

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Sean Davies, a prisoner at HMP Swaleside, on 25 February 2023**

**A report by the Prisons and Probation Ombudsman**

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

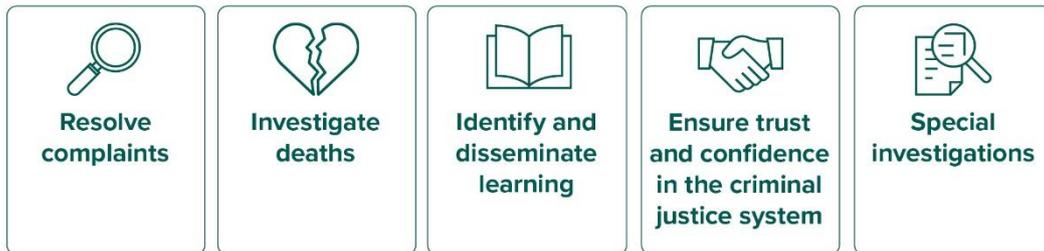
Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100

## OUR VISION

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

## WHAT WE DO



## WHAT WE VALUE



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 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 Sean Davies was found hanged in his cell on 25 February 2023 at HMP Swaleside. He was 30 years old. I offer my condolences to Mr Davies' family and friends.

Mr Davies was the ninth prisoner to die by suicide at Swaleside in three years. Up to the end of 2023, there had been no self-inflicted deaths since Mr Davies' death.

Mr Davies was serving an indeterminate sentence for public protection (IPP) and had been in prison since 2011. Until his arrival at Swaleside in 2021, his behaviour had been poor, and he had made little progress through his sentence.

My investigation found that Mr Davies was generally well supported at Swaleside, and he developed good relationships with key staff who were trying to help him move towards release. However, Mr Davies' death is a stark reminder of the difficulties for prisoners serving IPP sentences, who feel bleak about their prospects of release. My office recently published a Learning Lessons Bulletin highlighting the increased risk of suicide among men serving IPP sentences.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**April 2024**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	7
Findings .....	14

## Summary

### Events

1. Mr Sean Davies had been in prison since 15 November 2011. In November 2012, he was convicted of wounding with intent and sentenced to an indeterminate sentence for public protection (IPP), with a minimum term of seven years (later reduced to five years and 12 days on appeal). Mr Davies became eligible for parole on 15 November 2017.
2. Mr Davies had a history of attempted suicide and self-harm in prison and the community. He was also diagnosed with antisocial personality disorder (which is characterised by impulsive, irresponsible and often criminal behaviour).
3. Prior to his arrival at HMP Swaleside in February 2021, Mr Davies' behaviour had been poor. There were reported incidents of assaults on prisoners and staff, and evidence of illicit drug use.
4. On 3 February, Mr Davies transferred to Swaleside to join the Psychologically Informed Planned Environment (PIPE) unit. (PIPE units aim to improve the psychological health of participants, improve relationships and relationship skills and reduce reoffending.) Mr Davies settled in well at Swaleside, engaged fully with the clinicians on the PIPE unit and was focused on progressing towards his next parole hearing.
5. On 9 February 2022, during a routine cell search, an adapted vape capsule was found in Mr Davies' cell, which tested positive for a psychoactive substance (Spice). Mr Davies denied it belonged to him, but staff placed him on report, and he was reduced to the basic level of the incentives and earned privileges (IEP) scheme (meaning certain privileges were removed). Mr Davies was angry and felt that his chance of securing release had been ruined. He was monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) for a period.
6. On 11 April, Mr Davies was assessed as suitable for a category C prison (lower security and indicating a progression towards release). However, on 24 August, during a routine cell search, staff found unprescribed medication in Mr Davies' cell. He was placed on report and subsequently awarded seven days loss of privileges, suspended for three months. He was re-assessed and found unsuitable for a category C prison in October.
7. At 8.50am on 25 February 2023, a prisoner went to Mr Davies' cell, looked through the observation panel of the cell door and saw Mr Davies hanging by a ligature around his neck. The prisoner alerted staff who started cardiopulmonary resuscitation (CPR). Nurses attended and concluded that Mr Davies was dead and that resuscitation attempts should stop. Paramedics arrived shortly afterwards and confirmed that Mr Davies had died.

### Findings

8. There were no apparent changes in Mr Davies' behaviour in the time before his death that indicated he was at any increased risk of self-harm.

