Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sheldon Jeans, a prisoner at HMP Guys Marsh, on 13 November 2022

A report by the Prisons and Probation Ombudsman

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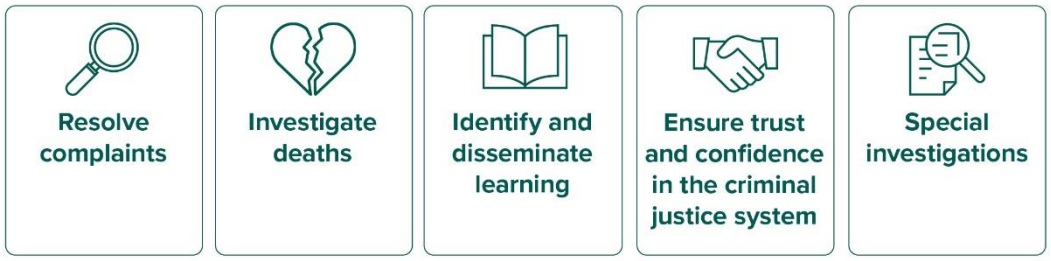
OUR VISION

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 Sheldon Jeans died from a reaction to a combination of alcohol and medication which had not been prescribed to him on 13 November 2022 at HMP Guys Marsh. He was 32 years old. I offer my condolences to Mr Jeans' family and friends.

Mr Jeans had a history of substance misuse. While he was in prison, he was seen regularly by the substance misuse team and warned about the risks and dangers of taking drugs. He attended regular support sessions, and all of his eleven voluntary drug tests were negative for illicit and non-prescribed drugs. We are satisfied that Guys Marsh did all they could to manage the risks associated with Mr Jeans' substance misuse.

Regrettably, as with other prisons, the trading and misuse of drugs, including prescribed medications, remains an intractable problem at Guys Marsh. I am satisfied that the prison is taking reasonable steps to tackle this issue.

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 **August 2024**

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Summary

Events

1. On 10 January 2022, Mr Sheldon Jeans was sentenced to 31 months imprisonment for grievous bodily harm (GBH) with intent. He was sent to HMP Winchester. He had a history of substance misuse.

2. On 28 January, Mr Jeans transferred to HMP Guys Marsh. The next day, a mental health nurse saw Mr Jeans, referred him for bereavement counselling and added him to the list to be discussed at the next mental health team meeting.

3. On 1 February, Mr Jeans met a substance misuse recovery worker who told him about the risks associated with taking substances. Over the next few months, Mr Jeans completed multiple substance misuse workbooks, attended support groups, and engaged positively with his recovery worker.

4. On 24 May, Mr Jeans saw a psychiatrist who arranged some additional support to help manage his mental health. A referral for therapy was sent to the psychology team. On 9 June, a clinical psychologist saw Mr Jeans for an initial psychology assessment. Mr Jeans was added to the waiting list for therapy.

5. On 19 September, Mr Jeans was found under the influence of an illicit substance. The next day, Mr Jeans admitted to drinking hooch (illicitly brewed alcohol) and said that he was struggling after the deaths of his aunt and father. Over the next few weeks, Mr Jeans continued to engage with his recovery worker and gave two negative voluntary drug tests.

6. On 27 October, Mr Jeans attended his Parole Board hearing (to decide whether an individual should be released from prison). Records note this went well and the Parole Board told Mr Jeans that he would be given the outcome of the hearing in two weeks' time.

7. At approximately 5.08am on 13 November, staff noticed an alarm clock going off in Mr Jeans' cell. They looked through the observation panel and noticed that he was lying on his front on the cell floor, unresponsive, in a pool of blood. They radioed a medical emergency code.

8. Staff attended, went into the cell and found that Mr Jeans was not conscious or breathing. They started chest compressions. At 5.39am, paramedics arrived and took over treatment. At 5.55am, a senior paramedic arrived and pronounced that Mr Jeans was deceased. Shortly afterwards, police attended and removed a bottle containing orange liquid from Mr Jeans' cell. This was later tested and found to contain 13% ethanol.

9. The pathologist concluded that Mr Jeans died from an unusual reaction to having consumed hooch and illicit medication which had not been prescribed to him.

Findings

10. Mr Jeans had a history of substance misuse. While he was in prison, he was seen regularly by the substance misuse team and warned about the risks and dangers of taking drugs. We are satisfied that Guys Marsh did all they could to manage the risks associated with Mr Jeans' substance misuse.

