Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Storey, a prisoner at HMP Northumberland, on 14 June 2024

A report by the Prisons and Probation Ombudsman

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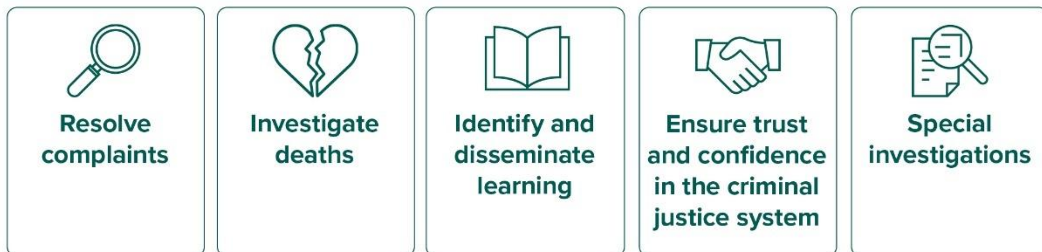
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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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 Storey was found on the floor of his cell with a ligature around his neck at HMP Northumberland on 14 June 2024. Staff and paramedics tried to resuscitate him but were unsuccessful. Mr Storey was 69 years old. I offer my condolences to his family and friends.

Mr Storey had a history of mental health issues and had signs of dementia. Overall, we consider that staff at Northumberland provided a good level of support to him. However, we found that staff stopped suicide and self-harm monitoring for Mr Storey prematurely on 10 June, despite a recent act of self-harm and unresolved memory and health concerns.

The clinical reviewer found that Mr Storey's clinical care at Northumberland was reasonable and was equivalent to that which he could have expected to receive in the community. However, no memory assessment was ever completed for Mr Storey, despite a referral in March.

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 **January 2025**

Contents

Summary 1

The Investigation Process..3

Background Information..4

Key Events..5

Findings 13

Summary

Events

1. On 14 December 2023, Mr Colin Storey was remanded in prison, charged with sexual assault. The next day, he was sentenced to six years in prison. On 17 January 2024, Mr Storey was moved to HMP Northumberland.

2. Mr Storey had a history of mental health issues and alcohol abuse. He also had memory problems and was showing signs of dementia.

3. On 1 March, staff started suicide and self-harm monitoring (known as ACCT) after Mr Storey expressed suicidal thoughts. Staff stopped ACCT monitoring on 18 March when Mr Storey appeared more settled. Later that month, Mr Storey told a prison custody officer (PCO) that after no contact for six years, he had been in contact with his son by letter.

4. On 2 June, staff started ACCT monitoring again after Mr Storey said he had tried to take his life during the night by choking himself on a vape pen. That day, at his ACCT review, Mr Storey told staff that he had been in a dark place because his son had not given him his phone number and did not want contact with him.

5. On 6 June, Mr Storey told a PCO that he had seen and talked to his son and grandson. Mr Storey had no visitors and made no telephone calls while at Northumberland and later told staff he assumed he was psychotic and had been hallucinating.

6. On 8 June, Mr Storey made superficial cuts to his forearms and neck with a razor blade. At the case review that day, Mr Storey told staff he had been struggling due to his memory loss and had felt guilt, paranoia and anxiety.

7. At the next case review on 10 June, Mr Storey said that his memory issues confused and frustrated him and led to him self-harming. Mr Storey also said he thought he was psychotic and that he was having problems with his bowels and bladder, which he was embarrassed about. Staff referred him to healthcare. Mr Storey said he had no thoughts of self-harm and did not want to die so staff stopped ACCT monitoring.

8. At around 1.50pm on 14 June, a PCO unlocked Mr Storey's cell. He did not check on him and then carried on unlocking other cells. A few moments later, he heard a prisoner shout and returned to Mr Storey's cell. He saw Mr Storey on the floor of the cell with a ligature around his neck. At 1.54pm, the PCO radioed a medical emergency code, entered the cell and cut the ligature. More prison staff arrived, followed by healthcare staff.

