Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Williams, a prisoner at HMP Swansea, on 3 October 2016

A report by the Prisons and Probation Ombudsman

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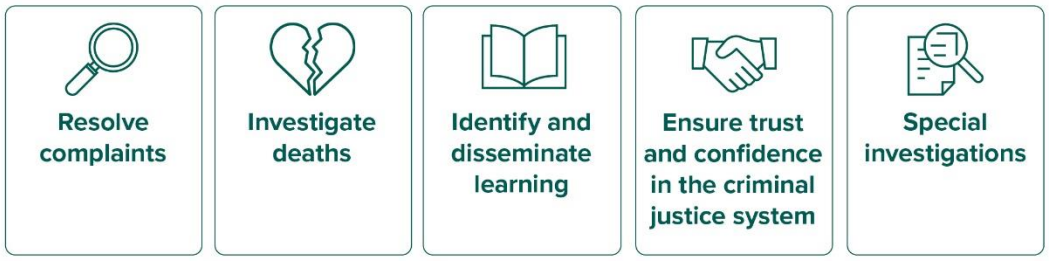
OUR VISION

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.

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

Mr David Williams was found hanged in his cell at HMP Swansea on 3 October 2016. He was 56 years old. I offer my condolences to Mr Williams' family and friends.

Mr Williams had a number of risk factors for suicide and self-harm. Including not having been in prison before, his offence and his history of alcohol abuse for which he was undergoing detoxification. Five days before Mr Williams' death, an officer stopped him from taking his life. While staff at Swansea appropriately identified and took some steps to address Mr Williams' risk of suicide and self-harm, there were procedural failures and the actions taken were insufficient in the circumstances. I am also concerned that the care Mr Williams received regarding alcohol misuse was not equivalent to that which he could have expected in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2018**

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Summary

Events

1. On 26 September 2016, Mr David Williams was remanded to HMP Swansea for breaching bail conditions set in relation to charges of assault against his former partner. It was his first time in prison.

2. At an initial health screen, Mr Williams disclosed that his weekly alcohol intake was very high. On 27 September, a GP prescribed medication to manage the symptoms of alcohol withdrawal. A nurse manager referred him to the mental health team as his use of alcohol seemed a significant issue for him. Mr Williams had no history of suicide attempts or self-harm and told staff that he had no such thoughts, although he was missing his family and hoped to be released on bail.

3. On 28 September, he appeared at court by videolink from prison and was convicted of the assault offences. He was remanded to prison to await sentencing. That lunchtime, an officer saw Mr Williams stand on a chair and place a ligature around his neck. The officer banged on Mr Williams' cell door and he removed the ligature. Staff began Prison Service suicide and self-harm monitoring procedures (known as ACCT) and checked Mr Williams every 10 minutes, which was reduced to half-hourly after an ACCT case review.

4. Mr Williams declined a mental health assessment and said that he had been stupid and did not intend to take his life. However, he told staff that he had a number of anxieties about his situation, and staff noted that he should be referred to a resettlement organisation for support. The earlier mental health referral was not pursued and no referral for substance abuse was made. Although Mr Williams was seen by a substance misuse support worker as part of the induction process, he did not disclose his alcohol misuse problems and the information held in clinical records about his alcohol treatment was not available to the support worker.

5. On 30 September, Mr Williams and a supervising officer met for another ACCT review. No one else attended. Mr Williams seemed less anxious and the officer reduced the frequency of staff checks to one every hour.

6. At 5.12am on 3 October, an officer carrying out early morning checks found Mr Williams hanged. She raised the alarm and officers responded quickly. Staff and paramedics tried to resuscitate Mr Williams, but at 5.48am it was confirmed that he had died.

Findings

7. Mr Williams had no known history of self-harm or attempted suicide prior to his arrival at Swansea, although a number of known risks for suicide and self harm were present. After he was seen in the process of attempting to hang himself, staff started ACCT suicide and self-harm prevention procedures. Although they identified the issues affecting Mr Williams' risk, insufficient practical measures were taken to reduce that risk. There was no input to the ACCT review process by either health care or mental health staff.

