Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Gorton a prisoner at HMYOI Deerbolt on 2 May 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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 Ryan Gorton was found hanged in his cell at HMYOI Deerbolt on 2 May 2016. He was 19 years old. I offer my condolences to Mr Gorton's family and friends.

Mr Gorton had a history of self-harm but did not talk to staff about it. Staff generally supported him appropriately using suicide and self-harm prevention procedures. When Mr Gorton had an altercation with another prisoner in April 2016, staff managed his behaviour through disciplinary procedures but appropriately recognised the impact that the punishment of segregation could have had on him, and found an alternative way to deal with the incident which addressed his vulnerability.

The investigation found that there was little to indicate that Mr Gorton was at high or imminent risk of suicide immediately before his death and I consider that it would have been difficult for staff to have predicted and prevented his actions. However, when the control room received a medical emergency code after Mr Gorton was found hanged on 2 May, there was an unacceptable delay in calling an ambulance. This did not affect the outcome for Mr Gorton, but in other cases might be crucial.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

Contents

Summary

Events

1. On 11 May 2015, Ryan Gorton was remanded to HMP and Young Offender Institution (YOI) Forest Bank. On 24 August, he was sentenced to four years and nine months in prison and, four days later, was transferred to HMYOI Deerbolt.

2. Mr Gorton had a history of self-harm. Between September and December, staff monitored Mr Gorton under suicide and self-harm prevention procedures four times after he harmed himself. He was referred to the mental health team but would not discuss his self-harm and often refused support from clinical and mental health staff. Staff discharged him from mental health services in February 2016 after he had refused to attend four times. Mr Gorton then appeared to settle into prison life.

3. On 28 April, during the association period (when prisoners mix with other prisoners), Mr Gorton had an altercation with another prisoner and threw pool balls at him. An officer restrained Mr Gorton and took him back to his cell. Staff did not consider that Mr Gorton was likely to harm himself but checked him overnight as a precaution.

4. On 29 April, because of his behaviour the previous day, Mr Gorton attended a disciplinary hearing. He was found guilty of assaulting another prisoner and, as a punishment, received four days of confinement in a cell in the segregation unit and lost his privileges. Staff separately started monitoring Mr Gorton under Deerbolt's violence reduction procedures which meant that he was reduced to the basic level of the Incentives and Earned Privileges scheme for three weeks. A nurse assessed Mr Gorton and concluded that he was not fit for segregation because of his history of self-harm. Instead, staff moved him to another wing to avoid any repercussions on the wing from the incident of 28 April. Staff checked Mr Gorton overnight. He told staff that he accepted the transfer and appeared to settle on the wing.

5. Mr Gorton wrote a letter to his mother on 1 May, which was forward looking and referred to her forthcoming visit on 6 May.

6. On 2 May, the night patrol officer was conducting a roll check at 5.55am and found Mr Gorton hanged. Staff did not try to resuscitate him, as he was clearly dead. Paramedics arrived and pronounced Mr Gorton dead at 6.29am.

Findings

7. While staff had supported Mr Gorton under ACCT suicide and self-harm prevention procedures four times at Deerbolt, we have seen no evidence that Mr Gorton harmed himself from December 2015 until his death in May 2016. Staff operated ACCT procedures appropriately and, until the altercation on 28 April, Mr Gorton appeared to have settled at Deerbolt.

8. A nurse appropriately assessed Mr Gorton as unfit to stay in the segregation unit after a disciplinary hearing for throwing pool balls at other prisoners in April 2016. Mr Gorton had however been found guilty at the disciplinary hearing and he

accepted that he had done wrong. As Mr Gorton was deemed unfit for segregation because of his history of self-harm, he was moved to the drug detoxification unit. The unit has single cells and a more structured regime, which staff found necessary to manage his risk to others after his behaviour on 28 April and he was appropriately monitored. We found it reasonable that staff managed Mr Gorton in this way.

9. When Mr Gorton was found hanged at 5.58am on 2 May, control room staff logged the call to the ambulance service as being made at 6.03am, an unacceptable delay of five minutes. This did not affect the outcome on this occasion but could be crucial in other circumstances. In addition, the relevant local protocol on emergency procedures did not reflect national instructions.

