Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Lewis Callaghan, a prisoner at HMP Wealstun, on 6 June 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.**

## Our Values

**We are:**

**Impartial:** *we do not take sides*
**Respectful:** *we are considerate and courteous*
**Inclusive:** *we value diversity*
**Dedicated:** *we are determined and focused*
**Fair:** *we are honest and act with integrity*

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.

Our 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 Lewis Callaghan died on 6 June 2018, having been found hanging in his cell in HMP Wealstun the previous day. He was 23 years old. I offer my condolences to Mr Callaghan's family and friends. Our investigation was suspended for some time, while the police investigated Mr Callaghan's death.

This is a very troubling case where prison policy for managing those at risk to themselves was not followed. Staff missed checks, falsified records, missed reviews and did not assess Mr Callaghan's risk appropriately after he was given extra days on his sentence. Following an internal investigation, three members of staff were dismissed and two were given further training.

I am also concerned that there was a delay entering Mr Callaghan's cell, after he had prevented staff being able to see into his cell.

Senior managers at Wealstun took the prison's failings seriously and made a number of sensible changes to practices as a result. Managers now need to ensure that those changes have been properly embedded.

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** **December 2020**

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# Summary

## Events

1. In April 2016, Mr Lewis Callaghan was sentenced to a total of seven years' imprisonment for possession of drugs with intent to supply, breach of a restraining order, affray, destroying/damaging property and assault. Mr Callaghan thought his sentence was unjust.

2. Mr Callaghan arrived in HMP Wealstun in April 2017. Throughout his time there he largely refused to engage with the prison regime and had many disciplinary hearings. He was frequently on the basic level of the Incentives and Earned Privileges (IEP) scheme. He also had a history of substance misuse, self-harm and suicidal thoughts.

3. Mr Callaghan protested about not being allowed to contact his daughter. Prison and probation staff tried to help him apply to gain access, but he would rarely engage with them. When they identified offender behaviour courses that would assist his applications, he refused to take them.

4. In late 2017, staff started suicide and self-harm prevention procedures (known as ACCT) but Mr Callaghan would not engage with the process. He declined to see a doctor or anyone from the mental health team. He admitted to taking psychoactive substances (PS) and said he intended to continue to do so. On one occasion, staff had to persuade Mr Callaghan to remove a ligature from his neck. He remained under ACCT management until February 2018.

5. In May, Mr Callaghan refused to take a drug test and was put on a disciplinary charge. On 27 May, he threatened to jump from a landing, and had to be held back. Staff started ACCT procedures but Mr Callaghan barricaded his cell and tied a ligature around his neck. Staff persuaded him to remove it and started constant observation.

6. At an ACCT review on 30 May, Mr Callaghan seemed more positive and staff reduced observations to four times per hour, but the following day he again refused to engage. Mr Callaghan's case manager recommended that they start constant observation again but a senior manager assessed him and disagreed.

7. Staff did not hold Mr Callaghan's scheduled ACCT review on 4 June. It was postponed to the afternoon of 5 June.

8. On the morning of 5 June, staff did not conduct scheduled ACCT checks and falsified records to say they had done the checks. Mr Callaghan attended a disciplinary hearing and was awarded extra days on his sentence.

9. At approximately 12.15pm, staff locked Mr Callaghan in his cell. Staff did not complete scheduled ACCT checks, and when an officer tried to check him at 1.15pm, the photochromic door had been covered from the inside, making it impossible to see inside the cell. The officer went to get assistance and when staff went into the cell, they found Mr Callaghan hanging. Staff tried to resuscitate Mr Callaghan. Paramedics took him to hospital, but he died the following afternoon.

## Findings

### ACCT Management

10. We have serious concerns about the management of Mr Callaghan's ACCT. There were instances of delayed ACCT reviews and poor administrative procedures. Reasons for risk assessments were not always noted. An ACCT review was missed the day before Mr Callaghan hanged himself.

11. We are particularly concerned that, when Mr Callaghan was given extra days on his sentence on the morning of 5 June, he was not risk assessed but locked alone in his cell. Several scheduled ACCT checks did not take place, though staff recorded that they had been made.

12. The prison identified some of these failings after Mr Callaghan's death. Three members of staff were dismissed, and training and advice were provided to other staff. Nevertheless, we make several recommendations designed to ensure that the lessons learned are embedded.

### Emergency response

13. When a prison officer was unable to see into Mr Callaghan's cell or get a response on 5 June, there was a delay in accessing the cell.

