Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Governor for HMP Styal** **2 Minister of State for Prisons, Probation and Reducing Reoffending** **3 Ministry of Justice**
1	**CORONER** I am Victoria DAVIES, Area Coroner for the coroner area of Cheshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 24 July 2024 I commenced an investigation into the death of Sarah Frances BOYLE aged 35. The investigation concluded at the end of the inquest on 29 April 2025. The conclusion of the inquest was that: Sarah Boyle died as a result of a self-applied ligature. Her intention at the time of applying the ligature cannot be determined.
4	**CIRCUMSTANCES OF THE DEATH** Sarah Boyle was detained at HMP Styal between 8 April 2024 and 11 July 2024. She was monitored via the ACCT process for the entirety of that period save for one day (the ACCT was closed on 9 July and re-opened on 10 July following an act of self harm). Sarah suffered from emotionally unstable personality disorder, a condition which is associated with thoughts of self harm and suicide. She was not on the caseload of the mental health team in prison as was not felt to meet the criteria, but was assessed for psychological therapies. A formulation and plan was made from this assessment but it could not start prior to her release on 11 July. On 13 July, Sarah was recalled to prison due to a breach of her licence. It became apparent during her court hearing that she had tried to end her life by ligature whilst released (11-12 July) and again tried to ligature [redacted] whilst in the custody of GeoAmey, prior to transfer back to HMP Styal. On reception screening, Sarah was assessed by a prison officer and, whilst she did not fully engage, responded 'yes' to the question of d you have any current thoughts of self harm or suicide. The prison officer did not immediately open an ACCT as she wanted more information, and commented that the vast majority of women in reception will indicate they want to end their life. Sarah was subsequently seen by a nurse for a healthcare screening, who opened an ACCT. On 14 July, in the morning, Sarah was found to have tied a ligature around her neck in her cell, and this was discovered when the officer attended to carry out the ACCT assessment. She did not require any medical intervention and the ligature was removed. Shortly after (within the hour), the mental health team attended to carry out the well person assessment, as was routine for every new prisoner at that time. The assessment was unable to be completed as Sarah did not engage. Sarah then walked off from the mental health nurses, and tried to get over the railings on the second floor landing. She was

	restrained and taken back to her cell. An ACCT case review was attempted by the officer, without healthcare input, but Sarah did not engage. Her observations were increased from hourly to two an hour and she was to remain in her cell due to the risk of her getting at height. At around 5pm that evening, Sarah was discovered in her cell with a ligature around her neck, [redacted]. A code blue was called, and paramedics attended, taking her to hospital. She had suffered irreversible brain damage and died on 20 July 2024.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: I am concerned that the ACCT process or system currently in place designed to keep women safe at HMP Styal is not working effectively, and that there is a risk of future deaths if the process is not reconsidered or amended to better suit the needs of this prison. The ACCT process allows for observations of a woman who is at risk of self harm or suicide to keep her safe, but these are not a therapeutic observation and are essentially a check to ensure that the woman is alive and not actively self harming. Mental health input, if a woman is not case loaded to the mental health team, can be minimal, limited to attendance at a case review at best, and this does not allow for an opportunity to improve the woman's mental health, to reduce the risk of future suicide attempts. Care plans allowing for meaningful activity assist but their effectiveness is limited alongside the prison regime. I acknowledge that prison is not intended to be a therapeutic environment but given the number of women with mental health needs, I am concerned that the current environment or processes will give rise to a risk of future deaths. My concerns are based on the following points which I heard in evidence: • HMP Styal is a women's prison with a high number of self inflicted deaths, compared to the rest of the female estate. I am told by the prison ombudsman that they have the highest number of deaths between January 2022 and January 2025, accounting on my calculation for almost half of the total deaths in the female estate across England. I am aware that there has been one self inflicted death this year to date, and we are only 4 months in; • I heard evidence from the Head of Safer Prisons and Equality at HMP Styal and the Service Manager for Greater Manchester Mental Health NHS FT, who provide the mental health care in the prison, that the mental health needs of the women detained at Styal are high and can be complex. The latter explained that they receive women from court who have been sent to prison following a criminal act but are essentially awaiting assessment to see whether they should be detained in prison, or in a mental health hospital. The mental health team is then expected to care for the woman for the prolonged period of assessment and awaiting a bed if deemed necessary, something they are not set up to do. It was the view of this witness that Styal was receiving a number of prisoners who are complex and risky and require treatment in a mental health hospital. The process for transfer then takes time and is an additional pressure on the team. The powers of a mental health team in prison are far more restricted, for example, they cannot force medication if needed, and it is reliant on the engagement of prisoners which they frequently do not get. The mental health Trust confirmed that in 2025 to date (29.4.25), 11 prisoners have been referred for a Mental Health Act assessment and of these 11, 8 were accepted for transfer and treatment in a mental health inpatient setting; • It was the evidence of the Head of Safer Prisons and Equality that they also receive women who are there for a 'warrant of concern'. A 'warrant of concern' is where a woman attends court and is not sentenced at that point but remanded into prison custody due to the Judge having concerns that they are not safe to be released into the community and

	where it is perceived that they will be safer in custody. This is usually where there are concerns around the woman's mental health and/or risk to self. This adds pressure on an already stretched resource level in prisons as more resources are generally required to manage such complex individuals; • Prison data suggests that HMP Styal have received 7 women on 'warrants of concern' since November 2024 to date (April 2025); • I heard from one witness that a 'good day' on one side of the wing would just be one incident of self harm, but there would be frequently multiple incidents; • The number of self harm incidents and ACCT documents open appears to have hardened the prison team to expressions of self harm etc. I heard comments throughout the inquest such as "If I opened an ACCT on every woman who said she was suicidal we'd have loads open", and "2 incidents of self harm in a morning for one prisoner might seem like a lot but it's not in the context of Styal". This may lead to key cases being missed; • The number of ACCTs open within the prison can be high given the mental health need. I have heard evidence from a number of witnesses as to the pressures that the ACCT process places on staff, primarily due to the high number compared to staffing numbers. The severity of this varied in evidence depending seemingly on whether the member of staff was still with the prison service or had left. The clear consensus however was that the carrying out of ACCT checks, meaningful conversations and documentation of this was difficult whilst also trying to manage the day to day regime. It was accepted by the Head of Safer Prisons and Equality at HMP Styal that the officer on duty on the day of Sarah's death would have been responsible for 48 checks an hour, and that was not unusual. Evidence from one witness, who has since left the prison, was that as a result of the number of checks required, and the limited resource to do them, checks were frequently missed; • Meaningful conversations, designed to find out how the person is feeling and check in with them, are being carried out by prison officers with very limited mental health training, with very limited time resource to do this. Mental health training is not mandatory for the officers and can be overlooked due to more pressing, mandatory training. The jury findings record "Understaffing and a high number of ACCT documents at HMP Styal led to inconsistencies with how staff completed each part of the ACCT process". In addition to the evidence heard from the witnesses, I am mindful of the report of HM Chief Inspector of Prisons (Time to care: what helps women cope in prison February 2025) which notes that the rate of self harm among women in prison is now 8.5 times higher than in men's jails, and highlights a number of issues which contribute to this, which have been reflected in this inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by June 27, 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

	[redacted] **family** **Greater Manchester Mental Health NHS Foundation Trust** **Spectrum Community Health CIC** I have also sent it to **Prisons and probation ombudsman** **NHS England (on the basis this may require joint working given the health aspect)** **HM Chief Inspector of Prisons** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 02/05/2025** V Davies **Victoria DAVIES** **Area Coroner for** **Cheshire**