Recommendations

- The Governor should ensure that the prison's local emergency protocol meets the requirements of PSI 3/2013, and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for confirmation or further information.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMYOI Deerbolt informing them of the investigation and asking anyone with relevant information to contact her.

11. The investigator visited HMYOI Deerbolt on 11 May 2016. She obtained copies of relevant extracts from Mr Gorton's prison and medical records. She also met the Governor, the family liaison officer, Head of Safer Custody and Diversity and a member of the IMB. She visited the cell where Mr Gorton had lived and spoke to officers and prisoners on the wing.

12. NHS England commissioned a clinical reviewer to review Mr Gorton's clinical care at the prison.

13. Another investigator interviewed staff and prisoners at Deerbolt in July 2016. he and the clinical reviewer interviewed all staff together.

14. We informed HM Coroner for Durham of the investigation. The coroner gave us the results of the post-mortem examination. We sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Gorton's mother to explain the investigation. Mr Gorton's mother said that she felt her son had not been properly cared for at Deerbolt and asked why he had been transferred so far from his family. She said she had been able to visit him three times a week at Forest Bank and felt that the lack of family support had negatively impacted on him. Mr Gorton's mother said that in December 2015, her daughter had received an anonymous text from someone at Deerbolt, which said that Mr Gorton had cut off his ear. She telephoned the prison but staff told her that he was fine and had not cut himself. She felt Deerbolt should have asked her to contribute to the suicide and self-harm prevention procedures. She asked whether Mr Gorton had been offered a transfer to another prison, and if so, why he had chosen not to take it.

16. We sent a copy of this report to Mr Gorton's mother. She did not identify any inaccuracies or omissions.

Background Information

HM YOI Deerbolt

17. HM Youth Offenders Institution (YOI) Deerbolt in County Durham holds approximately 513 male, young offenders from 18 to 21 years old. Care UK provides healthcare at Deerbolt, but no staff on duty between 8.30pm to 7.30pm.

HM Inspectorate of Prisons

18. The most recent inspection of HMYOI Deerbolt was in December 2014. Inspectors said Deerbolt was generally a safe prison but they were concerned about a recent increase in the use of force and how it was carried out. Inspectors found the quality of care for those at risk of self-harm was good. They said suicide and self-harm prevention procedures were consistent, with good support from the mental health team and good provision of activities for those at risk. They found staff tried to ensure that prisoners in crisis and subject to suicide and self-harm monitoring were not held longer than necessary in the segregation unit.

Independent Monitoring Board

19. 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 to the year ending September 2015, the IMB reported that access to psychology and mental health services was good, and that Deerbolt continued to demonstrate excellent ACCT procedures, which had the best ratings of any North East prison. The segregation unit only held those prisoners who could not reasonably be returned to normal location.

Deaths at HMYOI Deerbolt

20. Mr Gorton was the first prisoner to take his life at Deerbolt since the prison opened in 1973.

Assessment, Care in Custody and Teamwork (ACCT)

21. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. On 11 May 2015, Mr Ryan Gorton was remanded to HMP Forest Bank, charged with wounding. It was his first time in prison. He told a nurse that he had no thoughts of self-harm or suicide but the nurse noticed scars on his arms from apparent self-harm and he admitted that the last time he had harmed himself was approximately a month earlier. The nurse referred him to the mental health team and prison staff started ACCT procedures in reception. They stopped monitoring him on 15 May, when he was more settled.

23. On 30 May, Mr Gorton damaged property in his cell and, on 18 June, assaulted his cell-mate at Forest Bank. He did not explain why he did this.

24. In July 2015, a clinical psychologist diagnosed Mr Gorton with a borderline learning disability. Mr Gorton said he began cutting himself when he was 16 years old to reduce his anxiety. He said he smoked cannabis and drank alcohol (until he was drunk) before he was in prison.

25. On 24 August 2015, Mr Gorton was sentenced to four years and eight months in prison, and on 28 August, he was transferred to HMYOI Deerbolt.

26. A nurse in reception referred Mr Gorton to the Drug and Alcohol Rehabilitation Team (DART) for advice and support after he said he had used cannabis and alcohol in the community, but he refused to engage with the service or attend appointments for a second health screen on 30 and 31 August.

