visitors had allegedly passed him illicit items. On 17 October, an intelligence report noted that Mr Stephens had been found in possession of a mobile phone. There is no evidence that staff took any further action.

42. On 3 November, Mr Stephens' mother phoned the prison. She said that Mr Stephens did not want to live on Saxon Wing (a standard residential wing) as he feared for his safety there. No further information was recorded so it is unknown if staff spoke to Mr Stephens. There is no other evidence to indicate Mr Stephens was at risk on Saxon Wing.

2024

43. The investigator noted that no key work sessions were completed for Mr Stephens in 2024. On 15 January, Mr Stephens moved to Dorset Wing, A Spur.

44. On 16 January, an intelligence report noted that staff had intercepted a throw over parcel that had been destined for Mr Stephens. A second parcel was also thrown over but was not intercepted. Staff suspected that Mr Stephens was in possession of an iPhone which was used for the organisation of deliveries and movement of drugs around the wings. Staff searched Mr Stephens' cell and found a number of unauthorised articles, which included makeshift wooden door wedges, a USB charging cable, a magnetic centerpunch (used to mark pipes) and a piece of paper, which tested positive for PS. Mr Stephens was given a disciplinary warning but did not face a disciplinary hearing so did not face any sanctions as a result.

45. On 23 January, the POM spoke to Mr Stephens and made an appointment to see him on 29 January to discuss his oral hearing in March. Mr Stephens raised no concerns. She sent a movement slip (a letter granting permission for a prisoner to leave their wing to attend an appointment) to Mr Stephens' wing for the appointment.

46. On 24 January, Mr Stephens moved to Mercia Wing, C Spur. He shared a cell with another prisoner. On 29 January, Mr Stephens failed to attend his appointment with the POM. He told her that he had not received his appointment movement slip to enable him to attend the meeting. She rescheduled the meeting for 8 February and re-sent a movement slip.

47. On 8 February, Mr Stephens again failed to attend his appointment with the POM. She told us that as she approached Mr Stephens' cell door, there were a few

prisoners hanging around outside who were acting suspiciously. One prisoner made a distinct noise as she approached, which she believed might have been a warning signal to let Mr Stephens know that staff were present. She could not open the cell door as Mr Stephens had blocked it from the inside. Mr Stephens then called out and said that he was using the toilet, so she waited outside. A few minutes later, Mr Stephens came out of the cell and they talked about why he had missed a further appointment. She made another appointment with Mr Stephens for 28 February and ensured that he noted this on his calendar.

48. The POM told us that she knew that Ms Stephens had a history of using illicit substances, but that when she talked to him, he did not appear to be under the influence of any substances. However, she thought that his (and the other prisoners') behaviour that day was suspicious and she believed that she may have interrupted some sort of illicit substance trading or use when she had arrived at his cell. None of this information was recorded in Mr Stephens' prison records nor did she submit an intelligence report.

49. On 11 February, staff recorded that Mr Stephens would be subject to closed prison visits for three months after a visitor had been searched and found to be in possession of what staff suspected to be drugs.

50. On 5 March, Mr Stephens' oral hearing was held and adjourned until 28 May 2024. The Parole Board wanted more information about Mr Stephens' visitor bringing drugs into the prison. The POM said that she spoke to Mr Stephens at some point after the hearing and he raised no concerns.

51. On 16 March, staff issued Mr Stephens with a disciplinary warning after he barricaded his cell door and refused to let staff in. Mr Stephens said that he was under threat on the wing. After staff gained entry, Mr Stephens said that he wanted to self-isolate. At the time, Mr Stephens had a cellmate, who staff relocated to another cell. Mr Stephens was supposed to face a disciplinary hearing for his actions but this was not proceeded with.

52. A prisoner told us that Mr Stephens was not in fear for his safety, but wanted to limit his interaction with staff so that they would not detect his drug use. He said Mr Stephens remained in his cell, with his door shut.

53. Guys Marsh's isolating policy states that staff are expected to make daily entries in prisoners' records about their wellbeing, levels of regime offered and how they are being managed while self-isolating. The investigator found very few entries which related to Mr Stephens' self-isolation.