11. Mr Jeans was able to obtain hooch and illicit medication while he was at Guys Marsh. The prison is taking proactive steps to reduce the supply of drugs and hooch in the prison and we make no recommendation in this regard.

12. The clinical reviewer found that the care Mr Jeans received at Guys Marsh was of a satisfactory standard and was equivalent to that which he could have expected to receive in the community.

13. We make no recommendations.

The Investigation Process

14. HMPPS notified us of Mr Sheldon Jeans' death on 13 November 2022.

15. 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 her. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Jeans' prison and medical records. The CCTV was not available due to a technical issue.

17. The investigator interviewed five members of staff at Guys Marsh in March 2023. In April 2024, the investigation was reallocated to another investigator.

18. NHS England (NHSE) commissioned a clinical reviewer to review Mr Jeans' clinical care at the prison.

19. 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.

20. The Ombudsman's office contacted Mr Jeans' next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked:

    - Why Mr Jeans was not considered to be a vulnerable prisoner, given his history of self-harm?
    - Why were staff not regularly checking Mr Jeans?
    - Why was it left to a prisoner in the cell next door to raise the alarm that something was not right with Mr Jeans?

21. We have answered these questions within this report and in separate correspondence to Mr Jeans' mother.

22. Mr Jeans' family received a copy of the draft report. They did not make any comments.

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

Background Information

HMP Guys Marsh

24. HMP Guys Marsh is a medium security prison. Practice Plus Group (PPG) provides primary and secondary mental healthcare and, at the time of Mr Jeans' death, commissioned the Exeter Drugs Project (EDP) to provide integrated substance misuse services. That service is now provided by Change Grow Live (CGL). 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

25. The most recent inspection of HMP Guys Marsh was in July 2022. Inspectors reported that the prison was safer than the previous inspection in 2019, but levels of violence were still high and there was a very significant drug problem. Staff/prisoner relationships were strong and there was a lot of individual work with prisoners and cross-departmental working.

26. Inspectors reported that EDP clinical caseloads were high, but joint prescribing reviews with the prisoner and psychosocial worker were frequent. Suitable harm minimisation advice was given to new arrivals, with comprehensive psychosocial assessments being completed within three days. Psychosocial workers had high caseloads and although care plans were in place, they did not always have mental health practitioner input. A key concern was the high level of illicit drugs coming into the prison. Although security measures had improved, inspectors found that not enough had been done to reduce supply. 45% of prisoners said it was easy to get illicit drugs, which was higher than in similar prisons. The use of psychoactive substances (PS) had risen sharply in 2022 and this was a critical issue for the prison.

27. A successful NHS funding bid was supporting innovative demand reduction initiatives and a recovery wing was being developed. There was good cooperation with the police. Clinical management of substance misuse was good, there was a range of psychosocial interventions, and the high number of psychoactive substance incidents were managed well.

Independent Monitoring Board

28. 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 2022 to 2023, the IMB reported that illicit items continued to be a problem at the prison. They noted that the prison was prone to "throwovers" due to its geographical situation. Illicitly brewed alcohol (hooch) continued to be made on a significant scale which the prison tried to detect through searches and preventing the materials needed to manufacture it from being available. The IMB found that body worn video camera (BWVC) use was still low, as it had been in previous years.

Previous deaths at HMP Guys Marsh

29. Mr Jeans was the third prisoner to die at Guys Marsh since November 2019. Of the previous deaths, one was drug related and one was self-inflicted. We have previously highlighted the need for all staff to wear and turn on body worn video cameras when responding to an incident.

30. Up to May 2024, two prisoners had died since Mr Jeans. The first of these, in July 2023, was due to drug toxicity (cocaine, psychoactive substances and non-prescribed pregabalin). The second death, which occurred in April 2024, has no confirmed cause of death and our investigation remains ongoing.

Assessment, Care in Custody and Teamwork

31. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

32. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

33. Mr Sheldon Jeans had a history of self-harm, depression, anxiety and substance misuse. He had diagnoses for attention deficit hyperactivity disorder (ADHD, a condition that includes symptoms such as being restless and having trouble concentrating), post-traumatic stress disorder (PTSD, a mental health condition caused by a traumatic experience) and emotionally unstable personality disorder (EUPD, a condition that affects how you think, feel and interact with other people).