9. When an officer completed the routine roll check on 25 February, they made no attempt to speak to Mr Davies and continued with the roll count, and an officer who was tasked with unlocking prisoner's cells did not check on the welfare of each prisoner before unlocking the doors as they should have done, which is not in line with national policy.
10. There were several missed opportunities to refer Mr Davies for substance misuse support.

## **Recommendations**

- The Governor, Head of Healthcare and Service Manager for Change, Grow, Live should work together to ensure that referral processes to the service are clear and established and that all staff understand when and how to refer a prisoner to the service.

## The Investigation Process

11. HMPPS notified us of Mr Davies' death on 25 February 2023.
12. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners contacted him, all of whom shared their concerns about welfare checks.
13. The investigator obtained copies of relevant extracts from Mr Davies' prison and medical records.
14. The investigator interviewed seven members of staff at Swaleside on 11 and 12 May.
15. NHS England commissioned a clinical reviewer to review Mr Davies' clinical care at the prison.
16. We informed HM Coroner for Kent and Medway of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. The Ombudsman's family liaison officer contacted Mr Davies' family to explain the investigation and to ask if they had any matters, they wanted us to consider. They said:
  - They thought that Mr Davies had self-harmed in September/October 2022 and had attended hospital as a result and asked why he had not been kept on suicide and self-harm monitoring following this? (We found no evidence that Mr Davies had self-harmed at this time or that he was hospitalised.)
  - Mr Davies was an IPP prisoner and had little luck at receiving positive responses regarding his release from custody. What impact did being an IPP prisoner have on Mr Davies?
  - Mr Davies had been asking his family to send him large amounts of money, which he said was to buy vapes. They were concerned that he might have been in debt to other prisoners or was being bullied by other prisoners.

We have addressed these concerns in this report.
18. Mr Davies' family received a copy of initial report, but no response to our findings had been received.
19. HMPPS responded to the initial report, no factual inaccuracies were identified, and all recommendations were accepted.

## Background Information

### HMP Swaleside

20. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security Estate. It holds up to 1,090 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. GPs work at the prison Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services. Forward Trust provides substance misuse treatment.

### HM Inspectorate of Prisons

21. The most recent inspection of HMP Swaleside was in October 2021. Inspectors reported that incidents of self-harm had almost doubled since the last inspection. The quality of support delivered through ACCT case management for prisoners at risk of suicide and self-harm was variable, with some inconsistent case management and care plans that lacked meaningful or completed actions. They found that only just under half of prisoners with experience of being on an ACCT said that they had felt cared for by staff.
22. Inspectors noted that in their survey, more respondents than at the time of the last inspection said that they had a named officer or key worker, with around half saying that this officer was helpful or very helpful. However, the key worker scheme had almost stalled as a result of more of the already stretched prison officer resource being required to manage prisoners during the increased time out of their cells. With the notable exception of the specialist wings, such as the psychologically informed planned environment (PIPE) unit and the drug support wing, few case notes evidenced any meaningful contact and support from key workers.
23. HMIP carried out an Independent Review of Progress (IRP) in July 2022. Inspectors found that the shortage of officers was worse than at the previous inspection leading to very limited time out of cell. The rate of self-harm had declined considerably but there had been five self-inflicted deaths, four since the last inspection and a fifth death two months after the IRP visit.

### Independent Monitoring Board

24. 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 2023, the IMB noted that continued staff shortages had resulted in a lack of meaningful activity for prisoners on all but two wings. The IMB said that this was clearly having an impact on the mental health and general well-being of the prisoners and the incidence of self-harm, serious incidents and attacks on both prisoners and staff were likely to have been exacerbated by the restrictions. The IMB also noted that self-inflicted deaths were at very worrying levels. Staff were frustrated by their inability to implement anything approaching a full regime. However, the Board also said that the senior leadership team recognised the problems and had taken positive action, with the support of regional and national safety teams, to improve the situation.

