Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Williams a prisoner at HMP Lancaster Farms on 15 May 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

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We are:

Impartial: *we do not take sides*
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Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Kevin Williams died on 15 May 2018, after being found hanged in his cell at HMP Lancaster Farms. He was 29 years old. I offer my condolences to Mr Williams' family and friends.

Mr Williams had a history of suicidal thoughts and self-harm. He was appropriately made subject to suicide and self-harm support procedures when he first went into prison in November 2017, but gave staff no reason to consider that he posed a risk to himself after that.

Mr Williams was happy to transfer to Lancaster Farms two weeks before he died because it meant he was closer to his partner. The subsequent breakdown of this relationship in the last week of his life caused him considerable distress, but he did not disclose this to staff and I am satisfied that they had no reason to consider that he was at risk of suicide. It follows that I do not consider that staff could have been expected to have foreseen or prevented Mr Williams' death.

I am, however, concerned that there is no evidence that wing staff had any meaningful interaction with Mr Williams during the two weeks he was at Lancaster Farms. Such interaction may have allowed staff to pick up on the distress he felt at the end of this relationship. I note that the prison has now introduced the new key worker model and I hope that this will help to improve staff/prisoner relationships.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **January 2019**

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Summary

Events

1. On 10 November 2017, Mr Kevin Williams was arrested for offences of violence against his father and sister. He told police that he had recently self-harmed and would hang himself if he was sent to prison.

2. On 13 November, he was taken to HMP Swansea, where staff started suicide and self-harm prevention procedures, known as ACCT. Mr Williams was prescribed antidepressants. Over the following week, his mood improved, he settled at the prison and said he no longer had thoughts of suicide or self-harm. On 22 November, staff ended ACCT procedures.

3. On 22 January, Mr Williams was sentenced to 18 months imprisonment. He sometimes suffered from anxiety, paranoia and insomnia. He was appropriately referred to the mental health team at Swansea and to a GP, who altered his medication twice to include an increased dose of antidepressants and medication to help him sleep. He had no history of drug or alcohol misuse.

4. On 30 April, Mr Williams was transferred to HMP Dovegate for one night. His Person Escort Record (PER) which accompanied him from Swansea noted previous thoughts of suicide and that he had been on an ACCT in November 2017.

5. The following day he was transferred to HMP Lancaster Farms. The PER which accompanied him from Dovegate said nothing about suicide and self-harm issues.

6. When he arrived at Lancaster Farms, Mr Williams told a nurse that he was happy to be there as it meant he was nearer to his partner. The nurse was aware that Mr Williams was prescribed medication for his mental health but he told her that he did not want to be referred to the mental health team.

7. Mr Williams telephoned his partner several times a day. These conversations were not monitored at the time. They were generally positive in tone until 9 May when his partner told him she had doubts about the future of their relationship. Mr Williams told her he was going to take all his medication so that he did not wake up the next day.

8. Over the following days, Mr Williams rang his partner with increasing frequency. Mr Williams' partner told police that Mr Williams had last called her on an illicit mobile phone on 14 May. She said she had made it clear that their relationship was over and that she would not visit him as planned the next day.

9. On 15 May, Mr Williams went to the visit hall at 2.00pm to see his partner. Having waited for a few minutes for her to attend, he asked to return to the wing. He telephoned his partner and left a message saying he was "devastated" that she had not shown up. He said he would call her that evening. An officer locked Mr Williams back into his cell at 2.24pm. He said Mr Williams did not appear distressed.

10. At 3.48pm, another officer unlocked Mr Williams' cell. She discovered Mr Williams hanged from the light fitting. She radioed an emergency code and staff responded and cut Mr Williams down and attempted resuscitation. Paramedics arrived and pronounced Mr Williams dead at 4.26pm.

11. Mr Williams had left a note in his cell which set out his intention to take his own life.

Findings

Assessment of risk and management of ACCT

12. Mr Williams' risk to himself was appropriately managed through ACCT procedures when he first arrived in prison. These procedures were appropriately ended a week later once Mr Williams had settled in prison and was feeling more positive about the future.