34. In September 2021, Mr Jeans was released from prison on licence. In December, he was recalled after he was suspected to have been violent towards his partner. A warrant was issued for his arrest. Mr Jeans remained unlawfully at large until 7 January 2022, when he handed himself in to police.

35. On 10 January, Mr Jeans was sentenced to 31 months imprisonment for grievous bodily harm (GBH) with intent. He was sent to HMP Winchester.

36. On 19 January, Mr Jeans cut his throat and required hospital treatment after being told he was due to transfer to HMP Portland. Staff began Prison Service suicide and self-harm monitoring procedures (known as ACCT) the same day. Mr Jeans said he had cut himself to avoid transferring to Portland.

37. On 27 January, staff closed Mr Jeans' ACCT and he was assessed as being medically fit for transfer. The next day, he transferred to HMP Guys Marsh.

HMP Guys Marsh

38. On his arrival at Guys Marsh on 28 January, a nurse saw Mr Jeans for his initial health screening and noted his mental health diagnoses. He told the nurse that he did not have any thoughts of suicide or self-harm, but that he would like to be referred to the Mental Health In-Reach Team (MHIRT) and to Exeter Drugs Project (EDP) for substance misuse support.

39. The next day, a MHIRT nurse saw Mr Jeans to complete a triage assessment. Mr Jeans told the nurse that he had anxiety and felt low in mood after the death of his father in December 2021. The nurse referred him for bereavement counselling, and he was added to the list to be discussed at the next MHIRT meeting. A nurse later saw Mr Jeans for an initial substance misuse assessment. Mr Jeans said that he would like help with his substance misuse issues whilst at Guys Marsh. The nurse warned him about the dangers of taking psychoactive substances (PS) and noted that he had a good understanding of the risks associated with substance misuse.

40. On 1 February, an EDP recovery worker saw Mr Jeans for a full substance misuse assessment. Mr Jeans told her that he had had drug and alcohol problems since he was a teenager and asked to complete substance misuse services (SMS) programmes whilst at Guys Marsh. Mr Jeans recognised that his alcohol use was related to his offending behaviour, and he said he wanted help to remain alcohol free. The recovery worker told Mr Jeans about the risks associated with taking substances and they agreed a recovery care plan.

41. On 21 February, the recovery worker saw Mr Jeans who told her that he was hoping to be released to supported accommodation in Portsmouth, where he would attend Alcoholics Anonymous groups and be given additional support to remain sober. She noted that Mr Jeans had completed his SMS workbooks to a high standard.

42. On 11 March, Mr Jeans told a recovery worker that he used drugs and alcohol to manage his emotions, specifically anxiety and depression. They discussed alternative ways to manage his emotions and created an action plan to keep him focused. The recovery worker gave Mr Jeans some additional recovery workbooks to complete in his cell.

43. On 20 April, the recovery worker saw Mr Jeans for his 13-week review. She noted that he presented well and engaged in the session. She gave him more workbooks to complete. She noted that he had good insight into the problems alcohol had caused him and recognised his triggers to substance misuse.

44. On 28 April, Mr Jeans attended healthcare for an appointment with a psychiatrist to discuss a treatment plan for his ADHD. He waited for 45 minutes but left before he was seen as he said he did not want to wait any longer (the psychiatrist was delayed due to attending an emergency). Staff rebooked the appointment.

45. On 29 April, Mr Jeans attended his first substance misuse group session. Over the next month, Mr Jeans attended weekly sessions in which the group discussed multiple topics such as the dangers of poly drug use (taking multiple drugs at the same time) and harm minimisation. The group facilitator noted that Mr Jeans always engaged in the discussions, took part in the group activities, and gave advice to other prisoners.

46. On 24 May, Mr Jeans attended his psychiatry appointment. The psychiatrist arranged some additional support to help manage his mental health which included additional gym time, access to talking therapies, and prescription of Atomoxetine (prescribed for those with ADHD). A few days later, staff discussed him at the MHIRT meeting due to his mental health and substance misuse issues making him more at risk of suicide and self-harm. They agreed to urgently refer him to the psychology team.

47. On 1 June, Mr Jeans asked healthcare staff if he could have a job within the prison as the substance misuse representative. They said they would speak to the activities board and let him know.

48. On 9 June, a clinical psychologist saw Mr Jeans for an initial psychology assessment. The psychologist noted that Mr Jeans said he felt settled, had no thoughts of suicide or self-harm and that his sleep had improved. Mr Jeans said that he would like to be referred for therapy, so the psychologist added him to the waiting list.

