Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Pickering, a prisoner at HMP Doncaster, on 9 June 2019

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*

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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 we oversee can improve their work in the future.

Mr Simon Pickering died on 9 June, having been found hanging in his cell at HMP Doncaster. Mr Pickering was 28 years old. I offer my condolences to Mr Pickering's family and friends.

Mr Pickering was remanded to Doncaster on 8 June. Prior to this, he had tied ligatures round his neck in both police and court custody and had been placed on constant observations as a result. When he arrived at Doncaster, staff appropriately started Prison Service suicide and self-harm procedures (known as ACCT).

However, Doncaster's implementation of these procedures, designed to protect and support Mr Pickering, was wholly inadequate. Mr Pickering had some significant risk factors: he presented as tearful and distressed at times, and he told staff that he was hearing voices (he had mental health issues) and wanted to die. Despite these factors, the day after he arrived at Doncaster, a prison manager assessed him as a low risk to himself and reduced his observations to once per hour. Mr Pickering killed himself later that day.

There were numerous other failings in the prison's adherence to ACCT procedures: checks were not carried out as intended; the assessment and review processes were combined, insufficient and not carried out in private; and Mr Pickering's ACCT document did not accompany him around the prison.

I have previously expressed similar concerns with Doncaster and it is disappointing to be repeating them here. I have escalated my concerns to the Head of Custodial Contracts in HMPPS and I expect to see significant improvements in future.

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 **April 2020**

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Summary

Events

1. Mr Simon Pickering was remanded to HMP Doncaster on Saturday 8 June. He had only recently been released from prison. He had tied ligatures around his neck in police and court custody, had been under constant observation as a result and arrived with a suicide and self-harm warning form.

2. Mr Pickering had a history of substance misuse and mental health problems. These were noted, and he was prescribed medication to help him through drug withdrawal before staff could confirm his prescribed medication with his GP on the Monday morning. Because of the warning form, ACCT procedures were opened. Staff were to check on Mr Pickering twice per hour.

3. That evening Mr Pickering scalded his foot with hot water. He was treated in the healthcare centre and arrangements were made for him to go to hospital the following morning.

4. On 9 June, Mr Pickering went to hospital as planned and his injury was treated. He returned to prison.

5. That afternoon, staff held Mr Pickering's ACCT assessment interview and first review. A nurse from the mental health team attended. Mr Pickering was tearful and distressed. He said that he had been hearing voices and had not received his antipsychotic medication. He said he wanted to die. The ACCT case manager explained the sources of support he could access. The case manager marked Mr Pickering's risk as low and reduced the level of observation to a minimum of one per hour, although the other staff present told the investigator they did not realise this.

6. Mr Pickering returned to his cell. Staff provided him with a television and a new kettle, and said that he seemed to be alright. In two telephone calls to his mother, however, Mr Pickering was very upset and said he intended to take his own life. Prison staff were unaware of this at the time.

7. At approximately 9.30pm, a prison officer was unable to see clearly into Mr Pickering's cell. Staff opened the door, and found Mr Pickering hanging from the bedframe. They cut the ligature, lowered him to the floor, and tried to revive him. They were joined by nurses, and then by ambulance staff. At 10.13pm, Mr Pickering was pronounced dead.

Findings

Management and assessment of risk

8. Mr Pickering was appropriately identified as at risk on arrival in Doncaster and placed under ACCT management. Thereafter, however, his ACCT management was poor.

9. Mr Pickering had several risk factors indicating that he was vulnerable to harming himself, but the risk was underestimated. The assessment interview was held outside the stipulated time (although there were mitigating circumstances). The

ACCT document did not accompany Mr Pickering around the prison. Checks were not made as directed and when they were, they were often of poor quality. Staff assessing Mr Pickering had not familiarised themselves with his background. The assessment interview and first review were combined, and the assessment of risk was unclear and inappropriate.

Clinical care

10. The clinical reviewer concluded that Doncaster provided appropriate care to Mr Pickering in terms of his physical healthcare, his substance misuse care, and identifying his mental health issues. However, he concluded that a two week wait to provide an urgent mental health assessment was unacceptable.