## Previous deaths at HMP Swaleside

25. Mr Davies was the twenty-third prisoner to die at Swaleside since September 2020. Of the previous deaths, eight were self-inflicted (five of which were during 2022) two were drug-related and twelve were from natural causes. Up to the end of 2023, there had been no self-inflicted deaths at Swaleside since Mr Davies' death.
26. As a result of the number of self-inflicted deaths during 2022, Swaleside was receiving additional support from HMPPS headquarters.
27. In an investigation into the death of a prisoner at Swaleside in June 2022, we made a recommendation about staff completing routine checks appropriately. The prison responded to our recommendation and said that routine checks were reported to the orderly officer as per the local security strategy which would be assured through ad-hoc checks carried out by supervising officers and covert testing by the security department. The prison also said that multiple safety briefings had been delivered, the latest in December 2022, to highlight the importance of carrying out routine checks and to re-iterate the actions required when staff find an observation panel covered.

## Assessment, Care in Custody and Teamwork

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

## Indeterminant sentence for Public Protection (IPP)

29. Indeterminant sentence for Public Protection (IPP) sentences, began in 2005 and were abolished in 2012 under the Legal Aid, Sentencing and Punishment of Offenders Act. They were introduced to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the independent Parole Board that they had sufficiently reduced their risk. There are currently about 3000 IPP prisoners, of which half have never been released.
30. Since June 2022, all Parole Board recommendations for the transfer to open conditions and release of IPP prisoners must be approved by the Secretary of State for Justice.
31. In September 2023, we published our Learning Lessons Bulletin (LLB) on Self Inflicted Deaths of IPP Prisoners. The LLB was prompted by the increase in deaths amongst those serving IPP Sentences in 2022. The LLB noted that an IPP sentence should be considered as a potential risk factor for suicide and self-harm because of the uncertain nature of the sentence, which can lead to feelings of

hopelessness and frustration. Our investigations indicated that parole hearings, transfers, changes in security categorisation and upcoming release could all act as risk triggers, increasing the risk of suicide among this group of prisoners.

### **Incentives and Earned Privileges (IEP) Scheme**

32. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

## Key Events

33. On 15 November 2011, Mr Sean Davies was remanded to prison charged with Section 18 wounding with intent. He was sentenced on 2 November 2012 to an indeterminate sentence for public protection (IPP) with a minimum term of seven years. This was later reduced to five years and 12 days on appeal. Mr Davies' minimum term expired on 15 November 2017, when he became eligible for parole.
34. Mr Davies had a history of attempted suicide and self-harm in the community, and substance misuse. He was also diagnosed with antisocial personality disorder.
35. Mr Davies transferred to several different prisons before moving to Swaleside on 3 February 2021. Mr Davies had been subject to suicide and self-harm prevention measures known as ACCT on two occasions; in July 2019 after he had refused food and August 2020, after he had made cuts to his forearm with a razor blade.

### HMP Swaleside

36. Mr Davies transferred to Swaleside to join the Psychologically Informed Planned Environment (PIPE) unit. The units have dedicated staff made up of prison staff and psychologists (clinicians).
37. Mr Davies was initially located on the induction wing but moved to the PIPE unit on F wing after a few days. Mr Davies had regular contact with his PIPE clinician, a specialist forensic psychologist, and his keyworker. Although the keyworker made regular visits to see Mr Davies, Mr Davies chose to say little about how he was getting on and told him that if he had any issues then he would contact him. Mr Davies engaged well with the clinicians and responded positively to the PIPE regime. The expectation was that Mr Davies would remain on the unit for around two years. As well as engaging in group work, Mr Davies was employed in the prison laundry, farm and gardens.
38. In October 2021, prior to his parole hearing, Mr Davies started schema therapy (a form of cognitive behavioural therapy that focuses on the individual's past behaviours and experiences to help them understand their current patterns of behaviour). He was keen to gain his category D status and transfer to an open prison (with minimal security where prisoners can spend most of their day away from the prison on license to carry out work, education or for other resettlement purposes). He also volunteered as a 'buddy' (a designated prisoner who supports prisoners with additional needs) for another prisoner with chronic health issues who was located in the cell next to him.
39. In October, Mr Davies asked to defer his parole hearing by 12 months so that he could complete his schema therapy.
40. On 9 February 2022, staff completed a routine search of Mr Davies' cell and found an adapted vape capsule. The capsule tested positive for a psychoactive substance (Spice). Staff placed Mr Davies on report. At the time of the search, another prisoner was in Mr Davies' cell, visiting. Mr Davies denied that the capsule belonged to him. Mr Davies was not referred to the Change, Grow, Live (CGL) substance misuse service as he should have been.

