

**REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS
2013**

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1.	CORONER I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset.
2.	DATE OF REPORT 24th June 2026
3.	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	THIS REPORT IS BEING SENT TO 1. Director General Chief Executive Officer of His Majesty's Prison and Probation Service (HMPPS) 2. Governor of HMP Guys Marsh You are under a duty to respond to this report within 56 days of the date of this report, namely by 19th August 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	YOUR RESPONSE Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

5.	SUMMARY OF CORONER'S CONCERN 1. The lack of local safety measures in place at HMP Guys Marsh in respect of observation panels on cell doors in accordance with the HMPPS safety briefing revised in 2018 (attached) 2. The failure to undertake welfare checks on prisoners at HMP Guys Marsh at roll checks and unlocking of cell doors in accordance with national and local guidance to ensure that the prisoner is alive, safe and well 3. The failure to deliver keyworker sessions to the prisoners at HMP Guys Marsh
6.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	INVESTIGATION AND INQUEST On 15th November 2024, I commenced an investigation into the death of Christopher John Stephens, aged 33 years, born on 30th September 1990. The Inquest concluded before a jury on the 15th June 2026. The medical cause of death was: Ia Mixed Drug Intoxication ([REDACTED]) How, when and where Christopher came by his death was recorded by the jury as: At the time of Christopher's death there was an environment of the use of illicit drugs at HMP Guys Marsh. While not a registered drug user, there were indications that Christopher was a user of illicit drugs whilst at Guys Marsh. This was due to observations from staff and prisoners regarding his appearance and behaviours. During the weekend of the 13th/14th April 2024 Christopher self administered a mixture of drugs. Welfare checks at the roll checks and the unlock of Christopher's cell between 4.34pm on the 14th April and 9.03am on the 15th April were not undertaken in accordance with local guidance and mandatory orders. It cannot be said that this fact was probably, or even possibly, causative or contributory in Christopher's death.

	Fabric was draped over Christopher's bed which obscured the view of him during welfare checks between 4.34pm on the 14th April and 9.03am on the 15th April and this was not dealt with in accordance with the national safety briefing on obscuring observation panels. It cannot be said that this fact was probably, or even possibly, causative or contributory in Christopher's death. The time of death is unable to be precisely determined. Death occurred at some point between 4.17pm on the 14th of April and 9.25am on the 15th of April in his cell 54, C Spur, Mercia Wing, HMP Guys Marsh. The conclusion recorded by the jury was Misadventure.
8.	CIRCUMSTANCES OF DEATH At the time of his death Christopher was a serving prisoner at HMP Guys Marsh having arrived there on 10th August 2023. He resided alone in a double cell. At around 4pm on the 14th April 2024 Christopher was seen by other prisoners who suspected he was under the influence of drugs. They did not alert staff to this. At 4.34pm a prison officer went into Christopher's cell and found him lay on the bed with a mobile phone beside him. She activated her body worn video (BWV), removed the phone, left the cell and closed the door which locked upon closing. During her evidence the prison officer stated that she believed Christopher was fast asleep at that time. The cell door remained locked until opened the following morning. From the BWV, material was seen draped over the top bunk of the bed in the cell which meant that Christopher could not be seen on the bed. His arm was sticking out but that was all that could be seen from the door. A roll count was undertaken by a prison officer on the wing at 7.30pm. The officer made an entry in the observation book that there was a lot of observation panels covered. There was no escalation to the Oscar 1 in the Prison. A roll count was undertaken by an operational support grade (OSG) member of staff at 8.42pm. Whilst locked in their cells, prisoners tried to communicate with Christopher between 6pm and 8pm but he did not respond which was unusual. A roll count was undertaken by the same operational support grade (OSG) member of staff at 5.42am on the 15th April. A roll count was undertaken by a prison officer at 7.20am. The same prison officer unlocked the cells at 8.20am. He did not undertake a welfare check on Christopher, check for signs of life or receive a verbal response from him. He unlocked the door and moved to the next cell.

	At 9.03am prisoners asked staff to unlock Christopher's door as it was closed. This was done by a different prison officer who did not undertake a welfare check, check for signs of life or obtain a verbal response from Christopher. Prisoners entered the cell and found Christopher deceased. He was cold and in rigor mortis. Prison officers responded and activated their BWV. From this Christopher was in exactly the same position he had been when the prison officer went in the previous day at 4.34pm.
9.	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: At the time of Christopher's death, there was a safety briefing in place from HMPPS relating to prisoners obstructing the observation panels on cell doors. It states: <i>"Observation panels in cell doors allow staff to carry out regular safety checks on prisoners when they are locked in their cells. Every time staff approach a prisoner's cell, they must ensure that the observation panel is clear, in case of an emergency situation."</i> It gives guidance as to what to do when panels are obstructed. It also states: <i>"Local safety measures should explain what to do if the occupant(s) of a cell cannot be seen due to the panel being covered or blocked."</i> Evidence confirmed that there are currently no local safety measures in place at HMP Guys Marsh in relation to observation panels. The safety briefing also states: <i>"Staff should always be able to clearly observe the occupants of a cell, in case they are unwell or there is an emergency situation."</i> <i>A clear observation panel can help to save lives."</i> At the time of Christopher's death there were local procedures in place by the Governing Governor, through operational orders, and the Head of Safety Governor, through Governor notices to staff, that directed: <i>"When conducting a roll check all staff must satisfy themselves for signs of life for every Prisoner that they are accounting for."</i>

When unlocking a cell door staff must obtain a verbal response from each Prisoner. If a response is not obtained then staff will access the cell to check on their welfare.”

Evidence was given that there was a culture at the time of Christopher’s death, on the wing where he resided at HMP Guys Marsh, that prisoners would obscure panels which would not be challenged and that prison staff would not undertake roll checks and the unlocking of cells in accordance with the orders given. Whilst some witnesses said this has improved since Christopher’s death, one prison officer stated that when she was working at the prison in May 2026, before she left for another posting, this lack of compliance with national and local guidance regarding these issues was still ongoing at HMP Guys Marsh.

I am concerned that the lack of local safety measures in place at HMP Guys Marsh in respect of observation panels on cell doors, the culture at HMP Guys Marsh around not challenging prisoners on obscuring observation panels or ensuring prisoners are seen in cells, and not undertaking welfare checks at unlock and roll checks could compromise prisoners’ health and lead to future deaths.

It states at paragraph 111 of the Prison and Probation Ombudsmen report into Christopher’s death:

“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”

Christopher had only 2 key worker sessions recorded in the prison records whilst he was at HMP Guys Marsh, one on his day of arrival and the other 6 days later. Information provided during the Inquest was that of all the prisoners at HMP Guys Marsh, only the top 40 priority cohort identified through the Safety Intervention Meeting (SIM) process are currently seen once a month by an allocated keyworker and are discussed at a monthly key work meeting. Further, that normal keywork is not taking place as it should be due to staffing levels as they are unable to detail staff daily.

Each prisoner should be allocated a keyworker and the key worker is a member of prison staff whose responsibility is to support the prisoner throughout their custodial period. As an article on the government website states:

“It’s a way for offenders to build relationships with officers that are healthy and make them feel comfortable speaking to prison officers. It’s a process to reduce violence, reduce drug-use, give offenders a point of contact with an officer to help them cope with custodial life.”

I am concerned that the lack of delivery of key work to all prisoners at HMP Guys Marsh could lead to future deaths as key work is an opportunity to disclose issues or concerns which can include matters relating to mental health or drugs use.

10.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Chirstopher's family 2. Government Legal Department 3. Prison and Probation Ombudsmen I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE