

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Terence Storey a prisoner at HMP Liverpool on 17 September 2017

A report by the Prisons and Probation Ombudsman

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Storey was found hanged in his cell at HMP Liverpool on 17 September 2017. He was 52 years old. I offer my condolences to Mr Storey's family and friends.

Mr Storey's risk was extremely challenging for staff to manage. Given the nature of Mr Storey's mental health issues and the challenges of managing personality disorder in a prison setting, it is debatable whether Liverpool was the right location for him. In the circumstances I am satisfied that staff at Liverpool sought to provide him with a high level of support through the suicide and self-harm prevention procedures.

However, I do have some concerns about the overall management of those procedures. In particular, when staff became aware that Mr Storey had items he could use to harm himself, they relied on his presentation and reassurances that he had no thoughts of suicide or self-harm, instead of reviewing whether his level of risk had increased. I am also concerned that most observations for Mr Storey were recorded at regular intervals that he would have been able to predict, and that there were shortcomings in the emergency response.

This office has made recommendations about these issues in several previous investigations into deaths at Liverpool. The Prison Group Director for the North-West should assure himself that realistic action is now taken to address the recommendations in this report.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

June 2017

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Summary

Events

1. In August 1996, Mr Storey was sent to HMP Liverpool after being charged with murder. In October 1997, he was sentenced to life imprisonment with a minimum term of 17 years. During his sentence, Mr Storey was located in a number of prisons including HMP Grendon, HMP Bullingdon, HMP Coldingley and HMP Wandsworth.
2. Mr Storey had been diagnosed with personality disorders and depression, had a history of self-harm, and had made numerous suicide attempts in prison. At various times during his sentence, staff managed Mr Storey under suicide and self-harm prevention procedures (known as ACCT) and the mental health team provided ongoing support.
3. In August 2016, the Parole Board did not support Mr Storey's request to transfer to open conditions. From October to December 2016, Mr Storey made three suicide attempts using a ligature and by trying to set fire to himself. On 28 December 2016, he was transferred to a medium secure mental hospital under the Mental Health Act.
4. On 19 May 2017, Mr Storey was discharged from the hospital and transferred to HMP Liverpool. Staff noted Mr Storey's history of suicide attempts and self-harm and that he had been diagnosed with severe depression and two personality disorders. They started ACCT procedures in reception and Mr Storey was placed under constant observation in the prison's inpatient unit.
5. On 8 June, staff reduced the frequency of Mr Storey's observations from constant to six an hour during the day with constant observation at night. On 12 June and 23 June, Mr Storey attempted suicide using ligatures. Following each incident, staff provided emergency medical treatment and held an ACCT case review where they assessed Mr Storey's risk as high and continued to monitor him under constant observation. From July until September, staff assessed Mr Storey's level of risk as high or raised and gradually reduced the frequency of his observations.
6. On 21 August, Mr Storey punched an officer through the hatch of his cell. Staff held an ACCT case review, assessed his risk as high, and increased the frequency of his observations. Staff disciplined Mr Storey and referred the assault to the police.
7. On 17 September, Mr Storey gave a nurse a blade. The nurse did not hold an ACCT case review and there are no further notes about this in Mr Storey's records.
8. At 4.20pm, a nurse spoke to Mr Storey through the hatch of his cell. Mr Storey gave the nurse some ligatures he had made from torn bed sheets but told her he did not intend to harm himself. The nurse did not hold an ACCT case review, or change his assessed level of risk or frequency of observations. At 5.00pm, a healthcare assistant noted that Mr Storey was standing at his hatch and that he said he was fine.

9. At 5.50pm, the nurse went back to Mr Storey's cell to give him his medication. She looked through the hatch and saw Mr Storey hanging. She asked another nurse to press the general alarm and told an officer to call an emergency code. The officer asked for assistance over the radio but did not call an emergency code. Nursing staff waited for an officer to arrive before going into Mr Storey's cell to give emergency medical treatment. After listening to staff over the radio, an officer in the control room decided to call an ambulance at 5.56pm. Shortly afterwards, a governor called a code blue emergency (indicating that a prisoner is unconscious or having difficulty breathing). Staff continued trying to resuscitate Mr Storey until paramedics arrived at 6.30pm. At 6.44pm, paramedics took Mr Storey to hospital but recorded that he died at 6.56pm.