Substance misuse

11. Mr Pickering was a known drug user, and post-mortem tests found various drugs in his system. These included therapeutic medication and drugs likely to still be in his system from before his arrest. There is no evidence to show that he obtained or used any drugs during his time in Doncaster.

Recommendations

- The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that:
    - all known risk factors are considered when determining the level of risk of suicide and self-harm;
    - ACCT documents accompany prisoners under ACCT management when they move between different areas of the prison; and
    - systems are in place to inform staff coming on duty when prisoners in their care are under ACCT management.

- The Director should ensure that ACCT checks are made in line with national guidelines, in particular that they:
    - adhere to the frequency of observations set out in the ACCT document
    - are not made at predictable times;
    - are noted with meaningful entries on the ongoing record; and
    - are subject to proper management checks.

- The Director should ensure that ACCT reviews are held in line with national guidelines, in particular that:
    - ACCT assessment interviews are held within the correct timescales and clearly consider all information pertinent to risk;
    - ACCT assessments and case reviews are held separately;
    - case managers and healthcare staff familiarise themselves with a prisoner's background before attending reviews;
    - ACCT reviews are held in private; and
    - care map objectives are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them.

- The Director should provide a particular COM and PCO with additional ACCT training, and the COM should not chair ACCT reviews until this has been completed.
- The Director should ensure that all staff named in this report receive a copy so that they are aware of the Ombudsman's findings.
- The Head of Custodial Contracts in HMPPS should ensure that the issues identified in this report regarding assessing and managing prisoners who are a risk to themselves have been addressed at Doncaster.
- The Head of Healthcare should review the waiting times for urgent mental health assessments and ensure that these take place within an appropriate timeframe.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Doncaster informing them of the investigation and asking anyone with information to contact him. No one responded.

13. The investigator visited Doncaster in July 2019. He obtained copies of relevant extracts from Mr Pickering's prison and medical records. He contacted the police investigating the circumstances of Mr Pickering's death and remained in contact with them through the investigation.

14. The investigator interviewed seven members of staff at Doncaster in July and September 2019. NHS England commissioned a clinical reviewer to review Mr Pickering's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

15. We informed HM Coroner for Yorkshire South East of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Pickering's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised no specific issues. We provided Mr Pickering's next of kin with a copy of this report.

Background Information

HMP Doncaster

17. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 prisoners who have been remanded into custody or sentenced. Care UK provides physical and mental health services as well as substance misuse services. Nurses are available 24 hours a day.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Doncaster was in July 2017. Inspectors noted that health services had improved considerably since the previous inspection in October 2015 and overall, were reasonably good. They noted that many prisoners were assessed as being at risk of suicide and self-harm, and the prison needed to ensure that they received a consistently high level of care. Inspectors noted that the quality of some ACCT documents remained inadequate, with poor care plans and poorly attended reviews.

Independent Monitoring Board

19. 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 September 2016, the IMB reported serious concerns about healthcare provision.

Previous deaths at HMP Doncaster

20. Mr Pickering was the third prisoner at Doncaster to take his own life since 2017. We have previously made recommendations about the management of prisoners under ACCT procedures. In a report issued in March 2019, we identified that staff had failed to take all risk factors into account when assessing a prisoner's risk to themselves, and had not fully recorded information. We raise further concerns about these issues in this report. Since Mr Pickering's death a further four prisoners have apparently taken their own lives in Doncaster.

Assessment, Care in Custody and Teamwork

21. 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.

22. 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 multidisciplinary reviews involving the prisoner.

23. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the caremap actions 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.

Key Events

Saturday, 8 June 2019

24. On Saturday 8 June 2019, Mr Simon Pickering appeared in court charged with criminal damage and assault against a family member. He was remanded to HMP Doncaster.

25. Mr Pickering had been homeless prior to his arrest on 7 June. While in police custody he had tied a ligature around his neck and attempted to choke himself, and had been placed on constant watch as a result. Mr Pickering had again tied a ligature around his neck in court cells and was once more placed in a constant watch cell. Court staff completed a suicide and self-harm warning form, which accompanied Mr Pickering to Doncaster.

