Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Alex Davies, a prisoner at HMP Styal, on 24 December 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Ms Alex Davies died on 24 December 2024, after being found unresponsive with a ligature around her neck in her cell at HMP Styal. Staff and paramedics tried to resuscitate her but were unsuccessful. She was 25 years old. I offer my condolences to Ms Davies' family and friends. This report will make distressing reading for them.

Ms Davies was the fifth prisoner to take her own life at Styal in three years. Up to the end of May 2025, there has been one further self-inflicted death at the prison.

Ms Davies had a long history of mental health issues and frequently tied ligatures around her neck while at Styal. She was supported using suicide and self-harm prevention procedures (known as ACCT) throughout her 10 weeks there.

On the morning of 24 December, Ms Davies had an altercation with another prisoner in the prison gardens and then ran off. When staff found her hiding, they immediately restrained her and despite her being visibly distressed, moved her to the segregation unit. She told staff that she hated it there and was anxious that she would have to spend Christmas Day there. She died fewer than seven hours later.

Staff displayed poor judgement throughout the events of 24 December. Officers were too quick to deploy force against Ms Davies and then once she was in the segregation unit, managers failed to properly assess the risk she posed to herself and to put adequate monitoring and support in place. Despite Ms Davies repeatedly expressing her anxiety about being left in the segregation unit over Christmas, no one properly considered the impact of this on her already fragile mental state, and no one communicated to her that she might be able to return to a standard wing if her behaviour calmed. My investigation found that both the use of force and decision to segregate her on 24 December were contrary to policy. I do not believe that Ms Davies would have taken the actions she did had staff responded differently that day. The Governor and staff at Styal should reflect carefully on the learning from Ms Davies' death.

Adrian Usher
Prisons and Probation Ombudsman **October 2025**

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Summary

Events

1. On 16 October 2024, Ms Alex Davies was remanded in prison charged with assault, criminal damage and possession of a knife. It was her first time in prison.

2. The reception nurse noted that Ms Davies had an extensive mental health history and had attempted suicide two days earlier. She started suicide and self-harm monitoring (known as ACCT).

3. Ms Davies frequently tied ligatures around her neck and remained under ACCT monitoring throughout her time at Styal. Staff held frequent multidisciplinary case reviews and set ACCT checks in line with her level of risk.

4. On 9 November, staff took Ms Davies to the segregation unit after she climbed onto the landing railings on her residential unit. Over the next few weeks, staff held regular ACCT reviews and segregation reviews. After 27 days in the segregation unit, staff agreed that Ms Davies' behaviour had improved. On 6 December, staff moved her from the segregation unit to the Valentina Unit.

5. Staff noted that Ms Davies was coping well on the wing and interacting well with staff and prisoners.

6. On 24 December, while being escorted back from an activity in the prison gardens, Ms Davies became upset and ran away from officers. (The officer escorting her later told colleagues that Ms Davies had stopped to look at a prisoner with whom she had had a recent fight and to try to get her to carry on walking the officer had said, "Come on, stop perving.") Staff found Ms Davies hiding in a polytunnel in the prison grounds. Officers restrained Ms Davies and took her to the segregation unit. While walking under restraint to the segregation unit, Ms Davies shouted, "I hate it in here, please help me."

7. Shortly after being taken to her cell in the segregation unit, Ms Davies tied a ligature round her neck on two separate occasions. Each time staff removed the ligature. Staff did not hold an ACCT review and Ms Davies remained on five checks an hour.

8. Staff recorded that Ms Davies was very distressed at being held in segregation. She kept asking staff how long she would have to stay there and whether she would have to spend Christmas there. When staff called a governor and asked how long Ms Davies would be in segregation, they said they had not decided yet.

9. At around 5.12pm, an officer went to Ms Davies' cell to carry out an ACCT check. He saw that Ms Davies had obstructed the observation panel with her mattress. He called to another officer for assistance. They opened the cell door and could see that Ms Davies had tied a ligature around her neck and was unconscious. The officer radioed a medical emergency code and started CPR. Staff in the control room called an ambulance.

10. Ambulance paramedics arrived at 5.34pm, and continued CPR. They were not able to regain a pulse and at 5.56pm, they declared life extinct.

Findings

11. We found that overall, the ACCT procedures were well managed and provided good support to Ms Davies up until 24 December.

12. On 24 December, officers were too quick to use force on Ms Davies when they found her hiding in the gardens. Force should be used only when necessary and staff should attempt to de-escalate wherever possible to avoid use of force. This did not happen in Ms Davies' case. The prison told us that staff would receive further training.

13. Staff failed to reassess Ms Davies' risk after she tied two ligatures round her neck shortly after arriving in the segregation unit. Staff did not hold an ACCT case review and there was no record that managers considered whether she should be monitored under constant supervision.

14. Managers also failed to record justification for Ms Davies' segregation. As Ms Davies was on an ACCT, there needed to be exceptional reasons for segregation but there was no record that managers had properly considered this. The duty governor A passed on responsibility for completing the segregation paperwork to another governor who was in the segregation unit at the time, and it was unclear who had overall responsibility for the decision to segregate Ms Davies.