27. On 20 September, Mr Gorton deliberately damaged his cell and cut his forearm. He was sent to the segregation unit, where a nurse saw him. He told the nurse that he had cut his forearm accidentally when he smashed his window. Mr Gorton would not discuss why he had damaged his cell, nor allow the nurse to treat his injury. The nurse noted in the clinical record that Mr Gorton's pupils were dilated and he appeared to be under the influence of a substance, which he denied. The nurse assessed whether Mr Gorton was fit to remain in the segregation unit. He concluded that he was, and Mr Gorton remained there overnight but moved to a wing on normal location the next day.

28. On 21 September, Mr Gorton deliberately cut his left arm. A nurse took him to the healthcare unit and treated his cuts. The nurse said that Mr Gorton's cuts were very deep. Staff started ACCT monitoring that day. Mr Gorton told a Supervising Officer (SO) that he missed his family and Deerbolt was too far for them to visit. He said that he had harmed himself as an attempt to take his life because he could not think of any reasons to live. He said that he would harm himself again that night. The Head of Safer Custody and Diversity and Mr Gorton's ACCT case manager arranged for Mr Gorton to be constantly supervised overnight in a gated cell.

29. Mr Gorton told those attending the ACCT case review, including the Head of Safer Custody and Diversity, that he did not want his family to know about his self-harm and did not want a transfer to another prison. Staff reduced his observations to four an hour. Mr Gorton also agreed to have a mental health assessment.

30. On 22 September, a GP saw Mr Gorton about his self-harm. The GP noted that Mr Gorton said that he did not have thoughts of suicide, had no debts and did not use drugs. He said that he was frustrated at being in his cell all day but had applied to do a construction course. The GP stated that Mr Gorton did not appear depressed, was not tearful and smiled appropriately with good eye contact. He referred him to the mental health team and arranged for the nurse to re-dress his wounds. A nurse later saw Mr Gorton and he allowed her to treat his injuries.

31. On 23 September, the Head of the mental health team assessed Mr Gorton. She said Mr Gorton was quiet but noted no significant evidence of a depressive illness. During Mr Gorton's subsequent ACCT case reviews, she said Mr Gorton presented in a better frame of mind and agreed to see the mental health team. Staff reduced the frequency of his ACCT observations.

32. A number of staff noted in the ACCT ongoing log that Mr Gorton was not eating much. He denied feeling worried or threatened by prisoners at the servery and said he did not have an appetite. On 27 September, healthcare staff started monitoring his weight, as he was underweight.

33. On 28 September, staff stopped ACCT monitoring but re-started procedures when Mr Gorton cut his arms again the next day.

34. From 1 to 3 October, Mr Gorton refused food. The ACCT case manager held an additional ACCT case review. Mr Gorton told him he was not hungry and did not like the food. Staff stopped ACCT monitoring on 9 October.

35. On 12 October, Mr Gorton deliberately cut his arms and upper body with a razor blade. The Head of the mental health team attended to him but he refused to talk to her about his self-harm, other than to say that he had planned it. Staff opened ACCT procedures again but Mr Gorton refused to go to the healthcare unit for treatment. On 14 October, Mr Gorton saw a GP and allowed his wounds to be treated.

36. On 15 October, Mr Gorton refused to see the Head of the mental health team for a mental health review, but she saw him at an ACCT case review on 16 October. Mr Gorton denied thoughts of suicide or self-harm and said that he was eating better than previously. He would not talk about his self-harm or what triggered it.

37. On 17 October, Mr Gorton told a healthcare support worker that his family did not know about his self-harm and, when he lived at home, he hid his injuries by wearing long sleeves. He said that he did not want his family to know about his self-harm while he was in prison. He said that his family had not visited him since August but he contacted them by telephone regularly.

38. On 2 November, staff stopped ACCT procedures after Mr Gorton said that he would not harm himself and healthcare staff said he had no symptoms of mental health deterioration.

39. On 5 November, Mr Gorton told the Head of the mental health team that he had settled on the wing, was starting a full time job and he had had contact with his mother at the weekend. He said that he was happy at Deerbolt and did not want a transfer nearer to his family home. He denied thoughts of suicide or self-harm.