41. At his disciplinary hearing, Mr Davies pleaded not guilty to being in possession of the adapted vape capsule, and as it was not possible to prove who it belonged to, the charge against Mr Davies was dismissed, but he was downgraded to the basic level of the Incentives and Earned Privileges (IEP) scheme for seven days and was removed from his role as a buddy. He was reinstated to the standard level of IEP on 15 February.
42. On 16 February during a PIPE group session, Mr Davies spoke about being downgraded to the basic regime and felt it had been unjust. Mr Davies was angry and felt that his chances of being released on parole had been ruined. Mr Davies said that he would get out of prison 'one way or another' and that staff were sabotaging his progress on purpose.
43. A PIPE clinician asked Mr Davies what he meant by his comments. Mr Davies said that if staff continued to 'play games' and jeopardise his release, then he would stab himself in the jugular and get taken out of prison in a body bag. Mr Davies said that while he did not feel like he was suicidal, he would do if officers did things which he perceived as 'playing games'. She made an entry in the wing observation book detailing her conversation with Mr Davies, submitted an intelligence report and started ACCT procedures.
44. A Custodial Manager (CM) chaired a multidisciplinary ACCT case review later that afternoon. PIPE staff and Mr Davies attended. Mr Davies told the review that his comments had been said in the heat of the moment and that he had no intention of harming himself. Mr Davies talked about working towards his parole and said that he was feeling positive. The review discussed Mr Davies' previous history of self-harm, and he said that although he had harmed himself in the past, it was a long time ago and he had no current thoughts or intent to harm himself. The meeting agreed to stop ACCT procedures.
45. On 22 February, an officer completed a post closure ACCT review. Mr Davies said that he did not know why the document had been opened in the first place, however, he understood the process. He wanted to focus on his schema therapy group and his parole hearing, which was not too far away. Mr Davies said that he had a good working relationship with his keyworker, and should he feel the need to talk, he knew that his keyworker was approachable.
46. Mr Davies continued engaging with PIPE group work between March and 24 August. He attended his schema therapy sessions and had contact with PIPE clinicians and his keyworker regularly.
47. On 11 April, Mr Davies was re-categorised from category B to category C status, meaning he was eligible to move to a lower category prison. A move was not sought for or requested by Mr Davies as he was still engaged with PIPE group work.
48. On 24 August, during a routine search of Mr Davies' cell, staff found medication which did not belong to him. Staff placed him on report. Mr Davies was subsequently found guilty and given a suspended punishment of seven days loss of privileges. Mr Davies was not referred to CGL substance misuse service as he should have been.

49. On 1 November, a manager attended F wing for a pre-arranged telephone conference call, between Mr Davies, the psychologist, the PIPE clinician, and community offender manager (COM). Before the call started, the manager told Mr Davies that he had been re-assessed as unsuitable for category C conditions and that he would remain a category B prisoner. She explained that the decision had been taken based on the most recent proven adjudication for having unprescribed medication and the vape capsule being found in his cell. The next review was scheduled for April 2023. Mr Davies did not take this news well and decided not to stay for the telephone conference.
50. After the conference call, the psychologist spoke to Mr Davies and recorded that he was understandably frustrated and upset about decision and was concerned about the implications for his parole hearing and progression. Mr Davies appealed against the decision, and on 23 November, a Supervising Officer (SO) responded to the appeal. The SO told Mr Davies that although his adjudication for the vape capsule had been dismissed, the item had tested positive for illicit drugs and was found in his cell. The SO encouraged Mr Davies to see that his previous involvement in drug taking and the drug culture was a risk factor and needed to be acted upon. However, she also noted that the manager had commended him for the good work he was doing and that if full compliance with prison rules was maintained then progression to category C status would be considered in April 2023.
51. Mr Davies continued to engage with PIPE and schema therapy and although he told the clinicians that he was initially frustrated and anxious about being downgraded to category B, he was focused on his parole hearing and regaining his category C status. However, during further contacts with his clinicians and his keyworker, it was recorded that Mr Davies was sometimes negative about his chances of being granted parole, and he believed that he stood little chance, due to his past behaviour.
52. Between 1 April 2021 and 26 December 2022, Mr Davies was named in 15 security intelligence reports. The information included having non-prescribed medication, the vape capsule being found in his cell and being suspected of involvement in drug activity.
53. On 26 December, Mr Davies had injuries to his face. He told staff that he had fallen over, that he had not been assaulted and that no one else was involved. Staff investigated and reviewed the CCTV footage, but they found no evidence that Mr Davies had been assaulted and submitted an intelligence report to that effect. Although there was no evidence that Mr Davies was at increased risk of violence, staff referred him for a Challenge and Support Intervention Plan (CSIP– a process used to manage difficult prisoners and victims of violence or threat). The referral was assessed and rejected on the basis that Mr Davies' risk of violence score was low and indicated no risk, therefore the CSIP was not deemed suitable or reasonable.