8. Mr Williams disclosed on his arrival at Swansea that he drank the equivalent of 250 units of alcohol a week. He was prescribed medication to manage his symptoms of alcohol withdrawal. However, a substance misuse worker who interviewed Mr Williams did not have access to his clinical records which should have informed any care plan and assessments.

9. The control room appears to have called an ambulance on receiving the emergency medical code but the time the Welsh Ambulance Service logged the call suggests a delay while they requested more information before despatching the ambulance.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
    - a multidisciplinary case review is held within 24 hours of an ACCT plan being opened;
    - caremaps contain meaningful actions designed to support the prisoner and reduce their risk of self-harm or suicide;
    - ACCT observations are made at irregular and unpredictable intervals;
    - prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

- The Governor and Head of Healthcare should ensure there is an agreed procedure for appropriate sharing of information about risk between all staff groups in health services and others in the prison.

- The Governor and Head of Healthcare should improve the communications systems and processes between healthcare, clinical and substance misuse professionals to ensure better sharing of information and treatment of prisoners with healthcare needs.

- The Governor should review the protocol between Swansea and the Welsh Ambulance Service to clarify when an ambulance should be dispatched and how accurate timings are recorded.

The Investigation Process

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

11. The investigator visited Swansea on 6 October 2016. She obtained copies of relevant extracts from Mr Williams' prison and medical records.

12. Healthcare Inspectorate Wales reviewed the clinical care Mr Williams received at the prison.

13. The investigator interviewed ten members of staff and one prisoner at the prison, by videolink and telephone. Healthcare Inspectorate Wales were represented at some staff interviews.

14. We informed HM Coroner for Swansea and Neath Port Talbot of the investigation who sent us the results of a post mortem investigation. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Williams' family to explain the investigation. Mr Williams' sister asked how long Mr Williams had been monitored under ACCT procedures, the frequency of staff observations and what the prison had done to help him.

16. The initial report was shared with HM Prison and Probation Service (HMPPS) and Mr Williams' sister. HMPPS noted two factual inaccuracies which we have amended. Their action plan is annexed to this report. Mr Williams' sister did not raise any factual inaccuracies.

Background Information

HMP Swansea

17. HMP Swansea is a local prison serving the courts in the South Wales area. It holds up to 500 sentenced or remanded men. Abertawe Bro Morgannwg University (ABMU) Health Board provides healthcare services at Swansea. It has been a smoke-free prison since March 2016.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Swansea was in October 2014. Inspectors found that the prison was a reasonably safe place with good reception arrangements but reported that first night induction was sometimes rushed. A high proportion of prisoners felt safe on their first night and there were enhanced checks for new arrivals.

19. Inspectors found that incidents of self-harm were low for a local prison, but that there had been a number of serious incidents of self-harm among new prisoners. Inspectors reported that the quality of ACCT documents used to manage those prisoners considered being at risk of suicide or self-harm was poor. It reported that initial assessment interviews did not always take place within 24 hours; caremaps did not reflect prisoners' needs and staff entries in ACCT records did not demonstrate a good level of care. Prisoners monitored under ACCT procedures were positive about the support they had received from staff. Inspectors also reported that Swansea had not acted on the learning points from previous Prisons and Probation Ombudsman investigation reports.

20. Inspectors noted that although health screening was thorough, treatment outcomes for all prisoners were seriously diminished by the lack of recovery-focused groups. It found that drug and alcohol services were not sufficiently integrated with other departments.

Independent Monitoring Board

21. 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 May 2016, the IMB reported that Swansea was one of the first prisons to adopt the smoke-free policy since March 2016. The Board noted that implementation of the policy was well planned and organised, but maintenance of the policy would be a significant challenge.

22. The IMB also reported that, although the quality of recordings in ACCT documents had been a cause for concern, increased training and consistent quality assurance checks were bringing about positive change.