54. On 17 March, when staff tried to enter Mr Stephens's cell, he threw coffee at them through the crack in the door and refused them entry. Staff gave Mr Stephens a disciplinary warning. He was immediately placed on the basic level of the incentives scheme and subject to 14 days loss of privileges (like access to the prison shop or to a television in his cell). Staff noted that Mr Stephens had refused his evening meals two days in a row and he said that he was on hunger strike. He gave no reason for this.

55. On 18 March, staff noted that Mr Stephens continued to self-isolate. On 20 March, 22 March, 25 March and 26 March, staff recorded no concerns about Mr Stephens.

They noted that he had collected his food. Staff recorded no further entries about Mr Stephens' wellbeing.

56. Mr Stephens' period on basic regime ended on 27 March, when he returned to the standard level of the incentives scheme. Staff did not record this or whether Mr Stephens was still self-isolating. The Safer Custody Manager told us that from information she obtained from wing staff, Mr Stephens had only actually self-isolated for one day. On notification of this, on 4 April, she updated his prison records to note that Mr Stephens had stopped isolating.

Sunday 14 April

57. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 14 and 15 April. He also obtained information from the South Western Ambulance Service. The following account has been taken from all sources.

58. Around 9.00am on 14 April, an officer unlocked prisoners on the wing. (He was not available for interview as he was on long-term sick leave.) He did not look through the cell door observation panels to conduct welfare checks on prisoners as he should have done.

59. Staff raised no concerns about Mr Stephens during the day. CCTV shows Mr Stephens' cell door remained closed and several prisoners spoke to him through his cell door. At 11.05am, an officer completed the daily fabric checks of cells on the wing. He raised no concerns when he checked Mr Stephens' cell. Afterwards, prisoners continued to visit Mr Stephens and several prisoners went in and out of Mr Stephens' cell.

60. From around 11.30am, prisoners collected their lunch. Mr Stephens did not leave his cell. A prisoner told us that he was one of the prisoners that had visited Mr Stephens in his cell. He said that Mr Stephens appeared to be under the influence: his pupils were large, he was swaying about, and he appeared to be falling asleep. He told us that Mr Stephens had taken cocaine, pregabalin (used to treat pain, epilepsy, and anxiety but also widely misused) and Xanax (a sedative).

61. At 12.11pm, Officer A locked prisoners back into their cells and completed the lunchtime routine check. She raised no concerns about Mr Stephens. The majority of prisoners remained locked in their cells until around 2.30pm, when all prisoners were once again unlocked.

62. Mr Stephens used his in-cell phone to make six calls that afternoon. These were all fairly general conversations. In the last call made at 3.38pm to his partner (that lasted 38 minutes), Mr Stephens said that he was stressed because he had a lot going on. In the middle of their conversation, Mr Stephens can be heard shouting to a prisoner, who was at his cell door. He told the prisoner that he was in bed and they had a short discussion about "swinging food" (a means of passing items between cells via their windows on a piece of string) later that evening. Mr Stephens' conversation with the prisoner included him saying that he was having a "big bender", that he felt "like shit" and that "on my mum's life I'm never taking this shit again". During the latter part of Mr Stephens' conversation with his girlfriend, she asked what was wrong with him. Mr Stephens responded that he was scared

that he would not wake up one day. Mr Stephens' partner asked him what he had meant, but Mr Stephens did not respond and started snoring. The call ended at that point. The investigator noted that Mr Stephens' speech seemed slurred at times during the conversation.

63. A prisoner who lived next door to Mr Stephens. He said he visited Mr Stephens in his cell around 4.30pm. Mr Stephens told him that he was tired.

64. At 4.34pm, Officer A arrived at Mr Stephens' cell to conduct a welfare check and to see if he had collected his evening meal. She told us that his door was locked, which was unusual. His observation panel was also blocked. She knocked on Mr Stephens' cell door a few times in an attempt to get his attention, but he failed respond.