Findings

10. The investigation found that Mr Storey had a number of very clear risk factors for suicide and self-harm but that staff relied on his presentation in assessing his level of risk and setting the frequency of observations. Staff did not schedule a case review to reassess his level of risk when he gave staff items that he could use to harm himself. ACCT observations were often recorded at predictable intervals.
11. We consider that healthcare staff should have gone into Mr Storey's cell to administer basic first aid as soon as they discovered that he had hanged himself. Nursing staff waited outside Mr Storey's cell for an officer to arrive and said they would not go into a cell without an officer present under any circumstances.
12. Staff did not call an emergency code as soon as they found Mr Storey in his cell. This resulted in a delay of five minutes until the officer in the control room decided to call an ambulance after listening to what was happening over the radio. A governor called an emergency code just after the officer called an ambulance.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including in particular that:
 - staff consider all known risk factors when determining the level of risk of self-harm;
 - staff hold a case review when significant new information about risk becomes known; and
 - ACCT observations are at irregular and unpredictable intervals.
- The Head of Healthcare should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.
- The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the

nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

- The Prison Group Director, North West, should assure himself that realistic action is now taken to address these and previous recommendations.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator visited HMP Liverpool on 20 September 2017. She obtained copies of relevant extracts from Mr Storey's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Storey's clinical care at the prison.
16. The investigator and the clinical reviewer interviewed 13 members of staff and three prisoners at HMP Liverpool on 8 and 9 November. The investigator conducted phone interviews with a further member of staff on 21 November and two members of staff on 23 January 2018. She also interviewed a prisoner by phone on 4 January 2018.
17. We informed HM Coroner for Liverpool of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Storey's sister's legal representation to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Storey's sister asked for a more detailed chronology of what happened before and after her brother was found, and whether he should have been checked more often by prison staff.
19. Mr Storey's sister received a copy of the initial report. Her legal representation raised a number of issues that have been addressed through separate correspondence. One factual inaccuracy was raised and the report had been amended accordingly.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Liverpool

21. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 1400 adult men. Lancashire Care NHS Foundation Trust provides health care services at the prison.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Liverpool by HM Inspectorate of Prisons (HMIP) was conducted in September 2017. Inspectors found that only 22 of the 89 recommendations made in the 2015 inspection had been achieved and that 'the bare statistics of the failure to respond to previous inspection findings do not adequately describe the abject failure of HMP Liverpool to offer a safe, decent and purposeful environment'.
23. Inspectors found that violence had increased significantly and drug availability and use were high. Levels of self-harm were increasing and the overall strategic response to reducing self-harm was underdeveloped. The prison had anywhere between 70 and 90 men on an ACCT at any one time. Inspectors found that ACCT documentation was variable and required improvement. Triggers were incorrectly recorded, caremaps lacked detail and some observational entries were poor.
24. Inpatients had a very poor regime and were offered little therapeutic activity. Mental health service provision had deteriorated. One registered mental health nurse was assigned each day to attend all ACCT case reviews which inspectors found to be disproportionate and to undermine the capacity of the mental health team which was stretched to unacceptable levels. It was recommended that a more proportionate and risk based approach be developed by the prison.
25. In February 2018, the Justice Select Committee released a report finding that HM Prison and Probation Service (HMPPS) had failed to respond properly to HMIP recommendations to improve safety, conditions and other outcomes for prisoners.

Independent Monitoring Board

26. 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 January to December 2016, the IMB stated that there was a gap in services at Liverpool for personality disorders and serious mental health issues.

Previous deaths at HMP Liverpool

27. Mr Storey was the fifth of six self-inflicted deaths since 2016. In all four previous deaths, we identified deficiencies with the operation of suicide and self-harm prevention procedures. In three previous investigations we identified issues in assessing risk and setting observations that reflect the level of risk. In one of those investigations we identified that ACCT observations were not carried out at unpredictable intervals. In another, we found there was a failure to call an emergency code, which resulted in a slight delay in calling the ambulance.

Assessment, Care in Custody and Teamwork

28. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.
29. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. 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 actions of the caremap have been completed.
30. 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.
31. Governors have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners under the enhanced ACCT case management process. This may include prisoners with a prolonged active suicidal intent which may require constant supervision at times and those who present an extreme risk of harm to self, staff or other prisoners. In such cases, the ACCT case review team must be led by a minimum of a Band 5, Custodial Manager and will involve all relevant disciplines and include more specialists and a higher level of operational management than a typical ACCT case review team. PSI 64/2011 says that the use of an enhanced case management approach will allow staff to respond more effectively to the prisoner's individual needs to help reduce or modify their challenging behaviour.