26. Mr Pickering had a history of substance misuse. He suffered from mental health problems, including depression and anxiety. He had also been diagnosed with Emotionally Unstable Personality Disorder. (Also known as Borderline Personality Disorder, traits can include impulsive behaviour, difficulty in forming and maintaining relationships and fluctuating mood.) His medical records showed that he had suffered from asthma since childhood, and had been diagnosed with epilepsy (although when he had been diagnosed was unclear and there was no evidence that he had received any treatment for it).

27. He had been released from HMP Moorland on licence on 23 May 2019. Before release from that sentence, he had twice been managed under ACCT procedures for relatively short periods of six and seven days respectively. One of these occasions was due to Mr Pickering having suicidal thoughts. The other was due to concern at his behaviour after taking illicit drugs. On several occasions he had been found to be under the influence of drugs in prison.

28. On his arrival in Doncaster, a nurse assessed Mr Pickering. He told her that he had injected heroin and crack cocaine two days ago. A drug test was positive for opiates, benzodiazepines (sedatives), cocaine and cannabinoids. He scored 10 on the Clinical Opiate Withdrawal Scale (COWS), indicating he had mild withdrawal symptoms.

29. The nurse saw the documents that arrived with Mr Pickering and was aware that Mr Pickering had tied a ligature around his neck in police and court custody and had been under constant observation. He also told her that he had tried to overdose on heroin two days before that.

30. Mr Pickering told the nurse that he had psychotic tendencies: depression, anxiety, mood swings and a personality disorder. He told her that he suffered from asthma, epilepsy, a high metabolism, arthritis and chronic back pain. She noted that he had previously been prescribed quetiapine (an antipsychotic), sertraline (an antidepressant) and diazepam (a sedative). However, until his prescription medication could be confirmed with his community GP on Monday, he would not be prescribed this medication. She referred Mr Pickering for a mental health assessment.

31. The nurse noted on Mr Pickering's medical record that there were "mild concerns" about self-harm. In interview, she said that Mr Pickering's main concern was to get his prescription of methadone. She said that he was not displaying obvious signs of drug withdrawal or psychosis and she did not think he needed to be under constant observation.

32. As Mr Pickering had arrived with self-harm warnings detailing two recent incidents where he had tied ligatures around his neck, the nurse started Prison Service suicide and self-harm monitoring procedures (known as ACCT). On the concern and keep safe form, she ticked the box to indicate other concerns, including "vulnerability due to age or immaturity". She did not note what these concerns were and in interview said she did not remember.

33. A Custodial Operations Manager (COM), who was Duty Manager that afternoon, assessed Mr Pickering, who he knew from a previous sentence at Doncaster. In interview, he said that Mr Pickering told him that he was glad to be back in Doncaster, where he felt safe and knew many staff. The COM told the investigator that Mr Pickering seemed reasonably relaxed and was laughing and joking.

34. The COM assigned Mr Pickering to the detoxification unit. He was aware that Mr Pickering had been under constant observation in police and court custody for tying ligatures, but said in interview that he did not assess that Mr Pickering needed that level of observation. He noted on the ACCT document that Mr Pickering would have access to an in-cell telephone, and that he could request access to Listeners (prisoners trained by the Samaritans to provide peer support). Staff were to check on him at least twice per hour.

35. A substance misuse nurse assessed Mr Pickering. Mr Pickering told the nurse that he had been injecting crack cocaine and heroin daily before coming to prison and had also been taking cannabis and benzodiazepines. The nurse referred Mr Pickering to the substance misuse team, noting that he should be put on a methadone programme, and should engage with psychosocial treatment to help him address his drug issues. As it was the weekend, the nurse was not able to contact Mr Pickering's GP, so he expected one of the healthcare team would confirm Mr Pickering's medication with his GP on Monday. The nurse prescribed Mr Pickering methadone and medication to try to alleviate symptoms of drug withdrawal. The nurse knew that Mr Pickering was subject to ACCT monitoring but said that he did not display signs of hopelessness or any tearful or emotional behaviour during his assessment.