The Head of Safer Custody and Diversity said that he had asked Mr Gorton many times if he wanted a transfer nearer to home, to HMYOI Hindley, but Mr Gorton said he did not want to move.

40. On 19 November, Mr Gorton's key worker reviewed his mental health. He told her that he was doing well. He said he was taking part in education and spending time with other prisoners on association. He denied thoughts of self-harm.

41. On 24 November, during the evening, Mr Gorton pressed his cell bell after cutting off his ear lobes and cutting his wrist. Mr Gorton also said he had swallowed two razor blades. Staff took him to the hospital, where his wounds were stitched. He returned to Deerbolt and staff started ACCT procedures that night.

42. Staff considered Mr Gorton to be at high risk of self-harm. They set the frequency of observations at three times an hour until his ACCT assessment the next day.

43. On 25 November, a nurse re-dressed one of Mr Gorton's ear lobes. Mr Gorton told her that he did not think he needed to self-harm. He said he had been stressed the previous night but did not want to discuss why. While he did not want to see the mental health team, she contacted them about Mr Gorton.

44. That day, Mr Gorton told an officer during his ACCT assessment that he had not felt better when staff stopped the last set of ACCT procedures but had pretended. Mr Gorton said he was not sure if he wanted to take his life but knew he would not die from cutting his ear lobes off. Despite saying that he was not receiving visits, he said he liked his job and was not being bullied. He maintained that he had nothing to live for and that he would probably harm himself in the future.

45. A SO chaired the first ACCT case review that day. Mr Gorton had been to work and had mixed with other prisoners on the wing during the association period. He denied thoughts of suicide and self-harm. Staff assessed Mr Gorton as at low risk of harm to himself and set caremap actions for the mental health team to speak to Mr Gorton, for Mr Gorton to have a smokers pack; to move to another wing in the next two weeks; and for staff to monitor his food intake and give him appropriate menu choices. The Head of Safer Custody and Diversity explained to the investigator that Mr Gorton wanted to move to another wing with in-cell showers. He said Mr Gorton's wing had communal showers, and Mr Gorton had not wanted to use them because he was embarrassed about his scars from self-harming. However, once he arranged the wing transfer, Mr Gorton decided not to move as he wanted to stay with his friends.

46. That evening, a healthcare support worker noted that Mr Gorton was crying and had damaged his cell. Mr Gorton did not talk to her and she could not see if he had any injuries.

47. On 26 November, the Head of Safer Custody and Diversity chaired the second case review, which was multi-disciplinary. Mr Gorton said he was happy at work and did not need mental health intervention. The Head of the mental health team and the Head of Safer Custody and Diversity said they believed that Mr Gorton had copied another prisoner who had recently cut off his ear lobe. Mr Gorton

denied this. They said that Mr Gorton's self-harm was more serious and they increased his risk level to raised. They arranged for a custodial manager to continue as ACCT case manager and for Mr Gorton to remain on three observations an hour. They reviewed his caremap actions, which remained the same.

48. Mr Gorton's mother said after Mr Gorton had cut his ear lobes and wrist, her daughter had received an anonymous text from someone at the prison about Mr Gorton's self-harm. She said that she had spoken by telephone to a member of staff, who said that he could not put her through to the wing. He had told her that Mr Gorton was fine and had not harmed himself. The Head of Safer Custody and Diversity said he did not know about the telephone call and was unable to find a record of it without a date or name.

49. On 27 November, a SO held the third case review, which was multi-disciplinary. Mr Gorton refused to attend. The key worker said that she would arrange for the psychiatrist to see Mr Gorton the next week, as she was worried about him not eating. (He had declined all meals for 24 hours.) His observation level remained at three an hour but they assessed that his risk level had increased to high because of his reluctance to talk to staff and his poor eating pattern.

50. On 28 November, Mr Gorton refused to attend the next case review so it took place without him. It was multi-disciplinary and his risk and observation level remained the same. There was however a different case manager.

51. On 29 November, there was another multi-disciplinary case review but Mr Gorton again refused to attend. A custodial manager and a SO went to see Mr Gorton in his cell, but he refused to talk to them, other than saying he had not eaten since 25 November. They asked what they could arrange for him from the kitchen.

