Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Stephens, a prisoner at HMP Winchester, on 2 November 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

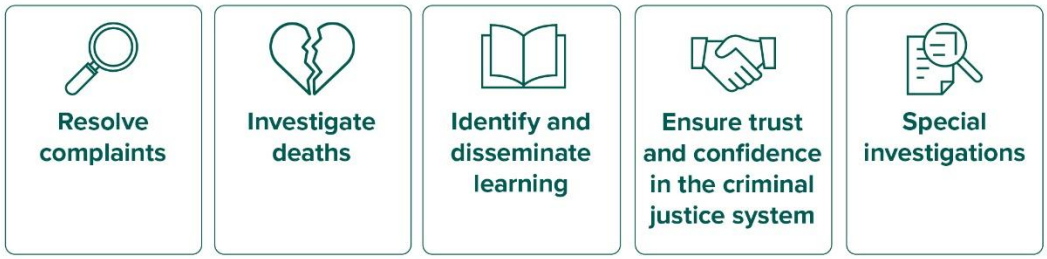
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 Martin Stephens, a prisoner at HMP Winchester, died in hospital of the delayed effects of electric shock on 2 November 2023. Six days earlier, staff at Winchester had inundated Mr Stephens' cell with water to put out a fire that he had started. Unknown to them at the time, he had started the fire using live wires that he had exposed from his kettle. He was 45 years old. I offer my condolences to Mr Stephens' family and friends.

Prison staff responded promptly to the fire on 27 October and I am satisfied that they took appropriate action. While I recognise the risks of inundating cells with water while they are connected to an electrical circuit, I accept the Crown Premises Fire Safety Inspectorate's findings that the risks are outweighed by that of not inundating the cell immediately.

The decision to restrain Mr Stephens when he was taken to hospital unconscious and on a ventilator was not justified and was inappropriate.

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 **April 2025**

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Summary

Events

1. On 21 August 2023, Mr Martin Stephens was remanded to HMP Winchester, charged with burglary. He had a history of substance misuse and mental health difficulties.

2. Over the following two months, Mr Stephens intermittently displayed challenging behaviour and prison and healthcare staff monitored and supported him. Much of Mr Stephens' frustration was linked to his location within the prison and having to share a cell, which led to him assaulting a prisoner and flooding a wing.

3. At around 9.40am on 27 October, after Mr Stephens threatened to stab the next person who went into his cell, an officer decided that Mr Stephens' cell should not be unlocked unless a manager deemed it safe.

4. At 9.49am, several officers responded to a fire in Mr Stephens' cell. They took turns inundating the cell with water but found it difficult to see Mr Stephens due to the smoke and they therefore could not assess whether he would comply with instructions if they unlocked him.

5. At 10.03am, an officer inundating the cell saw Mr Stephens lurch forward through the smoke and collapse by the door. At 10.05am, officers unlocked the door, found Mr Stephens naked on the floor and removed him from the cell. Nurses treated him on the wing landing, with assistance from prison staff.

6. At 10.17am, paramedics arrived and took the lead on Mr Stephens' care. However, they had to wait before they could transfer him to hospital due a disturbance in the prison. During that time, Mr Stephens' breathing slowed and paramedics put him on a ventilator.

7. At 11.10am, the ambulance left the prison and three officers escorted Mr Stephens, who was restrained with a single handcuff and an escort chain. A short while after he arrived at hospital, Mr Stephens went into cardiac arrest and officers removed the restraints. Mr Stephens remained critically ill in hospital.

8. At 9.32am on 2 November, a hospital doctor confirmed that Mr Stephens had died.

Findings

9. Prison staff responded promptly to the fire on 27 October and correctly followed national instructions on a safe system of work when dealing with cell fires. Given Mr Stephens' history and behaviour that morning, we are satisfied that staff took appropriate action by not going into his cell straight away. While we have concerns about inundating cells with water while they are connected to an electrical circuit, we accept the findings of the Crown Premises Fire Safety Inspectorate that the risks are outweighed by not inundating the cell immediately.