36. Staff assessed Mr Pickering as suitable to share a cell with another prisoner. However, when staff told him he would be sharing a cell he became agitated and aggressive. Staff then assessed Mr Pickering as unsuitable to share a cell and allocated him a cell on his own. At 3.15pm, Mr Pickering arrived in the detoxification unit. Staff recorded in his ACCT ongoing record that he seemed happy to be there. At 3.45pm, staff noted he was cleaning his cell and talking to another prisoner.

37. A Prison Custody Officer (PCO) interviewed Mr Pickering as part of his induction. She was aware that he was under ACCT management and made an entry on his ACCT ongoing record. A note on his electronic record (made the following day

by a colleague on her behalf) noted that Mr Pickering told her that he had thoughts of self-harm. She confirmed that he had been offered a phone call in reception, been given his identification card, had adequate clothing, and had been issued a vape pack. Mr Pickering said that he was dyslexic and had trouble reading and writing. Last time he was in prison, a fellow prisoner had helped him if he needed to read or write anything.

38. Mr Pickering told a PCO that he was in a local gang, but did not provide any further information. He said that he did not have any mobility issues. The PCO explained that he would be allocated a keyworker (a prison officer who would be his first port of call for any problems or queries) in the next few days. He told her that he had been in prison before so knew how things worked. She took him back to his cell. Other prisoners were out of their cells on association (time where prisoners can socialise), and the PCO said that Mr Pickering talked briefly to some of them before being locked into his cell for the night.

39. At approximately 5.50pm, Mr Pickering shouted for assistance. Staff went to his cell, and he said that he had scalded his foot with hot water while trying to make a drink. Mr Pickering's skin was peeling and he said that he was in pain. Staff took him to the healthcare centre, where a nurse treated his burn and gave him pain relief medication. He said that Mr Pickering should go to A&E for review, but not as an emergency. Prison officers had already taken another prisoner as an emergency admission to hospital that evening, so there was a reduced number of staff available. As Mr Pickering was not an emergency and had already been given medical treatment, it was agreed that he would attend hospital the following morning. Aware that he was under ACCT management, staff asked Mr Pickering if he had harmed himself deliberately, but he was adamant that he had not.

40. There are no entries on Mr Pickering's ACCT document from 3.45pm until 7.42pm, when a PCO noted that the document had not accompanied Mr Pickering to the healthcare centre. She also wrote on the ACCT ongoing record that she had not been informed when she started work that Mr Pickering was under ACCT management, nor that he was in the healthcare centre.

41. Healthcare staff made routine substance misuse observations on Mr Pickering through the night. His ACCT ongoing record contains entries to indicate that staff checked him twice per hour.

Sunday, 9 June

42. At 8.28am on Sunday 9 June, staff took Mr Pickering to hospital to have his burn looked at. A COM was in reception when Mr Pickering was discharged to hospital and said in interview that he had been "quite cheerful". The COM did not assess there was any reason to alter Mr Pickering's level of risk. In hospital, Mr Pickering's injury was dressed and he was given an appointment at the burns clinic for the following Wednesday (13 June). He was given crutches to help him move about in the meantime, and prison healthcare staff were told to monitor him for any infection.

43. An entry on Mr Pickering's ACCT document at 1.30pm noted that Mr Pickering had been happy during the trip to the hospital. He returned to prison at 1.43pm.

The COM saw him on his return, and told the investigator that Mr Pickering did not display any behaviour that caused him any concern. There are no further entries on his ACCT ongoing record until 4.10pm.

44. A PCO said in interview that Mr Pickering asked her if he could have a shower when he returned from hospital. He was concerned that his foot was bandaged, and that he was not particularly stable while needing crutches to walk. She obtained a waterproof bag from the healthcare department to cover his dressing. She also arranged for one of her colleagues to allow him to be in the shower alone. She said that Mr Pickering was concerned that he did not have any vapes, so the wing representative provided him with two vape packs. At 3.36pm, Mr Pickering went to the medication hatch and asked for some painkillers. A nurse gave him ibuprofen and paracetamol.