9. Staff and ambulance paramedics tried to resuscitate Mr Storey but were unsuccessful. At 2.41pm, an air ambulance doctor pronounced that Mr Storey had died.

Findings

10. We consider that staff stopped ACCT monitoring prematurely. Mr Storey's issues, with memory, possible psychosis, and his physical health, remained unresolved at the time the ACCT was closed. He had also self-harmed only two days before. When interviewed, the chair of the review seemed unsure whether he had been aware of the most recent self-harm incident and suggested that the 8 June case review record had not been added to the ACCT document. However, it was clearly noted in Mr Storey's prison record so the chair should have been aware.

11. In a previous investigation into a self-inflicted death at Northumberland we found that ACCT procedures had been stopped prematurely, with issues not added to the prisoner's care plan and left unresolved. The Head of Safety told us in July 2023 that staff and managers were being retrained.

12. The PCO who unlocked Mr Storey on the afternoon of 14 June should have checked that Mr Storey was alive and well. Initially he provided an inaccurate statement to the prison saying that he had discovered Mr Storey when he unlocked the cell, but later told the PPO investigator that it was a prisoner who had found him. The prison carried out an internal investigation and held a disciplinary hearing with the PCO (outcome awaited).

13. The clinical reviewer found that the care Mr Storey received at Northumberland was equivalent to that which he could have expected to receive in the community. However, he noted that mental health staff were not always at the ACCT reviews. He also found that no memory assessment was completed for Mr Storey, despite a referral being made in March, and that, given Mr Storey's cognitive function issues, a mental capacity assessment should have been completed when Mr Storey refused to attend a hospital appointment.

Recommendations

- The Head of Healthcare, in conjunction with the mental health team lead, should ensure that there is representation from the mental health team at all ACCT reviews of prisoners on the team's caseload.

- The Head of Healthcare should ensure that there is a robust system in place to confirm that all healthcare-related referrals are actioned and followed up promptly if there is a delay in receiving an appointment.

- The Head of Healthcare, in partnership with the prison GP, should ensure that mental capacity assessments are completed whenever a prisoner with known cognitive functioning issues refuses to attend a hospital appointment.

The Investigation Process

14. HMPPS notified us of Mr Storey's death on 14 June 2024.

15. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact him. Five prisoners contacted the investigator.

16. The investigator visited Northumberland on 27 June and 30 July. He obtained copies of relevant extracts from Mr Storey's prison and medical records, and body worn video camera (BWVC) footage. He also obtained the HMPPS Early Learning Review, and Ambulance Service records.

17. The investigator interviewed five members of staff and five prisoners at Northumberland on 27 June and 30 July.

18. NHS England commissioned a clinical reviewer to review Mr Storey's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with three members of healthcare staff in August and September by video call.

19. We informed HM Coroner for Northumberland of the investigation. He provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's office contacted Mr Storey's wife to explain the investigation and to ask if she had any matters she wanted us to consider. We did not receive a response.

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Background Information

HMP Northumberland

21. HMP Northumberland, run by Sodexo Justice Services, is a category C prison which holds male prisoners. Spectrum Community Health CIC provides healthcare services. Healthcare staff are on duty from 7.30am to 7.30pm, Monday to Thursday, and 7.30am to 5.30pm Friday to Sunday.

22. Rethink provides primary mental health services. Tees, Esk, and Wear Valley Mental Health NHS Foundation Trust provides secondary mental health services. Mental health services are available Monday to Friday, from 8.00am to 6.00pm.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Northumberland was in August and September 2022. Inspectors found that safety and respect had improved at the prison since their last inspection in 2017. Inspectors were concerned that the number of self-inflicted deaths at Northumberland was higher than at most comparable prisons. Suicide and self-harm monitoring (ACCT) documents were poorly completed, and prisoners said they did not feel supported. Too many ACCTs were closed without the underlying reasons for self-harm having been addressed.

Independent Monitoring Board

24. 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 31 December 2023, the IMB reported that there had been 463 incidents of self-harm, which was higher than the previous year. There were 549 ACCT documents opened during the year.