10. We are concerned that the decision to restrain Mr Stephens when he was taken to hospital did not take full account of his poor health and its impact on his level of risk.

11. Prison staff did not follow postvention procedures after Mr Stephens died.

Recommendations

- The Governor and Head of Healthcare should ensure that staff involved in completing escort risk assessments understand the legal position on the use of restraints and that in all cases:
    - the medical information accurately reflects a prisoner's current clinical condition and its impact on his ability to escape unaided,
    - operational staff take account of clinical information and fully document all decisions about using restraints, and
    - There is a robust quality assurance process in place to check these measures are effective.

The Investigation Process

12. HMPPS notified us of Mr Stephens' death on 2 November 2023.

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

14. The investigator visited Winchester on 21 November. He obtained copies of relevant extracts from Mr Stephens' prison and medical records.

15. The investigator interviewed four members of staff at Winchester on 29 January 2024. He also interviewed six members of staff by video conference between 2 February and 5 March.

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

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

18. Mr Stephens did not have an identified next of kin and there was therefore no family involvement in this investigation.

Background Information

HMP Winchester

19. Winchester is a local men's prison, and holds up to 649 prisoners, including some young adults. Practice Plus Group (PPG) provide physical and mental health services.

HM Inspectorate of Prisons

20. The most recent inspection of Winchester took place between 7 and 18 October 2024. Inspectors found that the prison was unsafe and that many prisoners were frustrated by a lack of activity, insufficient mental health support and an inability to contact their families. Inspectors also found that not enough had been done by senior managers to make sure that processes worked consistently, that standards were enforced or that prisoners' basic needs were met.

21. On 24 October 2024, HM Chief Inspector of Prisons issued an Urgent Notification after the prison attracted the lowest healthy prison assessment in three out of the four tests; safety, respect and purposeful activity. In the Urgent Notification, the Chief Inspector noted that Winchester remained one of the most unsafe prisons in the country, and many men lived in poor conditions.

Independent Monitoring Board

22. 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 May 2024, the IMB reported that the recruitment of newly qualified officers had meant that staffing levels were much higher than in recent years. They also reported that many prisoners exhibited challenging behaviour that was made worse by poor accommodation, illicit drug use, debts to other prisoners, restrictions on the daily regime and, occasionally, negative interactions with inexperienced officers.

Previous deaths at HMP Winchester

23. Mr Stephens was the twelfth prisoner to die at Winchester since November 2020. Of the previous deaths, six were from natural causes, three were self-inflicted, one was drug-related and the cause of one was unascertained. Since Mr Stephens' death and up to the end of December 2024, there has been one further death from natural causes at Winchester.

Fire safety in prisons

24. PSI 11/2015 gives guidance on following fire safety regulations in prison. Annex A to the PSI provides prison staff with the pathways to follow to maintain a safe system of work in the event of a cell fire. It sets out that once a fire is detected, it should be investigated and a fire alarm activated. It states that a water mist system should be operated, prison staff should wear respiratory protective equipment, the

cell should be inundated with water and contact should be maintained with the occupant of the cell.

25. If the prisoner is compliant with instructions, prison staff should unlock and release the prisoner from the cell if it is safe to do so. If it is not safe, inundation of the cell should continue until it is safe to remove the prisoner.

26. If a prisoner is not compliant, prison staff should continue to inundate the cell until:

- he becomes compliant and it is safe to unlock and remove him from the cell; or
- he becomes unresponsive and it safe to unlock and remove him.

27. The use of pressurised water mist when inundating the cell improves 'life tenability' for occupants of a cell. If possible, an occupant should be removed from a cell within 20 minutes of detection of the fire.

Key Events

28. On 21 August 2023, Mr Martin Stephens was remanded to HMP Winchester, charged with burglary.

29. At 9.30pm, an officer conducted Mr Stephens' reception assessment. He noted that Mr Stephens had served a sentence at Winchester before (May 2023) and reported a history of illicit substance misuse.

