Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Storr, a prisoner at HMP Durham, on 22 March 2024

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Colin Storr died in hospital on 22 March 2024, after being found hanging in his cell at HMP Durham, on 16 March 2024. He was 63 years old. I offer my condolences to Mr Storr's family and friends.

Mr Storr was only at Durham for around 24 hours before he took his own life. Prison staff appropriately started suicide and self-harm prevention procedures (known as ACCT) when Mr Storr arrived. However, staff did not use the information available to them to properly assess the seriousness of his risk, or the frequency of checks required. In addition, healthcare staff did not have access to documentation which contained pertinent risk information. An issue that comes up too frequently in my investigations.

That evening, staff did not check Mr Storr as they should have for five hours and a member of staff later falsified the records to indicate that he had completed these checks.

There were five self-inflicted deaths at Durham between June 2021 and June 2024, including two within 9 days of arrival at Durham. I am extremely concerned that, having been assured that progress had been made following previous recommendations to the prison, this investigation raises similar issues.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2024**

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Summary

Events

1. Mr Colin Storr had a history of suicide attempts in prison and the community. On 15 March 2024, he was remanded to prison for breaching a sexual harm prevention order. Staff at court assessed Mr Storr as a risk to himself. He was taken to HMP Durham and constantly observed on his way there.

2. Prison staff began Prison Service suicide and self-harm support measures, known as ACCT. They set Mr Storr's observation levels at hourly. Mr Storr moved to the first night centre (E Wing).

3. Staff were initially unaware that Mr Storr was on an ACCT and so did not carry out ACCT observations between 5.45pm and 10.55pm. The night officer discovered Mr Storr's ACCT document at 10.55pm. ACCT observations were appropriately undertaken from then.

4. On 16 March, Mr Storr declined to engage in the regime and presented as quiet and withdrawn. Prison staff attempted to engage with Mr Storr during this time.

5. Staff went to Mr Storr's cell at 2.35pm to complete his ACCT assessment. Mr Storr had hanged himself from his bed. Staff entered the cell, radioed an emergency medical code, cut the ligature and began CPR. Paramedics took over Mr Storr's care at 2.45pm and, after they had managed to establish a pulse, took him to hospital.

6. Mr Storr did not regain consciousness, and on 19 March, hospital staff withdrew treatment. Mr Storr was pronounced dead on 22 March.

Findings

7. Prison staff and healthcare staff in reception did not use the information available to them to appropriately assess Mr Storr's risk. Staff set observation levels based on a standard approach, rather than a personalised assessment of Mr Storr's risk to himself.

8. E Wing staff were initially unaware that Mr Storr was on an ACCT and so his ACCT observations were not undertaken for a five-hour period. A supervising officer (SO) later falsified records stating that he had undertaken these checks and the management check.

9. Reception is a busy area in the prison. Healthcare staff raised concerns about their relationships with prison staff, not having access to relevant risk information, and delays caused by the process. We have previously made recommendations to Durham to ensure staff have access to relevant risk information and are not making decisions based solely on a prisoner's presentation. We were assured these issues had been fixed, and we are frustrated to identify the same issues here.

10. Information sharing in reception is an issue that comes up too frequently in PPO investigations and we will be working with HMPPS and NHS England to identify workable solutions.

Recommendations

- The Prison Group Director and NHS Commissioner should ensure that reception staff have access to, review and appropriately consider all relevant information when assessing a prisoner’s risk to themselves.
- The Prison Group Director should undertake a review of the ACCT quality assurance process to satisfy themselves that systemic issues are identified, and suitable remedial actions taken in response.
- The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure himself that there is not a systemic issue with false entries.
- The Governor should ensure that reception supervising officers understand their responsibilities to inform first night centre staff if a prisoner is on an open ACCT and introduce a quality assurance process to satisfy himself the process is embedded.

The Investigation Process

11. HMPPS notified us of Mr Colin Storr's death on 22 March 2024.

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

13. The investigator visited Durham on 4 April. She obtained copies of relevant extracts from Mr Storr's prison and medical records.

14. The investigator interviewed 11 members of staff at Durham in May. The investigator interviewed six members of staff via Microsoft Teams in May and June.

15. NHS England commissioned a clinical reviewer to review Mr Storr's clinical care at the prison. She attended all interviews jointly.

16. We informed HM Coroner for Country Durham of the investigation. At the time of writing, the post mortem report was not available. We have sent the Coroner a copy of this report.

