



HM Prison & Probation Service

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Interim Director General of Prisons
HM Prison and Probation Service
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Mrs Rachael Clare Griffin
HM Senior Coroner for Dorset
BCP Civic Centre
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03 August 2026

Dear Mrs Griffin,

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS: MR CHRISTOPHER STEPHENS

Thank you for your Regulation 28 report of 24 June 2026 addressed to the Governor of HMP Guys Marsh and Director General Chief Executive Officer of His Majesty's Prison and Probation Service on behalf of the Ministry of Justice following the inquest into the death of Christopher Stephens at HMP Guys Marsh on 15 April 2024. I am providing the response on behalf of His Majesty's Prison and Probation Service (HMPPS) as Interim Director General of Prisons.

I know that you will share a copy of this response with Mr Stephens family, and I would first like to express my condolences for their loss. Every death in custody is a tragedy and the safety of those in our care is my absolute priority.

You have raised concerns regarding the management of observation panels, welfare checks and delivery of key work sessions.

HMP Guys Marsh has updated its local guidance to set out clearly the expectation on staff to ensure that observation panels, which are used to check the welfare of prisoners when they are in their cell, are unblocked and allow a clear view into the cell. Aligning with national HMPPS safety guidance, and to ensure consistent practice, the new local guidance has been issued individually to all staff with a letter explaining expectations regarding keeping observation panels clear on residential units.

Staff are reminded in both the letter and instruction that they are required to ensure that observation panels remain unobstructed whenever prisoners are locked behind their cell doors, with compliance monitored through routine unlock procedures and daily completion of Accommodation Fabric Decency Checks (AFDCs). Where a prisoner has blocked an observation panel staff are required to challenge the behaviour immediately, obtain visual confirmation of the prisoner's welfare, and consider further action. Any concerns identified by night operational support grade staff are escalated to the night orderly officer and then to both the head of residence and the head of safety for review and action where necessary.

These expectations have been reinforced through staff briefings, local notices, and roll check guidance. Compliance is also incorporated into management assurance activity conducted on residential units, including custodial manager and supervising officer decency checks.

A comprehensive review of local procedures relating to roll checks and cell unlocking has been undertaken and a range of activity has taken place as a result. Operational instructions requiring staff conducting roll checks to account for every prisoner and obtain confirmation that there is no immediate cause for concern has been re-issued. Staff have also been reminded of the need to obtain a verbal response when unlocking a cell and take appropriate action immediately where a response is not received.

Learning arising from this death in custody has been shared with staff through targeted briefings, and supervisory oversight of both roll checks and unlock procedures have been strengthened to promote consistency and compliance. Where areas for improvement are identified, these are addressed through line management engagement, learning discussions, or formal management action where appropriate.

Work continues with the learning and development team to ensure all new staff complete and successfully pass assessments relating to roll checks, and the security team carries out routine reviews of observation books and wing diaries to identify and investigate any anomalies. Taken together, these measures are intended to strengthen local practice, promote consistency in welfare monitoring, and provide greater assurance that staff understand and fulfil their responsibilities in maintaining prisoner safety.

Delivery and quality of key work remain a priority for HMPPS. We are working to improve the quality and quantity of key work across all prisons during 2026/27. This is a vital part of our work to improve safety and reduce reoffending.

All male closed prisons are resourced to deliver one key work session per week to eligible prisoners. Any reduction of the resourced delivery of one session per week should only be considered in line with existing policy as part of the local Regime Management Planning process and balanced alongside other local risks and priorities. Where prisons are balancing priorities in this way, Governors are encouraged wherever possible to deliver at least two key work sessions per prisoner over the course of a four -week period.

HMP Guys Marsh is reviewing its approach to key work delivery to strengthen prisoner engagement and ensure available resources are directed towards those with the greatest identified needs. This work has been undertaken within the context of operational pressures and staffing challenges that have affected the consistency with which key work can be delivered across the prison. Currently, the establishment has introduced a priority cohort approach, ensuring that prisoners identified as having the highest levels of need, including those discussed through the Safety Intervention Meeting (SIM) process, receive consistent key worker attention and oversight. By focusing available resources in this way, the prison seeks to maximise the benefit of key worker engagement for those prisoners who are most vulnerable or who present the greatest welfare concerns. The prison is committed to further improving the quality and frequency of meaningful key worker contact in support of safer outcomes for all prisoners, and the senior management team continue to look to address barriers to the full provision of key work to all prisoners.

Thank you for bringing these matters to my attention. I trust that this response provides assurance that action is being taken to address the concerns identified.

Yours sincerely,

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Interim Director General of Prisons