30. At 9.38pm, a nurse saw Mr Stephens for an initial health screen and recorded that he had a diagnosis of emotionally unstable personality disorder. He also noted that Mr Stephens reported a history of opiate dependency, for which he was prescribed methadone. He made a referral to the mental health and substance misuse teams.

31. While in reception, prison staff completed a cell sharing risk assessment (CSRA) and assessed Mr Stephens as high risk which meant he was not suitable to share a cell due to a historic offence. They moved him to A Wing (induction unit).

32. At 8.25am on 22 August, a nurse reviewed Mr Stephens and recorded that he had tested positive for methadone, cocaine and cannabis. She contacted his local pharmacy and confirmed his prescription of methadone. At 3.55pm, another nurse, the clinical lead for substance misuse, conducted an initial assessment, recorded that Mr Stephens presented as stable and continued his prescription of methadone.

33. On 26 August, prison staff reviewed Mr Stephens' CSRA and reduced his risk to standard and assessed him as suitable to share a cell because five years had passed since the offence that led to them assessing him as high risk.

34. On 31 August, a nurse saw Mr Stephens for a substance misuse care plan review. She noted that nothing had changed since he was last at Winchester and that he was happy to have regular meetings.

35. On 8 September, prison staff started suicide and self-harm prevention procedures, known as ACCT, after Mr Stephens made a cut to his arm. When asked why he had harmed himself, Mr Stephens said he wanted a phone in his cell. He said that when a prisoner had harmed himself the previous day, he got what he wanted.

36. On 18 September, prison staff held an ACCT case review, which a mental health nurse attended. He recorded that he had known Mr Stephens for many years, and had worked with him in a secure hospital and prison setting. He added that while Mr Stephens had progressed significantly, and tended not to act violently when having difficulty understanding people's intentions, but that he often felt vulnerable when low in mood. Attendees decided to stop ACCT monitoring as Mr Stephens did not report any thoughts of suicide or self-harm. The nurse agreed to offer him support outside of the ACCT process.

37. On 24 September, prison staff restarted ACCT procedures after Mr Stephens made further cuts to his arm. He said that he did not know why he had harmed himself but his head was "consistently fucked" and he was anxious about a planned move to D Wing (used for vulnerable prisoners, where staff thought Mr Stephens should move given his historic offence), despite recognising that it was his best option. Later that day, prison staff moved Mr Stephens to a shared cell on D Wing but he refused to

share, stating that he posed a high risk. He then punched his cellmate in the face, which resulted in prison staff returning him to A Wing.

38. At around 2.30pm on 26 September, an Acting Supervising Officer (SO) and a Custodial Manager (CM) met Mr Stephens in the A Wing office. They told him that they had changed his CSRA to high risk and that they were moving him to B Wing for assaulting a prisoner (it is not clear why he was moved from A Wing). They also told him that he would be downgraded to basic under the Incentives scheme regime for seven days due to the seriousness of the assault (meaning he would have reduced access to some things like in-cell television and the prison shop). Shortly after he arrived on B Wing, Mr Stephens kicked the sink off the wall in his cell which flooded two landings. A CM attended the incident and noted that Mr Stephens told him that he was "losing his head". Prison staff subsequently moved him to the care and separation unit (CSU, where prisoners are segregated from the general population).

39. At 3.30pm, the CM phoned a mental health nurse to request immediate support for Mr Stephens. She noted that she told him that the mental health team had triaged him and he did not meet the criteria for ongoing involvement. She added that his current issues were situational and the prison should deal with them accordingly. However, she also noted that mental health staff would discuss his case at their next team meeting.

40. On 3 October, a nurse reviewed Mr Stephens with the inpatient lead and a consultant psychiatrist. The nurse noted that, for context, he explained his previous involvement with Mr Stephens, and his extensive history of assault and disruptive behaviour in hospital and prison. Later that day, the clinical lead for mental health recorded that staff discussed Mr Stephens at a multi-professional complex case clinic meeting and agreed that he should remain in a single cell.