Previous deaths at HMP Swansea

23. Mr Williams was the eighth prisoner to apparently take his life at Swansea since 2010. All but one died within their first week in prison. In four of those deaths, we

made recommendations to Swansea about the quality of their ACCT records. After an apparently self-inflicted death at Swansea in April 2016, we pointed out that ACCT checks should be made at irregular intervals.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. On 25 September 2016, South Wales police arrested and charged Mr Williams with breaching a bail condition not to contact his former partner. The next day, he was remanded to HMP Swansea. Mr Williams' escort record noted that he was alcohol dependent and that he thought he was in custody 'by mistake'. He had never been in prison before.

26. At an initial health screen, Mr Williams told a nurse that in the previous week, he had drunk the equivalent of 250 units of alcohol. The nurse noted that Mr Williams had mild to moderate symptoms of alcohol withdrawal including nausea, sweating, restlessness and tremors and referred him to a GP. The nurse gave Mr Williams symptomatic relief for his alcohol withdrawal symptoms and nicotine patches to alleviate his nicotine withdrawal symptoms as Swansea has a no smoking policy. Although Mr Williams was withdrawing from alcohol, he was placed in the first night centre because he was a new prisoner and his symptoms were considered mild to moderate rather than severe. He did not see a GP that evening but Swansea's healthcare protocol advises that a nurse can issue the appropriate medication if a patient meets relevant criteria. Mr Williams said that he had no thoughts of suicide or self-harm but he was missing his family and was hoping to be bailed after his next court appearance. He had no history of suicide attempts or self-harm.

27. An officer interviewed Mr Williams in the first night and induction wing. He said it was his first time in prison and the officer explained the support available to him. She told him that he would not be able to make any telephone calls immediately as there were restrictions on who he could contact. She gave him an e-cigarette and noted that he did not appear to acknowledge what she was saying to him. She completed an immediate risk and needs assessment. She concluded that, although his offence against a family member was an indicator of risk, she did not think an ACCT needed to be opened. Mr Williams was placed in a shared cell on the wing.

28. At 6.33am on 27 September, a nurse recorded in Mr Williams' medical record that he had not slept all night. Later that morning, a nurse manager asked Mr Williams more questions about his use of alcohol which indicated that it was a significant issue for him. She referred him to the mental health team. She did not refer him to substance misuse services. A GP saw Mr Williams at 11.43am. He prescribed 14 days of medication for alcohol withdrawal, with a reducing dose, and noted that Mr Williams had appeared composed and pleasant with no sweating, tremors or agitation.

29. A resettlement worker with St Giles Trust, a charity that provides induction, housing, health and financial advice to prisoners, assessed Mr Williams using a peer mentor, on 27 September, and drew up a resettlement plan. He told her that he had no children but would like help contacting his former partner who was pregnant. She referred him to PACT, an organisation that provides resettlement advice and support. Mr Williams said he did not want support with alcohol on his release but she referred him to the Welsh Centre for Action on Drug Addiction (WCADA), an organisation that provides substance misuse support for offenders and their families. An offender interventions practitioner from WCADA interviewed Mr Williams later that day as part of the standard induction process for new prisoners. Mr Williams said he did not have any drug or alcohol issues. He did not have access to Mr Williams' clinical records; he was not aware that Mr Williams had

alcohol misuse problems and the fact he was taking medication for alcohol withdrawal.

30. At 5.25am on 28 September, a nurse recorded that Mr Williams again had not slept all night. Later that morning, Mr Williams appeared at magistrates' court via videolink from the prison and was convicted of two counts of assault against his partner. He was remanded in custody for sentence on 12 October. Mr Williams' cellmate told the investigator that Mr Williams was convinced that he would be released at the court hearing and so had been feeling elated that morning. When he returned to their shared cell after his application for bail was turned down, his behaviour seemed erratic. His cellmate ate lunch and then fell asleep.