Key Events

32. On 16 August 1996, Mr Terence Storey was remanded to HMP Liverpool. On 27 October 1997, he was convicted of murder and sentenced to life imprisonment with a minimum term of 17 years.
33. Mr Storey made numerous suicide attempts while in prison using ligatures and by swallowing tablets and glass, starving himself, and attempting to set fire to himself. He told staff on a number of occasions that he deserved to die because he had taken a life and had no reason to live. Mr Storey also had a history of self-harming in prison by cutting himself. During these periods, staff managed Mr Storey's risk of suicide under the ACCT process.
34. Mr Storey received ongoing support from the mental health team during his sentence. In May 2006, he was transferred to the therapeutic community at HMP Grendon (therapeutic communities provide group based therapy to promote positive relationships, personal responsibility and social participation) but was transferred out of Grendon after two months because he was found to have taken opiates. He returned to the therapeutic community at Grendon in September 2006 and eventually engaged and participated in treatment. Towards the end of 2008, Mr Storey's mental state and behaviour began to deteriorate and a doctor prescribed antidepressants for him.
35. In May 2009, Mr Storey seriously assaulted a prisoner during a group session at Grendon and was transferred to HMP Bullingdon where he was managed by the mental health in-reach team. Between 2009 and 2010, Mr Storey was diagnosed with dissociative personality disorder and emotionally unstable personality disorder (EUPD). (Dissociative personality disorder, also known as antisocial personality disorder or sociopathy, is characterised by a long-term pattern of disregard for, or violation of, the rights of others. Lack of conscience is often apparent, as well as a history of crime, legal problems, or impulsive and aggressive behaviour. EUPD is also known as borderline personality disorder and is characterised by episodes of abrupt mood swings, instability in relationships, and poor self-image and identity, often resulting in self-harm and impulsivity.)
36. Mr Storey had a history of substance misuse and successfully completed a methadone reduction programme in September 2011 (methadone reduction is designed to manage withdrawal from heroin). From May 2012, there were no reports of Mr Storey taking drugs in prison. He was regularly reviewed by mental health nurses and psychiatrists and attended weekly psychotherapy sessions at HMP Bullingdon in 2013 and 2014. On 19 December 2014, Mr Storey transferred to HMP Coldingley.

HMP Wandsworth

37. On 6 September 2015, Mr Storey transferred to HMP Wandsworth. In February 2016, a psychiatrist prescribed mirtazapine, an antidepressant.
38. On 16 August 2016, the Parole Board did not support Mr Storey's request to transfer to open conditions because they were worried about his risk to himself and others. They said that a transfer to open conditions was 'unrealistic', and he needed a period of stability and a 'coherent plan' for his future management.

39. On 7 October 2016, Mr Storey barricaded his cell door and ligatured using bedding tied to his bunk bed. Staff performed CPR and Mr Storey was taken to hospital. He was discharged from hospital and transferred back to Wandsworth after 10 days, and staff monitored him under the ACCT process. The mental health in-reach team provided ongoing support and several psychiatrists assessed him.
40. On 2 November and 19 December, Mr Storey put paper and tissues under his clothes and attempted to set fire to himself. Staff continued to monitor him under constant observation. On 28 December, Mr Storey was transferred to the Scott Clinic, a medium secure mental hospital, under section 47 of the Mental Health Act for treatment for his depressive symptoms.

Transfer from secure mental hospital to HMP Liverpool

41. On 19 May 2017, Mr Storey was discharged from hospital and transferred back to prison after psychiatrists concluded that there was no evidence that he was depressed or psychotic and that he no longer required treatment in hospital for a mental disorder. He was transferred to Liverpool.
42. On 3 May, a psychiatrist emailed healthcare staff at Liverpool and said that Mr Storey had been managed in seclusion at the Scott Clinic, was 'regularly hostile and threatening, had smeared faeces' and had tried to store weapons. The doctor noted that Mr Storey would need a gated cell in the inpatient unit at Liverpool. (A gated cell has a clear door so that staff can constantly observe a prisoner. It is specially designed to have minimal ligature points to help prevent prisoners hanging themselves.)

HMP Liverpool

43. When Mr Storey arrived at Liverpool, a prison manager noted in his prison record that the Scott Clinic said that Mr Storey could be manipulative, sometimes hid blades to use to self-harm, and had damaged accommodation a number of times.
44. Nurse A started ACCT procedures for Mr Storey and noted his history of significant self-harm. Mr Storey told Nurse B, a mental health nurse, that he had no current thoughts of self-harm. She recorded that Mr Storey had been diagnosed with various personality disorders and severe depression. Mr Storey was located in a gated cell in the inpatient unit so he could be monitored under constant observation.
45. A psychiatrist prescribed amoxicillin (an antibiotic), codeine (a painkiller), diazepam (used to treat anxiety), lactulose (a laxative), oxcarbazepine (for seizures that were part of Mr Storey's injuries after his suicide attempt at Wandsworth) and sertraline (an antidepressant).
46. Nurse C assessed Mr Storey under the ACCT process. She noted that Mr Storey might use his likeability to manipulate people or situations and that staff should remember the risk he posed to others. Mr Storey told the nurse that he did not have current thoughts of suicide or self-harm and that, although he did not like life, 'this did not mean he did not want to live'. The nurse noted that Mr Storey had been booked in for a mental health assessment the next day.