52. Mr Gorton attended the healthcare unit that afternoon and talked to a nurse, who changed his dressings. He did not tell her why he was not eating, but she noted that he told her that he did not like the attention he received from the ACCT procedures. She told him that staff were concerned about his weight, and as long as he did not eat, they would have to be involved because they owed him a duty of care. Mr Gorton said that not eating made him feel better.

53. On 30 November, Mr Gorton attended the next case review, which was multi-disciplinary. Mr Gorton said he would eat his sandwich that day, and suggested what else he might eat. The panel reduced his level of risk to low and reduced his observations to two an hour. That day, staff noted that Mr Gorton seemed happy on the wing and played pool with his friends. He collected and ate his evening meal.

54. Mr Gorton had refused to eat regularly up to 1 December. At an ACCT case review on 1 December, Mr Gorton said he felt "in a much better place", had started eating again and was enjoying his job. The panel agreed that his risk level remained low and they reduced his observations to one an hour.

55. On 7 December, Mr Gorton had his eighth ACCT case review. He was upbeat and said that he had started eating properly again. He had mixed with other

prisoners and enjoyed his job. The panel said his risk remained low and reduced his observations to one every two hours.

56. Staff held three more case reviews, at which Mr Gorton said he continued to eat properly. He denied thoughts of suicide and self-harm. At Mr Gorton's final ACCT case review on 22 December, the case manager asked how Mr Gorton felt about Christmas coming up. Mr Gorton said that he did not care. They agreed to stop ACCT monitoring. Mr Gorton's post-closure review did not take place until 4 January 2016. A SO said he did not know why it had been late but thought it might have been because of staffing issues.

57. The key worker tried to see Mr Gorton four times between January and 17 February but he refused to see her. She discharged him from mental health services on 17 February.

58. Mr Gorton appeared to settle over the next couple of months. Staff were not aware of further incidents of self-harm. The Head of Safer Custody and Diversity said that he believed ACCT monitoring had been effective in supporting Mr Gorton.

59. On 28 April, Mr Gorton argued with another prisoner during association. A number of prisoners and staff said Mr Gorton had been playing pool when another prisoner threw a pen at him. There are conflicting accounts of what happened but Mr Gorton lost his temper and started to throw pool balls at the other prisoners.

60. An officer said he saw Mr Gorton throwing pool balls and put him in what he described as a "loose bear hug". Mr Gorton immediately stopped throwing the balls and relaxed. He and another officer led him back to his cell.

61. The officer said Mr Gorton remained agitated for some time but eventually calmed down. He considered starting ACCT procedures but felt that they were not needed, as Mr Gorton had settled down and denied that he would self-harm. However, he spoke to the night patrol officer and the orderly officer (the person in charge of the prison at night) and asked them to check on Mr Gorton overnight because of his history of self-harm. The night patrol officer checked on Mr Gorton throughout the night and had a short conversation with him as he asked what would happen to him. The next time he checked him, he was settled on his bed watching television.

62. A SO opened violence reduction procedures and placed Mr Gorton on report for disciplinary matters. These are separate procedures, which can run concurrently. This was Mr Gorton's first instance of violence at Deerbolt. The Violence Reduction Policy says that with a first instance of violence, a prisoner should be reduced to basic Incentives and Earned Privileges (IEP) level for at least three weeks, and staff should review behaviour weekly, with a view to the prisoner returning to standard IEP level. Mr Gorton accepted the consequences of his actions. He said Mr Gorton seemed fine and he had no concerns about him harming himself again.

63. A prisoner, who lived in the cell next to Mr Gorton, said Mr Gorton told him on the night of 28 April that he did not want to move wings.

64. PSI 17/2006 says that any prisoner who is to be segregated should be assessed by the healthcare team to check they are fit to be segregated. After a prisoner has been restrained, a member of healthcare staff should check that he is fit and well and has not received any injuries. A nurse, who knew Mr Gorton well, said that on 29 April she checked and confirmed that Mr Gorton was fit and well and had no injuries. She said she did not confirm that he was fit for segregation and completed the segregation risk assessment to say so. She said it would have been detrimental to Mr Gorton's health to segregate him.