15. The clinical reviewer concluded that overall, the clinical care that Ms Davies received at Styal was equivalent to that which she could have expected to receive in the community.

Recommendations

- The Governor should put robust and auditable measures in place to ensure that staff understand the importance of de-escalation techniques to avoid use of force and that staff use force only as a last resort.

- The Governor should conduct an urgent review of the use of segregation at Styal to satisfy herself that managers understand:

    - the roles and responsibilities for deciding if a prisoner is to be segregated and for completing the authorising documentation;

    - the impact that being segregated can have on the risk of suicide and self-harm and mental health;

    - the documents that must be completed when a prisoner on ACCT is segregated, including a defensible decision log that sets out the alternative options considered and why they were not deemed suitable.

The Investigation Process

16. HMPPS notified us of Ms Davies death on 24 December 2024.

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

18. The investigator visited Styal on 13 January. She obtained copies of relevant extracts from Ms Davies' prison and medical records.

19. NHS England commissioned a clinical reviewer to review Ms Davies' clinical care at the prison. The investigator and clinical reviewer interviewed 12 members of staff.

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

21. The Ombudsman's office contacted Ms Davies' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Ms Davies' mother said she was concerned that her daughter's medication had been stopped by her community psychiatrist and asked what medication she was on in prison. She also asked (via her legal representative) whether consideration had been given to transferring Ms Davies to a secure mental health hospital and why Ms Davies had not been under constant supervision given she had made several suicide attempts on the day she died. These issues have been addressed in our report and in the clinical review.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. They provided an action plan which is annexed to this report.

23. Ms Davies' family received a copy of the initial report. The solicitor representing Ms Davies' family wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Styal

24. HMP Styal holds women in a variety of residential units, with 16 separate houses each holding about 20 women. There is also a mother and baby unit.

25. Spectrum Community Health runs healthcare services at the prison. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. The prison has 24-hour nursing cover.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Styal was in December 2024. Inspectors noted that Styal was emerging from a lengthy period of instability with several changes of governor in recent years. The current governor was committed to the institution and aided by a deputy who was active in getting to grips with important operational challenges. Under their leadership, new priorities were being set, staff had been recruited, and a new confidence and competence were emerging, creating a sense of optimism for the future.

27. Inspectors noted that the rate of self-harm had doubled since the last inspection, with 5,262 incidents reported in the previous year, which was the second highest of the 12 women's prisons. The increased rate was influenced by a small number of women harming themselves multiple times. Leaders held regular sessions with case managers to drive forward improvements in the ACCT process, and the same case manager provided support throughout the period of need. Inspectors noted that there was still more to be done to ensure that the ACCT care plan reflected the range of help the woman needed.

28. Inspectors reported that, since the last inspection, there had been a significant increase in the number of times physical force had been used against women, with 739 incidents reported in the last year, up from 199 in the year leading up to the previous inspection. Almost three-quarters of staff had completed the Behind the Behaviour training programme (to teach staff how the mind and body work, as well as providing skills practice to enable them to work effectively with others).

29. Inspectors found that scrutiny and oversight of the use of force was good. All incidents were reviewed at a weekly meeting chaired by the deputy governor. Inspectors reported that in footage they reviewed, most incidents were justified and proportionate, and they saw evidence of good de-escalation techniques being used.

Independent Monitoring Board

30. 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 30 April 2024, the IMB reported that the number of ACCT plans had remained relatively stable, although they had increased over the reporting year from a daily average of 29 in May 2023, to a high of 44 in December 2023 and 34 in April 2024. The Board had seen evidence

through its monitoring that suggested the ACCT process was secure, properly documented and tracked and regularly reviewed.

31. The IMB also reported that the Valentina Unit continued to provide excellent care. The unit had been refurbished and redecorated, and the staff understood the complex needs of the prisoners and consistently responded to prisoners with patience, good humour and understanding.

Previous deaths at HMP Styal

32. Ms Davies was the seventh prisoner at Styal to die since December 2021. Of the previous deaths, two were from natural causes and four were self-inflicted. Up to the end of May 2025, there has been one further self-inflicted death and one further death from natural causes at the prison.

33. As a result of the number of self-inflicted deaths, Styal is receiving support and monitoring from HMPPS headquarters. The support includes regular visits and assurance checks.

Assessment, Care in Custody and Teamwork (ACCT)

34. 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.

35. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions 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. When Ms Davies was at Styal, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Segregation

36. Segregation is when a prisoner is kept apart from other prisoners in the segregation unit. The criteria for segregating a prisoner are set out in the Prison Rules. Most commonly, prisoners are segregated under Prison Rule 45 on good order or discipline (where a prisoner has behaved in a way that prison staff consider would put others in danger or cause a problem for the prison) or for the prisoner's own interests/protection (if the prisoner or prison staff consider they are in danger).