47. Mr Storey continued to be managed under the ACCT process and was monitored under constant observation. Staff assessed his risk as high or raised and actions noted in his caremap included obtaining his art materials and his TENS machine (a device that stimulates the nerves with electrical impulses), stopping smoking and being considered for vulnerable prisoner status (because he was bullied last time he was at Liverpool because of the high-profile nature of his offence).
48. On 6 June, Mr Storey told an offender manager, that he would take his own life and he had a plan to do so. The offender manager submitted an intelligence report and noted that it was approaching the anniversary of Mr Storey's offence and this often left him feeling extremely low. She told healthcare staff and the Safer Custody team about her concerns and noted them in Mr Storey's prison record. The offender manager asked a probation officer to refer Mr Storey to forensic psychology services. The probation officer referred Mr Storey to North West Forensic Psychology Services.
49. On 7 June, a psychiatrist assessed Mr Storey, who said that he was doing 'reasonably well'. He said that when he was at Wandsworth, the outcome of his parole hearing made things 'more difficult to deal with' and 'triggered negative thinking'. Mr Storey said that he still had thoughts of suicide but did not have any current plans. The psychiatrist noted that he would support a plan to gradually move Mr Storey from the inpatient unit to a normal location in the prison. The next day, following an ACCT case review, staff assessed Mr Storey's risk as raised and reduced the frequency of his observations to six an hour during the day with constant observation at night.
50. On 12 June, Mr Storey moved from the gated cell to a normal cell in the inpatient unit. The next day, Mr Storey attempted suicide by tying two ligatures around his neck. Staff went into Mr Storey's cell, cut off the ligatures, and gave him emergency medical treatment. Prison staff searched Mr Storey and moved him back to the gated cell in the inpatient unit so he could be monitored under constant observation. A nurse noted that Mr Storey was given anti-ligature clothing and bedding. Staff held an ACCT case review the next day, assessed his risk as high, and noted he would remain under constant observation.
51. On 28 June, Mr Storey ligatured using his shoelaces while staff were monitoring him under constant observation. Nurse C removed the ligature and assessed Mr Storey but no treatment was required. Staff continued to monitor Mr Storey under constant observation and assessed his risk as high.
52. On 29 June, Mr Storey told the probation officer and Nurse D that he constantly thought about taking his life and was looking for opportunities to do so. Mr Storey told the probation officer about an incident at the Scott Clinic where he was alleged to have assaulted a nurse. The Head of Residence, told the investigator that they spoke to Mr Storey about transferring him to HMP Wymott, which has a personality disorder treatment programme, after receiving confirmation that his parole hearing was deferred. She said that she wanted to wait until his parole hearing date was confirmed as deferred because Wymott would need this information to consider the transfer. Staff assessed Mr Storey's risk as high and continued to monitor him under constant observation.

53. On 3 July, a psychiatrist assessed Mr Storey in his cell. Mr Storey said that he would not self-harm again and wanted to move from the inpatient unit to the main prison so he could progress with his parole requirements. From 3 July to 14 July, staff spoke to Mr Storey during ACCT case reviews about gradually moving him from the inpatient unit to a normal location in the prison and deferring his parole review to give him more time to demonstrate progress. Staff assessed his risk as raised and gradually reduced the frequency of his observations from constant to six an hour during the day and four an hour at night. On 4 July, Mr Storey moved from the gated cell to a normal cell in the inpatient unit.
54. From 26 July until 10 August, the probation officer met Mr Storey several times to talk about his parole review and the upcoming anniversary of his offence on 13 August. He discussed safeguards that staff had put in place for him to provide support and suggested activities to distract Mr Storey from his thoughts. The probation officer said that he had spoken to Mr Storey's solicitor for an update on the outstanding assault charge from the Scott Clinic and about deferring his parole hearing. Mr Storey said he was positive about deferring his parole hearing, and that he felt motivated to get through the anniversary date and progress on his sentence. On 10 August, staff assessed his risk as high because of his upcoming anniversary date and increased the frequency of his observations to six an hour during the day and eight an hour at night.
55. On 12 and 13 August, a prisoner, who was a Listener co-ordinator, visited Mr Storey to provide him with support during the weekend of the anniversary of his offence. He said that he walked around the yard with Mr Storey and they talked and he seemed okay. On 18 August, staff held an ACCT case review with Mr Storey and discussed making him a safer custody order and gradually moving him to a normal wing. Staff assessed Mr Storey's risk as unchanged (high) but decided to reduce the frequency of his observations to three an hour.
56. On 21 August, Mr Storey called out to Officer A who was monitoring another prisoner under the ACCT process. The officer did not respond so Mr Storey told him to 'fuck off'. Officer B was carrying out observations for Mr Storey that day and went to his cell to ask what he wanted. Officer A said that Mr Storey tried to get Officer B to go into his cell but when Officer B turned his head, Mr Storey punched him on the left side of his face through the hatch. Mr Storey then tried to flood his cell and stuffed toilet paper in his clothes and said he would set himself on fire. He then handed a lighter to Officer C.
57. Officer A noted that the head of healthcare had spoken to Nurse A about how to manage Mr Storey most safely and effectively. Mr Storey was placed on basic level under the IEP scheme and on a disciplinary charge because of his behaviour. (The Incentive and Earned Privileges (IEP) scheme aims to encourage and reward responsible behaviour. Prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.)
58. On 23 August, staff reviewed Mr Storey under the ACCT process and noted that his mood was low. Staff spoke to Mr Storey about the assault incident being a 'bump in the road'. They assessed his risk as high and increased his