## **12 January to 10 February 2023**

54. On 12 January 2023, a psychologist saw Mr Davies to prepare a report for his parole hearing, which had yet to be scheduled. Mr Davies told her that he did not feel in the right frame of mind to be taking part in an interview as he had a lot

playing on his mind and he was in a 'defeatist mindset'. Mr Davies said that he felt this was as a consequence of having his category C status taken away and his recent adjudications. Mr Davies said that this had left him feeling hopeless about his parole review and therefore he did not feel able to participate in the interview. She advised Mr Davies to speak with the PIPE clinicians about how he was feeling and to let her know once he felt able to take part in the assessment.

55. On 30 January, a psychologist spoke to Mr Davies about the parole assessment again and he told her that he would feel more comfortable if it could be completed on the wing. It was agreed that the assessment would take place using Microsoft Teams on 7 and 21 February. She saw Mr Davies again the following day for an individual session. Mr Davies told her that he felt as though he was being treated differently to other prisoners and was worried that things from his past might be negatively interpreted by the Parole Board. She recorded that Mr Davies 'had such an overwhelming sense of hopelessness and did not feel he had a chance with his parole but was willing to go through it'. She told the investigator that when she wrote the comment, she had no concerns about Mr Davies' well-being or risk to himself, and that the feelings of hopelessness were in respect of his chances of achieving a favourable outcome at his parole hearing.
56. On 7 February, the psychologist sat in on an independent psychological assessment with Mr Davies as part of the parole hearing process. She recorded that Mr Davies did really well and was positive throughout the assessment. They discussed different Approved Premises that provided PIPE and Intensive Intervention and Risk Management services (IIRMS – designed for individuals with high risk and high harm violent offending histories) on release. She agreed with Mr Davies to revisit this again when the assessment process was out the way.
57. That day, staff searched Mr Davies' cell after an intelligence report indicated he might have been bullying another prisoner. The psychologist spoke to Mr Davies later that afternoon and asked him what had happened. She recorded that she reassured Mr Davies that if he had nothing to hide then nothing would come of it. Nothing was found to support the allegations and there were no further references or information about Mr Davies bullying other prisoners.
58. In 2022, the Justice Select Committee, appointed by the House of Commons began a review into IPP sentences. The Committee made a number of recommendations to the Ministry of Justice and HMPPS about how these sentences should be managed in order to reduce the number of IPP prisoners in prison. The Committee's findings were published in September 2022.
59. On 10 February, the psychologist spoke to Mr Davies about the findings of the IPP review and how it might affect him. Mr Davies told her that he did not want to speak to anyone from the Offender Management Unit (OMU) and talked about his frustrations in relation to his category C status. She tried to discuss the recent IPP review, but Mr Davies did not wish to speak about it and told her that he was 'fine'. She reassured Mr Davies that if he changed his mind, OMU staff and the clinicians were available to support him. (OMU staff spoke to all IPP prisoners at Swaleside following the Justice Select Committee review.)
60. The psychologist said that on 23 February, a wing officer told her that Mr Davies and several other prisoners had been suspected of being under the influence of an

illicit substance the previous day. She spoke to Mr Davies and asked him about this. Mr Davies said that he used illicit substances to manage his feelings about his parole. She agreed with Mr Davies that they would discuss the issues further at their therapy session booked for the following week. Mr Davies was not referred to CGL substance misuse service as he should have been.