17. The Ombudsman's Office contacted Mr Storr's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Storr's brother asked us to consider:

- Was the prison aware of Mr Storr's autism and was he receiving the right care?
- Did the prison give Mr Storr his medication?
- Was the prison aware of Mr Storr's previous suicide attempt in prison and was he suitably cared for?

18. These questions have been answered in this report.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

20. Mr Storr's brother received a copy of the draft report. They did not make any comments.

Background Information

HMP Durham

21. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. Spectrum Community Health CIC provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

22. The most recent inspection of Durham was in November 2021. Inspectors reported that new arrivals had the opportunity to discuss their concerns but late admissions and a busy first night centre sometimes impacted on the quality of the service provided. Recorded levels of self-harm were lower than at similar prisons, and there was good interrogation of self-harm data. The quality of support delivered through ACCT case management varied, with care maps poorly completed and records of daily interaction often missing. Prisoners' healthcare was affected by serious staff shortages in the department.

Independent Monitoring Board

23. 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 November 2021 to October 2022, the IMB reported that the prison was a safe environment. The Board raised concerns about the consistency of ACCT, particularly completion of supervisor daily checks and the quality assurance process.

Previous deaths at HMP Durham

24. In the three years before the death of Mr Storr, there were 11 deaths at Durham. Seven of these were due to natural causes, and four were self-inflicted. Up until the end of August 2024, there had been two self-inflicted deaths and one due to natural causes since that of Mr Storr.

25. We have previously made recommendations about reception staff properly assessing risk based on prisoners' risk factors and not solely on their presentation. In response to an action plan in 2022, the National Safety Team delivered risks, triggers and protective factors training to all custodial managers and supervising officers at Durham. Healthcare staff continued to access ACCT awareness training.

26. We have also made recommendations, following two deaths in November 2022, about all staff involved in completing initial risk assessments having access to relevant information, including digital person escort records (DPERs), suicide and self-harm warning forms and prison records. We were told in July 2023 that a partnership meeting was held with healthcare and the prison to review reception processes and an action plan produced. Monitoring was due to take place to ensure risk information was readily available to all staff when assessing risk.

27. The death of Mr Storr has highlighted that the response to previous PPO recommendations has not been effective or sufficient.

Assessment, Care in Custody and Teamwork

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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 multidisciplinary review meetings involving the prisoner.

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

Background

30. Mr Colin Storr had a history of suicidal thoughts and had been admitted to psychiatric hospitals to keep him safe. He had previously been in HMP Durham between November 2013 and May 2014. In March 2014, Mr Storr attempted to hang himself in his cell at Durham. He had attached a ligature made of bedding to his bed. He was cut down by his cellmate at the time. Mr Storr said he had done this because he had been remanded in prison charged with new offences. When released, he received a 10-year Sexual Harm Prevention Order (SHPO - a court order to prevent a person from engaging in a particular activity) due to end in May 2024.

15 March 2024

31. On 15 March 2024, Mr Storr was charged with breaching his SHPO and remanded to prison. Court staff recorded concerns about Mr Storr's low mood and behaviour (including rocking and head banging) on Mr Storr's Digital Person Escort Record (DPER – an electronic form that provides relevant details on a prisoner, including risk alerts). They noted that he had reacted badly to being remanded to custody and had been trying to get the drawstrings out of his trousers. Court staff completed a paper Suicide and Self-Harm (SASH) form for Mr Storr noting that he was '*lying in a foetal position rocking. Since coming down from court he seems a lot more emotional and mental health appears to have deteriorated*'. Staff observed him constantly during the journey from court to Durham.

32. Supervising Officer (SO) A and a mental health nurse completed a joint interview with Mr Storr in reception when he arrived at Durham. The SO noted that Mr Storr disclosed being autistic (there was no formal diagnosis of this in his clinical record) and had arrived with a SASH form. He could not specifically recall reviewing Mr Storr's DPER but stated that all DPERs are checked. He noted that Mr Storr said that he had lost everything and felt he wanted to die but had no plans to kill himself.

33. The mental health nurse recorded that Mr Storr denied wanting to die but said he had thoughts to harm himself but no plan or intent to do so. She recorded that Mr Storr was '*tearful on occasions however smiled and laughed on some occasions*'. She told us that she asked him directly if he wanted to end his life and he said he did not. She did not have access to the DPER and said she had never seen a DPER for any prisoner. She told us that she had reviewed Mr Storr's clinical records but, in interview, seemed unaware of key information contained within those records including Mr Storr's previous stay in a psychiatric hospital and incidents of self-harm in the community.

