

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Joseph Gornall on 3 July 2022, following his release from HMP Humber**

**A report by the Prisons and Probation Ombudsman**

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100

## 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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## Summary

1. 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.
2. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.
3. 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.
4. Mr Joseph Gornall died from the toxic effects of a range of drugs on 3 July 2022, following his release from HMP Humber on 1 July. He was 31 years old. I offer my condolences to those who knew him.
5. We did not find any issues of concern. We make no recommendations.

## The Investigation Process

6. HMPPS notified us of Mr Gornall's death on 8 July 2022.
7. The PPO investigator obtained copies of relevant extracts from Mr Gornall's prison and probation records.
8. We informed HM Coroner for Hull of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
9. The Ombudsman's family liaison officer contacted Mr Gornall's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
10. We shared our initial report with HMPPS. They found no factual inaccuracies.

## **Background Information**

### **HMP Humber**

11. HMP Humber is a Category C prison in Yorkshire that holds approximately 1,000 men. It was created in 2014 by the merger of two previously separate prisons, HMP Wolds and HMP Everthorpe. Spectrum Community Health C.I.C. provides healthcare services.

### **Probation Service**

12. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

## Key Events

13. On 5 April 2022, Mr Joseph Gornall was sentenced to 25 weeks in prison for multiple thefts. On 14 April, he was moved to HMP Humber.
14. Mr Gornall had a history of substance misuse including heroin and crack cocaine. He was put on a methadone (opiate substitute) programme when he arrived in prison but a week later, he said that he wanted to come off methadone. He agreed to continue to engage with the Drug and Alcohol Recovery Team (DART) for psychosocial support. They advised him of his reduced tolerance and risk of overdose.

## Pre-release planning

15. Mr Gornall was homeless when he was sent to prison. On 13 June, Mr Gornall's community offender manager (COM) submitted a referral to Commissioned Rehabilitative Services (CRS – probation system used to request support from external partnerships) to assist with Mr Gornall's housing needs.
16. On 22 June, a DART worker saw Mr Gornall. The DART worker recorded that Mr Gornall felt good about his upcoming release and that he said he did not need a referral to a community drug recovery service.
17. On 27 June, Mears, a temporary accommodation provider, agreed to house Mr Gornall for 12 weeks. Mr Gornall's COM informed Mr Gornall's prison offender manager on 29 June, who passed this onto Mr Gornall the same day.
18. On 1 July, the day of his release, a nurse saw Mr Gornall. She recorded that Mr Gornall was not provided with naloxone (a medication that can rapidly reverse opioid overdose). It is unclear from the notes whether Mr Gornall was not offered naloxone, or if Mr Gornall declined it.

## Post-release

19. On 1 July, Mr Gornall reported to Scunthorpe Probation Office, where he had a supervision appointment with his COM. She went through Mr Gornall's licence conditions with him and helped him complete the necessary paperwork for his accommodation.
20. Mr Gornall told his COM that he was not using drugs and had no intention of doing so in the future. The COM reminded Mr Gornall of his reduced tolerance and that if he did start using drugs again, he would have to engage with a drug rehabilitation service, as set out in his licence.
21. Mr Gornall's mother collected Mr Gornall from the probation office and took him to his accommodation.

## **Circumstances of Mr Gornall's death**

22. On 2 July, Mr Gornall stayed at a friend's house. When his friend came downstairs on the morning of 3 July, he found Mr Gornall unresponsive on the living room floor, and called the emergency services. Paramedics attended and at 8.13am, declared that Mr Gornall had died.
23. Humberside Police informed Mr Gornall's family and the Probation Service that Mr Gornall had died.

## **Post-mortem report**

24. The post-mortem report concluded that Mr Gornall died from cardiorespiratory depression caused by the combined effects of a cocktail of drugs including cocaine.

## **Findings**

25. Mr Gornall's COM did the necessary accommodation referrals and accommodation was arranged for Mr Gornall's release.
26. Mr Gornall had a long history of substance misuse and was under the care of DART at Humber. There is no record that he was offered reduced tolerance or harm reduction advice at his release planning appointment, although this had been discussed when he first arrived at Humber. In addition, he was not provided with naloxone before his release. It is unclear from the medical record whether he was offered naloxone but declined, or whether he was not offered it. We do not make a recommendation, but the Head of Healthcare should consider how record keeping could be improved.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**August 2023**

## **Inquest**

The inquest, held on 13 May 2024, concluded that Mr Gornall died by misadventure.

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