49. On 11 July, Mr Jeans was given a trusted job working as a healthcare representative. His duties included delivering appointment slips to prisoners across Guys Marsh.

50. On 21 July, the recovery worker gave Mr Jeans a bronze recognition award for his positive attitude and his continued hard work with substance misuse services.

51. On 27 July, after missing a previous appointment, Mr Jeans told the recovery worker that he no longer wanted to engage with EDP. He was discharged but referred himself back into their service two days later. He said he would like to continue doing voluntary drug tests, attending group sessions and engaging with the service.

52. On 16 August, Mr Jeans moved from Anglia wing to Mercia wing. On 24 August, EDP held a substance misuse meeting. The prison had received information that Mr Jeans was attempting to attend group sessions on a different wing, when he was only permitted to attend the sessions on his own wing, Mercia. As a result, the next day, the recovery worker saw him and challenged him on this. She reiterated that he was only allowed to attend group sessions on Mercia, and he must not attempt to attend groups on any other wing. He subsequently complied with this.

53. On 19 September, staff suspected that Mr Jeans was under the influence (UTI) of hooch (illicitly brewed alcohol) while he was on the wing landing. As he became non-compliant, staff restrained him and took him to his cell. Staff were concerned for Mr Jeans' welfare, so they called an emergency code, and healthcare staff attended to assess him. Mr Jeans continued to be aggressive and healthcare staff could not fully assess him, but he was placed on a welfare log so that staff could monitor him. Staff submitted an intelligence report documenting the incident which involved several prisoners on the landing.

54. The next day, the recovery worker spoke to Mr Jeans to discuss the UTI incident. Mr Jeans admitted to drinking hooch but said he could not remember anything that had happened. He said that he was struggling after the deaths of his aunt and father and said that he knew that using substances was not the right way of dealing with his grief. He said that he was now refocussing on staying sober and they discussed the possibility of him attending the chapel for help with his grief.

55. Due to being found UTI, Mr Jeans temporarily lost his trusted position as a healthcare representative. Staff submitted a Challenge, Support and Intervention Plan (CSIP) referral the following week. CSIP is a process used to support and manage prisoners who are considered to pose a risk to or be a victim from other prisoners. Guys Marsh has incorporated the CSIP process into a local system of enhanced case management for those with serious risk issues in relation to substance misuse. We found no evidence that this CSIP referral was actioned. However, as this was the first time Mr Jeans had been found UTI, and there was no evidence to suggest that he had serious risk issues in relation to substance misuse, we are satisfied that he did not warrant the support of a CSIP at that time.

56. Over the next few weeks, Mr Jeans continued to engage with his recovery worker and gave two negative voluntary drug tests. His Prison Offender Manager (POM) noted that Mr Jeans received no further negative entries in his record and that he seemed more settled and committed to staying sober. Mr Jeans regained his trusted position as a healthcare representative as well as his enhanced regime status (where prisoners who have shown good behaviour have access to additional privileges).

57. An officer worked on Mercia wing and told us Mr Jeans was a well-known and popular prisoner. She described him as having a bubbly personality and said that he always seemed in a positive frame of mind. She was not aware that Mr Jeans had any issues or concerns and thought he would have approached staff if he had. She said Mr Jeans could look after himself and was friends with some influential prisoners on Mercia but appeared to stay out of any conflicts.

58. On 27 October, Mr Jeans attended his parole hearing with the Parole Board. Staff recorded that this went well. Mr Jeans' Community Offender Manager (COM) recommended that he was suitable to be released. The Parole Board told Mr Jeans that he would be given the outcome of the hearing in two weeks' time.

59. On 10 November, the COM asked the Parole Board if they had made a decision regarding his release. The caseworker told Ms Harding that he had not heard the outcome yet, but that he would email the relevant people to find out. The next day, the caseworker had still not been notified of the decision. The COM noted that Mr Jeans was feeling anxious about the outcome, but that he was being patient. The prison did not receive notification of the outcome of Mr Jeans' parole hearing until after his death (his release was granted).

60. An Operational Support Grade (OSG) was working overnight on Mercia wing on 12/13 November. We were unable to interview her, as she was on long-term sick leave. In her statement, she recorded that she saw Mr Jeans and said goodnight to him when she did her first routine check at approximately 8.45pm on 12 November. She was not required to check Mr Jeans again during the night.