### Substance misuse

14. Mr Callaghan used drugs before and during his time in prison. He admitted using PS and cannabis in Wealstun and had recently refused to take a drug test as he said he knew he would fail. There is no evidence, though, to suggest drug use was directly involved in his death. There were no signs of drugs in his cell, post-mortem tests showed only therapeutic medication and no traces of illicit substances.

### Clinical care

15. The clinical reviewer noted that Mr Callaghan was not on any medication and did not present with any significant physical problems. The physical healthcare provided to him was appropriate.

16. Although Mr Callaghan had no apparent mental health issues, his unwillingness to engage with mental health services prevented clinical assessment of his wellbeing and access to a wider range of support services.

17. The clinical review contains some additional recommendations that the Head of Healthcare will need to consider.

## Recommendations

- 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.

- 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.
- The Governor should ensure that there is a system in place to ensure that staff make and document ACCT checks as directed.
- 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.
- The Head of Healthcare should ensure that the mental health and substance misuse teams share relevant information about prisoners and appropriate referrals are made.
- The Head of Healthcare should ensure that in cases of persistent refusal to engage with mental health services, mental capacity should be assessed, documented and reviewed at appropriate intervals.
- 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.

## The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Wealstun informing them of the investigation and asking anyone with relevant information to contact him. Some prisoners responded and he interviewed them.

19. The investigator visited Wealstun in June and July 2018. He obtained copies of relevant extracts from Mr Callaghan's prison and medical records. He interviewed six prisoners at Wealstun. Our investigation was suspended between August 2018 and August 2019 while the police investigation was underway. He remained in contact with West Yorkshire Police through the course of their investigation and had access to their witness statements.

20. NHS England commissioned a clinical reviewer to review Mr Callaghan's clinical care at the prison.

21. We informed HM Coroner for West Yorkshire, Eastern District, of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

22. The investigator spoke to Mr Callaghan's parents to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. Mr Callaghan's parents did not have any specific questions but asked that he interview prisoners who had known Mr Callaghan.

# Background Information

## HMP Wealstun

23. HMP Wealstun is a category C prison near Wetherby, West Yorkshire, which holds up to 833 men. Care UK provides health services.

24. In August 2018, it was announced that Wealstun would be one of the prisons participating in the '10 Prisons Project'. The project seeks to improve safety, security and decency at the prisons by focussing on reducing violence, improving living conditions, preventing drugs entering the establishments and enhancing leadership training available to Governors and their staff.

## HM Inspectorate of Prisons

25. The most recent published report of an inspection of HMP Wealstun was in August 2015. Inspectors reported that prisoners harmed themselves less than at similar prisons. They found that suicide and self-harm preventions plans (ACCT) were of good quality, with consistent case management and a high level of continuing care. Prisoners being managed under ACCT procedures said that they felt well supported.

26. Inspectors also reported that an appropriate range of mental health services was provided, and information about risk was shared appropriately with relevant stakeholders.

27. HMIP inspected Wealstun most recently in October 2019. The report has not yet been published.

## Independent Monitoring Board

28. 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 2019, the IMB reported a difficult year for the prison, with shortfalls in staff numbers and frequent changes in senior management. Overall, prisoners were treated fairly. Positive drug tests fell by 50%, though the volume of drugs had not reduced significantly. There were high rates of violence, and incidents of self-harm and prisoners under ACCT management, despite a considerable amount of work by staff to reduce them.

## Previous deaths at HMP Wealstun

29. Mr Callaghan was the first prisoner to die at Wealstun since 2015. There have been three further deaths since Mr Callaghan's: one drug-related, one that is awaiting classification, and one self-inflicted death that is still being investigated. We also investigated the death of a man who killed himself a few days after being released from Wealstun in February 2019, and in that case, we identified some weaknesses in the management of the ACCT processes in the period before the man's release.

### Assessment, Care in Custody and Teamwork

30. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or 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 irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

31. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. 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).*

### Incentives and Earned Privileges scheme (IEP)

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.

### Psychoactive substances (PS)

33. Psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

34. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

35. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS

continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

# Key Events

36. In April 2016, Mr Lewis Callaghan was convicted of several offences (including possession of class A drugs with intent to supply, assault, breach of a restraining order and destroying/damaging property) and was sentenced to seven years' imprisonment. It was not his first time in prison.

37. Mr Callaghan was subject to a restraining order against his former partner. Social services had also prohibited him having contact with children under the age of 18, which meant that he was not allowed to contact his daughter. This, and a belief that he had been unfairly convicted, were sources of immense frustration to Mr Callaghan.