37. Once a prisoner has moved to the segregation unit, the Segregation Review Board (SRB) must carry out regular reviews to assess if the prisoner should remain segregated. The SRB comprises a governor (the Chair), a healthcare representative, an ACCT case manager (where applicable) and the prisoner. An IMB member must also be invited, and every effort should be made to facilitate their attendance.

38. Prison Service Order (PSO) 1700 on segregation acknowledges the specific risks of holding vulnerable prisoners in segregation. It notes that rates of suicide among segregated prisoners are high, and that segregation should only be used as a last resort.

Key Events

39. On 16 October 2024, Ms Alex Davies was remanded in prison charged with assault, criminal damage and possession of a knife. (The Liaison and Diversion Team, who identify individuals with significant vulnerabilities and can divert them away from the criminal justice system into a more appropriate setting if required, had assessed that Ms Davies did not need to be diverted.) She was sent to HMP Styal. It was her first time in prison.

40. Nurse A completed Ms Davies' initial healthcare screen. Nurse A noted that Ms Davies was on medication for epilepsy and depression. She also noted that Ms Davies had an extensive mental health history and since the age of 11 had been admitted to various psychiatric units. Nurse A noted that Ms Davies' most recent suicide attempt was two days earlier (when she threatened to cut her neck with a knife in hospital). She started suicide and self-harm prevention procedures (known as ACCT) and referred Ms Davies to the mental health team.

41. A Supervising Officer (SO) completed the ACCT immediate action plan. She set ACCT checks at two an hour.

42. Later that evening, Ms Davies' cellmate pressed the emergency cell bell and told staff that Ms Davies had used a sock to make a ligature. Staff removed the ligature and continued ACCT checks. That night Ms Davies' cellmate pressed the emergency cell bell on two more occasions and told staff that Ms Davies had tied a ligature round her neck. Each time prison and healthcare staff attended and removed the ligature. Night staff increased ACCT checks to four an hour.

43. The next morning, staff held an ACCT review. Ms Davies told staff that she was struggling with her mental health and was finding it difficult to cope since her medication had been stopped in the community. Staff kept ACCT checks at four an hour.

44. On 17 October, Ms Davies climbed onto the landing railings. Around 20 minutes later she climbed off the railings but refused to go into her cell. Staff restrained her and escorted her back to her cell.

45. Later that day, Nurse B from the mental health team saw Ms Davies to complete a mental health assessment. Ms Davies told Nurse B that she had been on clozapine (an antipsychotic medication used to treat schizophrenia but also sometimes prescribed to individuals with a severe personality disorder as it can help to reduce self-harm, aggression and other associated symptoms), but it was stopped because she had an abnormal ECG (antipsychotic medication can impact negatively on the heart so ECGs are carried out to check heart function). Ms Davies said that she would like support from the mental health team and asked if clozapine could be prescribed again. (Ms Davies' clozapine prescription in the community had been gradually reduced and then discontinued, following which her ECGs had returned to normal. She had been referred to a heart specialist before arriving in prison.) Healthcare staff noted that they planned to continue to monitor Ms Davies' heart with regular ECGs.

46. Over the next week, Ms Davies self-harmed daily by tying ligatures around her neck. She told staff that she was struggling to cope and that she kept having flashbacks of previous trauma. Staff held regular multidisciplinary ACCT reviews and continued to monitor Ms Davies four times an hour.

47. On 20 October, an officer from the young adult (YA) hub (run by Kinetic Youth, a charity, and offers a sensory room and calming space for young adults) saw Ms Davies to explain what the hub was and asked her if she would like to attend. Ms Davies said that she would. She said that it was her first time in prison and that she was struggling.

48. On 22 October, staff held a multidisciplinary ACCT review. Ms Davies told staff that she was enjoying attending the YA hub and it helped to keep her mind occupied. Ms Davies told staff that she struggled mostly at night. Staff noted that Ms Davies had self-harmed most nights that week. The team agreed to reduce ACCT checks during the day to one check an hour and kept checks at night at four an hour.

49. On 25 October, staff held a multidisciplinary ACCT case review. Ms Davies told staff that she self-harmed to help her cope with previous trauma, but she had no thoughts to end her life. Staff recorded that Ms Davies appeared in good spirits and agreed to reduce ACCT checks to one every two hours day and night.

50. On 31 October, staff held a multidisciplinary ACCT case review. The review was well attended and included wing staff, staff from education and the mental health team. Staff recorded that Ms Davies was still self-harming (by tying ligatures) but remained positive. She told the team about her hobbies and things she liked to do to occupy her time. Ms Davies told staff that she self-harmed as a way of coping but had no thoughts to end her life. Staff reduced ACCT checks to one every three hours.

Oak House

51. On 1 November, Ms Davies moved to Oak House (a house within the prison where around 20 prisoners live together). Ms Davies told staff that she was happy in the house and felt much more settled.

52. Over the next week, Ms Davies attended the YA hub daily. Staff recorded that she joined in with all activities and interacted well with staff and other prisoners.