65. On 29 April, Mr Gorton attended his disciplinary hearing, chaired by the Head of Residence. Mr Gorton admitted throwing the balls and gave no mitigating reasons for doing so. Mr Gorton was found guilty of assaulting another prisoner, and was given four days of cellular confinement and fourteen days' loss of privileges. Mr Gorton should then have moved to the segregation unit for his punishment but because the nurse deemed it not appropriate, Mr Gorton was moved to the drug detoxification wing instead. An officer said he was transferred to another wing to avoid any follow-up incidents in the immediate future. Mr Gorton told him that he was happy to move, and fully accepted the action taken.

66. Mr Gorton was not confined to his cell under segregation conditions in the drug detoxification wing. However, he was given a single cell and the wing had a stricter regime than a standard wing. Over the next two days, Mr Gorton seemed to settle on the wing. There are three entries in his violence reduction progress report. On 29 April, the entry indicates that Mr Gorton's mood appeared good and that he was offered a telephone call but declined it. On 30 April, the entry said he had mixed with other prisoners. On 1 May, the entry said there were no concerns about Mr Gorton.

Events on 1 and 2 May

67. On 1 May, the night patrol officer started work at 7.30pm. He completed a roll check (to check that all prisoners were present) and saw Mr Gorton in his single cell around 7.30pm. He said that Mr Gorton was fit and well at this time and he had asked him if he was okay. He said that Mr Gorton was at the sink and responded, "Yeah, boss". This was the last time anyone saw Mr Gorton alive. Overnight, there was banter between prisoners but nothing significant or relating to Mr Gorton.

68. Around 5.55am on 2 May (a Bank Holiday), the night patrol officer checked the roll again. He looked through the observation panel in Mr Gorton's cell door and saw that Mr Gorton was suspended from a ligature attached to the light fitting. He immediately at 5.58am radioed a medical emergency code blue (used when a prisoner is not breathing), removed his emergency key from its pouch, and entered the cell.

69. The night patrol officer lifted Mr Gorton's body up to relieve the pressure of the ligature (made from shoe laces) around his neck. He saw signs of rigor mortis and believed Mr Gorton was dead. While he was lifting Mr Gorton, an officer arrived at the cell and cut the ligature from the light fitting with his anti-ligature knife.

70. The orderly officer heard the code blue call over the radio. He picked up the emergency first aid bag and arrived at Mr Gorton's cell within seconds. He saw the officer and the night patrol officer lay Mr Gorton face up on his bed. He noticed that Mr Gorton still had a cloth around his neck and another around his wrists, so he removed them with his anti-ligature knife. He too believed Mr Gorton had been dead for some time because rigor mortis was present. He told the officer to call an ambulance.

71. The officer who worked in the control room said in a police statement that he received the code blue at 5.58am. He did not call an ambulance until 6.03am, after he received the orderly officer's instruction.

72. The night patrol officer left the cell to receive support. No one tried to resuscitate Mr Gorton as he had clear signs of death (rigor mortis and pooling of blood). The first paramedics arrived at 6.23am and subsequently pronounced that Mr Gorton had died.

73. After Mr Gorton's death, police found a letter dated 1 May to Mr Gorton's mother in his cell. Despite saying he had moved wings and was on basic IEP level, he said that he had a nicer cell than before and he asked his mother for some items when she visited him on 6 May.

Contact with Mr Gorton's family

74. After Mr Gorton's death, the Head of Safer Custody and Diversity was appointed as the family liaison officer. He tried to visit Mr Gorton's mother (his next of kin) with another family liaison officer. When they arrived at the address listed in Mr Gorton's file, they found that his family had moved house two weeks earlier but no-one knew their new address. Because of the time since Mr Gorton had died and despite not wanting to break the news of Mr Gorton's death by telephone, he called Mr Gorton's mother. Mr Gorton's mother gave him her new address and they visited her there. Deerbolt contributed to the funeral costs in line with national policy.

Support for prisoners and staff

75. The orderly officer debriefed staff involved in the emergency response at 10.25am on 2 May. The duty care team attended and offered support to staff. The prison posted notices informing other prisoners of Mr Gorton's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Gorton's death.

Post-mortem examination

76. A post-mortem examination found that Mr Gorton died from hanging. The toxicology tests found no drugs in Mr Gorton's blood or urine, and the pathologist said there was no evidence of recent use of new psychoactive substances.