13. Mr Williams said he was happy to transfer to Lancaster Farms on 1 May to be nearer his partner. He did not tell staff about the breakdown of his relationship a week later and did not disclose his distress to staff when his partner did not visit on 15 May.

14. We have concluded that Mr Williams' risk to himself was managed appropriately. Staff at Lancaster Farms were not aware that Mr Williams' relationship with his partner had broken down a week before he died and, therefore, had no reason to consider he was at risk of suicide.

15. Although we do not consider it made any difference to the risk assessment for Mr Williams', we are concerned that Dovegate did not include information about his past risk to himself on his Person Escort Record when he transferred to Lancaster Farms. In other cases, this could be of critical importance.

Staff relationships with Mr Williams

16. Mr Williams was at Lancaster Farms for two weeks. Although he had a personal officer for at least one week, the officer did not introduce himself, and there is no evidence that wing staff had any significant one-to-one contact with him. Such contact may have identified the difficulties Mr Williams was having. We are pleased to note that Lancaster Farms has now implemented a new keyworker system and we therefore make no recommendation about this.

Recommendations

- The Director of Dovegate should ensure that all information that is relevant to a prisoner's risk of suicide and self-harm is included on their Person Escort Record (PER).

The Investigation Process

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

18. The investigator visited Lancaster Farms on 22 May. She obtained copies of relevant extracts from Mr Williams' prison and medical records. She interviewed four members of staff and one prisoner at Lancaster Farms in May and June.

19. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison. He conducted joint interviews with the investigator.

20. We informed HM Coroner for Preston and West Lancashire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

21. The investigator contacted Mr Williams' mother and partner to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. Mr Williams' mother asked whether Mr Williams was prescribed antidepressants at Lancaster Farms. She also wanted to know whether he had been subject to suicide and self-harm prevention procedures. Mr Williams' partner said that she had contacted HMP Swansea when Mr Williams was there as she had concerns he was a risk to himself. She wanted to know why Mr Williams was not monitored more closely at the time of his death.

22. Mr Williams' mother and partner received copies of the initial report. They did not make any comments.

23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Lancaster Farms

24. HMP Lancaster Farms is a modern, medium security resettlement prison with accommodation for 560 adult male prisoners. Healthcare is provided by Spectrum. Healthcare staff work from 7.30am to 8.00pm on weekdays and 8.00am until 6.00pm at weekends.

HM Inspectorate of Prisons

25. The last inspection of HMP Lancaster Farms was conducted in 2015. Inspectors reported that Lancaster Farms was a basically safe and respectful prison. Support on arrival and through the early days at the prison was good, although some aspects of induction needed to improve. Most prisoners felt safe and violence levels were not excessive. Support for those at risk of self-harm was good, particularly in the mental health and chaplaincy teams. Inspectors found that the personal officer scheme was working well.

Independent Monitoring Board

26. 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 January 2018, the IMB reported that overall Lancaster Farms was a well-managed prison and generally provided a safe environment for prisoners. The board noted that suicide and self-harm prevention procedures were adhered to and the needs of vulnerable prisoners were carefully considered.

Previous deaths at HMP Lancaster Farms

27. Mr Williams is the fourth prisoner to die at Lancaster Farms since it became an adult prison in 2014, and the second to take his own life. None of our investigations into these deaths raised concerns relevant to that of Mr Williams.

Assessment, Care in Custody and Teamwork

28. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

29. On 10 November 2017, Mr Kevin Williams was arrested for offences of violence against his father and sister. While he was in police custody, he said he would hang himself if he was sent to prison. He also said he had cut his arms a few weeks earlier. This information was included in his Person Escort Record (PER) which accompanied him to court on 13 November. Court staff completed a suicide and self-harm warning form highlighting the information on the PER and recording that Mr Williams had said that he wanted to kill himself and did not "want to be here anymore".

30. The court remanded Mr Williams into custody and he was taken to HMP Swansea. Staff started Prison Service suicide and self-harm prevention procedures, known as ACCT. Mr Williams told a nurse that he had previously been prescribed antidepressants but had not taken them. He said he wanted to take them now. The nurse referred him to a GP.