31. An officer was responsible for covering both the first night and induction unit and C Wing (including the segregation unit) over lunch time. (The normal level of staffing is one officer per unit but the officer had been ordered to cover both.) At about 1.00pm, Mr Williams pressed his emergency cell bell and told her that he had not been given bail and that she would be seeing a lot more of him. She said she would speak to him again that afternoon. After answering another nearby cell bell, she looked into Mr Williams' cell again and saw him standing on a chair, pulling a ligature over his head. She banged on his door, told him remove it and then radioed for staff assistance. Mr Williams removed it and untied the knot.

32. The officer began ACCT suicide and self-harm prevention procedures. She noted in the ACCT concern and keep safe form that Mr Williams was a 'poor coper' and could be quite vulnerable. The Supervising Officer (SO) noted in the ACCT immediate action plan that Mr Williams should continue to share a cell with his cellmate as they got on well and staff should check him every ten minutes until an ACCT review had been completed. She noted that Mr Williams knew how to access the Samaritans telephone and Listeners, prisoners trained by Samaritans.

33. A nurse from the mental health team tried to speak to Mr Williams about his suicide attempt, but he refused to talk to her, saying he was fine now. She offered to make him an appointment with the Lighthouse, a nurse-led prison mental health clinic, but he declined. She told Healthcare Inspectorate Wales (HIW) that Mr Williams was not agitated, but was abrupt and monosyllabic. She recorded the interaction in his clinical records and the healthcare handover book.

34. At 5.30pm, a trained ACCT assessor based in the custody office, assessed Mr Williams as part of the ACCT procedures. He told the investigator that Mr Williams would not talk about his earlier actions because he did not regard it as a suicide attempt. He said that, although Mr Williams had spoken to the resettlement advice worker from St Giles Trust about his housing concerns, he remained concerned and almost pleaded with the trained ACCT assessor to let him out of prison. Mr Williams was convinced that his former partner would drop the charges against him if he could talk to her. He had no insight into the behaviour which had led to his arrest and did not appear to understand why he was in prison. He told the trained ACCT assessor not to worry about him placing the noose around his neck and was repeatedly dismissive of the trained ACCT assessor attempts to discuss it, referring to it as 'something silly' which he would not have followed through with. The trained ACCT assessor concluded that Mr Williams' current suicidal thoughts and intentions were difficult to gauge and that he did not have a positive outlook or support.

35. Immediately after seeing Mr Williams, he arranged a case review with the SO. No healthcare or mental health staff attended the case review. He was unable to recall why, but thought it might have been because the review took place at 5.50pm. Mr Williams told him and the SO that he had been stupid to make the ligature, but he was worried what would happen to his belongings (particularly the tools for his business), and his housing, and he had too many issues to think about. He said he could talk to his cellmate and that he would alert staff if he felt he could not cope.

36. As Mr Williams was worried about losing his home and belongings, the SO wrote in his ACCT caremap that induction unit staff should refer Mr Williams to St Giles Trust who could help him with accommodation issues. There were no further entries in the caremap. Both members of staff agreed that Mr Williams' level of risk was raised and that staff should check Mr Williams at half-hourly intervals. They arranged another ACCT review for 30 September.

37. His cellmate said he and Mr Williams got on very well, but Mr Williams had periods of feeling low when he would pace in the cell, saying that he wanted a drink or a cigarette. Mr Williams told him that he had asked for his medication to be reduced but did not tell him what the medication was for. On 29 September, Mr Williams' birthday, he tried to smoke one of his nicotine patches mixed with a tea bag. Mr Williams asked him what sort of sentence he could expect for common assault. He replied that it would probably be a minimum of six months imprisonment. Mr Williams was worried that he would lose his rented home, his sign writing business and his tools which were in his home. A nurse noted in his clinical record that he appeared to sleep through the night.

38. On 30 September, the SO and Mr Williams had a further ACCT review as planned. No one else attended. According to the case review notes, no healthcare staff were able to attend because they had to run clinics. Mr Williams said that, although he was still worried about his home and belongings and had not managed to contact his solicitor, he was feeling much better. He said he had talked to his cellmate about his situation and he was happy with his medication. She decided that Mr Williams' level of risk was still raised and he needed the support of an ACCT but that staff observations should be reduced to once an hour. She set the next ACCT review for 4 October.