38. Mr Callaghan spent time in HMP Leeds and HMP Lindholme before transferring to HMP Wealstun on 21 April 2017. He had a history of substance misuse, self-harm and suicidal thoughts. In June 2016, he had taken an overdose of paracetamol. Despite this, at his reception healthscreen in Wealstun the nurse noted that he had no history of substance misuse or of harming himself in prison. The nurse also noted that he had no significant mental or physical health problems and was not on any medication.

39. While at Wealstun, Mr Callaghan had disciplinary findings against him for offences including breaching public protection orders (by using an illicit mobile phone to contact his ex-partner), being in possession of illicitly-brewed alcohol, making threats of violence, possessing a weapon, and refusing to take drug tests. He had incurred debts to other prisoners and was suspected of using psychoactive substances (PS).

40. In June 2017, Mr Callaghan began to refuse food in protest about not being allowed to contact his daughter. His offender manager (a probation officer working outside the prison) visited him but Mr Callaghan refused to see her. His offender supervisor (a probation officer seconded to the prison) explained to Mr Callaghan that she had contacted social services about Mr Callaghan applying to have contact with his daughter and she was awaiting a response.

41. After four days, Mr Callaghan began eating again, and said that he wanted to address the relevant issues. He agreed to talk to the mental health team and to consider available offender courses. Two members of the mental health team, a nurse and a trainee psychological wellbeing practitioner, assessed Mr Callaghan. He was reluctant to engage, so the practitioner said that she would be his case worker and would see him again.

42. Social services wrote to the prison notifying them that Mr Callaghan's application for contact with his daughter had been refused. On 29 June, the probation officer went to speak to Mr Callaghan about the safeguarding procedures, and how she could refer him to agencies that might help him. He was, however, reluctant to engage and became aggressive so she ended the conversation. She spoke to Mr Callaghan again on 20 July. She explained the courses available to him and said that she would go through the forms with him to help him apply. Mr Callaghan became angry, said that he would not do any programmes and did not want to engage with the prison system.

43. The trainee psychological wellbeing practitioner visited Mr Callaghan frequently. She advised him about courses that were available and explained how he might proceed to try to gain access to his daughter. Mr Callaghan engaged with her, but not with any other members of the mental health team. He refused to undergo mental health assessments and failed to attend several appointments with mental health nurses.

44. Mr Callaghan was given warnings under the Incentives and Earned Privileges (IEP) scheme for several reasons. He refused to attend work, attempted to breach his restraining order and caused damage to his cell. He was frequently put onto the basic level of the scheme. On 22 August, Mr Callaghan told the trainee psychological wellbeing practitioner that he had smoked PS and thought that it had been spiked with heroin.

45. In September, Mr Callaghan's low mood caused staff to manage him under ACCT procedures. He said that he would not engage with the process. In early October, he refused food for a short period, and declined to see a doctor or the mental health team. He also refused to engage with his offender supervisor to explore how he could undertake courses and develop ways to reduce the risk he was judged to present to gain access to his daughter.

46. On 6 October, Mr Callaghan told the trainee psychological wellbeing practitioner that he had been taking PS. She told him about the risks involved, and how they could affect his mental state and mood. On 8 October, staff found Mr Callaghan with a ligature tied loosely around his neck. He refused to engage with prison staff but asked to see a member of the Independent Monitoring Board (IMB) about contacting his daughter. Two members of the IMB went to see him on 10 October, but Mr Callaghan was uncooperative and refused their advice. He continued to refuse to engage with the ACCT process and the mental health team. Mr Callaghan told staff that he would continue to use PS and was given warnings about his behaviour. On 25 November, he became aggressive during an ACCT review and was restrained and taken to the segregation unit, where he remained for 10 days.

47. In December, Mr Callaghan refused to engage with a support worker from the substance misuse team. He was told that if he changed his mind, he should contact them. The offender supervisor informed Mr Callaghan that social services were assessing his safeguarding restrictions. Mr Callaghan admitted that he was still using PS but refused to attend a mental health appointment on 28 December.

### 2018

48. In January 2018, social services wrote to prison staff, saying that they would not allow Mr Callaghan to have contact with his daughter at that stage. They made recommendations about what he could do to apply for reassessment. The probation officer went to explain the report to Mr Callaghan but he refused to engage with her and threatened to hang himself. He left the meeting. She followed him and tried to explain that if he engaged with the mental health team and with offender courses then he could apply for reassessment. Mr Callaghan said that he would not engage.