## Events of 25 February

61. At 2.00am on 25 February, CCTV shows what appears to be a piece of fabric being posted through the top of Mr Davies' cell door and threaded across the top right-hand corner.
62. At 7.15am, Officer A completed the early routine roll check on F wing, the primary purpose of which is to count the prisoners in their cells. CCTV shows her moving along the landing looking in all cells through the observation panel. When she arrived at Mr Davies' cell, she opened the observation panel and looked towards his bed. She said that Mr Davies was not on his bed. She looked to the left side of the door to see if he was using the toilet, but he was not. She then noticed him standing to the right-hand side of the door. She told the investigator that the cell light was off, but the television was on, and she assumed that Mr Davies was standing watching the television. She did not speak to Mr Davies, had no concerns about him and carried on with the rest of the routine check on the wing.
63. The piece of fabric was still across the top corner of the door when Officer A completed the routine check. She said that she had not noticed anything at that time.
64. At around 8.00am, staff began unlocking prisoners who needed to collect their medication. CCTV shows around four staff on the landing outside Mr Davies' cell. The strip of fabric across the right-hand corner of Mr Davies' door was still visible. Once all the medication rounds had been completed, staff then began unlocking all prisoners for association (social time) and to complete welfare checks.
65. Officer B unlocked the cells on the side of the landing where Mr Davies was located. CCTV shows her making her way along the cells, unlocking each door. She did not look into the cells through the observation panel, did not look in the cells once the doors were unlocked or talk to the prisoners to check on their welfare. When she reached Mr Davies' cell, she unlocked the door, but did not try to open it.
66. After unlocking all prisoners, Officer A remained on the landing. At 8.50am CCTV shows a prisoner approaching Mr Davies' cell door and looking through the observation panel, before calling to her, who was sitting further along the landing. She said that when the prisoner called her, it sounded urgent, and she went straight over to the door and looked in through the observation panel. She said that she could see Mr Davies suspended by a ligature to the right-hand side of the door. She shouted to her colleagues for assistance. Staff pressed a general alarm which alerted staff to an incident on F wing, at 8.54am and at 8.55am, they then radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). Two officers responded and attempted to push the door open with the help of prisoners who were outside the cell, but Mr Davies' body was stopping the door from opening fully. The officers managed to create a gap, entered the cell and cut the ligature from around Mr Davies' neck and lowered him to the

floor. Mr Davies was unresponsive, and staff began CPR. Control room staff called an emergency ambulance, with the first response arriving at 9.08am.

67. Nursing staff attended and initially assisted prison staff with CPR, but they noted that they were unable to open Mr Davies' airway due to rigor mortis being present. An automated defibrillator was attached to Mr Davies but advised that no shockable rhythm was detected. Staff moved Mr Davies onto the landing outside his cell. Senior nursing staff attended and noted that rigor mortis was present and decided to stop resuscitation attempts at 9.09am. The first paramedics arrived at the cell shortly afterwards and after conducting their own observations confirmed that Mr Davies had died.

### **Events following Mr Davies' death**

68. Staff recovered a note from Mr Davies' cell, which was given to the police. The note said, 'Sorry for the people who find me, thank you to F wing and prison staff, I hope my death will change things for IPP people.'
69. Staff listened to Mr Davies' telephone calls after his death. During calls to his family on 17 and 19 February, Mr Davies asked his family to either send him money or deposit money into an unknown bank account. It is not clear what these monies were in relation to and often such calls are an indication that the prisoner is being bullied or threatened by other prisoners or is in debt due to drug use. However, other than the nature of these calls, there was no evidence to suggest that Mr Davies was being bullied or threatened by other prisoners.

### **Contact with Mr Davies' family**

70. Following Mr Davies' death, the prison appointed a CM as family liaison officer (FLO). A prison manager, the CM and another colleague travelled to Mr Davies' mother's home later that morning and informed her of Mr Davies' death. The CM remained in contact with the family, who asked him to arrange the funeral arrangements locally, which he did.
71. The prison contributed towards the funeral costs in line with national guidance.

### **Support for prisoners and staff**

72. 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.
73. After Mr Davies' death, a prison manager 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 local Samaritans were also involved in offering support.

74. The prison posted notices informing other prisoners of Mr 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 the death.

### **Post-mortem report**

75. The post-mortem gave Mr Davies' cause of death as suspension. Toxicology results found no illicit drugs in Mr Davies' body.