65. BWVC footage shows Officer A opened Mr Stephens' cell door and walked slowly into his cell. She called out his name and asked him if he was okay. Mr Stephens did not respond. He was laid on his back, in bed, with his arm extended, hanging off the bed, snoring loudly. She saw an iPhone resting on his stomach, which then slid off down to his left side due to his breathing. She did not attempt to wake Mr Stephens, but picked up the phone, left the cell and locked the door behind her. Mr Stephens did not wake up. She told us that, for safety reasons, she did not want to remain in Mr Stephens' cell for any longer than she had to, especially as she was the only officer on the landing at that time and other prisoners were present on the landing. She did not return to Mr Stephens' cell to check on his wellbeing, nor did she remove the blockage from his observation panel.

66. Officer A secured the iPhone in an evidence bag and gave it to a Custodial Manager (CM), who noted on Mr Stephens' records that he had not woken up when she removed the phone. He took no further action, nor did he ask staff to check Mr Stephens. Officer A finished her duty around 5.30pm.

67. The prisoner who lived next door told us that shortly after this, staff locked prisoners in their cells. He had tried to shout to Mr Stephens through their partition wall, something they both normally did. Other prisoners joined him from neighbouring cells, but Mr Stephens failed to respond. He assumed Mr Stephens was asleep and described him as a "deep sleeper". He said that Mr Stephens was a member of their nightly ritual, where prisoners passed items, such as condiments, between their cell windows. (It is not uncommon for illicit items such as drugs to also be passed between cells in this way.)

68. At 7.00pm, Officer B started the evening routine check. He found that several prisoners had blocked their observation panels so he was unable to see inside their cells. On each occasion, he banged the cell door to gain a response from the occupant and asked them to uncover their observation panel. He said that all prisoners complied, and he had no concerns. He recorded his concerns about the covered observation panels in the wing observation book.

69. Officer B told us that when he checked Mr Stephens' cell, although he was not certain, he did not believe that his observation panel was covered. However, he recalled that he was unable to see Mr Stephens in his cell, and described it as quite dark inside. He tapped on Mr Stephens' cell door, and he said Mr Stephens responded and said, "all right, Simmo". He said that he therefore had no concerns

about Mr Stephens. He also told us that Mr Stephens sometimes hung a dressing gown on the end of his bunk bed. This obscured the view to the bed from the observation panel, but he could not recall if this was the case when he checked him on this evening. CCTV does not show whether Mr Stephens' observation panel was covered at this point.

70. Officer B told us that he knew Mr Stephens had used drugs in the past and he suspected that he used them in his cell. However, he had not found him under the influence during his time at Guys Marsh. He told us that he was surprised that there was no intelligence recorded about Mr Stephens being found under the influence of or using drugs.

71. The prisoner who lived next door said he tried again, around 8.00pm or 9.00pm, to contact Mr Stephens by banging on the wall. Again, he did not respond and he assumed that Mr Stephens was asleep.

72. At 8.41pm, an Operational Support Grade (OSG) completed the evening routine check. He raised no concerns about Mr Stephens. (The OSG no longer works for HMPPS, and they were unable to contact him for us to interview.)

Events on Monday 15 April

73. At 5.24am, during the early morning routine check, the OSG looked through Mr Stephens' observation panel, using his torch to check him. He raised no concerns.

74. Officer C did the routine check of all prisoners that morning. When he checked on Mr Stephens at 7.29am, he raised no concerns. CCTV shows he unlocked the prisoners on Mr Stephens' landing, getting to his cell at 8.23am. He did not look through prisoners' observation panels and only remained at cell doors long enough to unlock them.

75. The prisoner who lived in the next cell told us that after staff unlocked his cell, he left to have a shower. Other prisoners had started to come out of their cells and were on the landing. He saw that Mr Stephens' cell door was still locked. (It appears Officer C had not unlocked Mr Stephens' cell properly, or it had shut itself closed after being unlocked.) A prisoner said that Mr Stephens observation panel was covered.