Previous deaths at HMP Northumberland

25. Mr Storey was the twenty first prisoner to die at Northumberland since June 2021. Of the previous deaths, five were self-inflicted, 13 were from natural causes, and two were drug related. We have previously made a recommendation about ACCT management at the prison.

Assessment, Care in Custody and Teamwork (ACCT)

26. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

27. On 14 December 2023, Mr Colin Storey was remanded in prison, charged with sexual assault, and sent to HMP Durham. He had been in prison before but not for a very long time.

28. On 15 December, Mr Storey was convicted and sentenced to six years.

29. Mr Storey had a history of alcohol abuse and mental health issues. He also had memory issues.

HMP Northumberland

30. On 17 January 2024, Mr Storey was moved to HMP Northumberland.

31. Mr Storey told reception staff he had no thoughts of suicide or self-harm. The reception nurse referred him to the primary mental health team.

32. On 23 February, a prison custody officer (PCO) saw Mr Storey for a key work session. Mr Storey told the PCO he felt settled and had no issues with drugs or bullying.

33. On 29 February, a counsellor tried to assess Mr Storey but was unable to as Mr Storey was too confused. The counsellor referred him to the secondary mental health team for assessment.

First ACCT: 1 to 18 March

34. On 1 March, staff started suicide and self-harm prevention procedures (known as ACCT) for Mr Storey after prisoners reported that he had been saying goodbye to them as he was planning to end his life. When staff spoke to Mr Storey, he said he was very depressed and had thoughts of ending his life.

35. On 2 March, a senior prison custody officer (SPCO) chaired the first ACCT review. Healthcare staff did not attend as they were unavailable (it was a Saturday, so fewer staff were on duty). The SPCO noted that Mr Storey said he had felt quite low but now felt okay. He said he had a history of self-harming in the community but had no intention of self-harming. Mr Storey said he had friends in the community for support and could contact them by phone (though he made no calls while at Northumberland). He intended to work to keep himself busy. The SPCO noted that Mr Storey was told about the support available, and a Samaritans phone number was placed on the back of his cell door. The case review team set observations at two in the morning, afternoon, and evening, and five at night.

36. On 4 March, a SPCO chaired the second ACCT review. A nurse from the mental health team attended. The SPCO noted that Mr Storey said he had been feeling confused and forgetful. He mentioned being told he was misusing his cell bell but could not remember doing so. He had difficulty remembering recent events but could recall past events and believed he had signs of dementia. Mr Storey said he was struggling with poor mental health and being in prison and was diagnosed with psychosis around 30 years ago. He planned to appeal his sentence. He had no

thoughts of suicide or self-harm. The review team agreed to keep the ACCT open but reduced observations to two in the morning, afternoon, and evening, and three at night.

37. On 5 March, prison staff raised concerns with healthcare staff about Mr Storey's memory issues. A nurse recorded that a social care needs review and a GP appointment had been booked for him.

38. The same day, a mental health nurse conducted a mental health assessment for Mr Storey. She noted he was unkempt and appeared depressed. Mr Storey told her that he had experienced psychosis in the past and had been detained under the Mental Health Act several times. He had been given a possible diagnosis of Korsakoff syndrome (a form of dementia caused by excessive alcohol use). The mental health nurse recorded that Mr Storey would be allocated a mental health key worker, would have a cognitive assessment and his key worker would liaise with the Memory Clinic.

39. On 8 March, a nurse saw Mr Storey to take a blood sample (as a GP had requested blood tests in light of Mr Storey's memory issues). She noted Mr Storey's cell was in a reasonable state, but he appeared unkempt, frail and malnourished. She noted Mr Storey was complaining of increased memory loss and was struggling with his sense of direction as sometimes he was not able to get back to his cell. Mr Storey said that he struggled to remember what he had done in the morning or the day before but was able to recall historical events. Mr Storey was using a note pad to write down his morning routine (get up, get dressed, wash face, shower, breakfast etc) and he said he was unable to cope without following this list. Mr Storey said he experienced "dark days" but was unable to elaborate. He said his family had disowned him due to his offences, and that prior to prison he was staying with different friends on their couches.