34. The SO started prison suicide and self-harm monitoring and support procedures, known as ACCT, and placed Mr Storr on hourly observations. During interview, he stated that hourly observations was standard practice at Durham, and he believed Mr Storr would be sharing a cell which would mean he would have someone to talk to. He told us that he would have increased the level of observations if he had known Mr Storr would be in a single cell. He was unaware that Mr Storr had previously attempted to hang himself whilst in a shared cell. The mental health

nurse agreed with the hourly observations. She also said that in general when opening an ACCT, hourly observations were standard unless staff had major concerns about the prisoner. There is no evidence that any referrals for specialist support or assessment were made following Mr Storr's disclosure that he was autistic.

35. A nurse completed Mr Storr's healthcare screening and noted that he was tearful and withdrawn, disengaged, and had thoughts of suicide with plans. She stated that she told the mental health nurse about her concerns following her contact with Mr Storr and the mental health nurse replied that they had already opened an ACCT. The mental health nurse told us she could not recall this conversation. The nurse confirmed that she had not reviewed Mr Storr's DPER or SASH form, nor was she aware of Mr Storr's suicide and self-harm history. She also did not see his ACCT document. During interview, she stated that she believed Mr Storr's observations should have been more frequent.

36. The nurse completed Mr Storr's Medication in Possession Risk Assessment (MIPRA – considers the ability of a prisoner to hold and safely manage their medication based on risk). Mr Storr's score indicated that he could hold his own medication. (The clinical reviewer concluded that this was based on inaccurate information because the nurse had answered several questions wrongly, including that Mr Storr was not subject to ACCT monitoring.) However, she overrode this outcome and did not permit Mr Storr to hold his own medication. A pharmacy technician later assessed Mr Storr as suitable for in-possession medication. She told us that she had searched Mr Storr's clinical record for 'overdose' and 'self-harm' and found no issues.

37. An officer completed Mr Storr's first night induction in reception. During interview, she recalled that Mr Storr was very tearful and stated that he had 'lost everything'.

38. An Advanced Nurse Prescriber (ANP) reviewed Mr Storr at 6.06pm. He sent a request to obtain Mr Storr's community medical record. Mr Storr was prescribed amitriptyline (a painkiller), paracetamol and sertraline (an antidepressant). Mr Storr did not receive any medication while at Durham due to the short length of his time there.

39. An officer (referred to as a runner who moves prisoners from reception to the first night centre) took Mr Storr and his wing file to the first night centre (E Wing). Mr Storr's wing file contained his vulnerabilities assessment, completed by SO A in reception, (which did not identify that he was on an ACCT), ACCT document and Cell Sharing Risk Assessment (CSRA - this identifies prisoners who cannot safely share a cell with others). Mr Storr was assessed as suitable to share a cell. At Durham, ACCT documents are usually put in a separate white folder but the prison had run out of them so staff put it in his wing file. No one from reception informed E Wing staff that Mr Storr was on an ACCT as they should have done.

40. CCTV shows that Mr Storr arrived on the first night centre at 6.17pm and was left alone for around three minutes before an orderly prisoner (who supports others) approached him. An officer left the wing office at 6.22pm and showed Mr Storr to his cell. This was the last time Mr Storr was seen on CCTV before the emergency event.

41. Officer A began his night shift at 9.00pm and completed a roll check (a check conducted to confirm the number of prisoners on the wing) shortly afterwards. He confirmed both the count and the number of ACCTs on the wing to the manager in charge of the prison overnight. Having checked their records, the manager phoned him at 10.55pm to tell him that there was an additional open ACCT on the wing. The officer then found Mr Storr's ACCT document in his wing file. He told us that staff completed no ACCT checks on Mr Storr between 5.45pm and 10.55pm as they had been unaware that Mr Storr was on an ACCT.

42. Officer A was sure that checks had not been recorded in Mr Storr's ACCT document between 5.45pm and 10.55pm on 15 March. However, when the PPO reviewed the ACCT document, checks were signed as being completed by SO B at 6.30pm, 7.27pm, and 8.27pm. The SO had also signed the supervisor entry check at 9.22am on 16 March. CCTV shows that no checks were done on Mr Storr by prison staff on the first night centre until the officer's check at 10.55pm. During interview, the SO could not recall making these entries or account for why CCTV showed that no checks had been carried out.