76. After he had returned from the shower, the prisoner in the next cell said that another prisoner in the other neighbouring cell to Mr Stephens (released from Guys Marsh after Mr Stephens' death and not interviewed) and another prisoner were on the landing. The prisoner in the neighbouring cell wanted to get some vapes from Mr Stephens' cell. He went to Mr Stephens' cell, but it was locked. He tried to speak to Mr Stephens through the door.

77. A prisoner asked Officer A, who was downstairs, to unlock Mr Stephens' cell. She arrived at Mr Stephens' cell at 9.03am, unlocked and opened his door. In doing so, she did not look into the cell or through the observation panel. She told us that it was a very busy morning and so, after opening the cell door, she immediately continued with her duties.

Emergency response

78. At 9.06am, a prisoner went into Mr Stephens' cell. Other prisoners followed him. Mr Stephens did not respond to them. The cell was dark and they turned the light on. When the prisoner saw Mr Stephens, he screamed. When another prisoner first went into the cell, he could not see Mr Stephens, as he had covered the end of his bed with clothing. He did, however, see Mr Stephens' arm hanging off the bed. He said that Mr Stephens looked dead. He checked him for any signs of life and found none. Another prisoner heard the prisoner's scream and got to the cell at 9.07am. He saw blood around Mr Stephens' mouth, and immediately left the cell and alerted staff.

79. Within seconds, three officers arrived at Mr Stephens' cell. Officer A examined Mr Stephens. Mr Stephens showed no signs of life, his skin was mottled, he was cold and had no pulse. Officer C radioed an emergency code blue alarm (to indicate that a prisoner has stopped or was having difficulty breathing). Control room staff immediately called an ambulance. Officer C started cardio-respiratory resuscitation (CPR) with Mr Stephens still on the bed, but only for around three seconds before staff lifted Mr Stephens onto the floor, to make use of the hard surface. In doing so, the staff realised Mr Stephens' body was stiff. At 9.09am, a CM arrived. He assessed Mr Stephens and identified that he was cold and had signs of rigor mortis (the stiffening of the body after death). He advised that staff should not proceed with CPR, as it was not appropriate as Mr Stephens was clearly dead. BWVC footage showed staff removed a green material that was covering the inside of the cell door observation panel.

80. At 9.11am, nurses got to Mr Stephens' cell, assessed him and concluded that he was dead. A prison GP arrived at 9.20am, assessed Mr Stephens and pronounced life extinct at 9:25am.

Events following Mr Stephens' death

81. After Mr Stephens' death, staff submitted several security intelligence reports relating to Mr Stephens. Prisoners said that he had been "partying" and claimed that he had been using multiple drugs. A prisoner told staff that he had been banging on their adjoining cell wall all night, but Mr Stephens did not respond. He said that Mr Stephens liked to take "tablets" and was on a three day "bender", and implied that he had been using drugs for a prolonged period. Another prisoner reported that a parcel of crack cocaine and Xanax had recently been delivered onto the wing. They said that Mr Stephens was snorting Xanax in large quantities. Another prisoner also reported that Mr Stephens had taken pregabalin.

Contact with Mr Stephens' family

82. At 10.00am, Mr Stephens' next of kin, his grandmother, telephoned the prison. She said Mr Stephens' partner had been told of Mr Stephens' death via another prisoner at Guys Marsh. A family liaison officer was appointed. She told Mr Stephens' grandmother that the prison Governor was already on route to speak to her and would provide further details. The Governor and another member of staff arrived at Mr Stephens' grandmother's house at 11.30am. Mr Stephens' partner was also

present. They offered their condolences. In line with HMPPS' policy, Guys Marsh offered a contribution to the cost of Mr Stephens' funeral.

Support for prisoners and staff

83. Guys Marsh initiated postvention procedures. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Listeners (prisoners trained by the Samaritans to provide confidential peer-support) were engaged to identify prisoners most affected by Mr Stephens' death. The staff care team offered support and a prison manager chaired a hot debrief for staff involved in the emergency response. However, both the prison GP and an emergency response nurse told us that they had not been invited to the debrief.

84. The prison posted notices informing other prisoners of Mr Stephens' 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 Stephens' death.