Events of 13 November

61. There was no CCTV footage for Mercia unit on 12 or 13 November (there was a fault in the system due a generator test some months earlier that had not been identified), nor did staff use their BWVC to respond to the emergency when Mr Jeans was found unresponsive. The following account is therefore taken from prison documents, staff statements and interviews and ambulance records.

62. At approximately 5.08am on 13 November, the OSG answered a cell bell two doors away from that of Mr Jeans. The prisoner asked what the noise was, and the OSG could hear that a loud alarm clock was going off in Mr Jeans' cell. She looked through his observation panel and noticed that he was lying on his front on the cell floor in what looked like a pool of blood. She banged on the door but did not get a response from Mr Jeans. As she realised she did not have her radio on her, she ran back down to collect it and on the way back up to the cell, she radioed a code red (a medical emergency code used when a prisoner has lost a significant amount of blood). According to the control room log, this was 5.10am.

63. A Custodial Manager (CM) and an officer immediately went to Mr Jeans' cell, picking up an emergency response bag on their way. The officer estimated it took him three minutes to get there. When they got to the cell, the OSG had opened the door (having had some difficulty breaking the seal on her emergency key pouch). They all went into the cell together. The CM said that Mr Jeans was not conscious or breathing, his face looked swollen, and his skin was dark in colour. The officer relayed this to the control room and requested that they called an ambulance as

soon as possible. Control room staff noted that they called an ambulance at 5.13am.

64. The OSG went to get a defibrillator from the wing office. The officer and CM turned Mr Jeans onto his back. In their statements, both officers described this as being difficult, as they said Mr Jeans limbs were stiff and they believed that he had signs of rigor mortis. They then applied the defibrillator and started chest compressions.

65. At approximately 5.39am, paramedics arrived. Staff moved Mr Jeans onto the landing and paramedics continued resuscitation attempts. Their notes confirm that there were signs of rigor mortis present with Mr Jeans' arms in a fixed position.

66. At approximately 5.55am, a senior paramedic arrived and pronounced that Mr Jeans had died. A blanket was placed over Mr Jeans' body for dignity purposes, and screens were placed around him to limit the amount of people that were able to see him. Staff later returned Mr Jeans' body to his cell, with the agreement of senior prison managers.

67. Police searched Mr Jeans' cell and found a bottle which contained an orange liquid. It was tested and found to contain 13% ethanol.

Contact with Mr Jeans' family

68. The prison appointed a senior prison manager as family liaison officer (FLO). The prison had received information to say that Mr Jeans' mother had been notified of his death via a prisoner using an illicit mobile phone. The Governor agreed that, in the circumstances, the FLO should contact Mr Jeans' mother as soon as possible by telephone. At 7.15am, the FLO spoke to her.

69. The FLO also attempted to contact Mr Jeans' partner because he had listed her as his next of kin on arrival at Guys Marsh. She eventually managed to speak to Mr Jeans' partner at 11.15am and discovered she was on holiday abroad. Mr Jeans' partner agreed that his mother should be the point of contact for the prison. The FLO and a prison chaplain visited Mr Jeans' mother, sister and brother at 11.50am.

70. Mr Jeans' mother subsequently visited the prison to see her son's cell. The prison offered a financial contribution to Mr Jeans' funeral in line with national guidance.

Support for prisoners and staff

71. After Mr Jeans' death, the Head of Security debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team and Trauma Risk Management (TRiM) team also offered support.

72. The prison posted notices informing other prisoners of Mr Jeans' death and offering support.

Post-mortem report

73. The post-mortem report concluded that Mr Jeans died from an idiosyncratic response (a rare and unpredictable reaction) to a combination of alcohol and prescription drugs.

74. The toxicology report found that alcohol, dihydrocodeine (a painkiller), mirtazapine (an antidepressant) and pregabalin (an anticonvulsant) were present in Mr Jeans' system at the time of his death. None of these drugs were prescribed to Mr Jeans. The pathologist noted that all of these substances are respiratory depressants to some degree, and each was present in either a moderate amount (alcohol) or at a therapeutic level. All three drugs together in the presence of alcohol may have caused a significant degree of respiratory depression in Mr Jeans. As Mr Jeans was found face down when under the influence, the pathologist noted that partial postural asphyxia (when an obstruction to the airway causes interference with breathing) was a contributing factor in his death.