41. On 4 October, prison and healthcare staff stopped ACCT procedures as Mr Stephens engaged well and they considered he did not present a risk of suicide or self-harm. A nurse noted that he would continue to offer Mr Stephens support outside of the ACCT process. On 7 October, staff moved Mr Stephens to a single cell on C Wing.

42. On 11 October, prison and healthcare staff discussed Mr Stephens at the weekly Safety Intervention Meeting (SIM, a meeting of senior managers to discuss prisoners who need multidisciplinary risk management). They noted that Mr Stephens was not sharing a cell and had an upcoming court appearance.

43. On 16 October, an officer visited Mr Stephens for a keywork session, but it could not take place as Mr Stephens was due at court.

44. On 18 October, staff discussed Mr Stephens at the SIM. They noted that had he been placed on report for smashing the observation panel on his cell door. There is no contemporaneous record to explain when or why he did this. Attendees noted that as Mr Stephens was not formally working with the mental health team, they would remove him from their complex prisoner caseload.

Events of 27 October

45. At 7.30am on 27 October, officers on C Wing started their shift without an SO present due to staffing pressures. (An SO's role is to oversee the day-to-day management of the wing and to support staff.) At interview, Officer A told the investigator that as the most experienced officer on shift, he took on part of the SO role to help.

46. Over the next two hours, CCTV footage shows that an officer unlocked Mr Stephens' cell. (We have not been able to confirm the timings as the CCTV footage which the prison provided was not timestamped.) Mr Stephens left his cell for one hour, returned for one minute, and then left for 18 minutes before an officer locked him in his cell.

47. At 9.40am, Officer A told us that he heard a banging noise coming from Mr Stephens' cell and spoke to him through the cell door observation panel. He said that Mr Stephens had broken his cell furniture, said his "head had gone," and threatened to stab the next person who went into his cell. Body-worn video camera (BWVC) footage shows that Mr Stephens was standing at the back of his cell, but there is no audio recording as the camera had a faulty microphone of which staff were not aware. The officer decided that Mr Stephens presented a risk to the safety of staff and/or prisoners and segregated him under Prison Rule 45, which meant he remained in his cell and was not to be unlocked unless a manager deemed it safe. (Such an instruction is generally authorised by a senior manager.)

48. At 9.49am, three officers responded to a fire alarm in Mr Stephens' cell. They looked through the cell door observation panel and saw a fire on top of a cupboard. Officer A radioed the control room to confirm a fire, while the other officers put on respiratory protective equipment which was on the wing.

49. At 9.51am, Officer B went to Mr Stephens' cell, opened the inundation panel on the cell door and used a hose to inundate the cell with water mist. At interview, he said that he could not see into the cell as the smoke was 'overwhelming' and the cell was 'pitch black'. BWVC footage shows that he and Officer C told Mr Stephens to move to the back of the cell. Mr Stephens responded to say that he could not breathe, and Officer B repeatedly told him to "get down". He told the investigator that he ordered Mr Stephens to get down to the ground, but he could not confirm if Mr Stephens followed his instruction as he could not see into the cell.

50. At 9.55am, Mr Stephens asked staff to open the door and said, "I'm dying in here". Officer B responded, "we can't open the door until we can clear it." Mr Stephens continued to ask staff to open the door but they responded that the smoke was too thick and they needed to be able to see him.

51. At around 9.59am, the water mister shook in Officer B's hand, and he told us that he panicked as he thought that it had not been active for the previous seven minutes. (However, a team leader at the Crown Premises' Fire Safety Inspectorate (CPFSI) who investigated the fire told us that his team had reviewed the CCTV footage and were happy that water was clearly visible from under the cell door within two to three minutes.)

52. At 10.00am, Officer C left the cell and made her way along the wing landing to where Officer D, a respiratory protective equipment instructor, stood. He told her to assess the level of smoke and to check the heat level by placing a hand on the cell door.