observations to six an hour. The same day, Mr Storey attended a disciplinary hearing and the prison decided to refer the assault on Officer B to the police. (The police had not charged Mr Storey for assault at the time of his death.)

59. On 1 September, a healthcare staff member noted in the ACCT ongoing record that Mr Storey gave Nurse A a blade and that 'I would assume he would have used this if the problem wasn't sorted'. At interview, Nurse A said she did not remember Mr Storey giving her a blade and there are no further notes about this incident in the ACCT document or in Mr Storey's medical record.
60. On 4 September, the Head of Safer Prisons and Equalities, the Listener coordinator and a mental health nurse attended an ACCT case review with Mr Storey. Mr Storey said that he was optimistic about his Parole Board hearing, was making plans for the future, and was positive about becoming a safer custody orderly and about moving from the inpatient unit to J wing. The Head of Safer Prisons and Equalities told the investigator that Mr Storey was remorseful about assaulting an officer and the time of crisis had passed so the team decided to move Mr Storey forwards. Staff assessed Mr Storey's risk as low and reduced the frequency of his observations to two per hour.
61. On 8 September, Mr Storey told staff during an ACCT case review they had helped him to move forward and had given him hope and Nurse D noted that it was a positive review. Staff assessed Mr Storey's risk as raised and reduced the frequency of his observations to once an hour. At interview, Nurse D and Nurse B said that Mr Storey's risk was incorrectly recorded and should have been noted as low and not raised.
62. On 11 September, the Head of Safer Prisons and Equalities asked an officer to bring Mr Storey to J wing. The officer noted that he had a good chat with Mr Storey over coffee and talked about the facilities on the wing for him to do his artwork. The officer introduced Mr Storey to some of the prisoners on the wing. Mr Storey thanked him and said he was looking forward to coming back the next day.
63. On 12 September, Mr Storey complained of back pain and a nurse noted that he would speak to the GP. A doctor assessed Mr Storey and noted that he could not move and was lying on the floor because of a sudden onset spasm in his back. The doctor prescribed diazepam for Mr Storey. That evening, Nurse E noted that Mr Storey said he was still in pain and asked the GP to review him again. A doctor reviewed Mr Storey who he said was initially unable to get up. The doctor diagnosed Mr Storey with muscle spasm and prescribed dihydrocodeine (pain medication) and diazepam.
64. On 13 September, a healthcare assistant saw Mr Storey kneeling in his cell with a blanket over his head. He asked Mr Storey to remove the blanket and saw that he had a white strap around his neck. Mr Storey tried to hide it and told the healthcare assistant he was not doing anything. He said that he had put a towel over his eyes to keep the light out and was using the strap to wrap around his head and keep it in place. Mr Storey gave the healthcare assistant the strap. The healthcare assistant told Nurse B about the strap and she asked Mr Storey about this. Mr Storey told her that it was to keep the light out of his eyes. He said that he felt that he had progressed, would not want to take a step backwards,

and that he did not have any thoughts, plans or intentions to harm himself. Nurse B said that she accepted his explanation and did not have any concerns about him.