Findings

Substance misuse support

75. Mr Jeans had a history of substance misuse. While he was in prison, he was seen regularly by the SMS team and warned about the risks and dangers of taking drugs. He attended regular support sessions, completed in-cell packs and had eleven voluntary drug tests, all of which were negative for illicit and non-prescribed substances. We are satisfied that Guys Marsh did all they could to manage the risks associated with Mr Jeans' substance misuse and support him.

Availability of illicit drugs, hooch and mobile phones

76. Mr Jeans died from an unusual reaction to hooch and illicitly obtained prescription medication. We have considered what Guys Marsh is doing to prevent the brewing of hooch and trading of illicit medication in the prison.

Illicit medication

77. Prescribed medications hold a value and the trading of them creates an illicit market. These medications can either be brought into the prison illegally or obtained from other prisoners to whom they have been prescribed. After his death, the prison received information that Mr Jeans had told his friend the morning before he died that he had got some hooch, pregabalin, dihydrocodeine and Subutex (an opioid substitute used to help people stop misusing opioids) and that he intended to have a party that evening in relation to his parole. The prison also received information to suggest that Mr Jeans used his role as a healthcare representative to transport illicit substances around the jail. The information did not reveal whether Mr Jeans obtained the prescription medication from prisoners to whom it had been legitimately prescribed, or by a throw over from outside the prison walls. (Additionally, the toxicology results from Mr Jeans' post-mortem examination were not available until a year after his death. In the meantime, the prison took measures to address PS use in the prison, assuming that his death was linked to their use.)

78. The HMPPS Drug Diagnostic Team (DDT) provide practical advice and offer suggestions to help regional drug strategy leads and establishments develop, implement, and embed their drug strategies. In January 2023, the DDT completed a targeted diagnostic visit to help Guys Marsh identify knowledge gaps and good practice. They found that medication diversion remained a constant risk, and they recommended an immediate review of the medication queue management to support staff and vulnerable men collecting their medication.

79. As a result, Guys Marsh reviewed the queue system and introduced a light system for the medication hatch. There can be no more than one prisoner at the hatch at any given time (behind a closed door), with the light on the outside turning green when the hatch is free. Additionally, medication is administered wing by wing, with controlled drugs being given first which limits the number of prisoners waiting in the queue. The prescribers check the prisoners' mouths to ensure that medication has been swallowed, and medication held 'in possession' (in the prisoner's cell) is regularly checked and counted by healthcare staff. Finally, there is a dedicated

officer to manage the medication queue and a substance misuse prison officer was introduced to improve the submission of intelligence reports to support the intelligence picture.

80. One of our investigators interviewed the temporary Deputy Governor in January 2024, about a subsequent death due to drug toxicity (including non-prescribed pregabalin) at the prison. She said that the demand for illicit drugs was high and that the prison's rural location and finite resources made it more difficult to effectively stop drugs coming into the prison. She said that drugs being thrown over the perimeter wall and drones dropping them over were a major problem as the prison was surrounded by open fields. She had ensured that trees and hedges had been cut back to improve CCTV coverage and portable fences were used to fence off areas where throw overs were coming in so that prisoners could not retrieve the items.

81. The temporary Deputy Governor said that Guys Marsh had also introduced a code orange radio call to be used by staff if anyone was seen attempting to throw something over the wall. There was an agreed protocol that then followed this.

Hooch

82. We recognise that hooch can be made by prisoners using items that are readily accessible to them in prison, and that it can be brewed in a matter of days. This makes reducing the supply of hooch more challenging. Since the death of Mr Jeans, Guys Marsh has taken steps to manage the control of ingredients and equipment used to make hooch, including removing certain items from the prison shop. They have also taken measures to improve accommodation fabric checks and cell searches through reinforcing information and training to prison staff. Finally, Guys Marsh continue to complete targeted cell searches upon receiving intelligence that suggests the presence of illicit items.

83. After the death of Mr Jeans, the Governor issued a notice to prisoners stating that there may be drugs and alcohol circulating illegally in the prison which might put their life at risk. He reminded prisoners to speak to a member of staff if they needed help with their substance misuse issues so that they could be signposted to an appropriate support service.

Mobile phones

84. Staff told the investigator that a prisoner used an illicit mobile phone to record a video of Mr Jeans' body after he was moved out of the cell and posted it to social media sites. We are satisfied that staff acted appropriately in following paramedics' instructions in moving Mr Jeans. Clearly such a video being put online is both undignified for Mr Jeans and extremely distressing for those who knew him. A prisoner also used an illicit mobile phone to tell Mr Jeans' mother about his death.