40. The nurse noted that an SPCO had discussed a move to HB14 (a wing for over 55s) so Mr Storey could have a carer present throughout the day and more support on the wing. The nurse booked Mr Storey in for a weight and welfare check to ensure he was safe and managing with his daily activities.

41. On 10 March, a PCO saw Mr Storey for a key work session. The PCO noted that Mr Storey felt better than a few days ago when he had not been sleeping well. He assured the PCO he had no thoughts of self-harm. Mr Storey said he had no family or friends in the community for support and that his community carer had taken all his money. The PCO noted that Mr Storey was having his food delivered to his cell but was willing to start collecting his own meals again. He had no issues with debt or bullying.

42. On 11 March, a SPCO chaired the third ACCT review. He noted that the mental health team had been invited but were unavailable. He recorded that Mr Storey said he felt safer when locked in his cell, not because he was nervous but because he got confused and would sometimes go to the wrong cell. They discussed a move to HB14, which was calm, settled and more of a community. The SPCO reduced observations to one in the morning, afternoon and evening, and three during the night.

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43. On 15 March, a GP saw Mr Storey. He told her he had been experiencing memory loss for about a year. He said he struggled with sleep and kept his TV on as his mental health issues were worse in the dark, and he felt panic during the night. He described having seizures, but the GP assessed these were panic attacks. She reviewed Mr Storey's blood test results which were abnormal, so she made a fast-track hospital referral.

44. On 17 March, a PCO saw Mr Storey for a key work session. Mr Storey had been identified as a priority for key work. The PCO noted Mr Storey told her he "hasn't got the balls to kill himself", but due to his memory loss he felt down at times. She said that Mr Storey would move to HB14 when a space became available. Mr Storey mentioned a legal visit that morning (he wanted to appeal his sentence), and said he did not want a "deal" as he wanted the truth to come out.

45. On 18 March, a SPCO chaired the fourth ACCT review. A nurse attended from the healthcare team. The SPCO noted Mr Storey said he had turned a corner and was settled on the unit, with a lot of support from other prisoners. Mr Storey said he had no thoughts of self-harm. The case review team closed the ACCT.

March to May

46. On 20 March, healthcare staff referred Mr Storey to the Memory Clinic.

47. On 24 March, a PCO saw Mr Storey for a key work session. She noted Mr Storey told her he felt a lot better and was looking forward to moving to HB14. Mr Storey said he had decided to keep to himself and remain in or near his cell as he got disorientated if he wandered around the unit. Mr Storey said he felt like he was getting used to being in prison. The PCO noted Mr Storey told her he had no thoughts of self-harm and "does not have the balls to do it".

48. At his post-closure review on 25 March, Mr Storey said he was still confused and anxious about leaving his cell but he felt supported and would speak to staff if he felt unsafe or vulnerable.

49. On 29 March, Mr Storey was moved to HB14.

50. On 31 March, a PCO saw Mr Storey for a key work session. Mr Storey told the PCO he was happy to be on HB14 and felt much safer, as it was not as rowdy. He said he had no thoughts of self-harm. He mentioned having mental health issues, suspected he had dementia, experienced memory loss, and got disorientated.

51. Mr Storey told the PCO he had spent a considerable amount of time in secure hospitals and was an alcoholic. He said he had lost over three stone in weight over the previous 12 months but was eating better since being at Northumberland. The PCO noted Mr Storey used scraps of paper to record information and dates so he could remember things. Mr Storey told the PCO that after six years with no contact with his son, he was now in contact by letter.

52. On 17 April, a healthcare administrator followed up the referral to the Memory Clinic.

53. On 25 April, a PCO saw Mr Storey for a key worker session. Mr Storey told the PCO he was still happy with the progress made with the contact with his son. Mr Storey said his son was the only person he was in contact with outside prison. He said he felt safe on the unit as it was quieter and calmer, and was happy keeping himself to himself, spending most of his time unlocked in his cell reading or watching TV.