Post-mortem report

85. The post-mortem report concluded Mr Stephens' cause of death was mixed drug intoxication. The pathologist concluded that Mr Stephens had taken heroin and cocaine before he died. He had also taken benzodiazepines (sedatives – Xanax is one) which he had not been prescribed and a synthetic cannabinoid.

Inquest

86. The Coroner's inquest concluded on 15 June 2026 and determined the medical cause of death to be mixed drug intoxication (diamorphine, cocaine, benzodiazepines, PS). The jury concluded the death to be due to misadventure (an unintended or accidental outcome of a deliberate act).

Findings

Drug supply and demand

87. Our investigation found no evidence that Mr Stephens intended to take his own life and it appears that his death was the result of an accidental overdose. Mr Stephens told other prisoners that he had consumed a large amount of drugs on 14 April.

88. Mr Stephens had a long history of substance misuse both in prison and the community. There was evidence that he had previously been involved in drug supply in prison and this appeared to continue while he was at Guys Marsh. During the six months he was there, staff suspected drugs were passed to him during visits, they detected a mobile phone signal coming from his cell, he was found with drug paraphernalia, mobile phones and accessories and paper which tested positive for PS, and staff intercepted an illicit parcel for him. On 14 April, Officer A found a mobile phone on his stomach while he slept. While he was never found under the influence of drugs at Guys Marsh, staff suspected he was using drugs in his cell, and prisoners we spoke to corroborated this. They also said that he was heavily under the influence on 14 April. It may also have been that he used periods of self-isolation to enable him to take drugs in his cell undetected.

89. We found little evidence of robust action to address Mr Stephens' involvement in the illicit economy. He was often not subject to disciplinary hearings as he should have been, there seems to have been no consideration of moving him to a different wing or prison, or referring him to the police. The evidence suggests that there was a staff culture of complacency, indifference or fear.

90. In December 2023, another prisoner on a different wing at Guys Marsh died in similar circumstances. That prisoner was also apparently involved in the supply of drugs in the prison. In our report following this death, issued in October 2024, we acknowledged the huge challenges inherent in preventing drugs entering Guys Marsh. Guys Marsh has a large perimeter and is situated in an open and accessible rural area vulnerable to throwovers and drones. Drones are highly sophisticated and can be directed to specific cells, from a distance of up to five miles away. The illicit drugs market in prison is controlled by organised crime gangs and the scale of the problem requires a co-ordinated approach.

91. The Governor told us that since taking up his post, he had focused on ways to tackle the illicit drug problem. He 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. He said that Guys Marsh also had a problem with prisoners' access to mobile phones, which were often used to direct both throwovers and drones and fed into the illicit economy in the prison. One member of staff told us that they believed around 80% of prisoners at Guys Marsh had access at some point to mobile phones. While the threat from drugs is constantly evolving, and more can always be done, Guys Marsh have introduced several important measures to try to address this problem, including:

    - Trees and hedges in the grounds were cut back to improve CCTV coverage .

- Additional portable fences were used to fence off areas prone to throwovers, so prisoners were unable to retrieve items.
- Windows are being replaced to limit access for drones.
- The introduction of a clear bag policy, to limit items brought in by staff and visitors.
- Random full gate searches of staff.
- Robust measures were in place for checking post and parcels. All mail was photocopied/scanned.

92. The prison had also put several measures in place to improve purposeful activity for prisoners, time out of their cells and engagement with staff in relation to substance misuse. New workshops had also been introduced to offer more varied work and more activity spaces.

93. Guys Marsh does not conduct Mandatory Drug Testing (MDT - routine testing of a proportion of prisoners), preferring other methods such as voluntary testing and suspicion testing. The prison had also recently recruited an analyst whose role is to capture and understand data around the supply and demand of illicit substances, including ways to identify organisers of criminal activity and disrupt and prevent their illegal activity on the wings. The Governor told us that staff were aware of their responsibilities and used the intelligence reporting system when they had suspicions or found a prisoner under the influence of illicit substances. He cited, for example, that recently staff had submitted 177 intelligence reports over a 72-hour period. He cited other interventions being introduced at Guys Marsh to tackle the issues with the illicit economy.