31. On 14 November, during his ACCT assessment, Mr Williams told staff that he was frustrated and felt "useless". He said he was a long way from his partner and wanted to transfer to a prison nearer to her once he had been sentenced. Mr Williams had self-inflicted scratches on both arms. He said he had considered taking his own life and wanted to die the day before. Mr Williams said that he had no current plans to harm himself but that he would not be alive apart from his partner.

32. A GP assessed Mr Williams and prescribed him mirtazapine (an antidepressant). Staff held an ACCT review. Mr Williams said that he felt better and was looking forward to the future. He said he had an appointment with the mental health team on 22 November and would start taking his antidepressants that evening. Mr Williams again said that he would like to transfer to a prison nearer to his partner once sentenced.

33. On 22 November, a nurse reviewed Mr Williams who said his mood had improved since he had started taking antidepressants. Staff also held an ACCT review. Mr Williams said he was in regular contact with his family and looked forward to reuniting with them on his release. He said he had no thoughts of suicide and self-harm and those present agreed the ACCT should be closed.

34. On 22 January 2018, Mr Williams pleaded guilty to wounding and was sentenced to 18 months imprisonment. On 26 January, an offender supervisor, noted that Mr Williams said that he had felt very down because of his current offence and because he had not been able to contact his partner until recently. Mr Williams said that he had had thoughts of suicide but since speaking to his partner, he realised that he could not put her or her children through that and he was looking forward to a future with them.

35. On 9 February, a mental health nurse assessed Mr Williams. He told the nurse that his mood was very changeable, he kept losing his temper for no reason, felt paranoid, was having difficulty sleeping and no longer felt that his medication was working. He was also anxious about his release address. The nurse referred Mr Williams to a GP.

36. On 27 February, a GP assessed Mr Williams. They discussed his increased anxiety and insomnia which centred on distressing events he had witnessed when previously in prison. The doctor prescribed him fluoxetine (an antidepressant) to be taken alongside the mirtazapine he was already prescribed. On 18 March, an officer noted that Mr Williams had settled well and that his attitude and anxiety had improved. His mother visited him regularly while he was at Swansea.

37. Mr Williams was eligible for release on home detention curfew on 31 March 2018. He wanted to live at his partner's address but this was initially deemed unsuitable pending a social services assessment. Mr Williams was aware of this. On 17 April, the offender supervisor discussed Mr Williams' release with him. He emailed Mr Williams' offender manager about a possible transfer to be nearer his partner.

38. On 23 April, a GP increased Mr Williams' prescription of fluoxetine at Mr Williams' request. The GP also prescribed promethazine to help Mr Williams sleep. Mr Williams held all the medication prescribed to him in his possession.

39. On 30 April, Mr Williams transferred to HMP Dovegate overnight on his way to HMP Lancaster Farms. His PER from Swansea noted previous thoughts of suicide and that he had been on an ACCT in November 2017. A reception nurse noted that Mr Williams seemed settled and had no physical health concerns, and Mr Williams told her that he had no thoughts of suicide or self-harm.

40. The following day, Mr Williams transferred to Lancaster Farms. Mr Williams' PER from Dovegate contained nothing about suicide and self-harm. On arrival at Lancaster Farms, Mr Williams told an officer that he had self-harmed in September 2017 but had no thoughts of self-harming at present. Mr Williams said he had no concerns and was happy to be at Lancaster Farms. He said he had asked to be transferred so that he could complete an offending behaviour programme.

41. A nurse assessed Mr Williams. She noted that he had good eye contact, was chatty and appeared positive about the transfer which was nearer to his partner's home. The nurse was aware Mr Williams was prescribed medication but he said he did not want to be referred to the mental health team. He said he had cut his arms in September 2017 but had no current thoughts of suicide and self-harm. He continued to be prescribed mirtazapine, fluoxetine and promethazine.

42. Mr Williams called his partner around 4.00pm. He said that he was glad to be at Lancaster Farms and they discussed her visiting him. They also discussed his release in 12 weeks' time. Over the next few days Mr Williams telephoned his partner several times each day. These calls were recorded but were not monitored by prison staff at the time. The investigator listened to some of these telephone calls. Those that she listened to were generally positive conversations until 9 May.