45. At 4.10pm, a PCO conducted Mr Pickering's ACCT assessment interview. She noted that he was tearful, stressed and fed up. He said that he felt low and had thoughts of self-harm, something that he had done in the past, most recently in police custody. He said that he had been taking drugs before being arrested, had been hearing voices and had not had his medication.

46. At 4.30pm, staff recorded that Mr Pickering was out of his cell for tea and was a "little distressed".

47. The ACCT document then contains a record of the first case review, timed at 4.50pm. A COM documented that he chaired Mr Pickering's ACCT review, with Mr Pickering, a PCO, and a nurse from the mental health team present. He recorded that Mr Pickering was tearful. Mr Pickering said that he was concerned about not having any of his antipsychotic medication for a week and was hearing voices. He said that he could not stand the voices any longer, and wanted to hurt himself and die. Mr Pickering said he needed someone to talk to. The COM explained the Buddies scheme (prisoners trained by HMP Doncaster to help other prisoners), the Listeners scheme, and telephone access to the Samaritans. Mr Pickering was also told that he could speak to chaplaincy staff.

48. The nurse said in interview that Mr Pickering was not displaying any bizarre behaviour or signs of psychosis. The nurse told Mr Pickering that he would leave instructions for a colleague in the healthcare department to address his medication issue as soon as possible the following morning (as it was a Sunday). He said that there was no indication that Mr Pickering needed to be prescribed medication more urgently than this.

49. The COM noted on the ACCT document that Mr Pickering's risk was low, and that the level of observations would be reduced to one per hour. In interview, he said that this was the consensus of the multidisciplinary group in attendance. However, the PCO said in interview that she did not recall discussing the level of observations. The nurse also said that he did not recall them discussing the level of risk, or reducing the level of observations. On his note of the meeting on Mr Pickering's medical record, the nurse recorded that observations remained at a minimum of two per hour. The nurse's note also stated that another COM was present in the room when the meeting was being held, working on an unrelated matter.

50. The PCO said in interview that she took Mr Pickering back to his cell. He was concerned that he did not have any vapes. She asked other prisoners if any of them had any they could spare and a prisoner gave Mr Pickering one. She said that Mr Pickering appeared to be happy with this.

51. CCTV footage showed that Mr Pickering returned to his cell at 4.51pm. A prisoner opened the door for him (as he was on crutches). Prisoners were then locked in for the night.

52. At 5.00pm, a PCO took Mr Pickering a television and a new kettle. The PCO noted further ACCT observations at 5.30pm and 6.00pm, with no issues raised. CCTV footage showed that staff checked on Mr Pickering at 6.58pm. Mr Pickering pressed his cell bell and asked for an aerial for his television. An officer noted in the ACCT record that at 7.05pm she gave this to him and, in her statement, said that he thanked her and told her that he was "alright".

53. Mr Pickering made two telephone calls to his next of kin from the telephone in his cell. These were at 6.58pm and 7.08pm. Mr Pickering was very tearful and said he intended to end his life. His next of kin advised him to let staff know how he was feeling, but he said that there was no point. Prison staff were unaware of the content of these calls.

54. Staff checked Mr Pickering at 8.03pm. This is the last check that was noted on the ACCT document. At 8.16pm, a PCO spoke to the occupant of the cell next door to Mr Pickering's. She did not approach Mr Pickering's door. She did not speak to Mr Pickering but told police that she saw him through the observation panel.

55. At approximately 9.30pm, a PCO tried to check Mr Pickering. She was unable to see clearly into his cell, so asked another PCO, who was nearby, to open the cell door. He did so, and the officers saw Mr Pickering hanging by a ligature attached to his bedframe. One of them radioed a code blue emergency (meaning a prisoner is unconscious or having difficulty breathing). This prompted the control room to call an ambulance. (Prison records showed that the code blue call was made at 9.35pm, although ambulance service records show that the ambulance was requested at 9.34pm.) The other used her anti-ligature knife to cut the ligature and they lowered Mr Pickering to the floor.