53. At 10.01am, having returned to the cell, Officer C told Officer D that they could not see anything in the cell, could not get a response from Mr Stephens and that the top of the cell door was warm to touch. Officer D told them to continue inundating the cell and trying to get a response from Mr Stephens.

54. At 10.02am, Officer E and Officer A took over. (At interview, Officer E told us that before they went to the cell, Officer D told them that Mr Stephens was offering resistance, and they should not open his cell door until he became compliant or unconscious.) Officer A told us that when he began to inundate the cell, he saw Mr Stephens move towards the door, but the amount of smoke made it difficult to see and to have proper judgement.

55. At 10.03am, Officer E took over inundating the cell. He told us that he could not see Mr Stephens at first, but he then suddenly lurched forward through the smoke and collapsed by the door. He said that Mr Stephens started to bang on the door and to shout out but stopped shortly afterwards. It was at this point that he and Officer A told us that they decided to open the cell.

56. At 10.05am, Officer A unlocked the cell while Officer E opened the door and found Mr Stephens naked on the floor. BWVC footage shows Mr Stephens say to the staff present that he could not breathe. The officers then each took one of Mr Stephens' legs and pulled him out of the cell and onto the landing. In the meantime, Officer D asked for a blanket and put it over Mr Stephens' body.

57. At 10.07am, a nurse and other healthcare staff, who had been waiting on the wing, assessed Mr Stephens. At interview, the nurse told us that Mr Stephens did not respond to them initially but then became very combative. She said that his blood oxygen levels were low so they gave him oxygen and tried to take his clinical observations but he kept flailing and thrashing around on the floor. At 10.12am, four officers in personal protective equipment (PPE) put their hands on Mr Stephens' arms and legs to reduce his movement. She said that he remained unsettled and briefly lost consciousness due to his increasingly low oxygen level.

58. At 10.17am, ambulance paramedics arrived on the wing and took the lead on Mr Stephens' care. In the ambulance log, paramedics recorded that there was a delay leaving the prison due to a disturbance. (Prison records show that several prisoners on B Wing, the chosen exit route, had refused to leave the showers and several more had climbed onto the safety netting.) Ambulance Service records show that Mr Stephens' breathing slowed while they waited, and paramedics connected him to a ventilator (to keeps the lungs working).

59. At around 11.10am, paramedics took Mr Stephens by ambulance to the Royal Hampshire County Hospital. Three officers escorted him restrained with a single handcuff and an escort cable. (An escort cable is a long cable with a handcuff at each end, one of which is attached to the prisoner and the other an officer).

60. At 11.22am, shortly after arriving at the hospital, Mr Stephens went into cardiac arrest. The Person Escort Record (PER) shows that Officer A, who escorted him to hospital, removed the restraints so that hospital staff could treat Mr Stephens.

Events from 28 October to 2 November

61. At 5.10pm on 28 October, a prison manager reviewed Mr Stephens' escort risk assessment and recorded that he did not need restraints as he was unconscious and on a ventilator in the intensive care unit (ICU).

62. At around 9.55am on 31 October, escort officers recorded that the hospital doctor overseeing Mr Stephens' care asked them to remain outside Mr Stephens' room due to confidentiality and infection control. They contacted a prison manager, who authorised them to do so.

63. At 9.32am on 2 November, a hospital doctor confirmed that Mr Stephens had died.

Events after Mr Stephens' death

64. On 17 November, at a case discussion meeting, the team leader at the Crown Premises' Fire Safety Inspectorate told the investigator that it had become apparent that Mr Stephens had started the fire by revealing kettle wiring to create a spark and placing combustible material underneath.

Contact with Mr Stephens' family

65. At 12.15pm on 27 October, the prison appointed two family liaison officers. They identified that Mr Stephens had not named a next of kin and tried to identify one. They liaised with several external organisations, including the police, Probation Service and the local authority, but were unsuccessful in tracing any family.

66. Mr Stephens' funeral took place on 7 December 2023. As he did not have a next of kin, the prison arranged and paid for his funeral.