39. The SO wrote in Mr Williams' prison record that she had spoken to the housing team who said that a colleague, the resettlement worker from St Giles Trust, would see him that day. The housing team told the investigator she could not recall the SO getting in touch with her and that she did not know that Mr Williams was on an ACCT. The resettlement worker said she did not see Mr Williams after completing his resettlement plan on 27 September. She was not invited to either of his ACCT reviews.

40. On 1 October, staff allowed Mr Williams to use their office telephone to contact a friend, as he was still subject to contact restrictions. His cellmate told the investigator that both he and Mr Williams were feeling down on 2 October and were unable to cheer each other up. At 6.00pm, Mr Williams asked an officer if he could make a phone call but was told he had to wait until the next morning. Staff checked him hourly and recorded no concerns in his ACCT document. His cellmate fell asleep that evening and, when he woke up at about 2.00am, Mr Williams was watching television. They talked for about half an hour until he went back to sleep.

41. An operational support grade (OSG) checked Mr Williams once an hour throughout the night, on the hour. At 5.12am on 3 October, an officer looked through Mr Williams' cell observation panel as an ACCT check and saw Mr Williams at the back of his cell, hanged from a bed sheet tied to the window frame. She radioed an emergency code blue at 5.12am (which indicates that a prisoner is unconscious or not breathing). She considered going into the cell by herself, but a custodial manager and the most senior officer on duty at the time, and a nurse arrived within a minute and opened the cell. His cellmate was asleep. He was woken up and taken out of the cell. A nurse checked Mr Williams for signs of life but there were none. The custodial manager began cardiopulmonary resuscitation while the nurse attached a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest), which found no shockable heart rhythm.

42. An officer who was working in the prison control room that morning, told the police he telephoned for an ambulance at 5.14am. The Welsh Ambulance Service records indicate that they received the ambulance request at 5.19am. The ambulance service asked for more information so he transferred the call to the induction unit where a custodial manager gave them further information.

43. Both prison and ambulance service records show that paramedics arrived at Mr Williams' cell at 5.25am. Paramedics continued trying to resuscitate Mr Williams, but recorded at 5.48am that he had died. Two letters were found in Mr Williams' cell, one addressed to his cellmate and one to his former partner in which he wrote that he could not cope with being away from her.

Contact with Mr Williams' family

44. Mr Williams had named a friend as his next of kin but did not provide a full address. At 9.30am, the Governor and a family liaison officer left the prison to inform Mr Williams' former partner of his death. She was not at home, so they returned to the prison at 12.30pm. At 1.00pm, the family liaison officer telephoned Mr Williams' friend to break the news of his death. Mr Williams' solicitor provided contact details for Mr Williams' sister. The prison offered to contribute to the cost of Mr Williams' funeral in line with national policy.

Support for prisoners and staff

45. After Mr Williams' death, managers 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.

46. 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

47. The post mortem report gave the cause of Mr Williams' death as hanging. The toxicology report found only diazepam, consistent with Mr Williams' alcohol detoxification programme, in his body.

Findings

Management of risk of suicide and self-harm

48. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. Mr Williams arrived at Swansea with some recognised risk factors for suicide, including that he had been charged with a violent offence against his former partner, that he had a history of alcohol misuse, and that it was his first time in prison. However, he had no history of suicide attempts or self-harm. When he arrived, Mr Williams told an officer and a nurse that he had no thoughts of suicide or self-harm. He said he was missing his family but displayed no signs of depression. We are satisfied that staff considered his risk and it was reasonable for them to conclude that Mr Williams did not need to be monitored under ACCT procedures when he arrived.

49. An officer began ACCT monitoring at 1.00pm on 28 September, after she saw Mr Williams place a ligature over his head. She was responsible for patrolling two residential wings, including the segregation unit, that lunchtime and it was sheer good fortune that she happened to look into his cell at that time. Although the first case review took place within 24 hours of the ACCT plan being opened, as specified in the PSI, and another took place two days later, neither were multidisciplinary. Under the PSI, it is mandatory that a member of healthcare staff attends the first ACCT review. Mr Williams was undergoing an alcohol detoxification programme and had earlier declined mental health support and insisted he was fine. We consider that, given these factors, it was all the more important to ensure a healthcare worker was present at his ACCT reviews and a missed opportunity that there was no mental health input to those reviews.