54. On 12 April, Mr Storey refused to attend a hospital appointment for a CT scan (following the GP’s referral). He signed a disclaimer and told healthcare staff he no longer needed the appointment. He later did attend for a CT scan on 18 April and was then given an appointment for an endoscopy.

55. On the morning of 1 May, Mr Storey was being taken to hospital for his endoscopy, but the taxi collided with a prison vehicle gate. A nurse attended and checked Mr Storey, with no injuries reported. Mr Storey did not attend the appointment and was returned to prison.

56. On 22 May, Mr Storey declined to attend hospital appointment for an endoscopy. He signed a disclaimer.

Second ACCT: 2 to 10 June

57. On 2 June, at around 5.45am, a SPCO responded to Mr Storey’s cell bell. When he got to the cell, Mr Storey said he had tried to take his life during the night by choking himself on a vape pen but had decided he wanted to get help. He passed the SPCO a note which said he was sick of letting people down, that he had received good support from the prison and taking his life was a coward’s way out. Mr Storey said he did not want to disappoint his family and prison staff and had been speaking to his friend and carer on the wing who was also a Listener (a prisoner trained by the Samaritans to support other prisoners in crisis). The SPCO started ACCT procedures and set observations at one an hour. He noted that Mr Storey said that he was not currently thinking of harming himself but that his mental health was bad, and he needed help.

58. Later that day, during his ACCT assessment, Mr Storey said he had done it out of guilt and due to his failing memory and that he wanted to work with the mental health team to improve the way he thought about things.

59. A SPCO chaired the first ACCT review that afternoon. Healthcare staff were unable to attend due to dealing with medical emergencies in the prison. The SPCO noted Mr Storey said he was in a dark place and it was due to his son not giving him his phone number and not wanting contact with him. Mr Storey told the SPCO he had thought about taking his life, but had a card written out with "coward" written on it and looked at it as he tried to choke himself, which stopped him.

60. Mr Storey said he had little support outside of prison and had one person on the unit who related well to him, the Listener. Mr Storey said he had no thoughts of self-harm. The SPCO noted Mr Storey had been referred to the mental health team and would see them the following day at a scheduled ACCT review. The case review team set observations at one an hour.

61. On 3 June, a SPCO chaired the second ACCT review. A member of the mental health team was present. The SPCO noted Mr Storey was in a better frame of mind and said he felt things were improving. Mr Storey told the care review team about his issues with short term memory loss and getting confused and was open to support. Mr Storey was worried about his son seeing him confused if he visited. The SPCO noted that Mr Storey was due to have a healthcare assessment which should help him with his needs. Mr Storey said he had no thoughts of self-harm. The case review team reduced observations to one in the morning, afternoon, and evening, and three at night.

62. On 5 June, prison staff radioed a code blue medical emergency (indicating a prisoner who is unconscious, not breathing or fitting) after finding Mr Storey who appeared to be having a seizure. A nurse arrived at Mr Storey's cell and found him lying on his back, his whole body appeared to tremor, and his eyes were rolling around in all directions. The nurse took Mr Storey's physical observations which were satisfactory. She said Mr Storey became more alert and said that he went to his sink and felt like his legs gave way which resulted in him falling. Mr Storey complained of pain to the back of his head where he fell and said that he banged it against the wall. The nurse noted that throughout the consultation, Mr Storey appeared vague, confused, and disorientated. An ambulance took Mr Storey to hospital. He was discharged the same day.

63. Following the incident, a nurse reviewed Mr Storey's health records and found that he had been refusing assessments at hospital and that a memory assessment had not been completed. She raised her concerns with a GP and the Head of Healthcare.

64. On 6 June, a PCO saw Mr Storey for a key work session. He noted that it was obvious that Mr Storey needed some help. The PCO said Mr Storey was unable to tell him why he had been taken to hospital, and just said he "felt unwell". The PCO said Mr Storey acknowledged that he was struggling to remember day to day information, and to come out of his cell.