Support for prisoners and staff

67. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

68. On 27 October, a prison manager debriefed the staff involved in the emergency response and staff and prisoners were offered support. On 2 November, a prison manager spoke to the officers present at the hospital when Mr Stephens died to offer support. However, a postvention response was not started after Mr Stephens' death.

Post-mortem report

69. The post-mortem report found that Mr Stephens died from the delayed effects of electric shock.

70. The pathologist noted that electric shock causes death by stopping the heart or causing it to stop pumping effectively. Seizures and brain damage may arise when the brain is starved of oxygen or from direct electrical stimulation. He added that as Mr Stephens was naked in a cell with exposed live conductors, he would have been extremely vulnerable to electric shock. They added that hospital tests revealed a marked increase in CPK, an enzyme that is a marker for damage to voluntary muscle. Seizures can cause such damage.

71. Toxicology analysis found the presence of methadone (which had been prescribed to Mr Stephens) within the therapeutic range and low levels of fentanyl (an opiate commonly used in emergency medical treatment). The pathologist concluded that there was no evidence to suggest Mr Stephens' agitated state was the result of drug intoxication.

72. The post-mortem report concluded that there was a clear chain of causation extending from a strong possibility of electric shock to a naked man in a wet cell with exposed electrical conductors to seizures and cardiac arrest, which led to hypoxic brain injury and death.

Findings

Emergency response and assessment of risk to Mr Stephens

73. While Mr Stephens had some risk factors for suicide and self-harm, including a history of self-harm, substance misuse issues and evidence of violent and impulsive behaviour, we saw no evidence to indicate that Mr Stephens intended to take his life when he set the fire in his cell. The evidence indicates that Mr Stephens had a history of damaging cells when he was frustrated or angry.

74. Mr Stephens died from the delayed effects of electric shock. The post-mortem report established a clear cause-and-effect link from the electric shock of a naked man in a wet cell with exposed electrical conductors to seizures and cardiac arrest that led to a lack of oxygen to Mr Stephens' brain and his subsequent death.

75. Prison staff responded quickly when they became aware of the fire in Mr Stephens' cell. They wore appropriate respiratory protective equipment and inundated the cell with water in line with Prison Service Instruction (PSI) 11/2015 on fire safety in prisons. Given Mr Stephens' history of violence and that he was reported to have threatened staff that morning, we are satisfied that prison staff acted reasonably and in line with HMPPS' policy in assessing that he was a non-compliant prisoner and not releasing him from his cell immediately after inundating it.

76. BWVC footage shows that prison staff maintained contact with him. frequently gave him instructions and explained that they had to see him and confirm that he would comply before opening the cell. Staff opened the cell within 16 minutes of detecting the fire and therefore within the 20-minute timeframe set out in PSI 11/2015. BWVC footage shows that Mr Stephens was minimally responsive and therefore he was likely to be compliant.

77. The clinical reviewer considered that healthcare staff responded appropriately to the emergency and that their actions demonstrated a sufficient level of training and understanding. She also noted that impulsivity was a symptom of personality disorder (with which Mr Stephens had been diagnosed), and this would have made it difficult for staff to predict how he might respond.

78. The CPFSI established that Mr Stephens had started the fire by revealing kettle wiring to create a spark and placing combustible material underneath. When sprayed near live conductors, water can create a conductive path, allowing electricity to travel through water to a person. However, PSI 11/2015 does not address the risk of electric shock or isolating the electricity supply to the cell before inundation.

79. In their investigation report, the CPFSI also found that isolating a cell's electrical supply did not form part of the HMPPS inundation procedures. They noted that at Winchester, the electrical trip switch for the cells could only be accessed using a key which maintenance staff carry. They considered research-based evidence to indicate that a failure to implement a response in line with PSI 11/2015 within eight minutes could result in death, concluding that waiting for maintenance staff to arrive before starting the inundation process would cause a delay and increase the risk of serious injury from exposure to toxic smoke and heat.