94. The Governor said that staffing had also been a particular issue at Guys Marsh. This impacted on the prison being able to always offer a full regime and the delivery of key working. We also highlighted that Mr Stephens' had only been subject to one cell search.

95. Undoubtedly, there is targeted activity to address the problem of drugs at Guys Marsh, which we welcome. HMPPS accepted recommendations made both to Director General of Prisons and the Governor in our most recent investigation at Guys Marsh which covered better staff resourcing to be able to deliver an effective drug strategy and additional measures to prevent the supply and demand of drugs in the prison. These were due for completion by April 2025, so we make no further recommendation at this time.

Routine roll checks and unlocking procedures

96. Routine roll 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' *Management of Internal Security Procedures Framework* expects welfare checks to take place at roll checks including that staff are able to see the prisoner's face and satisfy themselves that they are alive and well. Before staff unlock a prisoner's door,

they are also required to look through the observation panel and check the welfare of the prisoner.

97. Mr Stephens was last seen alive when Officer A went into his cell at around 4.34pm on 14 April. At that point, he appeared to be asleep. She said that she did not try to rouse him and challenge him about the phone because she was the only member of staff on the wing and other prisoners were unlocked. We accept that she made a risk assessment based on the circumstances. However, we are surprised that there was no plan to speak to Mr Stephens about the phone or issue him with a disciplinary warning before the end of that day. There is no evidence that the CM directed staff to take any particular action in response to the mobile phone find. This meant that staff did not return to speak to Mr Stephens and they did not realise that he was not simply asleep but was, in fact, unconscious.

98. Officer A did not remove the obstruction from Mr Stephens' observation panel when she left the cell. Guys Marsh issued advice and guidance to her after this incident.

99. Officer B said Mr Stephens responded when he checked him at around 7.00pm. However, he could not see him and although he said he did not believe the observation panel was blocked, we consider that it was highly likely that it remained so since the earlier check.

100. It was also highly likely that Mr Stephens' observation panel remained blocked when the OSG checked him overnight and when Officer C checked him the next morning, rendering these checks pointless and outside of policy guidance. When Officer C unlocked prisoners at 8.23am, he failed to look through their observation panels. (There is also some doubt as to whether he unlocked Mr Stephens' cell door properly, as she had to return to unlock it at the request of prisoners at 9.03am.) She also did not check Mr Stephens when she unlocked his door. Subsequently, three minutes later, prisoners discovered Mr Stephens, who had clearly been dead for some time.

101. It is not possible to say when Mr Stephens became unconscious or died but evidence (including the presence of rigor mortis) would suggest it was at least several hours before prisoners found him. He was in the same position when found dead as when Officer A saw him in the afternoon of 14 April, each time with his arm hanging off the bed. Had staff properly checked Mr Stephens and ensured he was alive and well, the outcome might have been different.

102. The Governor told us that, following the last death in custody at Guys Marsh, concerns had been raised about the quality of roll and welfare checks and disciplinary action was taken against staff. All staff were briefed on their responsibilities when conducting roll and welfare checks (that included staff being able to see the prisoner's face and satisfy themselves that they are alive and well) and a quality assurance system managed by custodial managers had been introduced.

103. We note that in response to our previous death in custody investigation, HMPPS agreed that they would re-issue the operational order and notice to prisoners about roll checks and unlocking procedures at six monthly intervals, starting in December 2024. At Guy's Marsh, CMs on every houseblock are now required to conduct quality assurance checks to ensure the process is being followed and this is being

monitored at a weekly assurance meeting. Additional staff training events have also been planned to improve staff understanding of the process to be followed when unlocking a cell door. We therefore make no further recommendation on this matter.

104. Mr Stephens was apparently deeply asleep and snoring loudly when Officer A went into his cell. She did not know that these can be indications of unconsciousness and drug overdose. We see many drug-related deaths where heavy snoring is taken at face value, when in fact it can be a recognised sign of respiratory distress caused by a drug overdose. We make the following recommendation:

The Governor should ensure that staff are aware that heavy snoring and/or being in a deep sleep can be a sign of unconsciousness and drug overdose and conduct appropriate checks on the prisoner.