53. On 5 November, staff held a multidisciplinary ACCT review and recorded that Ms Davies said she was enjoying attending the YA hub and was happy living in the house. Staff agreed to reduce ACCT checks to three a day.

54. Later that day, while at the YA hub, Ms Davies had an altercation with another prisoner. Ms Davies threw cold coffee over her and shouted that she wanted to kill her. Staff told Ms Davies that because of the altercation she was not allowed to attend the hub for the rest of the week.

55. On 7 November, a psychiatrist, saw Ms Davies for a psychiatric review. She recorded that she was concerned that Ms Davies said that she had thoughts of harming others. The psychiatrist recorded that she would have a discussion with

secure mental health in patient services to consider whether Ms Davies should be detained under the Mental Health Act. The psychiatrist began this process.

56. Later that day, Ms Davies made a ligature from her clothing. Staff removed it and a nurse saw Ms Davies. Staff increased ACCT checks to four an hour and moved Ms Davies to Waite Wing because they could not monitor her four times an hour in Oak House.

57. Ms Davies told staff that she did not want to move to Waite Wing and tried to climb onto the landing railings in protest. Staff restrained Ms Davies and took her back to her cell.

58. Over the next 24 hours, Ms Davies tied a ligature round her neck four times. Staff removed the ligatures, and Ms Davies saw healthcare staff on each occasion. When staff asked her why she kept ligaturing she said that the voices were telling her to.

Segregation – 9 November to 6 December

59. At around 11.00am on 9 November, Ms Davies climbed onto the landing railings again and refused to come off. After around an hour, Ms Davies climbed off the railings and staff placed her on report pending a disciplinary hearing and walked her to the segregation unit. A duty governor, decided that Ms Davies' behaviour was too disruptive for her to stay on the wing and that she should stay in the segregation unit until her disciplinary hearing. ACCT monitoring was increased to five checks an hour in line with prison policy (which says that if a prisoner is segregated while under ACCT monitoring, checks should be set at five an hour) pending the next ACCT review. (When we asked the prison for documentation that gave more detail about the decision to segregate Ms Davies, they said that some of the documents had been lost.)

60. After being in the segregation unit for around 20 minutes, Ms Davies hid under the bed and made a ligature using a sheet. Staff removed the sheet. Later that day, staff held an ACCT review. A member of the mental health team attended but Ms Davies said that she did not want her there, so this member if staff left the review. Ms Davies told staff that the reason she climbed over the railings was because no one was listening to her. Staff reduced ACCT checks to four an hour.

61. The next day, a prison governor held the disciplinary hearing. They told Ms Davies that she would have to stay in the segregation unit for ten days as punishment for climbing over the railings.

62. Over the next ten days, Ms Davies remained in the segregation unit. Ms Davies continued to self-harm. Staff held regular multidisciplinary ACCT reviews.

63. On 14 November, Ms Davies self-harmed by ligature. Healthcare staff saw her and conducted an ECG, the results of which were abnormal, and advised prison staff to call an ambulance. Staff called an ambulance and escorted Ms Davies to hospital.

64. While Ms Davies was at hospital, a prison manager held a multi-disciplinary meeting to discuss whether it was appropriate for Ms Davies to return to segregation when she came back from hospital. The team agreed that because of

her violent and disruptive behaviour she could not be managed on any other unit. Ms Davies returned to the prison and to the segregation unit the following day.

65. On 20 November, a prison governor held a segregation review board to decide if Ms Davies should remain in segregation. They recorded that since being in the segregation unit, Ms Davies had assaulted two prison officers and a member of the mental health team. They concluded that Ms Davies' behaviour was too unpredictable to go back to the wing and that she would remain in segregation for another week.

66. On 22 November, staff recorded that Ms Davies' mental health had significantly deteriorated. Ms Davies was crying and told staff that she felt hopeless. That afternoon she tried twice to strangle herself with a laptop wire. Staff held an ACCT review and agreed to start constant supervision (where staff constantly monitor the prisoner by remaining at the cell at all times).

67. The next day, while under constant supervision, Ms Davies tried to tie a ligature round her neck four times. Staff removed the ligatures and continued to monitor her.

68. Over the next few days, Ms Davies was continually abusive to staff, particularly staff from the mental health team. Nurse B from the mental health team went to Ms Davies' cell to see her. Ms Davies refused to engage and shouted that the mental health team were liars and that she would cut their throats. Ms Davies was placed on report for threatening behaviour.

69. On 25 November, Ms Davies was escorted to a video link room for a call with her solicitor. At the end of the video call, Ms Davies suddenly got upset and said that she thought someone had been listening to her call. As staff took Ms Davies out of the video link room, she activated the fire alarm and started hitting her head on the glass pane on the door. Staff restrained her and took her back to the segregation unit

70. Ms Davies continued to be disruptive and abusive to staff that were observing her and to staff in the segregation unit. Ms Davies made ligatures several times a day.