56. A third PCO responded to the emergency call, and she and one of the other PCOs checked Mr Pickering for signs of life. Unable to find a pulse or any signs of breathing, the PCO began to perform cardiopulmonary resuscitation (CPR). A nurse arrived at the cell within two minutes of the officers entering the cell. She applied a defibrillator (a machine that, in certain circumstances, can restart the heart) but the machine indicated that they should continue with CPR. Joined by other nurses, they continued to provide CPR until the ambulance crew arrived and took over at 9.40pm. At 10.13pm, paramedics pronounced that Mr Pickering had died.

Contact with Mr Pickering's family

57. Mr Pickering's next of kin was identified and the duty Director and the family liaison officer went to her address that night and informed her of Mr Pickering's death.

58. In line with Prison Service guidance, Doncaster offered a contribution to the cost of Mr Pickering's funeral.

Support for prisoners and staff

59. After Mr Pickering's death, staff involved in the emergency response attended a debrief to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

60. The prison posted notices informing other prisoners of Mr Pickering's 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 Pickering's death.

Post-mortem report

61. Post-mortem tests showed that Mr Pickering died of asphyxia, due to neck compression. The pathologist noted that there was a mixture of drugs in his system that included traces of cocaine, benzodiazepines and methadone. Although these were not present at a level to cause toxicity, the pathologist noted that, in combination, they may have had some bearing on Mr Pickering's choices/actions on the day of his death.

Findings

Assessment and management of risk

62. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* and PSI 7/2015, *Early Days in Custody – Reception in, first night in custody, and induction to custody*, both list a number of risk factors and potential triggers for suicide and self-harm. All staff who come into contact with prisoners are expected to be aware of these risk factors.

63. When Mr Pickering arrived at Doncaster he had a number of risk factors, including a history of mental health problems and substance misuse, being charged with a violent offence against a family member and two very recent attempts to hang himself in police and court custody. He also said he had tried to overdose on heroin two days earlier.

64. A nurse appropriately opened ACCT monitoring in reception but, despite his very recent self-harm attempts, she assessed that there were only "mild concerns" about his risk to himself. A COM said he was aware that Mr Pickering had been on constant observation in police and court custody, but judged that he did not require that level of supervision in Doncaster. He set the observation level at a minimum of two per hour. We are concerned that both the nurse and the COM relied too heavily on Mr Pickering's presentation, without balancing this against the significant risk factors present, particularly the very recent self-harm.

65. Mr Pickering was subsequently seen by a nurse, who was aware that he was on an ACCT but said that he did not appear hopeless or emotional – again focussing solely on presentation.

66. A few hours later, Mr Pickering scalded his foot quite badly. Mr Pickering was an unknown quantity for staff at this point and we are concerned that they accepted his assurances that this was an accident, and not self-harm, too readily given his recent self-harm attempts.

67. When Mr Pickering was taken to the healthcare centre to have his burn treated, his ACCT document did not accompany him there as it should have done. Although we accept that he would have been under staff observation most of the time, this meant that healthcare staff would not necessarily have been aware of the risks he presented.

68. When a PCO came on duty that evening, she was not told that Mr Pickering was under ACCT management. It is crucial that staff are aware that prisoners in their care are at raised risk, to provide the care necessary and to maintain ongoing assessment of the level of risk. We make the following recommendation:

The Director should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that:

- **all known risk factors are considered when determining the level of risk of suicide and self-harm;**

- **ACCT documents accompany prisoners under ACCT management when they move between different areas of the prison; and**
- **systems are in place to inform staff coming on duty when prisoners in their care are under ACCT management.**

69. Several of Mr Pickering's ACCT observations were not carried out. None were noted between 3.45pm and 7.43pm on 8 June. Although this includes a period when Mr Pickering was in the healthcare centre, he only went there at 5.50pm so, even if he were under observation during that time, there were still missing entries.

