Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aaron Gornall, on 30 November 2023 following his release from HMP Holme House

A report by the Prisons and Probation Ombudsman

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

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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 Aaron Gornall died of multiple drug toxicity on 30 November 2023, following his release from HMP Holme House on 24 November. He was 35 years old. We offer our condolences to those who knew him.

5. We did not find any issues of concern relating to the pre and post-release planning. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Gornall's death on 1 December 2023.

7. The PPO investigator obtained copies of relevant extracts from Mr Gornall's prison and probation records.

8. We informed HM Coroner for Northeast Lincolnshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. The Ombudsman's Office contacted Mr Gornall's family, to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Gornall's family said that Mr Gornall was let down by the prison and probation service when he was released.

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

11. Mr Gornall's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Holme House

12. HMP Holme House is a category C resettlement prison which holds convicted male prisoners. It is managed by HMPPS.

Probation Service

13. 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 supervise people throughout their licence period and post-sentence supervision.

Key Events

14. On 23 August 2023, Mr Aaron Gornall was convicted of absconding from lawful custody and was sentenced to six months in prison. He was sent to HMP Durham and transferred to Holme House on 4 September. He was due for release on 24 November.

15. A nurse completed Mr Gornall's initial health screen. Mr Gornall said he did not have any problems with drug use and had not used drugs before. He said that he suffered from psychosis, anxiety and depression. She referred him to the mental health team, added him to the waiting list to see a psychiatrist and referred him to a GP for a medication review.

16. On 11 September, a GP at the prison completed a medication review. Mr Gornall said that he used to be prescribed pregabalin for his anxiety but had not been prescribed this since coming into prison. The GP noted Mr Gornall was waiting to see the psychiatrist but, in the meantime, she prescribed Mr Gornall with citalopram (an antidepressant) for his anxiety, along with his other prescribed medications. He was allowed to keep a supply of medication in his cell.

17. On 15 September, a pre-release officer at Holme House completed Mr Gornall's pre-release report. Mr Gornall said that he was working with the mental health team which he found helpful and had no thoughts of self-harm or suicide.

18. That day, Mr Gornall pressed his emergency cell bell. An officer attended and saw that Mr Gornall had pulled his sink off the wall, which caused the cell to flood, and he had made a deep cut to his right forearm.

19. Staff started Prison Service suicide and self-harm prevention procedures known as ACCT and an ACCT review was held on 16 September. Mr Gornall said that he did not want to die and agreed to have a mandatory drug test to rule out any drug use. There is no evidence that Mr Gornall had a mandatory drug test.

20. A Supervising officer (SO) reviewed Mr Gornall's records before his ACCT review and noted that he had a history of drug induced psychosis and had previously been under threat by other prisoners while in prison. Mr Gornall said he was not in debt on the wing. However, a nurse from the mental health team said Mr Gornall had told her he had been buying pregabalin on the wing. Staff conducted a spot check of Mr Gornall's cell and found discrepancies with some of his prescribed medications. Staff removed his medication from the cell, and he had to collect it from the medication hatch thereafter.

21. On 16 October, Mr Gornall said he had no faith in the mental health team and did not want to engage with them anymore but was happy to be referred to the community mental health team (CMHT) once an address had been found for him. However, Mr Gornall was not referred to the CMHT because an address had not been found at that time.

22. On 6 November, Mr Gornall said that he had continued to buy illicit pregabalin and subutex and that he was in £100 worth of drug debt, which he did not plan on paying back. Mr Gornall said that he knew he had gone about this the wrong way but felt that using illicit drugs was the only way he could get through the last couple

of weeks of his sentence. Mr Gornall was moved to another house block due to his drug debt and continued to be supported through ACCT procedures and the mental health team.

23. On 7 November, Mr Gornall's Community Offender Manager (COM) referred Mr Gornall for CAS3 (temporary accommodation for up 84 days for those who would be leaving prison homeless) which was approved a few days prior to his release.

24. On 11 November, Mr Gornall's ACCT was closed.

25. On 24 November, Mr Gornall was released from Holme House. Because Mr Gornall was not under the care of the substance misuse service, he was not released with a naloxone kit (which can reverse the effects of an opioid overdose).

Post-release management

26. On 27 November, Mr Gornall attended his initial appointment with his COM, and his licence conditions were explained, as well as the terms of his CAS3 temporary housing. Once he completed his probation induction, he was met by a CAS3 worker to discuss the accommodation and complete the paperwork.

27. Mr Gornall was directed to attend the local drug and alcohol service (We Are With You (WAWY) - a charity that supports people who have challenges with drugs, alcohol or mental health) that day, for relapse prevention work but Mr Gornall did not attend as he said that he did not want to engage with them. The COM planned to have a further discussion with him about engaging with WAWY, but Mr Gornall died before this could happen.

28. That day, the COM emailed the community mental health team to let them know Mr Gornall had been released. They replied and said that they had no open case for Mr Gornall and a new referral would need to be completed. The referral was not completed prior to Mr Gornall's death.

Circumstances of Mr Gornall's death

29. On the evening of the 29 November, Mr Gornall was at an address with two males, and they were taking drugs together. The two males left Mr Gornall at the address at around 2.00am and returned at 2.30am. They thought Mr Gornall was asleep but realised he was non-responsive, and they called an ambulance.

30. The paramedics arrived and started cardiopulmonary resuscitation (CPR) and gave Mr Gornall naloxone. The paramedics noted he was cold to touch and there were empty strips of gabapentin (anticonvulsant medication used to treat seizures and neuropathic pain) found near his body. He was taken to hospital and was given six cycles of adrenaline, but medics were not able to resuscitate him, and they confirmed that Mr Gornall had died.

Post-mortem report

31. The post-mortem report concluded that Mr Gornall died of multiple drug toxicity.

Findings

Management of risk of suicide and self-harm

32. Mr Gornall was managed under ACCT procedures at Holme House, from September 2023 for around two weeks before he was released. The annex to Prison Service Instruction (PSI) 64/2011, which sets out the ACCT process, says that if a prisoner who is due to be released has been supported using ACCT in the previous 12 months, relevant risk information from their most recent ACCT must be shared by the prison with probation prior to release wherever possible. Mr Gornall's COM was aware he was on an ACCT, and he had an additional licence condition to attend all appointments arranged with a psychiatrist, psychologist or medical practitioner. We are satisfied the prison adequately informed probation of the ACCT to ensure relevant support could be put in place in the community.

Mental health services

33. We found that Mr Gornall was well supported by the mental health services at Holme House and treatment focused on developing strategies to support him. Mr Gornall decided to dis-engage with the mental health team because he felt they were not helping him, but he was happy to accept a referral to the CMHT for additional support in the community. Mr Gornall's COM was not able to complete the referral while he was in prison because Mr Gornall did not have a confirmed address at that time (a requirement of the referral in that area). Mr Gornall's COM had contacted the CMHT on his release and planned to submit a new referral.

Substance misuse services

34. During Mr Gornall's initial health screen at Holme House he said that he did not have any issues with drugs and had not previously used drugs, therefore the nurse did not refer him to the substance misuse team in prison. However, Mr Gornall later admitted to using illicit Subutex and pregabalin and staff supported him through the ACCT process and the mental health team.

35. On release, Mr Gornall was referred to WAWY, but he did not want to engage.

36. We are satisfied that prison and probation staff made appropriate referrals to manage Mr Gornall's risk associated with his substance misuse and mental health. We make no recommendations.

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

At the inquest held on 19 November 2024, the coroner concluded Mr Gornall's cause of death was drug related.

Prisons & Probation Ombudsman
Independent Investigations

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

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100