43. On 2 May, Mr Williams moved from the first night centre to cell B1-07. This was a double cell but Mr Williams did not have a cellmate. On 8 May, a resettlement worker, met Mr Williams to complete a pre-release resettlement assessment. He said that Mr Williams seemed quite "jovial" and "chatty". Mr Williams told him

that he took medication for anxiety and depression, felt stable and had no drug or alcohol issues. Mr Williams said he was looking forward to being released to live with his partner. The resettlement worker had no concerns that Mr Williams was a risk to himself. An officer told the investigator that Mr Williams was a quiet prisoner, who “just wanted to keep his head down and get on with things”.

44. From around this time, an officer was assigned as Mr Williams’ personal officer, although he himself was unaware of this having just moved to work on the wing where Mr Williams was located. This meant that the officer was theoretically Mr Williams’ first point of contact if he had any needs or concerns.

45. On 9 May, Mr Williams telephoned his partner several times. They discussed the difficulties in their relationship and as a result he told her that he was going to take all his prescribed medication so that he did not wake up the next day. On 10 May, Mr Williams rang his partner eight times. She told him that she was worried that he would “do something stupid” if she ended their relationship. He said that it would not matter to her as she would not see him again anyway. Mr Williams asked his partner to give him a chance and she said that she had booked a visit to see him on 15 May.

46. On 11 May, Mr Williams rang his partner 11 times. On 12 May, Mr Williams rang his partner who said that she did not want to be in a relationship with him anymore and did not know whether she wanted to visit him. Mr Williams sounded desperate when asking her to visit him and said he did not know what he would do without her. He said he would not be able to get on with his life.

47. On 13 May, Mr Williams rang his partner 19 times and left voicemails asking what was happening with their relationship. Mr Williams also rang his mother. Because his calls to his mother were incorrectly marked as ‘legal’, these calls were not recorded (in line with Prison Service policy). His mother told police that Mr Williams had asked her to contact his partner to check she was well. Mr Williams’ partner told police that Mr Williams also had access to an illicit mobile phone from which he called her several times that day.

48. On 14 May, Mr Williams called his partner 26 times between 8.00am and 7.00pm. He did not talk to her but left several voicemail messages asking her to visit him the next day and told her that he was finding it hard not talking to her. Mr Williams’ partner told police that he also called her from a mobile telephone, that she spoke to him and told him that their relationship was over but he kept asking her to visit him the next day. Mr Williams’ partner said that he telephoned her again later, her friend answered and he again asked her to visit. His partner told police that she had told Mr Williams that she was not going to visit him. She also told police that she did not have any concerns that Mr Williams was a risk to himself.

49. On the same day another prisoner moved into Mr Williams’ cell. He had not met Mr Williams before. He told the investigator that Mr Williams seemed quiet, but not unusually so, and had seemed happy to have a cellmate to talk to. Mr Williams told his cellmate that he had transferred from Swansea to be nearer to his partner but that she had told him that she did not love him anymore. The cellmate said that Mr Williams seemed happy that his partner was going to visit

him the following day and was hopeful that they could reconcile. The cellmate had no concerns that Mr Williams was a risk to himself.

50. Another prisoner also saw Mr Williams that day. He told police that Mr Williams had seemed his usual self and said he was getting on well with his new cellmate. They talked about him playing football later in the week. A different prisoner also said that Mr Williams seemed his normal self and that he had always been a quiet prisoner.

Events on 15 May

51. On 15 May at 8.00am, Mr Williams was unlocked from his cell and telephoned his partner. He said he felt lonely and asked her to visit that afternoon. Mr Williams also telephoned his mother who said that she had not heard from his partner. His mother told police that he seemed “fine” and he had told her not to worry as he had a visit with his partner later in the day. Mr William’s resettlement worker also saw him that morning and later told police that Mr Williams seemed fine.

52. Mr Williams was then locked in his cell until lunchtime. His cellmate returned before lunch and said that Mr Williams seemed his usual self and was playing music in their cell. They played cards together over lunch and his cellmate said that Mr Williams was looking forward to his partner’s visit.