80. In Mr Stephens' case, the presence of water and live conductors, coupled with him being naked, put him at high risk of electric shock. Enabling prison staff to isolate a cell's electricity would potentially eliminate the risk of electric shock to prisoners. However, we accept that, operationally, this may be hard to implement and delayed inundation could potentially have more significant consequences. A death occurring from electric shock in these circumstances is extremely rare, and while we recognise the risk of immediate inundation, we accept the conclusion of the CPFSI's report that a change to local and national policy is not needed.

81. Overall, we are satisfied that prison staff managed the emergency response well. We do not make a recommendation.

Restraints, security and escorts

82. The Prison Service has a duty to protect the public when escorting prisoners outside prison such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

83. A judgement in the High Court in 2007 (the Graham judgment) made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

84. When Mr Stephens went to hospital on 27 October, a prison manager reviewed his risk assessment and authorised three officers to restrain him with a single handcuff and an escort cable. In the medical section, a nurse recorded that healthcare staff did not have any concerns about the use of restraints. The assessment identified Mr Stephens' overall risk as 'normal' and suggested double cuffs (when the prisoners' hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs) as the appropriate level of restraint.

85. The prison manager told the investigator that he knew Mr Stephens had lost consciousness before he left the prison and that on the risk assessment he instructed staff not to use restraints unless he came around and displayed refractory behaviour. However, this is not what he recorded. In the section signed by him, the following is noted: 'double cuff escort chain, when comes around, cuff + cuff.' He said that he was "pretty confident" that he signed for no restraints and there was "no way" that he would have sent an unconscious prisoner to hospital in double cuffs. The documentary evidence suggests otherwise.

86. We consider that the use of restraints on 27 October was not justified, was inappropriate and did not meet the requirements set out in the High Court judgment. While we accept that Mr Stephens had a history of violent behaviour, had threatened staff that morning and resisted healthcare attempts to treat him, his health had deteriorated considerably at the time he was restrained and he lost consciousness and was on a ventilator. Whenever restraints are used, the risk

assessment must accurately reflect the risk posed at the time. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff involved in completing escort risk assessments understand the legal position on the use of restraints and that in all cases:

- **the medical information accurately reflects a prisoner's current clinical condition and its impact on his ability to escape unaided;**
- **operational staff take account of clinical information and fully document all decisions concerning the use of restraints, and.**
- **There is a robust quality assurance process in place to check these measures are effective.**

Governor to note

Segregation

87. Officer A did not obtain approval from a senior manager before segregating Mr Stephens under Prison Rule 45, as required by national and local policy. The Head of Safety and Equalities at the time told us that a custodial manager (CM) had informed the officer that he did not have the authority to implement Prison Rule 45 without seeking approval form a senior manager, and that he had acknowledged it. Seeking authority from a senior manager allows for an assessment of the situation and for consideration of alternative arrangements such as a transfer to another wing.

Postvention

88. There was no evidence that staff implemented postvention procedures after Mr Stephens died. A prison manager told us that postvention did not take place because staff did not think it was required, as Mr Stephens' death was not believed to be self-inflicted, and he was in hospital for five days before he died. While postvention is mainly for self-inflicted deaths, it can be used for other deaths on a case-by-case basis. We consider that the circumstances of Mr Stephens' death could have been traumatic for the staff involved and they might have benefited from the postvention approach. Considering postvention after a death has occurred is more likely to ensure that staff and prisoners receive adequate support.

Keyworker scheme

89. Keywork is a primary source of support for prisoners but Mr Stephens only had one keywork session during the two months he was at Winchester. A prison manager told the investigator that at the time of Mr Stephens' death staff shortages significantly affected keywork delivery but a recovery plan had been implemented to improve the quality and quantity of keywork.

Inquest

90. At the inquest, which took place on between 20 and 27 October 2025, the Coroner concluded that the cause of Mr Stephens' death was unclear and could have been caused by several factors. These included substance misuse, smoke inhalation and electric shock.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100