65. The PCO said Mr Storey told him he saw and talked to his son and grandson on HB14. (Mr Storey had no visits from them and he made no telephone calls.) Mr Storey told the PCO that he wanted to get out of his cell and did not really want to self-harm or take his life. Mr Storey said he liked being on HB14 and felt safe, but was very anxious around others, and had contact with only two other prisoners on his landing.

66. The PCO noted he suggested getting some fresh air, Mr Storey agreed, and they left Mr Storey's cell and went to the exercise yard. The Listener asked to go out on the exercise yard with Mr Storey and the PCO agreed. The PCO referred Mr Storey to the mental health team.

67. On 7 June, a paramedic at Northumberland saw Mr Storey for a welfare check following his return from hospital. He noted Mr Storey was feeling intermittently low in mood and anxious and said that fellow prisoners had questioned some of his behaviour as being out of character for him. Mr Storey said he had increased bowel movements and perceived urinary hesitancy but felt otherwise physically well. The paramedic noted Mr Storey was independently mobile, was eating and drinking well and appeared well with no overt signs of injury or distress.

68. That day, a GP reviewed Mr Storey's medical records, and following a CT scan Mr Storey had at hospital on 5 June, she made a referral to a neurologist. The GP also requested advice on Mr Storey's future care needs.

69. On the morning of 8 June, Mr Storey made superficial cuts to his forearms and neck with a razorblade. He told healthcare staff he was experiencing paranoia and anxiety.

70. At 2.00pm, a SPCO chaired an ACCT review. Mr Storey asked the Listener to attend for support. A healthcare support worker also joined the review, and encouraged Mr Storey to open up. Mr Storey said he made the cuts to get attention but did not want to do it and did not want to take his life. The case review team decided to keep the observations at the same level.

71. On 10 June, a SPCO chaired the fourth ACCT review. A staff member from the mental health team attended and the Listener attended again to support Mr Storey. Mr Storey said his memory issues confused and frustrated him and led to him self-harming. The SPCO noted they discussed different ways of coping when he was having problems. Mr Storey said he used to make notes about his thoughts and feelings, but he sometimes found it hard to make sense of the notes which added to his frustration.

72. Mr Storey said he thought he was psychotic as he had been hallucinating and seeing his grandson. He said he struggled with his bladder and bowel and was embarrassed by this, which added to his frustration. Mr Storey was referred to healthcare regarding his bowel and bladder. The SPCO noted that the Listener was happy to support Mr Storey at any time. Mr Storey told the case review team he had no thoughts of self-harm and did not want to die. The review team agreed to close the ACCT.

Post-closure

73. On the same day the ACCT was closed, staff recorded on the post-closure monitoring form that Mr Storey seemed very positive and keen to move on. They noted he was embarrassed about self-harming and said he wanted to initiate contact with his son and grandson.

74. On 11 June, staff recorded on the post-closure monitoring form that they had had a chat with Mr Storey who said he was feeling fine and was sorry for any trouble he had caused.

75. The same day, healthcare staff discussed Mr Storey at a primary healthcare meeting. Staff noted that a Montreal Cognitive Assessment (a brief assessment that tests for mild cognitive impairment) had been completed and no issues identified. They also noted that Mr Storey had been referred for an MRI scan and a memory assessment.

76. The next day, staff recorded on the post-closure monitoring form that they had had a chat with Mr Storey, and he said he was feeling much better and had been out of his cell most of the day.

77. On 13 June, staff noted that Mr Storey had taken the opportunity to assist the gardener on HB14 and had spent two hours in the sun and was very appreciative.

Events of 14 June

78. On the morning of 14 June, HB14 had been locked down due to staff shortages. A PCO unlocked Mr Storey and other prisoners to collect their lunch. A prisoner told us that he saw Mr Storey at lunchtime and asked him if he was alright. He said Mr Storey confirmed he was, but the prisoner thought Mr Storey looked anxious and a bit unwell.