43. A nurse completed three routine healthcare first night checks on Mr Storr overnight through his observation panel. During the first of these at 9.59pm, Mr Storr was vaping and said that he was okay.

16 March 2024

44. On 16 March at 12.26am, the nurse checked Mr Storr and noted that he was vaping on his bottom bunk. Officer A submitted a security intelligence report at 1.00am regarding the missed ACCT checks the evening before.

45. Officer A completed Mr Storr's ACCT checks between 10.55pm on 15 March and 6.00am on 16 March. He told us that that Mr Storr was crying and shaking on the bed. When asked if he was feeling suicidal, Mr Storr said that he was not. The officer checked on him more regularly through the night due to his concerns. He stated that he managed to get Mr Storr 'laughing and smiling' and then Mr Storr settled down to sleep. The nurse also checked Mr Storr at 5.12am and noted that he was asleep.

46. An officer completed four ACCT checks on Mr Storr between 9.20am and 12.05pm. He recorded that Mr Storr declined access to the exercise yard and did not want to engage. He told us that Mr Storr was quiet and thoughtful. He did not assess Mr Storr as being in distress or anxious.

47. Another officer completed the second day induction with Mr Storr at approximately 9.40am. She told us that he was not crying as much as he was on the first day but that he did not want to share a cell. The chaplain visited Mr Storr at 9.56am and tried to engage Mr Storr in conversation but said that he barely responded.

48. Another officer went to Mr Storr's cell five times between 12.00pm and 2.19pm. She told us that she tried to engage with Mr Storr, but he was very quiet, and he said he found it difficult to speak to people as he was autistic. She asked him whether he was okay and he replied he was 'fine'. She informed Mr Storr that his ACCT case review would take place that afternoon. She told us that she had no concerns Mr Storr was a risk to himself.

49. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio communications from 16 March. She also obtained information from the North East Ambulance Service. The following account has been taken from all sources.

50. At 2.34pm, a SO and an officer attended the first night centre to complete Mr Storr's ACCT assessment and case review. The SO looked through the flap in Mr Storr's cell door and saw that Mr Storr had a ligature made of bedsheets around his neck attached to the bed. He was in a seated position with his legs touching the floor but his bottom suspended.

51. The SO radioed a code blue (an emergency code used when a prisoner is having difficulty or is not breathing) at 2.35pm. Control room staff immediately called an ambulance. The SO and officer went into Mr Storr's cell, and the SO cut the ligature using their anti-ligature knife, laid Mr Storr on the floor and the officer started cardiopulmonary resuscitation (CPR). A Healthcare Assistant (HCA) was working on the wing and went straight to the cell, arriving within a minute of the code blue being called. She left to collect the emergency healthcare bag, oxygen and defibrillator. She returned as three nurses also got to the cell. Staff attached the defibrillator and followed its instructions. Staff continued CPR.

52. Paramedics reached Mr Storr at 2.45pm and took over his treatment. They managed to obtain a return of spontaneous circulation (where there is a sustained heart rhythm that spreads through the body after a cardiac arrest). Paramedics took Mr Storr to hospital.

53. Police found two final notes in Mr Storr's cell. In one, Mr Storr referred to not wanting to be a burden anymore. In the second, Mr Storr referred to losing his home and dog, and expressing anger at the police.

54. Mr Storr did not regain consciousness and, on 19 March, hospital staff withdrew treatment. Mr Storr died at 4.34pm on 22 March.

Contact with Mr Storr's family

55. The prison appointed two family liaison officers (FLOs). Mr Storr had not nominated a next of kin when he arrived at Durham. On 17 March at 10.00am, the police provided prison staff with Mr Storr's brother's contact details. One FLO phoned Mr Storr's brother immediately and told him that Mr Storr was in hospital. She remained in contact with Mr Storr's brother via telephone while Mr Storr was in hospital.

56. The FLO phoned Mr Storr's brother on 22 March to tell him that Mr Storr had died. In line with national policy, Durham offered a contribution to the cost of Mr Storr's funeral.

Support for prisoners and staff

57. On 16 March, a senior manager debriefed prison and healthcare 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.

58. The prison posted notices informing other prisoners of Mr Storr'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 Storr's death.

Post-mortem report

59. At the time of writing this report, the post-mortem report was not available.

Inquest

60. At the Coroner's inquest, held from 11 February to 17 February 2026, the jury concluded that Mr Storr died by suicide.