Findings

ACCT procedures and assessing risk

77. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Mr Gorton had a number of these risks when he arrived at Deerbolt:

- He had a history of self-harm, and admitted recently harming himself;
- He was young and it was his first time in prison;
- He had been charged with a violent offence.

78. Staff at Forest Bank appropriately monitored Mr Gorton's risk of self-harm when he arrived after noting scars on his arms. Staff at Deerbolt appropriately considered Mr Gorton's risk and operated ACCT procedures four times from September to December 2015 to support him after he had seriously self-harmed and damaged his cell.

79. Case reviews were held frequently and appropriately and a member of healthcare attended the majority of case reviews, broadly in line with PSI 64/2011 which requires case reviews to be multidisciplinary. Staff also set and addressed caremap actions. They referred Mr Gorton to the mental health team a number of times, and it was only after Mr Gorton had not attended his appointments four times that the mental health team discharged him from their caseload in February 2016. While we were broadly satisfied that staff at Deerbolt monitored Mr Gorton's risk of suicide and self-harm appropriately between September and December 2015, we were concerned that he had four ACCT case managers between September and November 2015.

80. We saw no evidence that Mr Gorton harmed himself from December 2015 until his death in May 2016 and until the altercation on 28 April, Mr Gorton appeared to have settled at Deerbolt.

Balancing Mr Gorton's risk of suicide and self-harm with prison discipline

81. We recognise that prison disciplinary procedures and violence reduction procedures are crucial to ensure a safe environment at prison. When Mr Gorton was found guilty of assaulting another prisoner, it was reasonable and appropriate that staff managed his behaviour through disciplinary procedures. In doing so, they appropriately recognised the impact that the punishment of segregation could have had on someone with a history of self-harm, and found an alternative way to deal with the incident, which addressed his vulnerability.

82. A nurse appropriately assessed Mr Gorton as unfit to stay in the segregation unit. As he had been found guilty of assaulting another prisoner at a disciplinary hearing, it was reasonable to transfer Mr Gorton to the drug detoxification wing. They appropriately monitored him during the night of 28 April.

83. Prison Service Order 3050 (PSO) on the continuity of healthcare says that events such as changes within the prison environment can have a significant impact on a prisoners' health. It gives examples such as a "bad or missed visit, and being questioned by the police and being transferred", but this list is not exhaustive or definitive. We recognise that Mr Gorton went through a disciplinary hearing and moved wings in the days before his death. While these changes might have had an impact on Mr Gorton's state of mind and increased his risk of suicide and self-harm, there was little to indicate that Mr Gorton was at high or imminent risk of suicide immediately before his death and it would have been difficult for staff reasonably to have predicted his actions.

Emergency response

84. PSI 3/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI says that when staff radio a medical emergency, an ambulance must be called immediately and the local policy should reflect this position. Control room staff should not check with managers, healthcare staff or others at the scene before calling an ambulance, but should be alert to updates and keep the ambulance service informed. The PSI notes that it is better to act with caution and call an ambulance as it can be cancelled later, if not needed. In contrast, the emergency response protocol in place at Deerbolt at the time of Mr Gorton's death says that, "On receiving a code blue, the control room operator will call the emergency services when requested to do so". This is not in line with the protocol in PSI 3/2013, which says that they should do so when a code blue is called, and not wait for staff to call or for a manager's approval.

85. The night patrol officer found Mr Gorton hanged and radioed a code blue promptly at 5.58am. Staff attended the cell swiftly and the orderly officer asked an officer to call for an ambulance. The officer in the control room waited for the orderly officer to confirm that he should call an ambulance, which delayed one being called by five minutes. We recognise that the delay did not affect the outcome for Mr Gorton but the delay was too long and in other emergencies, such a delay could be critical.

The Governor should ensure that the prison's local emergency protocol meets the requirements of PSI 3/2013, and that the control room calls an ambulance immediately a medical emergency code is called, without waiting for confirmation or further information.

Clinical care

86. The clinical reviewer concluded that Mr Gorton's care was equivalent to the care he would have received in the community and said the segregation risk assessment was properly carried out. He made one recommendation about the failure to record the outcome of Mr Gorton's assessment to check whether he was fit for segregation, in the clinical record, which the Head of Healthcare will need to address.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141