65. On 14 September, Mr Storey told a nurse that he was unable to stand because of back pain which he described as '9 out of 10'. The same day, Nurse D and Nurse E held an ACCT case review with Mr Storey. He said that he was happy with how staff had supported him and that this had given him some hope. Mr Storey said that he was not having any thoughts of suicide or self-harm and that he did not want to let people down. Staff assessed Mr Storey's risk as unchanged and noted that he would continue to be observed once an hour. (Because staff had incorrectly recorded Mr Storey's assessed level of risk at his previous review as 'raised' when they apparently meant 'low', it is unclear whether 'unchanged' meant that staff at this review assessed his level of risk as raised or low.) This was Mr Storey's last ACCT case review.
66. On 16 September, a GP prescribed diazepam for Mr Storey's back pain.

Events of 17 September

67. Between 12.30 and 1.30pm on 17 September, an officer observed Mr Storey under the ACCT process and noted that there were no concerns. She told the investigator that Mr Storey was not himself that day, seemed a little grumpy and had been complaining to staff. She said that Mr Storey was sitting with some other prisoners at lunchtime and as she walked past, he asked her to tell Nurse B and a healthcare assistant that he was sorry. The officer said that she thought that Mr Storey was apologising because he had been complaining a lot that day.
68. At 2.41pm, Nurse B noted that Mr Storey was feeling well in himself, had no new concerns or problems to discuss, and did not have any thoughts of suicide. At 3.00pm, healthcare staff noted in Mr Storey's ACCT ongoing record that he was standing at his door, said hello and appeared to be settled.
69. At 4.00pm, healthcare staff noted in Mr Storey's ACCT ongoing record that he had 'accepted his diet no issue'. At 4.20pm, Mr Storey asked Nurse B to come to his cell. He said that prisoners had been spitting at him through the hatch of their cells and he was not happy with what other prisoners were saying about healthcare staff. Nurse F joined Nurse B outside Mr Storey's cell and heard him tell her that he 'wouldn't hurt himself or do anything silly' and that she could trust him to be alright. Mr Storey told Nurse F that she was his favourite nurse and gave her a note saying that she was beautiful. Nurse F told Mr Storey not to be silly and went to speak to the prisoner in the cell next to Mr Storey's cell. Nurse F noted that she had spoken to her colleague about what Mr Storey said to her, and that if Mr Storey's behaviour continued she would submit an intelligence report and tell her manager. She said that she did not feel threatened by Mr Storey.
70. Nurse B continued talking to Mr Storey from outside his cell. Mr Storey handed her two pieces of ripped bed linen that were approximately 50cm x 3cm. She asked Mr Storey what the pieces of linen were for and he told her that he had no current plans or intentions to end his life. He said that he would not let the staff at Liverpool down because he had felt supported there. Nurse B asked Mr

Storey if he had been set back because the other prisoners were spitting at him and whether she needed to be concerned. Mr Storey said, 'No, not at all.' She asked Mr Storey if he had any intention of doing anything with the strips of linen. Mr Storey said he did not and that he got along with her and would tell her. She asked Mr Storey if he was thinking about harming himself in any way or ending his life and spoke to him about his future and his upcoming move to J wing. Mr Storey said that he did not want to do anything to jeopardise the move. Nurse B said that she believed what Mr Storey said and did not have any concerns about him. She said that this was the only time that he had handed her ligatures.

71. At 4.30pm, Nurse B started speaking to the prisoner in the cell next to Mr Storey's cell with Nurse F. Approximately five minutes later, CCTV shows that Nurse B looked through the hatch into Mr Storey's cell for a few seconds before she returned to the cell next door. At 4.40pm, the two nurses left the cell next to Mr Storey's cell. At 5.00pm, the officer who was observing Mr Storey noted that he was standing at the hatch of his cell and appeared okay and said he was fine.
72. At 5.30pm, Nurse B and Nurse F started to give prisoners their medication. Nurse F told the investigator that medication rounds can take about an hour.
73. At 5.50pm, Nurse B arrived at Mr Storey's cell to give him his medication. She opened the hatch and saw him sitting on the floor. She called Mr Storey's name but he did not respond. She saw that Mr Storey was facing to the right and had a ligature around his neck. Nurse F was giving medication to the prisoner in the cell next to Mr Storey. She told the investigator that Nurse B called out, 'Terry's in danger, bang the alarm'. At 5.51pm, Nurse F pressed the general alarm and went to get the emergency bag.
74. Nurse B said she told an officer to call a code blue (indicating that a prisoner is unconscious, not breathing or is having breathing problems). Nurse B said that she had a radio but asked the office to call the emergency code because she was trying to be calm and did not want to upset other patients. At 5.53pm, the officer radioed the control room and asked for staff assistance but did not call a code blue.
75. Nurse B ran to the office to help Nurse F with the emergency bag. Nurse B and Nurse F took the bag to Mr Storey's cell, and, although they had keys, they waited outside for an officer to unlock the door.
76. Approximately one minute later, an officer arrived and unlocked Mr Storey's cell. More staff arrived and went into Mr Storey's cell. A prison manager cut the ligature made from torn bed sheets from Mr Storey's neck. Nurse F checked for vital signs but Mr Storey was not responding, had no pulse, was not breathing and there were no signs of circulation. Nurse F applied the oxygen mask and took turns doing CPR with Nurse B. Nurse F inserted an airway to give Mr Storey oxygen.
77. Nurse G heard the general alarm and tried to contact healthcare to see if she was needed. She said that she waited because it was a general alarm and not an emergency code and knew there were two nurses in the inpatient unit.