79. At around 12.15pm, staff locked prisoners back in their cells. (There is no CCTV on HB14 so approximate timings have been taken from statements.)

80. At around 1.50pm, a PCO unlocked Mr Storey's cell and then went to open the cell opposite. The PCO did not check on Mr Storey. He told us that a prisoner started talking to him, so he walked down the landing, got as far as the unit office, and then heard a prisoner shout. He said he ran back to Mr Storey's cell, looked through the observation panel, and saw Mr Storey on the floor with a ligature around his neck, which was tied to the bed. At 1.54pm, the PCO radioed a Code Blue. (The control room called for an ambulance at 1.56pm.)

81. The PCO told us he immediately entered the cell and cut the ligature. He said he felt for a pulse but could not find one. A second PCO arrived followed by another PCO, who then left to fetch a defibrillator.

82. A nurse arrived, followed seconds later by another nurse. One nurse started CPR and the other nurse attached the defibrillator.

83. A SPCO arrived. Due to the limited space, a nurse asked a PCO and the SPCO to help her move Mr Storey onto the landing. Once on the landing, more healthcare and prison staff arrived.

84. At 2.04pm, prison staff activated their body-worn video camera (BWVC). BWVC footage shows healthcare staff continued to manage Mr Storey's airways, while a PCO, physical education instructor (PEI) and healthcare staff took turns doing chest compressions.

85. At 2.22pm, ambulance paramedics arrived. They continued CPR. At 2.30pm, an air ambulance crew arrived accompanied by a doctor. At 2.32pm, paramedics attached a chest compression machine to Mr Storey. However, resuscitation attempts were unsuccessful and at 2.41pm, the air ambulance doctor pronounced that Mr Storey had died.

Contact with Mr Storey's family

86. On 17 June, the prison appointed a PCO and operational support officer (OSO) as family liaison officers.

87. Mr Storey had not supplied the prison with contact details for his next of kin. That day, the police identified Mr Storey's wife as the next of kin and informed her of Mr Storey's death.

88. On 17 June, a family liaison officer spoke with Mr Storey's wife over the telephone and offered her condolences. The family liaison officers kept in contact with Mr Storey's wife over the following days, offering support and advice.

89. The prison contributed to the costs of Mr Storey's funeral in line with national policy.

Support for prisoners and staff

90. After Mr Storey's death, the Director 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.

91. The prison posted notices informing other prisoners of Mr Storey'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 Storey's death, and Listeners were deployed on HB14 to support prisoners if needed. The Listener said he had been supported well and that staff had recognised the impact of Mr Storey's death on him and others.

Post-mortem report

92. The post-mortem report concluded that Mr Storey died by hanging. Toxicology tests showed no illicit substances in his system.

Findings

Management of Mr Storey's risk of suicide and self-harm

93. Prison Service Instruction (PSI) 64/2011, Managing prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.

94. Mr Storey was monitored using ACCT from 1 to 18 March and from 2 to 10 June. The last ACCT was closed four days before Mr Storey died. We consider that it was closed prematurely. Not only was the decision to close the ACCT made only two days after Mr Storey had self-harmed by cutting on 8 June, but the issues that had led him to self-harm remained unresolved.

95. The SPCO who chaired the review on 10 June was unable to say at interview whether he was aware that Mr Storey had self-harmed on 8 June. He suggested that the case review form was not in the ACCT document and pointed out that it had not been noted on the front cover. However, it was clearly noted in Mr Storey's prison record so the SPCO should have been aware.

96. At the case review on 10 June, Mr Storey talked about his frustrations with his failing memory, that he thought he was psychotic, and he was concerned about bowel and bladder issues. The SPCO noted that Mr Storey had been referred to healthcare for his bowel and bladder, but it appears the referral had not been actioned at the time the ACCT was closed. More importantly, no actions were recorded in respect of diagnosing and supporting Mr Storey with his memory issues or with his suspected psychosis. We would have expected the ACCT care plan to have been updated with appropriate actions and for the ACCT to have remained open until these had been completed. We were unable to interview the mental health nurse who attended the case review as he no longer works at Northumberland, and we were unable to make contact with him.