49. In March, the offender supervisor spoke to Mr Callaghan about transferring to another prison to complete an offending behaviour course. Mr Callaghan refused to engage. On 16 March, he refused food and drink, which he said was due to his daughter's birthday. He would not allow medical staff to assess him. Staff began ACCT procedures, but Mr Callaghan refused to engage with the process. After four days he began eating again. Staff closed his ACCT on 28 March.

50. In April, during a cell search, prison officers found a bottle of fermented liquid in Mr Callaghan's cell. Later that month a prisoner on Mr Callaghan's wing was found using a mobile telephone. The following day, Mr Callaghan handed a letter to a prison officer that said it had been his telephone. Staff asked if he had been pressured into accepting responsibility. Mr Callaghan said that he had not, that he felt safe on the wing and wanted to stay there.

51. On 14 May, a mental health nurse saw Mr Callaghan at his request. Mr Callaghan said he used PS to lessen his anxiety but declined assistance from the nurse and said that he would not take any prescribed medication. He said he had thoughts of self-harm but would not act on them, as he wanted to be a father to his daughter in the future.

52. On 21 May, staff asked Mr Callaghan to provide a urine sample for a random drug test. He refused to do so and was charged with a disciplinary offence. A hearing was set for 23 May, but Mr Callaghan refused to attend on that date. The hearing was rescheduled for 5 June.

53. On 27 May, Mr Callaghan climbed over the railings on his wing, saying he was protesting about his sentence and the restrictions on him. Staff tried to negotiate with him, but when it appeared that he was about to jump off the landing, they intervened by physically restraining him. Staff took him back to his cell and began ACCT procedures. Shortly afterwards, they found that he had barricaded his cell door and tied a dressing gown cord round his neck. They persuaded him to remove the barricade and ligature. Staff agreed that he needed constant supervision, so he was taken to cell A5-04 on A wing, a single cell with a photochromic door (that can be made transparent or opaque by a key mechanism outside the cell).

54. On 28 May, one of the prison's senior managers chaired an ACCT review, attended by a nurse from the mental health team and an officer, who was the officer on constant watch duties at the time. Mr Callaghan said that he felt victimised by social services and the criminal justice system by not being allowed to see his daughter and by being imprisoned for a crime he did not commit. He said he had thoughts of self-harm but had no plans to act on them. The nurse offered him a distraction pack, but he declined the offer. Staff agreed that he would remain under constant observation.

55. On 29 May, during an ACCT review, a prison senior manager explained to Mr Callaghan that social services had said that they would review Mr Callaghan's non-contact with his daughter if he engaged with offending behaviour programmes, refrained from illicit drug use, and addressed his "problematic patterns of behaviour". Staff told him that it was positive that he knew what he needed to do, but Mr Callaghan said that he thought it unjust. The manager said

that he would contact Mr Callaghan's mother to see if she could attend a future review.

56. The senior manager chaired a further review on 30 May. Mr Callaghan engaged well and appeared to be more positive about working with the mental health team. His offender supervisor told him that she would contact the programmes team to assess what courses and interventions were available for him. He still, however, said he felt unjustly treated by social services. Those present agreed that they could stop constant observation and reduced Mr Callaghan's observations to four times per hour. The manager spoke to Mr Callaghan's mother before and after the review and noted that she was supportive. A Custodial Manager (CM), who was in the ACCT review, became Mr Callaghan's ACCT case manager.

57. On 31 May, the ACCT case manager chaired an ACCT review, attended by a nurse and an officer. Mr Callaghan refused to engage. He was aggressive and said he would take his own life. The manager assessed that Mr Callaghan should be put onto constant observation. He referred the decision to the duty governor. The duty governor, a nurse from the mental health team and a CM held a further review with Mr Callaghan. Although he initially remained reluctant to engage, he began to talk about his situation. He reiterated that he was unhappy at his sentence and lack of contact with his daughter, and that he was still not keen to engage with the prison regime as he saw that as making a concession. The duty governor concluded that Mr Callaghan did not require constant observation and maintained the level of observations at four per hour, with at least one conversation per hour.

58. Staff scheduled a review of Mr Callaghan's ACCT for 4 June. The ACCT case manager was on duty that afternoon as the Orderly Officer (in charge of the day to day running of the prison). An administrative manager telephoned him to tell him that an ACCT review was due. He told her that he had not been aware of this and, as he was the Orderly Officer, he did not think he would have time to complete it before the healthcare and mental health teams finished duty at 5.00pm.