71. Ms Davies repeatedly told staff that she wanted to go back to Waite Wing. Staff devised a reintegration plan that they shared with Ms Davies. The plan included long and short-term behaviour goals, staff told Ms Davies what she needed to do before managers could consider her returning to the wing.

72. On 29 November, a prison governor held a segregation review board to decide if Ms Davies should remain in segregation. They decided that Ms Davies would remain in segregation because her behaviour was still too unpredictable for staff to manage her elsewhere.

73. Over the next week, Ms Davies continued to self-harm and told staff that she could not cope with the noise in the segregation unit.

74. On 5 December, a psychiatrist and psychologist from Merseyside NHS Trust, saw Ms Davies to assess whether she should be transferred to a secure mental health unit. The results of this assessment had not been decided before Ms Davies died.

75. On 6 December, staff held an ACCT review. Staff recorded that Ms Davies had engaged well over the last week and had successfully followed her reintegration plan. Staff agreed to stop constant supervision and reduce ACCT checks to four an hour. Staff recorded that Ms Davies was looking forward to a fresh start and agreed that she could move to the Valentina Unit. (The Valentina Unit is a small ten bed unit, that aims to offer more support to prisoners in crisis and to have a more open regime where prisoners are unlocked from 8.30am -12.30pm and 1.30pm – 5.30pm.)

Valentina Unit

76. Over the next two weeks, officers recorded that Ms Davies was getting on well on Valentina Unit and had received four positive behaviour entries. Ms Davies continued to self-harm and remained on four checks an hour. Ms Davies received continued support from the YA hub and wing staff.

77. On 23 December, Ms Davies became upset and climbed onto the healthcare unit roof. After approximately 40 minutes, she agreed to get down. Officers escorted her back to her cell. No force was used.

Events of 24 December

78. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 24 December. She also obtained information from North West Ambulance Service. The following account has been taken from all sources.

79. At around 9.30am, Ms Davies went to the prison gardens to take part in a Christmas treasure hunt. While being escorted back across the prison grounds after the treasure hunt had finished, Ms Davies became upset and ran away from officers. (The officer escorting her later told colleagues that Ms Davies had stopped to look at a prisoner with whom she had had a recent fight and that to try to get her to keep walking, the officer had said to her, “Come on, stop perving”.) An officer radioed for staff assistance. Several members of staff responded and helped to look for Ms Davies.

80. After a few minutes they found her in a polytunnel in the prison gardens. When staff approached Ms Davies, she started shouting that they should not touch her. Officers immediately restrained Ms Davies. A SO said in her statement that when she approached Ms Davies, she began kicking at her legs. The BWVC footage does not show this. Officer A said in her statement that Ms Davies shoved Officer B. Again, BWVC footage does not show this, and Officer B did not provide a statement.

81. Governor B s was duty governor that day. When the duty governor B arrived in the prison gardens, she saw that Ms Davies was screaming and kicking the officers that were restraining her. She told staff to take Ms Davies to the segregation unit. BWVC footage shows Ms Davies walking under restraint to the segregation unit shouting, ‘I hate it in here, please help me’.

82. During the walk to the segregation unit staff regularly stopped and tried to calm Ms Davies, telling her that if she stopped shouting and kicking, they would remove the

restraints and Ms Davies could walk to the segregation unit. Each time staff stopped Ms Davies tried to kick staff and continued shouting so she was restrained throughout the walk to the segregation unit

83. Ms Davies arrived at the segregation unit at around 10.25am. Officers took Ms Davies to a cell in the segregation unit and restrained her to the floor. Nurse C completed the healthcare section of the safety algorithm and signed to say that he was satisfied that Ms Davies was fit to be held in segregation. Duty Governor B asked Duty Governor A to complete the paperwork authorising Ms Davies to be held in segregation. Duty Governor A signed the document to say he was satisfied that Ms Davies was fit to be held in segregation. ACCT monitoring was increased to five checks an hour.

84. Shortly after being restrained into her cell, an officer went to check on Ms Davies. He saw that she had tied a ligature around her neck. He went into the cell and removed the ligature. CCTV shows that officers removed items of Ms Davies' clothing from her cell, though it is not clear from the CCTV which clothes were removed. At around 10.50am, Ms Davies tied a ligature again. Officers went into the cell and removed the ligature. Staff did not hold an ACCT review.

85. When the investigator asked the orderly officer (the most senior officer on duty) why an ACCT review was not held, she said that the ACCT case manager was not on duty until the afternoon, so she sent him an email asking him to hold an ACCT review when he began work. At around 4.00pm, the orderly officer realised that a case review had not been held and emailed the case manager to ask why not. He told her that he was busy working in reception and would go to the segregation unit to hold the ACCT review as soon as he could. Ms Davies died before an ACCT review was held.

86. Officer A, who worked closely with Ms Davies on the Valentina unit went to the segregation unit to see how Ms Davies was. Officer A recorded that Ms Davies was in her underwear. CCTV footage shows that Officer A fetched a prison tracksuit for Ms Davies to put on. She also recorded that Ms Davies was extremely distressed and emotional. Ms Davies told Officer At that being in segregation had a negative impact on her mental health and that she was worried about spending Christmas Day there.