97. We found in a previous investigation into a self-inflicted death at Northumberland that staff had closed the ACCT prematurely, with issues left unresolved and not added to the care plan. We were told in July 2023 that all ACCT case managers had been trained and had been reminded that care plans should be managed in line with the prisoner's outstanding risk and actions updated at each review.

98. When interviewed, the Head of Safety at Northumberland accepted that the ACCT had been closed prematurely. She said that retraining on ACCT was about to be delivered to staff at Northumberland. In light of this, we make no recommendation.

Delay in discovering Mr Storey

99. In his initial statement to the prison (which was then passed to the police), the PCO said that when he unlocked Mr Storey's cell on 14 June, he pushed open the door, felt some resistance, and then saw that Mr Storey was on the floor with a ligature around his neck.

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100. During his interview with the PPO investigator, the PCO admitted that the statement he had provided was inaccurate. He said that he had walked away after opening Mr Storey's cell, and it was a prisoner who alerted him. Prisoners confirmed the PCO's updated version of events.

101. Officers should check on prisoners' welfare when unlocking them. The PCO who unlocked Mr Storey's cell on 14 June failed to do so, and this caused a short delay in Mr Storey being discovered and the Code Blue being called. As there was no CCTV on HB14, we were unable to determine the exact length of the delay. Prisoners on Mr Storey's spur, who were let out of their cells around the same time, gave different accounts of how long it was between being unlocked and a Code Blue being radioed by the PCO. Their estimates ranged from just a second to less than five minutes.

102. We cannot say that the delay made any difference to the outcome for Mr Storey, but we do know that in a medical emergency any delay in a person receiving medical treatment can be detrimental.

103. Northumberland commissioned an internal investigation into the PCO's actions, and as a result, he faced a disciplinary hearing. (We have not yet been informed of the outcome.)

Clinical care

104. The clinical reviewer concluded that the care Mr Storey received at Northumberland was reasonable and equivalent to that which he could have expected to receive in the community. He found that the mental healthcare was reasonable, though he noted that as Mr Storey was showing signs of dementia, a memory assessment would have informed the mental health treatment pathway. He also found that mental health staff were absent from some of the ACCT reviews. We are aware that one was on a weekend, when mental health staff are not on duty, but they should have been at the weekday reviews as Mr Storey was on their caseload. We recommend:

The Head of Healthcare, in conjunction with the mental health team lead, should ensure that there is representation from the mental health team at all ACCT reviews of prisoners on the team's caseload.

105. The clinical reviewer noted that despite Mr Storey having been referred for a memory assessment in March 2024, no memory assessment was ever completed during his time at Northumberland. He said a more vigilant approach should have been taken to ensure the referral was followed up and actioned. The clinical reviewer also noted that, given Mr Storey's issues with memory and confusion, a mental capacity assessment should have been completed when Mr Storey refused to attend a hospital appointment. We recommend:

The Head of Healthcare should ensure that there is a robust system in place to confirm that all healthcare-related referrals are actioned and followed up promptly if there is a delay in receiving an appointment.

The Head of Healthcare, in partnership with the prison GP, should ensure that mental capacity assessments are completed whenever a prisoner with known cognitive functioning issues refuses to attend a hospital appointment.

Good practice

106. Overall, we consider that staff provided a good level of support to Mr Storey, which he appreciated. He was appropriately located on HB14, a unit for prisoners over 55, where a strong sense of community had been fostered, where staff and prisoners encouraged Mr Storey to leave his cell, engage with others and in purposeful activity such as gardening. He received assistance from a personal carer, who did his best to support Mr Storey, including helping him to write letters to his son. We were impressed by the processes put in place by Northumberland and the genuine care and support shown by staff and prisoners.

Inquest

107. At the inquest, held from 13 to 16 April 2026, the jury concluded that Mr Storey died by suicide.

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