70. On 9 June, there was a gap of over two hours between entries on the ongoing record after Mr Pickering returned from hospital. Staff checked him at 8.03pm, then nothing further was noted on the ACCT document before he was found hanging at approximately 9.30pm. We are not able to say when Mr Pickering hanged himself, but the lack of checks means that he could have been hanging for some time before he was discovered.

71. Guidance on ACCT documents states that all entries on the ongoing record must be meaningful. Furthermore, times of checks should be irregular, so that if prisoners do intend to harm themselves they are unable to judge when they will next be checked. Observations noted in Mr Pickering's ACCT ongoing record through the night of 8/9 June are all at the hour and the half hour. They almost all state "appears asleep". At 8.00am on 9 June, the record noted that he was discharged to hospital, and then the entries are every hour and half hour and all say "cuffed no issues" until 1.30pm when it stated that he had been "happy" while out.

72. After his return to prison there were no further entries until 4.10pm. The ongoing record contains notes of management checks at 1.48am and an untimed stamp between 6.00pm and 6.30pm, but no mention was made of the number, regularity or quality of the checks. The COM said in interview that he would usually look through the ongoing record before an ACCT review but had not picked this up. We make the following recommendation:

The Director should ensure that ACCT checks are made in line with national guidelines, in particular that they:

- **adhere to the frequency of observations set out in the ACCT document**
- **are not made at predictable times;**
- **are noted with meaningful entries on the ongoing record; and**
- **are subject to proper management checks.**

73. ACCT guidance directs that assessment interviews must be held within 24 hours of the concern and keep safe form being raised. The nurse did not note the time on the concern and keep safe form but the front of the ACCT document showed that it was opened at 2.10pm on 8 June. The assessment interview was not held until 4.10pm the following day, meaning that it was not held within the required time. However, we accept that there were mitigating circumstances. We

understand that there was a disturbance in the prison on 8 June that diverted staff to another area. Also, Mr Pickering was out of the prison at hospital on the Sunday morning, not returning until 1.43pm.

74. We are, however, concerned at the quality of the assessment interview and the first case review. The nurse and the PCO both said in interview that they had not had the opportunity to familiarise themselves with Mr Pickering's records before the assessment and review. It is important that staff have background knowledge of a prisoner to help them assess risk.

75. We are concerned that the COM, PCO and nurse combined the assessment interview and first case review into one meeting. The ACCT process is deliberately split into sections to give prisoners at risk the best opportunity to engage, and to give staff the best opportunity to properly assess risk.

76. We are also concerned that the interview/review was held in an office, with another member of staff working in the same office but not involved in the meeting. This was not appropriate and did not afford Mr Pickering adequate privacy if he wanted to disclose anything that he felt was personal or sensitive.

77. The note of the assessment interview was brief. It showed that Mr Pickering felt "low" and had "thoughts of suicide". In the section titled "Other areas of discussion" the PCO wrote "single cell status" and "chapel" with no explanation of what was discussed. In the section to reflect what was agreed as next steps, the note stated, "substance misuse" and "medication", again with no further explanation. Whether or not the burn to Mr Pickering's foot was deliberate self-harm, the note of the ACCT review does not reflect that this was discussed.

78. During the meeting Mr Pickering was tearful and said he felt lonely. He said that he had been hearing voices, and that he wanted to hurt himself and to die. He had several risk indicators. He was undergoing drug withdrawal, he had a history of impulsive behaviour, he had very recently tied ligatures in police and court custody, he had only arrived in prison the previous day and staff were not familiar with him.

79. Despite this, the COM marked Mr Pickering's risk as low and reduced the level of observations to a minimum of one per hour. We find this extremely difficult to understand and we consider that the decision to reduce the level of observation was premature and misguided.

80. In interview, the COM said that this was the decision of the multi-disciplinary team. However, the PCO and nurse both said that this was not discussed and they were unaware that the COM had concluded this. The nurse told the investigator that he did not think that Mr Pickering's risk was low, and at the time he noted on Mr Pickering's medical record that the level of observation remained at two observations per hour.