## Findings

### Indeterminate sentence for public protection (IPP)

76. When Mr Davies arrived at HMP Swaleside he was already three years over his tariff. He had done little to address his offending behaviour and prior to this his behaviour had been poor.
77. Mr Davies engaged well with the clinicians on the PIPE unit and responded well to group work. His improved behaviour resulted in him being re-categorised to category C in April 2022. His indirect involvement with a psychoactive substance and being found with unprescribed medication resulted in him being downgraded to category B. Mr Davies believed that his previous poor behaviour would affect his chances of parole and saw his recategorisation as a major setback. Despite his negative outlook towards his parole, Mr Davies continued to engage with the PIPE regime.
78. Mr Davies mentioned his IPP sentence in the note he left in his cell. He expressed his frustration with the slow progress of his sentence, recent re-categorisation and concerns about his parole hearing and how the Parole Board would view this and his past behaviour. Mr Davies had not had a date set for his parole hearing at the time of his death.
79. Although it is clear that Mr Davies was frustrated and hopeless about his prospects of release, there was no evidence of any identified changes in Mr Davies' behaviour or presentation leading up to his death that indicated he was at an increased risk of suicide, or that he needed to be supported by ACCT procedures. We found evidence that Mr Davies had a good, supportive relationship with the psychologist, and he continued to engage fully with group work.

### Staff actions on 25 February

80. HMPPS' National Security Framework expects welfare checks to take place during routine (roll) checks. Staff should be able to see the prisoner's face and satisfy themselves that they are alive and well.
81. When Officer A completed the routine check at 7.15am on 25 February, she said that she noticed Mr Davies standing to the right-hand side of the door and assumed that he was watching television. She did not speak to him and continued with her check.
82. Following an unlock for medication, Officer B unlocked cells on one side of the landing. She did not look into any of the cells using the observation panel before unlocking the doors and did not speak with any prisoners while unlocking their cells. In her statement, she said that when she unlocked Mr Davies' door, it did not feel heavy or different from normal. She also said that she thought she saw a hand at the side of the door, trying to push it shut, and so thought that Mr Davies might have been using the toilet, which she said was quite normal. She said that when she responded to the calls from the prisoner and looked through the observation panel, she could immediately see Mr Davies suspended by a ligature at the right-hand side of the door.

83. In an investigation into the death of a prisoner at Swaleside in June 2022, we recommended that staff completed routine checks in accordance with policy. The prison responded to our recommendation and said that a system for assuring the quality of routine checks had been introduced, including ad-hoc checks by supervising officers and covert testing by the security department. The prison also said that multiple safety briefings had been delivered, the latest in December 2022, to highlight the importance of carrying out routine checks and to re-iterate the actions required when staff find an observation panel covered.
84. It is clear from the evidence gathered in this investigation that staff were not conducting routine roll checks or welfare checks in line with policy guidance at the time of Mr Davies' death. The Head of Safety at Swaleside told the investigator that managers did not conduct an internal investigation regarding staff actions on the morning of 25 February, because managers were satisfied that the officers responsible for checking Mr Davies thought he was alive and did not have any concerns about his welfare.
85. The Head of Safety was asked what actions had been taken in respect of roll checks and ensuring that staff were conducting these appropriately, since Mr Davies' death. He said that the following actions had been taken:
- Full staff briefings to remind staff of their responsibilities;
  - Briefings via residential supervising officers / custodial managers;
  - Global emails;
  - Supervising officers completing quality assurance checks on their units.

While we do not think, on the evidence available, that earlier intervention would have made any difference to the outcome for Mr Davies, it could prove critical in future. As the Governor has taken a range of actions to address the issue, we do not make a recommendation, but the Governor will want to continue to monitor this area.

### **Clinical care and substance misuse**

86. The clinical reviewer concluded that the clinical care Mr Davies received at Swaleside, including the therapy and care delivered on the PIPE unit was of a reasonable standard and equivalent to what he could have expected received in the community.
87. She did note, however, that there were a number of missed opportunities for Mr Davies to be referred to Change, Grow, Live (CGL, substance misuse services) for support with his substance misuse. There was no evidence that referrals had been made after staff found PS in Mr Davies' cell in February 2022, or after the discovery of unprescribed medication in August 2022, or after Mr Davies was suspected of being under the influence of illicit substances on 22 February 2023. We make the following recommendation:

**The Governor, Head of Healthcare and Service Manager for Change, Grow, Live should work together to ensure that referral processes to the service are**

**clear and established and that all staff understand when and how to refer a prisoner to the service.**

## **Inquest**

88. The inquest hearing into the death of Mr Davies concluded in August 2024, and confirmed that Mr Davies died from suspension. The Coroner gave a narrative conclusion of suicide.
89. The Coroner established that factors relevant to Mr Davies' death, but could not be concluded to have caused or contributed to his death, included a lack of communication and handovers between staff and insufficiently completed welfare checks.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100