87. Over the next four hours, Ms Davies repeatedly asked staff when she would be able to return to the Valentina Unit and if she would have to stay in segregation over Christmas. Officers called Duty Governor A to ask how long Ms Davies would be in segregation for and what she needed to do to be allowed back to Valentina Unit. The Duty Governor said he did not know. Staff relayed that to Ms Davies, and she became increasingly frustrated and distressed.

88. At around 4.53pm, officers opened Ms Davies' cell door and asked her if she wanted her evening meal. She said that she did not want anything to eat.

89. At around 5.12pm, Officer C went to Ms Davies' cell to do an ACCT check. When he looked through the observation panel, he could not see Ms Davies because she had put her mattress in front of the observation panel. Officer C called Officer D, and they unlocked the cell door. Ms Davies was under the bed and they saw that she had tied a ligature around her neck. Both officers pulled Ms Davies from under

the bed, her face was blue, and she was not breathing. A Custodial Manager (CM), who was also in the segregation unit, radioed a code blue. Both officers started CPR. The OSG in the control room immediately called for an ambulance. Healthcare staff responded to the code blue and took over CPR.

90. At around 5.34pm, paramedics arrived and took over the management of Ms Davies. At around 5.56pm, they declared life extinct.

91. After Ms Davies died, staff found in the adjudication room an undated note that she had written (we were unable to establish whether Ms Davies spent any time in the adjudication room that day, or how the note came to be there). The page long note was addressed to her mother and father, and the final paragraph said, “I had to die”. “I had to leave this cruel world, I wasn’t alright, I had to die”.

Contact with Ms Davies’ family

92. On 24 December, the prison appointed a prison manager as the family liaison officer. There was no address or telephone number recorded for Ms Davies’ next of kin so the prison contacted the police to see if they could help to find one. The police found an address for Ms Davies’ grandfather and the police visited him to break the news of Ms Davies’ death.

93. Over the following weeks, the prison manager offered support to Ms Davies’ family.

94. In line with national policy, the prison contributed towards Ms Davies’ funeral costs.

Support for prisoners and staff

95. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. 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.

96. After Ms Davies’ death, there is no record of a formal debrief. However, the staff involved in the emergency response told the investigator that they felt supported and that the staff care team offered support. Listeners were deployed and the staff care team also offered support.

97. The prison posted notices informing other prisoners of Ms Davies death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Davies death.

Post-mortem report

98. The post-mortem report concluded that Ms Davies died from hanging. Epilepsy was listed as a contributory factor.

Findings

Assessment of Ms Davies' risk of suicide and self-harm

ACCT management

99. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was in force at the time of Ms Davies' death, set out the processes (known as ACCT) that staff should follow when they identified that a prisoner was at risk of suicide and self-harm. (The policy has since been superseded by the Prison Safety Policy Framework though ACCT processes remain broadly the same.)

100. Ms Davies was a vulnerable young woman with several important risk factors for suicide. She had a history of self-harm (by particularly risky means) and suicide attempts and had extensive mental health issues. It was her first time in prison. When Ms Davies arrived at Styal on 16 October, staff quite rightly opened an ACCT.

101. Ms Davies regularly self-harmed and while she was at Styal did so on 77 occasions, with 68 of these involving ligatures.

102. We consider that until the morning of 24 December when she was taken to the segregation unit, ACCT procedures generally provided good support to Ms Davies. She had a consistent case manager who held regular case reviews which appropriately assessed her risk. After incidents of self-harm, staff held interim case reviews and increased the frequency of checks when appropriate. Ms Davies also spent periods of time under constant supervision. Prison staff implemented a meaningful care plan to reduce Ms Davies' risk. We consider that staff at Styal worked hard to support Ms Davies' complex needs and challenging behaviour.

103. However, on 24 December, while in segregation, Ms Davies twice tied a ligature around her neck. PSI 64/2011 states that if prisoners self-harm, an immediate case review should be held. Despite Ms Davies self-harming on two occasions, staff did not hold a case review. Staff told us that this was because Ms Davies' case co-ordinator had not been able to schedule one before she died.

104. We consider that given Ms Davies' level of self-harm and distress, and the increased risk factor of being held in segregation, staff should have held an immediate case review (chaired by another trained case co-ordinator if necessary) and considered whether constant supervision was appropriate. Throughout Ms Davies' ACCT we can see that until 24 December, staff held ACCT reviews appropriately when Ms Davies self-harmed. Therefore, we do not make a recommendation but bring this issue to the Governor's attention.

ACCT checks

105. CCTV shows that Ms Davies was checked at 4.53pm and not checked again until 5.12pm. Staff were required to carry out five checks an hour and while we accept that these need to be at unpredictable times rather than at precise 12-minute intervals, we consider that a gap of 19 minutes is too long. When the investigator

asked the officers why Ms Davies was not checked for 19 minutes, they said that they were busy serving prisoners with their tea, which CCTV confirms. It is important that the segregation unit is resourced sufficiently to run the regime as well as undertaking all the required ACCT checks, so we bring this to the Governor's attention.