81. PSI 64/2011 states that caremap actions should be detailed and time-bound and aimed at reducing risk. They should reflect prisoners' needs, level of risk, and the triggers of their distress. Mr Pickering's caremap was inadequate, only stating that he should work with the substance misuse team and that the healthcare department should address his medication.

82. We make the following recommendation:

The Director and Head of Healthcare should ensure that ACCT reviews are held in line with national guidelines, in particular that:

- **ACCT assessment interviews and case reviews are held within the correct timescales and clearly consider all information pertinent to risk;**
- **ACCT assessments and case reviews are held separately;**
- **case managers and healthcare staff familiarise themselves with a prisoner's background before attending reviews;**
- **ACCT reviews are held in private; and**
- **ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them.**

83. We are particularly concerned about the COM and the PCO's contributions to the assessment and management of Mr Pickering's risk to himself. We therefore make the following recommendation:

The Director should provide the COM and PCO with additional ACCT training, and the COM should not chair ACCT case reviews until this has been done.

84. Given the concerns we have raised in this report, we also make the following recommendation:

The Director should ensure that all staff named in this report receive a copy so that they are aware of the Ombudsman's findings.

85. In a report into a self-inflicted death at Doncaster in September 2018 we raised several similar issues about the management of the ACCT process. On 12 June, three days after Mr Pickering's death, the prison's action plan in response to our earlier report stated that the issues had been addressed. We are therefore concerned to be raising significant concerns with Doncaster once more about their management of prisoners at risk of suicide and self-harm. We are also concerned that there have been a further four apparently self-inflicted deaths at Doncaster since that of Mr Pickering. We make the following recommendation:

The Head of Custodial Contracts should ensure that the issues identified in this report regarding assessing and managing prisoners who are a risk to themselves have been addressed at Doncaster.

Clinical care

86. The clinical reviewer concluded that Mr Pickering's clinical care was of a mixed standard and partially equivalent to that he could have expected to receive in the community. He concluded that Mr Pickering's physical healthcare was appropriate, including the treatment for his scalded foot.

87. The clinical reviewer noted that at his reception health screening, the nurse appropriately assessed Mr Pickering, and referred him to the mental health team. He was then seen by a nurse and his drug misuse was identified. As it was a

weekend, the nurse was not able to contact Mr Pickering's GP to confirm his medication, but appropriate medication was prescribed to manage drug withdrawal and he was monitored through the night. The clinical reviewer concluded that Mr Pickering's substance misuse care was appropriate.

88. At his ACCT review, Mr Pickering said that he had been hearing voices. He had not had any antipsychotic medication for several days. A mental health nurse did not judge that this required immediate intervention as there was no evidence of psychotic symptoms and Mr Pickering was receiving drug withdrawal medication. The nurse was content that the issue would be addressed the following morning when his prescribed medication would be confirmed with his GP.

89. The clinical reviewer noted that the mental health involvement in Mr Pickering's care was good and that a mental health nurse attended his ACCT review. The clinical reviewer was, however, concerned that an urgent mental health assessment could take up to two weeks, which is not equivalent to that which is expected in the community. Accordingly, we make the following recommendation:

    The Head of Healthcare should review the waiting times for urgent mental health assessments and ensure that these take place within an appropriate timeframe.

90. The clinical reviewer was satisfied that the emergency response was appropriate and well-delivered.

Mr Pickering's drug use

91. The post-mortem report noted several drugs in Mr Pickering's system. Some were therapeutic, some were likely to have remained in his system from before his arrest. The pathologist concluded that while there appeared to be no individual drug toxicity that contributed to his death, the combination of drugs in his system may have had some bearing on his choices and actions.

92. Mr Pickering had a history of drug misuse. Prior to arriving in Doncaster, he had been in police custody and there were no indications that he had accessed any illicit drugs in that time. He was monitored for withdrawal symptoms in prison and there was no intelligence that he obtained any drugs during his time in Doncaster, nor any indications that he displayed any signs of intoxication while there. The police found no drug paraphernalia or signs of drug use in Mr Pickering's cell.

Prisons & Probation

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