

Action Plan – Mr Lewis Callaghan at HMP Wealstun – Self-Inflicted Death on 06/06/2018

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that ACCT reviews are held as scheduled and any conversations about a prisoner's level of risk or observations are documented in the ACCT.	Accepted	<p>A new system was introduced July 2018, immediately following Mr Callaghan's death, whereby all ACCTs are logged onto a database which is updated and managed daily by a designated member of the Safety Team. This highlights those cases that are due for review, enabling delegation to appropriate managers. The Safety Team then monitor throughout the day to ensure all reviews have been completed. If any are found to be outstanding at the end of the core day, the Safety Team will bring those cases to the attention of the Duty Governor and the Orderly Officer both in writing via email and verbally, so that appropriate action is taken to ensure a review is conducted without delay. The delegation of ACCT reviews is also discussed at the daily morning briefing.</p> <p>A Notice to Staff (NTS) has been circulated in June 2020, to remind staff of their responsibilities to document within the prisoner's ACCT and on NOMIS, any conversations relevant to a prisoners risk, mood or behaviour. They are also encouraged to contact the case manager directly and/or the Safety Team if they have any immediate concerns. This NTS will be issued on an annual basis.</p>	Head of Safety Completed
2	The Governor should ensure that when prisoners subject to ACCT management receive bad news, this is recorded and the impact on their risk is explicitly and promptly considered.	Accepted	A Notice to Staff (NTS) was issued in June 2020 to remind staff of the protocol associated with delivering bad news to prisoners, especially those on an ACCT. This will include the need to ensure that the potential impact on risk is properly considered and recorded. The NTS will then be issued on an annual basis. The staff induction package will also be updated to ensure all new staff are made aware of what to do in such circumstances.	Head of Safety Completed

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3	The Governor should ensure that there is a system in place to ensure that staff make and document ACCT checks as directed.	Accepted	<p>A Notice to Staff (NTS) has been distributed to remind staff of the importance of completing and documenting the required ACCT observations. The NTS will be issued on an annual basis.</p> <p>Additionally, a pilot was held whereby the cell bell call system was being utilised as part of the record keeping process, however this has not proved to be as effected as hoped. Consideration is now being given as to how the current Quality Assurance process can be improved to provide assurance that ACCT checks have been undertaken as directed.</p> <p>Further consideration has also been given to the appropriate use of CCTV and where a discrepancy is identified, the CCTV footage will be viewed to ensure that the ACCT check took place.</p>	Head of Safety January 2021
4	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: - continuity of case management, and; - caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and which identify who is responsible for them.	Accepted	<p>The Governor is committed to ensuring all staff are trained in Suicide and Self-Harm (SASH), the national training course that covers ACCT procedures. Initial and refresher SASH training is being prioritised within the establishment training plan, and reviewed within the Safety and Security meeting. All new staff are given an induction which includes information about ACCT. All operational staff will have adherence to PSI 64/2011 included within their SPDR.</p> <p>All ACCT case managers in post at the time of Mr Lewis Callaghan's death have now completed ACCT refresher training delivered by the Regional Safety team. Any staff at HMP Wealstun who have not received ACCT training within the last two years will also be put forward for refresher training.</p>	Head of Safety Completed

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			<p>The Safety Team also now have three band four Senior Officers in place who specialise in ACCT and CSIP to ensure continuity through delivery of single case management and to improve quality. All ACCTs are now delegated for case management to an individual manager. Only in unplanned circumstances where the case manager is not available will it deviate from the single case management model. The case manager will be responsible for ensuring caremap actions are specific, meaningful and aimed at a reduction in risk and have been completed before closure. Assurance of this is included in the 72 hour check of all ACCT documents and also undertaken through additional weekly and post closure checks.</p> <p>The quality of the ACCT process is further scrutinised during Regional Safety team assurance visits, who then provide a report for the attention of the Governor and is also discussed within the Head of Safety's bilateral.</p>	
5	The Head of Healthcare should ensure that the mental health and substance misuse teams share relevant information about prisoners and appropriate referrals are made.	Accepted	<p>Following receipt of a NHS specification, the Mental Health and SMS team are now a fully integrated service, ensuring that relevant information is shared effectively. Caseloads are discussed within the weekly multi-disciplinary team meetings, as well as at the multi-professional complex case clinics which are attended by all teams.</p> <p>The teams are also co-located to assist with joint working.</p>	Head of Healthcare Completed
6	The Head of Healthcare should ensure that in cases of persistent refusal to engage with mental health services,	Accepted	The Local Operating Procedure has been reviewed and ratified to make clear that if a patient chooses not to engage with the mental health service, then the individual practitioner must consider the patient's capacity to make the decision to disengage and consider the risk to the individual. At the point of	Head of Healthcare Completed

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	mental capacity should be assessed, documented and reviewed at appropriate intervals.		<p>disengagement, the practitioner must also complete and document a capacity assessment.</p> <p>These cases are then brought to and discussed within daily and weekly team meetings.</p>	
7	The Governor should ensure that, subject to a personal risk assessment, staff enter cells as quickly as possible when they cannot get a response from a prisoner.	Accepted	<p>A Notice to Staff was issued following Mr Callaghan's death reminding staff of the relevant security instruction about the need to enter a cell as quickly as possible if they are unable to obtain a response, subject to them carrying out a personal risk assessment. This NTS will be issued annually.</p> <p>To reinforce this instruction, a briefing will be included as part of the next full staff meeting.</p>	Head of Safety Completed