59. The administrative manager told the police that the ACCT case manager had expressed concerns about Mr Callaghan, and she had advised him to raise it with the duty governor. He said that he was aware that Mr Callaghan had an adjudication hearing the following morning, so he notified the duty governor that he had rearranged the review for 3.00pm the following day, after the hearing. He asked an officer to make a note in Mr Callaghan's record. There is a note in his electronic record, but not on the ACCT document, or in the wing observation book. The duty governor told the police that he did not recall being told that any ACCT reviews had been missed. He said that if he had been, he would have asked for a full explanation and for the review to be carried out.

60. An Operational Support Officer (OSG) started work at 7.30pm. Shortly afterwards, Mr Callaghan rang his cell bell and asked the OSG to pass him a newspaper from the prisoner in the cell opposite. He did so. The OSG completed the scheduled ACCT checks throughout the night until he finished his shift at 6.40am on 5 June. The OSG gave a handover to Officer A and said that there had been no issues through the night.

61. Officer A checked Mr Callaghan at 6.45am and recorded this on the ACCT document. He recorded that he completed a further check at 7.15am, but CCTV footage showed that this did not take place. At 7.30am, he checked Mr Callaghan and documented this. At 7.45am, the officer documented a check that he did not make. At 8.00am, the A wing day shift staff arrived, and the officer went to work elsewhere in the prison.

62. At 8.00am, Officer B falsely recorded that he had completed an ACCT check. At 8.10am, he checked Mr Callaghan as he unlocked the other cells on the landing. He noted five further checks on Mr Callaghan up to 9.48am, but CCTV footage showed that he did not make these checks. At 9.48am, another officer checked Mr Callaghan. She did not note this on his ACCT document at that time, but at 10.45am she documented that she had made a check. Officer B documented a further three checks that CCTV confirmed were not made, before another officer collected Mr Callaghan at 11.15am to take him to his adjudication hearing.

63. At approximately 11.00am, a staff safety intervention meeting was held. The ACCT case manager said that he was concerned about Mr Callaghan, as he had an adjudication that morning which could result in additional days being added to his sentence. The manager was concerned that this could trigger a response from Mr Callaghan. The meeting agreed that an ACCT review should be held after the adjudication hearing. The duty governor was at the meeting. He later told the police that as the ACCT case manager had been the one to raise concerns, he expected him to arrange for the review to take place directly after the adjudication.

64. Mr Callaghan appeared before a judge at his adjudication and pleaded guilty to refusing a drug test. He said that he had been using drugs and knew a test would be positive. He was sentenced to a further 20 days imprisonment. At 11.40am, he returned to A wing and an officer escorted him back to his cell. The officer told police that Mr Callaghan did not display any behaviour that concerned him.

65. At 11.47am, Mr Callaghan and Prisoner A went into another prisoner's cell, which was opposite Mr Callaghan's. Prisoner A told the investigator that this prisoner was in the cell along with another prisoner. He said that they were talking about ordinary things. At one point, Mr Callaghan said that he was going to hang himself. He said that Mr Callaghan said this frequently and did not appear to be in any distress or any different from his usual demeanour when he said it. He did not think Mr Callaghan would hang himself, having heard him say this several times before.

66. After five minutes, Prisoner A and Mr Callaghan came out of the cell. They went into Mr Callaghan's cell and Prisoner A took back a television that he had loaned to Mr Callaghan. (Mr Callaghan was not allowed a television as he was on the basic level of the IEP scheme. He also should not have been allowed to borrow one from another prisoner.)

67. Another prisoner told the investigator that he spoke with Mr Callaghan after he returned from his adjudication. Mr Callaghan told him that he was going to take his own life. He said that he intended to go onto constant observation, to make sure that a member of staff had to stay outside his cell all the time. He did not

think that Mr Callaghan presented a risk of harm to himself but thought he was trying to disrupt staff's time.

68. At 12.00pm, Mr Callaghan went onto the landing and spoke with other prisoners. He returned to his cell at 12.13pm, and at 12.15pm prisoners were locked in their cells. At 12.17pm Officer B checked that the doors on the landing were locked, and another officer conducted a roll check that included checking on Mr Callaghan.

69. Officer C started work at 12.30pm, taking over from another officer. The officer briefed Officer C on the necessary ACCT checks before leaving. Officer C told the police that he looked at Mr Callaghan's ACCT document and saw that the observations that were due had not been documented. He asked the officer if the checks had been made and said that the officer told him that they had. He said that he then filled in the ACCT checks as having been made at 12.20pm and 12.35pm, thinking that the officer had made them.