53. Around 1.50pm, an officer unlocked Mr Williams’ cell and told him he had a visit. She said that Mr Williams seemed keen and walked straight out of his cell. He waited in the visits hall for several minutes and then told a Supervising Officer (SO) that his visitor had not come and asked to return to the wing so that he could telephone her. The SO said that Mr Williams had seemed “fine” and he had no concerns that he was any risk to himself. He let Mr Williams out of the visits area and allowed him to walk across the prison courtyard on his own.

54. An officer let Mr Williams back onto the wing. The officer commented that it was early for him to be returning and Mr Williams said his visitor had not turned up. He asked to use the telephone, which the officer allowed. The officer said that this was not unusual and that prisoners could still return to the visits hall if they found out that their visitors were on their way to the prison. At 2.20pm, Mr Williams called his partner and left a voicemail. He said he was “absolutely devastated” that she had not visited him and asked her to answer his telephone call that evening. He said that if she did not see him again, he loved her.

55. A couple of minutes later, the officer noticed Mr Williams outside the wing office. The officer asked if he had not got through on the telephone and Mr Williams replied that he had not. The officer locked Mr Williams back into his cell at 2.24pm. The cellmate was at work at the time. The officer said that Mr Williams did not seem upset and he had no concerns that Mr Williams was a risk to himself.

56. At 3.48pm, another officer went to Mr Williams’ cell to return an application he had submitted. She opened the observation panel and noted it was pitch black inside the cell which was unusual for that time of day. She unlocked the cell, opened the door and found Mr Williams hanged from the light fitting by torn

bedsheets. She shouted for assistance and radioed a code blue emergency, along with her location. (A code blue emergency indicates circumstances where a prisoner has breathing difficulties, has collapsed, or is unconscious. Staff should respond immediately by taking emergency medical equipment to the scene and the prison should call an ambulance automatically.)

57. Two nearby prisoners ran into Mr Williams' cell and supported his body while the officer climbed onto the top bunk to try and cut Mr Williams down. A second officer reached the cell seconds later and assisted in supporting Mr Williams. The officer used her cut-down knife to cut the ligature and Mr Williams slumped onto the second officer's shoulder. He laid him on the floor outside the cell. The officer cut the ligature from Mr Williams neck. The second officer began chest compressions while the Custodial Manager (CM) administered breaths with the assistance of a mouth guard. The second officer turned on his body-worn camera. The investigator viewed this footage.

58. Within two minutes, nurses attended and checked Mr Williams' pulse while officers continued with chest compressions. The nurses attached a defibrillator, inserted an airway and administered oxygen. The paramedics arrived at 4.00pm and took the lead in Mr Williams' care while the officers continued with compressions. At 4.26pm, paramedics pronounced Mr Williams dead.

59. Mr Williams had left a letter addressed to his partner in his cell. It indicated his intention to kill himself because he felt he was a "failure". Mr Williams wrote on the envelope that he had written the letter on 12 May at 11.37am and that the date of death was Wednesday 16 May at 2.50pm. (It appears that he made a mistake about the date as he died on Tuesday 15 May.)

Contact with Mr Williams's family

60. The managing chaplain was appointed as the family liaison officer (FLO). He went to Mr Williams' partner's home address, along with the Governor, and informed her of Mr Williams' death and offered his condolences. The FLO telephoned Mr Williams' partner the next day. She said she agreed to Mr Williams' mother being treated as next of kin and for her to arrange Mr Williams' funeral. The FLO remained in contact with Mr Williams' partner.

61. A custodial manager was appointed as the family liaison officer (FLO) for Mr Williams' mother. At his request, staff from HMP Cardiff informed Mr Williams' mother of Mr Williams' death, since this was the closest prison to her home. The next day Lancaster Farms Governor telephoned Mr Williams' mother and offered his condolences. The FLO and governor remained in contact with Mr Williams' partner and offered a contribution to Mr Williams' funeral expenses in line with Prison Service instructions.