50. At both case reviews, the trained ACCT assessor and the SO assessed Mr Williams' risk as raised. Given that he might have succeeded in taking his life, but for the intervention of the officer, we consider that his risk was in fact high and it was too soon on 30 September to reduce his frequency of observation. Concrete actions to identify and address Mr Williams' risk in the caremap were limited and there had been insufficient progress to support this decision. Both Mr Williams' first suicide attempt and the second which resulted in his death, showed an awareness of planned observation times and reduced staffing periods.

51. The trained ACCT assessor, who carried out the ACCT assessment interview, identified a number of issues that were causing Mr Williams anxiety. However, the SO only made one entry in the caremap, which was for staff to refer Mr Williams to St Giles Trust, although he had already had contact with them. St Giles Trust did not have a written record of a request for further contact; the member of the housing team did not recall another SO talking to them about Mr Williams and the resettlement worker at St Giles Trust said she did not know Mr Williams was on an ACCT nor had further interaction with him. Contrary to Prison Service Instruction 64/2011, ACCT checks were conducted at regular hourly intervals which would have allowed Mr Williams to predict when the next check would be. This is an

observation we have made before about a previous death in 2016 at Swansea. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **a multidisciplinary case review is held within 24 hours of an ACCT plan being opened;**
- **caremaps contain meaningful actions designed to support the prisoner and reduce their risk of self-harm or suicide;**
- **ACCT observations are made at irregular and unpredictable intervals;**
- **prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.**

Management of Alcohol withdrawal

52. Mr Williams disclosed his alcohol abuse at his initial healthscreen and was subsequently prescribed medication to manage the symptoms of alcohol withdrawal. Healthcare did not refer Mr Williams to any additional substance misuse services; instead he was referred to WCADA via St Giles Trust. The WCADA offender interventions practitioner was not aware of Mr Williams' previous alcohol misuse history and the information healthcare had obtained about Mr Williams alcohol misuse was not communicated to him. The opportunity for WCADA to undertake the required assessments and devise a meaningful care plan based on Mr Williams's specific needs was missed.

53. Healthcare Inspectorate Wales concluded that the management of Mr Williams' alcohol detoxification was not equivalent to what he might have expected to receive in the community. In particular, withdrawal programmes should consist of a drug regime and psychosocial support. The opportunity was there for Mr Williams to be offered this programme but due to his denial of having any alcohol misuse problems and the lack of communication between Healthcare and WACDA about his alcohol problems; the opportunity for him to fully benefit from the programme was missed. We make the following recommendations:

The Governor and Head of Healthcare should ensure there is an agreed procedure for appropriate sharing of information about risk between all staff groups in health services and others in the prison.

The Governor and Head of Healthcare should improve the communications systems and processes between healthcare, clinical and substance misuse professionals to ensure better sharing of information and treatment of prisoners with healthcare needs.

Emergency response

54. PSI 03/2013 on Medical Emergency Response Codes requires staff to use a code blue or equivalent code in a medical emergency and for the control room to call an ambulance immediately an emergency code is used. The PSI is clear that prisons

should not wait for healthcare or a duty manager to decide whether an ambulance is needed and that an ambulance can be cancelled later if not needed.

55. Swansea's control room appears to have called an ambulance at 5.14am yet ambulance service documentation logs a call at 5.19am. It is unclear whether the timings refer to initial contact or when sufficient information had been gathered to dispatch an ambulance. We make the following recommendation:

The Governor should review the protocol between Swansea and the Welsh Ambulance Service to clarify when an ambulance should be dispatched and how accurate timings are recorded.

Inquest

56. At the inquest, heard from 5 to 9 June 2023, the jury concluded that Mr Williams died by suicide.

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