Findings

Assessment and management of risk

61. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), contains national requirements on the assessment and management of suicide and self-harm risks in prisons. The instruction lists risk factors and potential triggers that staff should be alert to and act appropriately to address. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

62. Mr Storr identified as autistic, hopeless, and having lost everything he cared about. He told staff that he wanted to die, and a nurse believed he had plans to harm himself. He was last in prison ten years previously when he had tried to take his own life by hanging himself, he had a history of suicide attempts in the community and had been admitted for inpatient psychiatric care due to his suicide risk. When in court on 15 March, court staff noted concerns about his risk to self based on his presentation. He was constantly observed while being transported from court to prison. On arrival at Durham, SO A, in agreement with the mental health nurse, appropriately started ACCT procedures for Mr Storr.

Initial action plan

63. The SO and the mental health nurse set observation levels at hourly pending the ACCT assessment and first case review. They said that this was routine practice when starting an ACCT in reception at Durham.

64. The investigator conducted a spot check of six open ACCT documents and two post closure ACCT documents on the first night centre and A-Wing on 1 May 2024. Of these, six were initially put on hourly observations, one was set at five times an hour (in line with the policy for segregated prisoners), and one was transferred in on an ACCT from another prison and so the frequency of checks remained unchanged. The prisoner in the segregation unit was reduced to hourly observations following the initial case review, despite stating that he ‘100% wanted to die’ and disclosing that he was hearing voices. The concern forms reviewed (which note the reasons for beginning ACCT procedures) detailed a prisoner tying a ligature around his neck and attaching it to the light fitting, a prisoner cutting his arms and stomach, and a prisoner disclosing struggling with thoughts of self-harm and their mental health.

65. The investigator spoke to several members of staff at Durham and was concerned about staff attitudes towards the ACCT process, including staff not taking it seriously enough. One member of staff that said that they rarely opened ACCT procedures because most prisoners who expressed thoughts of suicide or self-harm were manipulative.

66. The mental health nurse and SO A did not appropriately assess Mr Storr’s individual level of risk, details of which were contained in the DPER, SASH form, prison record, and clinical record. The nurse relied almost entirely on what Mr Storr told her. A nurse did not review relevant documents, including the SASH form, and was not able to see the ACCT document as SO A had kept it so that he could

complete the initial parts of it. The mental health nurse and the other nurse did not have access to the DPER.

67. When the nurse discussed Mr Storr with the mental health nurse, she said that the mental health nurse told her that the ACCT had already been opened.

68. Mr Storr's level of risk was not holistically assessed using all of the available evidence and, as a result, we consider that staff underestimated his risk to himself. Observation levels were insufficient and were based on a standard level for new prisoners rather than a personalised risk assessment. The Head of Safety told us that staff who set ACCT observation levels have completed the relevant learning to do so, and so will be aware that there is no 'standard' frequency. He sent out an email to prison staff re-iterating these requirements.

69. Following two deaths in November 2022, the PPO recommended that all staff involved in prisoner risk assessments have access to and consider relevant information, including DPERs and prison records. We also recommended that staff do not rely on a prisoner's presentation alone when assessing suicide and self-harm risks. In July 2023, the prison told us that prison staff and healthcare staff had access to relevant information necessary for risk assessment. We were also informed that prison staff underwent risk, triggers and protective factors training with the National Training Team. Healthcare staff continued to access ACCT training.

70. The Mental Health Team Manager confirmed in July 2024 that work was ongoing to ensure that mental health nurses based in reception had access to DPERs. However, at the time of writing, only one mental health nurse out of 12, had access to the appropriate account. The Head of Healthcare stated that work was undertaken at the end of 2023 to ensure healthcare staff had access to DPERs. She said that she was continuing to work with the prison regarding access for new healthcare staff. Since Mr Storr's death, the Head of Healthcare has also asked that DPERs are printed out in the interim to ensure staff have access to them.

71. It is deeply troubling that we have raised these concerns repeatedly with little sign of improvement, particularly in light of previous assurances that our concerns had been addressed. The clinical reviewer shares our concerns. We therefore make the following recommendation:

The Prison Group Director and NHS Commissioner should ensure that reception staff have access to, review and appropriately consider all relevant information when assessing a prisoner's risk to themselves.

The Prison Group Director should undertake a review of the ACCT quality assurance process to satisfy themselves that systemic issues are identified, and suitable remedial actions taken in response.