85. The temporary Deputy Governor acknowledged the issue of illicit mobile phones in the prison. Guys Marsh does not have enhanced gate security which includes additional equipment and staff to stop illicit items coming into the prison. However, the Deputy Governor outlined the measures they are taking in searching staff, visitors and prisoners coming into the prison when resources allowed. The prison

was also introducing a clear bag policy which it was hoped would limit the illicit items brought in. There were also robust measures in place for checking post and parcels.

86. We recognise the huge challenges inherent in preventing drugs and other illicit items entering Guys Marsh. The prison is attuned to these challenges and taking proactive steps to try to address them. We therefore make no recommendation.

Clinical care

87. The clinical reviewer found that the care Mr Jeans received at Guys Marsh was of a satisfactory standard and was equivalent to that which he could have expected to receive in the community. She made two recommendations, not related to Mr Jeans' death, which the Head of Healthcare will wish to address.

Resuscitation

88. We found that when staff found Mr Jeans unresponsive, they attempted CPR despite noticing clear signs of death. The European Resuscitation Guidelines 2015 state that resuscitation is inappropriate when there is clear evidence that it will be futile. We understand that staff act with the best intentions in emergencies, but they should be reminded that they are not required to attempt or continue CPR when there is rigor mortis or other clear signs of death.

89. Following learning from deaths in custody, the prison and PPG introduced the custody officer immediate life support (COILS) training, to ensure a proportion of managers were trained in emergency first aid. As part of internal learning after Mr Jeans' death it was identified that the night orderly officer had not received a recent Custodial Office Immediate Life Support (COILS) refresher training session. The prison has taken steps to ensure that COILS training is delivered to all CMs and introduced a new protocol to ensure that a certain percentage of night staff on duty on any given night will be COILS trained.

Availability of CCTV

90. The investigator asked Guys Marsh for CCTV footage of the events surrounding Mr Jeans' death. A CM is the security hub manager at Guys Marsh. Following the death of Mr Jeans, she attended Mercia Unit in order to download and secure the CCTV from 12/13 November. When she looked at the CCTV terminal there was an error message displayed. She logged in and the system successfully reset, however no footage from the previous several days was available to view or download as the system had been offline. As a result, there was no footage of the events surrounding Mr Jeans' death. Engineers identified that the prison had undertaken a generator test on 9 March that had involved the generator being switched off and on again. This was likely what caused the CCTV to malfunction.

91. Since Mr Jeans' death, Guys Marsh has introduced a new system to ensure that the CCTV is working on all units. Unit supervising officers (SOs) are required to check their CCTV is working twice a day and sign a document to that effect. We therefore make no recommendation.

Governor to Note

Emergency response

92. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, states that when a member of staff finds a prisoner unresponsive, they should alert the control room of this using a medical emergency code, without delay. This is to ensure timely, appropriate, and effective response to medical emergencies and to maximise the likelihood of a positive outcome for the prisoner. The control room should then automatically call an ambulance.

93. When the OSG found Mr Jeans unresponsive in his cell, she did not have her radio on her to alert the control room. This resulted in a short delay between her finding Mr Jeans, and her radioing an emergency code. Furthermore, control room staff did not immediately telephone an ambulance but waited a further three minutes to do so. As Mr Jeans was likely to have been deceased for several hours before he was discovered, we do not consider this delay as having any impact on the outcome for Mr Jeans. However, it may do in another situation. The Governor will want to consider how to ensure staff are aware of the importance of always carrying their radios and their responsibilities in a medical emergency.

Body Worn Video Cameras (BWVC)

94. Prison Service Instruction (PSI) 04/2017, *Body Worn Video Cameras (BWVC)*, requires prison staff to use BWVCs during any reportable incident. The PSI says that on attending an incident involving medical intervention, BWVC users must consider any sensitivities of the circumstances. This may involve turning their cameras away from the incident to capture only an audio recording.

95. Staff did not turn on their BWVCs when they found Mr Jeans unresponsive. We recognise that during an emergency event staff might forget to switch on their cameras, but someone managing the incident should have reminded staff this was necessary. We have also found this to be an issue in a previous investigation and the IMB have commented on the low use of BWVCs at the prison. The Governor will wish to ensure staff activate BWVCs when responding to an incident.

Inquest

96. The inquest into Mr Jeans' death concluded on 23 July 2025 and found that he died as a result of misadventure.

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