70. CCTV footage showed that at 12.44pm light shining from behind Mr Callaghan's cell door became dimmer. At 12.49pm, Officer C went to the landing, but did not check on Mr Callaghan. At 1.15pm, he went to Mr Callaghan's cell. He switched the photochromic door to transparent, but visibility into the cell was obscured by a towel and he was unable to see in. He called to Mr Callaghan but did not receive a response.

71. Officer C returned to the office and telephoned the Orderly Officer to ask for permission to open the cell even though he was unable to see into it. It has not been possible for the investigator to establish whether Officer C had a radio. The Orderly Officer gave permission, so Officer C, along with three other officers (who had been in the office) returned to Mr Callaghan's cell, arriving at 1.19pm. Officer C called to Mr Callaghan that he was coming into the cell and opened the door.

72. Mr Callaghan was hanging from a ligature, made from torn bedding, tied to the window. An officer used his radio to call a code blue emergency (meaning a prisoner not breathing, or having difficulty breathing), and this prompted the control room to call an ambulance. The control room log and ambulance service records confirm that this call was made at 1.20pm.

73. One officer supported Mr Callaghan's weight, whilst another cut the ligature and they lowered him to the bed. They found a second ligature around Mr Callaghan's neck and cut this. Unable to detect a pulse or any sign that he was breathing, they lowered Mr Callaghan to the floor and began to perform cardiopulmonary resuscitation (CPR). At 1.23pm, healthcare staff entered the cell with emergency equipment, including a defibrillator, and continued CPR. At 1.44pm, paramedics arrived and took over Mr Callaghan's care. At 2.45pm, Mr Callaghan was transferred to Leeds General Infirmary.

74. Mr Callaghan remained on life support until this was withdrawn the following day, 6 June. Mr Callaghan died at 12.46pm.

### Post-mortem report

75. The post-mortem report said that Mr Callaghan died as a result of hanging. Toxicology tests did not show evidence of any illicit substances in Mr Callaghan's system.

### Contact with Mr Callaghan's family

76. When Mr Callaghan was taken to hospital, an officer was appointed as family liaison officer. She identified Mr Callaghan's mother as his next of kin, and she and colleagues went to her home to inform her of what had happened. Mr Callaghan's family went to the hospital and were with him when he died.

77. In line with Prison Service policy, Wealstun offered a contribution towards the costs of Mr Callaghan's funeral.

### Support for prisoners and staff

78. After Mr Callaghan's death, the Governor of Wealstun 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. Additionally, the Head of Healthcare held a debrief for all clinical staff involved in the emergency response.

79. Prisoners were notified of Mr Callaghan's death by notices posted on the wings, which indicated where they could get support if they felt it necessary. All prisoners subject to ACCT monitoring were reviewed in case they had been affected by Mr Callaghan's death.

### Mr Callaghan's cell

80. When police examined Mr Callaghan's cell, they found a torn piece of bedding, like the one Mr Callaghan had used to make the ligature, tied to a smoke detector on the ceiling. The detector had been pulled away from the ceiling.

# Findings

## ACCT Management

81. After Mr Callaghan's death, Wealstun's internal review identified significant failings in the operation of the ACCT processes. The Governor wrote to all case managers, reminding them of the importance of using the process correctly. All case managers were instructed to attend a refresher course. Wealstun also distributed guidance on the ACCT process to all members of staff, stressing that it should be properly operated.

82. Four members of staff involved in Mr Callaghan's care were suspended, and Officers A, B and C were subsequently dismissed. Two managers attended further ACCT case manager training. The investigator asked for copies of the disciplinary investigation hearings but did not receive them before the initial version of this report was issued. The prison was seeking advice about disclosure

83. Since Mr Callaghan's death, random tests are made on staff's knowledge of the ACCT process and their recognition of risks and triggers for self-harm. The safety team adopted a new structure to ensure continuity of management of prisoners under the ACCT process. Monthly safety reports are created to allow analysis of self-harm. The safety administrator is responsible for ensuring that reviews are completed and escalating this if necessary.

84. We are satisfied that Wealstun took a serious view of the failings that had come to light and has taken sensible actions to try to ensure they do not occur again. Nevertheless, we have made some additional recommendations.