72. We are concerned, however, that issues around information sharing in reception, and particularly healthcare staff access to DPERs, is an issue that we identify in too many cases. HMPPS has agreed that this issue requires focus and we will be meeting HMPPS and NHS England colleagues to discuss.

ACCT management

73. CCTV showed that the ACCT checks signed by a SO B at 6.30pm, 7.27pm, and 8.27pm, were not completed. It appears that he falsely signed these ACCT checks, and the supervisor check, as complete after Mr Storr's death.

74. In interview, SO B stated that he could not recall completing these checks or recording them in the ACCT document. He said that he may have incorrectly recorded checks on another prisoner in Mr Storr's ACCT document. However, he also told us that he could not recall doing any ACCT checks on the wing. We are unconvinced by his version of events, particularly in light of Officer A's account that he was sure there were no checks logged at those times when he found the ACCT document at 10.55pm. He submitted an intelligence report about this at the time.

75. We referred the matter to the local police, who decided not to investigate further. The Head of Safer Custody at the time of Mr Storr's death was aware that ACCT checks had been falsified by SO B and confirmed that a managerial enquiry was commissioned. The SO was on long-term sick leave at the time of writing this report and, as such, the enquiry has not been completed. We trust that Durham will deal with this matter appropriately. During interview, the Head said that she did not think that falsification of ACCT checks was common at Durham. We consider this conclusion can only be reached following a robust analysis of evidence. We make the following recommendation:

The Governor should introduce a robust audit process to check the accuracy of recorded ACCT checks against CCTV to assure himself that there is not a systemic issue with false entries.

76. During interviews with staff, it became clear that they regularly put ACCT documents into a prisoner's wing file, rather than the white ACCT folder. Staff interviewed did not think that this meant ACCTs were missed because wing staff should open the wing file to review the CSRA and vulnerabilities assessment and so should see the ACCT document. In Mr Storr's case this did not happen. However, Durham has changed the process to ensure that ACCTs are placed in the separate white folder and cannot be so easily missed.

77. A senior manager told us that the reception supervising officer should also inform the first night centre when an ACCT is opened. He said that this process was in place at the time of Mr Storr's death. Our interviews concluded that this process was not known about or implemented by reception staff; certainly, SO A did not tell staff on the first night centre that Mr Storr was on an open ACCT.

The Governor should ensure that reception supervising officers understand their responsibilities to inform first night centre staff if a prisoner is on an open ACCT and introduce a quality assurance process to satisfy himself the process is embedded.

Reception

78. Reception is a busy area of the prison, with 23 new prisoners arriving on 15 March 2024 and 21 on 16 March 2024. SO A told us that he could not ensure that all

prisoners went through the correct process and that mistakes happened due to time constraints.

79. SO A and a nurse stated that relationships between healthcare staff and prison staff could be difficult, with an 'us versus them' mentality. This, combined with a busy reception department, sometimes did not promote collaborative working. Some healthcare staff did not seem confident in challenging prison staff and those who said they would be confident were not sure they would be listened to. The Head of Healthcare assured us that she is working with the prison to ensure a more collaborative way of working. Reception hours have been extended to try to reduce the pressure on staff and she said relationships have improved between officers and nurses in reception, with a clearer understanding of roles and responsibilities evidenced across teams. As this issue appears to be improving, we make no recommendation.

Clinical Care

80. The clinical reviewer concluded that the care Mr Storr received was of a moderate standard and partially equivalent to that which he could have received in the community. This was partly based on issues already discussed in assessing Mr Storr's risk to himself but she also identified several other issues which the Head of Healthcare will wish to address, one of which is detailed below.

Head of Healthcare to note

Medicine in possession risk assessment (MIPRA)

81. The nurse incorrectly input information into the MIPRA during her assessment with Mr Storr, including that he was not subject to ACCT procedures. This resulted in an incorrect MIPRA outcome. The nurse did not check whether she had answered questions correctly but did override the assessment and assessed Mr Storr as not suitable to have his medication in his possession based on his presentation.

61. However, this decision was reversed. This would have resulted in Mr Storr, who posed a risk to himself, being provided medication to hold in his cell. During interview, a colleague recognised her error in not checking whether Mr Storr was on an open ACCT. In any event, Mr Storr did not receive any medication due to the short amount of time he was at Durham. The Head of Healthcare will wish to ensure staff accurately complete MIPRAs and that they consider all available information if overriding the outcome of a MIPRA.

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Independent Investigations