Support for prisoners and staff

62. After Mr Williams' death, the governor 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 also offered support.

63. The prison posted notices informing other prisoners of Mr Williams' 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 Mr Williams' death.

Post-mortem report

64. The post-mortem report indicated that Mr Williams' cause of death was suspension by ligature.

Findings

Assessment of risk and management of ACCT

65. Prison Service Instruction (PSI) 64/2011, *Safer Custody,* lists several risk factors and potential triggers for suicide and self-harm. Mr Williams had a number of these risks when he arrived at Swansea on 13 November. He had recently self-harmed, had current thoughts of suicide, was charged with violent offences against family members and had a history of depression. Staff started ACCT procedures immediately. Staff closed this ACCT on 22 November when Mr Williams had started to feel more positive about the future and his mood had stabilised since he had started taking antidepressants. We consider that this was an appropriate decision.

66. When Mr Williams transferred to Lancaster Farms via an overnight stay at Dovegate, the information about his past risk of suicide and self-harm was not included on the PER that accompanied him from Dovegate. We do not consider this made a significant difference to the risk assessment for Mr Williams since he had not been monitored under ACCT since November and was happy to be at Lancaster Farms. However, in another situation it could be critical and we therefore make the following recommendation:

    The Director of Dovegate should ensure that all information that is relevant to a prisoner's risk of suicide and self-harm is included on their Person Escort Record (PER).

67. Once Mr Williams transferred to Lancaster Farms, he said he had no thoughts of suicide and self-harm. He said he was happy to be nearer his partner, and was looking forward to the possibility of living with her following his release a couple of months later.

68. Staff were unaware of the breakdown of this important relationship, during the last week of Mr Williams' life. During telephone calls to his partner, Mr Williams often sounded distressed and desperate and, at one point, he said he would take all his prescribed medication so that he did not wake up the next day. In addition, Mr Williams' partner told police after he had died that he also had access to a mobile phone which he had used to call her. Staff were unaware of this but we wish to note our concern at Mr Williams' apparent ability to obtain such an illegal item in prison.

69. Telephone calls at Lancaster Farms are not routinely monitored and staff did not listen to Mr Williams' telephone calls. They were not, therefore, aware of their content. Mr Williams intentionally withheld information from staff about the breakdown of his relationship and his state of mind. Furthermore, when Mr Williams' partner did not attend for their scheduled visit on 15 May, he did not disclose his distress about this to staff.

70. In these circumstances, we consider that staff could not have foreseen that Mr Williams presented a significant risk to himself on the day he died.

Staff relationships with Mr Williams

71. Although Mr Williams did have a designated personal officer at Lancaster Farms, the officer himself was unaware of this, having only recently started working on the wing, and so had not introduced himself to Mr Williams. Staff described Mr Williams as a quiet prisoner who kept his head down and there is no evidence that wing staff had any significant one-to-one contact with him. Such contact is particularly important in the first weeks of custody or in a new prison and, without such contact, it is more difficult for staff to identify whether a prisoner has any issues or might be more vulnerable to suicide and self-harm.

72. We note that Lancaster Farms has now implemented the new offender management model as part of a national roll-out. Under this new model every prisoner has a keyworker who is their first point of contact and assists him with any difficulties he is having in prison. Key workers are expected to have a meaningful conversation each week with each of the prisoners they are responsible for. The intention is that the key worker scheme will encourage better staff/prisoner relationships and, among other things, help to reduce instances of suicide and self-harm. We therefore make no recommendation but record our concern at a troubling lack of meaningful engagement between staff and Mr Williams while he was at Lancaster Farms.

Clinical care

73. The clinical reviewer concluded that Mr Williams' clinical care was equivalent to that which he could have expected to receive in the community. He noted that Mr Williams was involved with mental health services at Swansea. When he transferred to Lancaster Farms there was no evidence of overt mental health problems and he was looking forward to release. He was offered a referral to mental health services but refused. The prescription of his medication continued as required. The clinical reviewer has made no recommendations.

74. When Mr Williams was found hanged, staff reacted calmly and competently in summoning assistance and attempting to resuscitate him. Two prisoners also assisted in these efforts to save Mr Williams and should be commended for doing so.

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