78. An officer working in the control room responded to the general alarm by putting a call out over the radio to alert staff. She said that she was listening to staff over the radio and heard them ask for the green bag and knew the incident was serious from what staff were saying. At 5.56pm, she called an ambulance even though an emergency code had not been called. The officer said that she was placed in a queue because the ambulance service was receiving a lot of calls. Just after the officer called the ambulance service, the, duty governor, called a code blue over the radio. Ambulance records noted that the prison called and requested an ambulance at 6.02pm.
79. Nurse G heard the code blue called over the radio and quickly went to the inpatient unit. When she arrived at the cell, she saw Nurse B and Nurse F doing resuscitation. Staff continued to take turns doing CPR and Nurse G and another nurse attached the defibrillator, which advised no shock, and to continue resuscitation.
80. At 6.09pm, the duty governor radioed the control room again to ask when the ambulance would arrive. The officer working in the control office told the duty governor that she had told the ambulance service that Mr Storey had ligatured and was unconscious but they could not say when an ambulance would arrive because there was a high demand for services. At 6.12pm, Nurse G contacted the control room and asked them to call the ambulance again.
81. At 6.18pm the ambulance arrived at the prison. At 6.30pm, paramedics arrived at Mr Storey's cell and continued trying to resuscitate him. Paramedics noted that he was not breathing, had no pulse, and the skin on his head and face was blue. At 6.44pm, paramedics took Mr Storey to hospital but at 6.56pm they recorded that he had died.

Contact with Mr Storey's family

82. After Mr Storey died, the deputy governor and the duty governor went to visit Mr Storey's sister to tell her that he had died. When they arrived at the address recorded in Mr Storey's prison records, the family living there said that Mr Storey's sister had moved some years ago. They both returned to the prison at 11.00pm and the deputy governor decided to try and get Mr Storey's sister's address from police or probation staff in the morning. He said that he wanted to tell Mr Storey's sister the news in person because he thought this would be a more appropriate and decent way to pass on this information.
83. The next day, at 1.00pm, the deputy governor decided to phone Mr Storey's sister after they were unable to obtain her current address. At 1.15pm on 18 September, the deputy governor phoned Mr Storey's sister to tell her that her brother had died. They obtained her address and at 1.30pm, the deputy governor, the prison family liaison officer, and a chaplain left the prison and travelled to Mr Storey's sister's home. They offered their condolences and explained the role of the family liaison officer. The prison contributed to the costs of Mr Storey's funeral, in line with national guidance.

Support for prisoners and staff

84. After Mr Storey's death, the duty governor 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.
85. 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.

Post-mortem report

86. The post-mortem report noted that Mr Storey died from compression of the neck due to low hanging. The toxicology report found Mr Storey had a number of medications in his system at therapeutic levels only.

Findings

Management of the risk of suicide

87. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and suicidal ideation, a history of mental health problems, a personality disorder diagnosis, being charged with a violent offence, and recent contact with psychiatric services. All of these factors applied to Mr Storey. While Mr Storey's risk of suicide fluctuated, it continued throughout his time at Liverpool.
88. Mr Storey was a challenging person to manage in terms of the risk he posed to both himself and others. Staff correctly began ACCT suicide and self-harm prevention procedures as soon as Mr Storey arrived at Liverpool and healthcare and prison staff worked together to provide a high level of support to Mr Storey in managing his risk of suicide and self-harm for almost four months. Staff held a total of 50 case reviews and monitored Mr Storey under constant observation for more than half of his time at the prison. The mental health in-reach team provided Mr Storey with ongoing support and prison staff implemented a number of strategies to manage his risk of suicide and self-harm, including providing him with materials to work on his art as a distraction, implementing a plan to gradually move him to normal location, providing peer support and mentoring opportunities, working with him on his parole review, and making him a safer custody orderly.
89. Although staff provided Mr Storey with a high level of support throughout his time at Liverpool, we have some concerns about the management of the ACCT process, in particular, assessing the level of risk and carrying out observations. These are both issues that have been raised in previous investigations at Liverpool.