106. Prison staff recorded that Ms Davies was checked at 5.00pm when CCTV shows that she was not. Prison managers referred the matter to the police. The police investigated and concluded that there was no evidence of misconduct. An internal investigation also concluded that staff had not falsified the records and that the discrepancy was due to different clocks showing different times, which has since been addressed.

Segregation

Use of force preceding Ms Davies' segregation on 24 December

107. The Use of Force Policy Framework says that any use of force must be necessary, reasonable and proportionate. Staff must attempt to de-escalate before resorting to force and continue to de-escalate so they can cease to use force as soon as safe to do so.

108. BWVC footage shows that Ms Davies was very distressed after the incident in the prison grounds on 24 December. When staff found her in the prison gardens, she was crying and asking staff not to touch her. Ms Davies was not showing any signs of aggressive or violent behaviour. Staff immediately restrained Ms Davies without making any attempts to calm her or encourage her to comply. Duty Governor B, who arrived during the restraint did not use the opportunity to pause the restraint and consider the context of the situation and what the reasonable next steps should be. We do not consider that the use of force against Ms Davies on the morning of 24 December was necessary, reasonable or proportionate – and so conclude that it was not policy compliant. We recommend:

The Governor should put robust and auditable measures in place to ensure that staff understand the importance of de-escalation techniques to avoid use of force and that staff use force only as a last resort.

Authority to segregate

109. BWVC footage shows Ms Davies remained under restraint throughout the move to the segregation unit. She told staff that she hated being segregated and asked for help. She arrived at the unit crying and saying "please do not put me here, I do not want to spend Christmas in segregation".

110. Prison Service Order (PSO) 1700 on Segregation states that, 'Segregation should be used only as a last resort whilst maintaining a balance to ensure it remains an option for disruptive prisoners, this does include prisoners on an open ACCT plan, but only when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate'.

111. PSI 64/2011 states that prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances and that the reasons for segregation must be clearly documented and include other options that were considered but discounted. It says that when a prisoner on an ACCT is placed in segregation, the duty governor should complete and sign a defensible decision log, reflecting the consideration given to a prisoner's risks, triggers and protective factors.

112. On 24 December, Duty Governor B asked duty governor A to complete the authority to segregate forms as he was hearing adjudications in the segregation unit that day. She told the investigator that it was standard practice at Styal for the person hearing adjudications to complete the authority to segregate forms (though Duty Governor A said it was a grey area).

113. Duty Governor A did not complete form OTO26 - Reasons for Initial Segregation under Rule 45 document, which should have been shared with Ms Davies. Ms Davies did not know the reasons why she was segregated or for how long she would be held in segregation.

114. Annex E defensible decision log should have shown a clear rationale for Ms Davies' segregation. Duty Governor A completed the defensible decision log, but it lacked detail, and Duty Governor A did not record if alternative options and locations had been considered and if they had, why they had been discounted. We consider that there was insufficient evidence that Ms Davies needed to be segregated on 24 December and find that her behaviour that morning did not meet the threshold for either 'last resort' or 'exceptional circumstances'. On that basis, we find the decision to segregate her was contrary to national policy.

115. Duty Governor A worked until around 3.30pm on 24 December. Before he left the prison, he partially completed segregation form OTO27 – Notification to Prisoner of Outcome of Segregation Review Board. He recorded, "Following the segregation review board on 24 December you will remain in segregation till 27 December."

116. When the investigator asked for a record of the segregation review and who attended, Duty Manager A said he completed the form without holding a review and without knowing if Ms Davies was staying in segregation. He said he had left the form blank for Duty Governor B to complete, as she was responsible for deciding how long Ms Davies would be staying in segregation and was due to make that decision later that afternoon.

117. We found that neither manager took responsibility for the decision to segregate Ms Davies and that neither manager completed the required documentation.

118. At interview, Duty Governor A told the investigator that if Ms Davies had calmed down, she might have been able to return to the wing. When asked how she would have known this, he said that staff should have told her. When the investigator asked staff that were on duty in the segregation unit that day, they said that it was not up to them to decide what Ms Davies needed to do to return to the wing or how long she would be in segregation. Staff said that they called managers to ask what they should tell Ms Davies, but they were not given a definite answer and that Duty Governor A said that it was up to Duty Governor B.

119. Duty Governor B told the investigator that she and Duty Governor A agreed that they would leave Ms Davies in segregation for a couple of hours and then discuss how she was and what they should do. When the investigator asked Duty Governor B why she did not tell Ms Davies that she may be able to go back to the wing in a couple of hours if she calmed down, Duty Governor B said that she did not think that Ms Davies would listen because she was not listening to what staff were telling her. Ms Davies arrived in the segregation unit at 10.25am and was found unresponsive at 5.12pm. She had been in the unit for considerably more than a couple of hours with no indication of when she might return to her residential unit.