85. Mr Callaghan was subject to ACCT management between September 2017 and February 2018, for a brief period in March 2018, and then again from May 2018. In late 2017 and early 2018, four of Mr Callaghan's scheduled ACCT reviews were carried out late. When Mr Callaghan declined to attend a review on 6 February 2018, there is no note of any consideration of risk. When ACCT procedures were closed on 28 March, there were no healthcare staff present. A post-closure review was not held.

86. When the ACCT case manager had concerns about Mr Callaghan on 31 May, he assessed Mr Callaghan's level of risk as high and recommended that he should be put back onto constant observation. This was considered by the Duty Governor and rejected, without any recorded justification. The ACCT case manager, who had raised the concerns, was not present when they discussed it. There were no healthcare or mental health team staff present. This was not acceptable practice.

87. Mr Callaghan was due to have an ACCT review on 4 June. This did not take place. The prison's immediate learning review after Mr Callaghan died, noted that this was not the only incident of an ACCT review being missed. The ACCT case manager said that, as the prison's orderly officer, he did not have a chance to hold a multidisciplinary review on 4 June.

88. It is not acceptable that an ACCT review was missed, particularly for a prisoner who had only recently been judged to require constant observation. An administrative manager was aware that the review was due and reminded the ACCT case manager. The manager said that he told the duty governor that a review would be postponed (although the duty governor said that he did not recall this). We would expect the wing manager to be aware of scheduled ACCT reviews on their wing, but due to staff leave A wing did not have a named manager on 4 June.

89. We make the following recommendation:

**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.**

90. On 5 June, Mr Callaghan had an adjudication hearing. The ACCT case manager had raised in the safety intervention meeting that morning that this could be a trigger for Mr Callaghan. It was also recorded on the front of his ACCT that a trigger for Mr Callaghan could be "*perceived injustice – a sanction or decision that he does not agree with*". The duty governor told the police that he expected the ACCT case manager to arrange an ACCT review to follow on from his adjudication hearing, yet no ACCT review was scheduled or held. There is nothing noted on his ACCT ongoing record about the outcome of the adjudication hearing, or his reaction to it. There is no evidence that any member of staff considered the immediate effect this may have had, or asked Mr Callaghan how he was feeling. Fairly soon after returning to the wing, he was locked alone in his cell. We recommend:

**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 considered.**

91. The prisoner safer custody representative told the investigator that prisoners often said that they were not being checked in line with their ACCT requirements. The police investigation identified many ACCT checks that were recorded but not completed. From 6.45am on 5 June until Mr Callaghan was locked in his cell at lunchtime, at least 16 entries documented checks appear not to have been made. Despite being listed for four checks per hour, he was not checked from just after he was locked into his cell at 12.17pm until Officer C attempted to check at 1.15pm. This was clearly unacceptable. Mr Callaghan appears to have obscured his door at 12.44pm, but no member of staff checked him for over half an hour after that. There was no system in place to assign responsibility to any individual to ensure that checks were made. CCTV showed officers on the landing by Mr Callaghan's cell, but not checking him.

92. Mr Callaghan's cell had a piece of cloth, like the one he had used as a ligature, tied to a smoke detector that had come away from the ceiling. It seems likely that Mr Callaghan had tried to use this as a ligature point but it had been unable to take weight. We do not know when this happened, so can only speculate whether the missed ACCT checks might have made a difference to the outcome. It is of great concern, however, that a prisoner, under four observations an hour,

may have been able to test a ligature point unnoticed, fail, and go on to use an alternative.

**The Governor should ensure that there is a system in place to ensure that staff make and document ACCT checks as directed.**

93. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, instructs that a caremap should be updated to reflect the decisions of the case review team. The caremap should have actions designed to reduce a prisoner's risk of suicide and self-harm, and there should be a named person responsible for completing each action. In this case, caremap actions were inadequate and did not attempt to address the underlying issues behind Mr Callaghan's emotional state.

94. We consider that several issues such as Mr Callaghan's issues with social services about contacting his daughter and his younger siblings, and his grievances over his sentence should have been listed on the caremap, with effective actions to ensure he received structured support which could then be monitored and reviewed at each ACCT case review. There was also a lack of consistency in case managers, with four different case managers chairing six ACCT reviews. 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:**

- **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.**

### Substance misuse

95. Mr Callaghan had used drugs before and during his time in prison. He admitted using PS and cannabis on at least eight occasions in Wealstun. On the morning that he was found hanging, he admitted that he had recently refused to take a drug test as he knew he would fail. Throughout his sentence, there was evidence that Mr Callaghan was using illicit substances.