Assessing the level of risk

90. PSI 64-2011 states that in addition to planned case reviews, where there are other concerns raised, a case review must be held to consider if another assessment is required. There were a number of instances where Mr Storey handed staff items that he could have used to harm himself, but they did not hold a case review and there was no evidence that staff reassessed his level of risk or the frequency of his observations.
91. On 1 September, Mr Storey handed Nurse A a blade. A case review was held three days later but there is no evidence that the blade was discussed and Nurse A told investigators that she could not remember this incident. On 13 September, Nurse B spoke to Mr Storey after the healthcare assistant found him with a strap around his neck. At 4.20pm on the afternoon that Mr Storey died, Mr Storey handed Nurse B some torn strips of bed linen. On both occasions, Nurse B spoke to Mr Storey who told her that he did not intend to harm himself. At interview, Nurse B said that she decided that a case review was not needed and the frequency of his observations was appropriate, although this was not noted in his ACCT document.

92. Mr Storey had a number of risk factors for suicide and self-harm and his risk of suicide fluctuated. We are concerned that when staff became aware that Mr Storey had items he could use to harm himself, they relied on his presentation and reassurances that he had no thoughts of suicide or self-harm instead of his known risk factors, which had increased to include the availability of means. A case review would have provided the opportunity for a multi-disciplinary review of Mr Storey's level of risk and frequency of observations and to explore the reasons why he had these items in his cell.
93. We have also considered whether Mr Storey should have been managed under the enhanced ACCT case management procedures. The head of Safer Prisons and Equalities told us that, although Mr Storey was not formally managed under the enhanced procedures, he was effectively managed according to these principles as a senior member of staff attended case reviews and they took a multi-disciplinary approach to management (including inviting his offender manager, healthcare, peer mentor/support, etc to ACCT case reviews). In the circumstances we do not consider that the formal initiation of enhanced procedures would have made a significant difference, although it would have been preferable to have been explicit that enhanced procedures were being used.
94. PSI 64/2011 states that observations must be recorded at unpredictable times. We are concerned that most observations for Mr Storey were recorded at regular intervals that he would have been able to predict. For example, from 10.00pm on 16 September until 10.00am on 17 September, Mr Storey was observed on the hour. We make the following recommendations:

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

- **staff consider all known risk factors when determining the level of risk of self-harm;**
- **staff hold a case review when significant new information about risk becomes known; and**
- **ACCT observations are at irregular and unpredictable intervals.**

Emergency response

95. PSI 64/2011 states that all staff must be aware that the preservation of life is the priority when managing at-risk prisoners. Justifiable decisions about when to enter a cell must take account of the need to preserve life and should be documented in wing observation books, NOMIS history sheets and ACCT Plans.
96. On the day Mr Storey died, Nurse B and Nurse F waited for an officer before going into his cell. Both nurses carry keys but said it was healthcare policy not to go into a cell without an officer. They said that for safety reasons, they would not go into a prisoner's cell without an officer under any circumstances. The Clinical Manager of the inpatient unit told the investigator that the inpatient unit does not have a policy that requires staff to wait until there is an officer to enter cells. He said that staff should do a risk assessment before going into a cell that considers preservation of life and maintaining staff safety. We make the following recommendation:

The Head of Healthcare should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.

97. PSI 03/2013 on Medical Emergency Response Codes requires staff to use a code blue or equivalent code in a medical emergency and for the control room to call an ambulance immediately an emergency code is used.
98. When Nurse B found Mr Storey, there was a delay of five minutes in calling an emergency code. Nurse B had a radio but asked Nurse F to activate the general alarm and said that she told an officer to call a code blue. The officer called the control room and asked for assistance but did not call a code blue. Five minutes later, the officer working in the control room called an ambulance, shortly before the duty governor called a code blue.
99. The officer in the control room is to be commended for using her experience and common sense to call an ambulance before the emergency code was called. Nevertheless, there was a delay of five minutes in calling an ambulance because the code was not called immediately by staff at the scene. In an emergency, even a short delay in calling an ambulance can have a significant impact on a person's chance of survival. We make the following recommendation.

The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

100. We have identified similar issues in our investigations into previous deaths at Liverpool. We, therefore, made the following recommendation:

The Prison Group Director, North West, should assure himself that realistic action is now taken to address these and previous recommendations.

Contact with Mr Storey's family

101. We are satisfied that the prison made sufficient effort to inform Mr Storey's sister of his death face-to-face and in a timely manner. We make no recommendation.

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