120. At interview, the investigator asked what training managers had to support them in their role. Duty Governor B said that she had completed a variety of training to support her in the role of duty governor. Duty Governor A told the investigator that he had been temporarily promoted two years previously to a governor grade at Styal, and in September 2024, his role had changed from non-operational (not prisoner facing) to operational. Duty Governor A said he had completed some training courses and had shadowed colleagues.

121. Neither Duty Governor B nor Duty Governor A fully completed the documentation that is required when segregating a prisoner and neither told Ms Davies what was expected of her or what she needed to do to return to the wing. Ms Davies was clearly distressed and repeatedly told staff she was struggling to cope in the segregation unit. There were clear indicators that her risk of suicide was high. We consider that both Duty Governor A and B provided little leadership support to staff in the segregation unit and did not make an objective assessment of the risk of Ms Davies' segregation, focusing instead on her challenging and non-compliant behaviour.

122. PSO 1700 states that prisoners that are in segregation should be checked hourly and a log completed. In the seven hours that Ms Davies was segregated the log was only completed twice - at 11.45am and at 1.00pm. When the investigator asked staff about this, they said that they did not know why the log was not completed on that day, and that they always completed the hourly log on all prisoners in segregation. We found that when Ms Davies was previously segregated, the log was completed hourly. The Governor will wish to note our findings and satisfy herself that all prisoners in segregation are checked hourly and recorded on the daily log sheet.

Previous period of segregation

123. The investigator reviewed the documentation for Ms Davies' previous period of segregation from 9 November to 6 December. The prison was unable to provide the complete Authority for Continued Segregation document. The prison provided the investigator with the front sheet of that document but said that they could not find the second sheet which would record behaviour targets set, and signatures of those that attended the review.

124. When prisoners on an ACCT are held in segregation, a prison manager must complete a daily review summary that includes justification for why a prisoner should remain in segregation. The review summary was only completed on 18 of the 27 days that Ms Davies was held in segregation. The summaries that were

completed lacked detail and did not clearly set out the exceptional circumstances justifying segregation.

125. The investigator did not see any evidence that prison managers considered managing Ms Davies in another location. Nor did the investigator see any documentation detailing what the exceptional reasons for segregation were.

126. Prison managers did not demonstrate that they considered the impact that continued segregation may have had on Ms Davies' mental health. Indeed, we note that Ms Davies had been settled and engaged when living in standard residential units and her mental health and behaviour sharply and clearly declined after she was segregated. Instead of managers considering the impact continued segregation was having on her, they considered her deteriorating behaviour justified prolonged segregation.

127. PSO 1700 states that prison managers should hold a meeting with prisoners in segregation to agree a reintegration plan, to make the transition of returning to a prison wing successful. The investigator asked the prison for a copy of the reintegration plan. The plan was detailed and showed that staff had made appropriate considerations when considering the best way to reintegrate Ms Davies back to a prison wing. However, the plan was signed by a supervising officer not a prison manager, it is not clear whether a manager reviewed the reintegration plan to decide if it offered appropriate support to Ms Davies.

Conclusion

128. There were numerous failings on both occasions that Ms Davies was held in the segregation unit. This demonstrates systemic failings with the oversight of segregation procedures and documentation. On the evidence available, we consider that had Ms Davies not been segregated on 24 December, she might not have taken the actions she later did. We recommend:

The Governor should conduct an urgent review of the use of segregation at Styal to satisfy herself that managers understand:

- **the roles and responsibilities for deciding if a prisoner is to be segregated and for completing the authorising documentation;**
- **the impact that being segregated can have on the risk of suicide and self-harm and mental health;**
- **the documents that must be completed when a prisoner on ACCT is segregated, including a defensible decision log that sets out the alternative options considered and why they were not deemed suitable.**

Clinical care

129. The clinical reviewer found that the clinical care Ms Davies received was of a good standard and equivalent to that which she could have expected to receive in the community. She found that Ms Davies' mental health needs had been recognised, and she received regular input from the psychiatrist and mental health nurses.

130. The clinical reviewer also found that Ms Davies epilepsy was managed appropriately. The clinical reviewer noted that Ms Davies was often not compliant with her medication. Ms Davies said that she did not like queuing in the medication queue so healthcare staff risk assessed whether Ms Davies was suitable for in possession medication, they decided that because of her self harm she was not suitable for in possession medication. Ms Davies had no epileptic seizures while she was in custody.

131. The clinical reviewer made one recommendation, not directly related to Ms Davies' death, which the Head of Healthcare will wish to address.

Inquest

132. At the inquest, held on 3 November 2025, the jury reached a narrative conclusion which included the following findings:

"When Alex first ligatured on the CSU she was not placed on constant observations and this was a failing in care. Governors were present at the time and were able to make this decision. This failing probably caused Alex's death.

The fact that Alex was taken to the CSU on 24 December 24 probably contributed to Alex's death and was a failure of care.

There was a gross failure to place Alex on constant observations whilst on the CSU and as such the death was contributed to by neglect."

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