Blocked observation panels

105. 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.

106. Evidence from this investigation suggest that there is a systemic issue in the tackling of blocked observation panels at Guys Marsh. This was something highlighted in the last death at the prison that my office investigated. Staff accounts indicate that Mr Stephens' observation panel, as well as other prisoners, was blocked at various times in the 24 hour period leading up to when he was discovered unresponsive. Indeed, an officer told us that he would not always ask the prisoner to uncover the observation panel if they were not subject to suicide and self-harm monitoring.

107. In response to the previous death, the prison had re-issued a Notice to Staff regarding obscured observation panels. In addition, senior managers had been tasked with monitoring compliance during wing visits. The Governor told us that it was a mandatory action that if staff encountered a blocked observation panel during their roll and welfare checks, and could not get a response from the prisoner, they must request additional staff so that they could enter the cell. Prisoners who covered their observation panels would be managed through the incentives process. We welcome the actions already taken given the severity of the problem evident at Guys Marsh.

108. We have also brought this issue to the attention of His Majesty's Inspectorate of Prisons (HMIP) to consider at their next inspection. Given this and the recent actions taken, we make no further recommendation.

Recording contact with prisoners and self-isolation

109. Mr Stephens' offender manager had a number of significant contacts with him that were not recorded on his prison records. One of these included her suspicion that he was involved in some illegal drug trading on the wing. Wing staff also recorded

very few entries that referred to his general well-being. This included the period (from 22 March to 4 April) in which Mr Stephens reportedly self-isolated. Guys Marsh self-isolation policy states that staff need to make a daily record of their contact with the prisoner including when they are offered time out of their cell for personal hygiene reasons. This did not occur for Mr Stephens. There was no evidence that prison staff had any meaningful conversations with him about his situation, and we are concerned about their lack of attempted engagement with him during his self-isolation.

110. At interview, the Head of Safer Custody told us that Mr Stephens had only self-isolated for one day, which staff failed to record or reflect in his prison records. Indeed, staff entries in his record were infrequent and lacked details about his welfare. Information such as this is especially pertinent given the suspicion that Mr Stephens withdrew in order to misuse drugs. Any concerns about a prisoner's welfare or behaviour should be recorded and shared with relevant staff so that the appropriate monitoring and action can be taken. We make the following recommendation:

The Governor should introduce a robust quality assurance process to ensure that staff record significant contact with prisoners and follow the self-isolation policy.

Clinical care

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

Governor to note

Action following discovery of iPhone

112. Following Officer A's discovery of the iPhone on Mr Stephens, she gave it to a CM. As we have already described, there is no evidence that he took any further action to challenge Mr Stephens' possession of the phone before he died the next morning. The Governor will want to assure himself that the circumstances of this security breach are fully explored, and the lack of action taken by staff, including the CM, are fully investigated to ensure that a robust response is taken in the future when illicit items are found.

Postvention

113. Prison and healthcare staff told us that they received post incident debriefing and support. However, a prison GP and an emergency response nurse reported that they were not invited to the debrief that took place. The Governor and Head of Healthcare will want to ensure that healthcare staff are included in debriefs in future.

Key work

114. Under the Offender Management in Custody (OMiC) model, every prisoner should have a dedicated key worker with whom they have weekly contact. The purpose of the model is to improve safety by building better relationships between staff and prisoners.

115. Mr Stephens had no key work sessions in 2024. At the time, the key worker scheme at Guys Marsh did not comply with the OMiC model, due to staffing resources. It is difficult to measure the impact on Mr Stephens, given he generally liked to keep to himself and did not particularly engage with staff. However, it is possible that regular key work sessions with a consistent member of staff might have identified his substance misuse needs and appropriate support.

116. Prison staff told us that key working is still not fully operational due to staffing pressures but is being delivered to priority prisoners identified as needing additional support. Given this, we make no recommendation but the Governor will want to prioritise the roll-out of key working to all prisoners as soon as they are able.

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