96. However, we have seen no evidence to suggest that drug use played a direct part in Mr Callaghan's death. There were no signs of drug use found in his cell. Post-mortem tests found no traces of illicit substances, only the presence of therapeutic medication likely to have been administered while he was in hospital. Prisoners the investigator spoke to who had contact with Mr Callaghan on 5 June, including directly before being locked into his cell at lunchtime, said that he did not appear to be under the influence of any substances.

97. The clinical reviewer found that Mr Callaghan was offered access to substance misuse services but declined to engage. The clinical reviewer therefore concluded that this aspect of Mr Callaghan's care was equivalent to that he could have expected to receive in the community.

98. However, the clinical reviewer noted that, bearing in mind the clear indications that Mr Callaghan was misusing substances regularly, the input from the

substance misuse service was minimal. While this might largely have been down to Mr Callaghan's refusal to engage, there was also a lack of appropriate referrals. The clinical reviewer recommended that mental health and substance misuse team managers should develop an action plan to improve integrated working. We agree.

**The Head of Healthcare should ensure that the mental health and substance misuse teams share relevant information about prisoners and appropriate referrals are made.**

### Allegations of assault

99. In interview, Mr Callaghan's co-defendant said that Mr Callaghan had, in the past, complained of officers assaulting him. There is nothing in Mr Callaghan's file to indicate that he made any complaint about this. He did not mention it to any other staff or prisoners. He did not raise it with the prisoner safer custody representative or the Independent Monitoring Board. There are no relevant intelligence reports. CCTV shows that no staff entered his cell on the day of his death. The issue does not appear to have played a part in his death. In the absence of any other evidence, we are unable to comment any further.

### Mr Callaghan's contact with his daughter

100. Prior to his imprisonment, social services had prohibited Mr Callaghan from contacting his daughter until he had undergone treatment to help him control his temper and demonstrated a period of stability. Records show that Mr Callaghan had consistently refused to engage with social services.

101. In Wealstun, Mr Callaghan applied for contact with his daughter. Social services refused. His offender manager tried to discuss the safeguarding procedures and how she could help him but Mr Callaghan would not engage. In January 2018, social services made recommendations about what Mr Callaghan could do to enable him to reapply. Mr Callaghan refused to engage with any of the recommended programmes. In March, his offender supervisor tried to discuss a move to another prison where he could undertake a relevant offending behaviour course. Mr Callaghan refused to discuss it.

102. The restrictions on Mr Callaghan's contact with his daughter were imposed by social services, and the decision was beyond the remit of the prison. We are satisfied that staff tried to help him explore avenues that might assist his application to see her, but Mr Callaghan would not engage with them.

### Clinical care

#### *Physical healthcare*

103. The clinical reviewer concluded that Mr Callaghan's physical healthcare was equivalent to that which he could have expected to receive in the community.

#### *Mental healthcare*

104. Mr Callaghan had no diagnosed or significant mental health issues. Through his time in Wealstun he did not display any evidence of psychosis or mental illness.

Assessing his mental capacity further would have been difficult in view of Mr Callaghan's refusal to engage. The clinical reviewer concluded that the support provided by the trainee psychological wellbeing practitioner was "consistent, caring and compassionate and should be commended". We agree.

105. The mental health team repeatedly offered Mr Callaghan the opportunity to engage, even though he consistently declined. They regularly attended his ACCT reviews. The clinical reviewer noted, however, that his refusal to engage, lead to a management of his mental health via the ACCT process, which on occasions appears to have overshadowed clinical assessment of his wellbeing and access to a wider range of therapeutic support services. For this reason, the clinical reviewer concluded that Mr Callaghan's mental healthcare was not equivalent to that available in the community. We make the following recommendation:

**The Head of Healthcare should ensure that in cases of persistent refusal to engage with mental health services, mental capacity should be assessed, documented and reviewed at appropriate intervals.**

106. The clinical reviewer noted that from a healthcare perspective the emergency response was timely and efficient.

107. The clinical review contains some further recommendations that the Head of Healthcare will wish to address.

### Entering the cell

108. When Officer C was unable to see into Mr Callaghan's cell or get a response, he went to the office to telephone the duty governor to seek permission to open the cell door. He was subsequently dismissed, so we did not have the opportunity to ask him why he did this rather than use a radio. A prisoner on ACCT management, who had recently been on constant observation and had just received bad news had blocked visibility into his cell. Using the telephone indicated a lack of urgency that was inappropriate in the circumstances. It led to a further delay of some three minutes before staff accessed the cell and radioed an emergency code. This also led to a delay in calling an ambulance.

**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.**

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