Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Gorst, a prisoner at HMP Manchester, on 25 April 2023

A report by the Prisons and Probation Ombudsman

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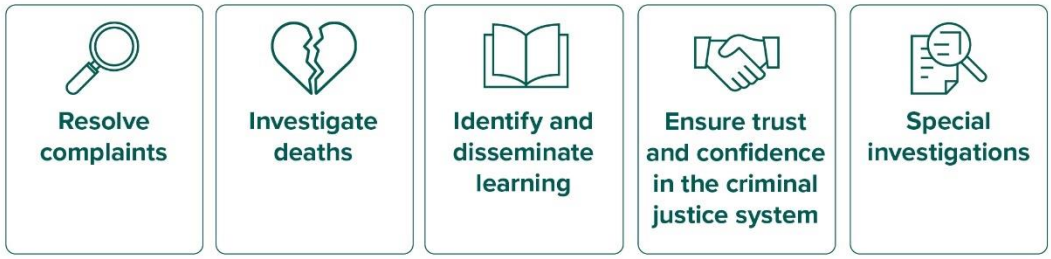
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Lee Gorst was found hanged in his cell on 25 April 2023 while a prisoner at HMP Manchester. He was 35 years old. I offer my condolences to Mr Gorst's family and friends.

The clinical reviewer concluded that Mr Gorst's clinical care was equivalent to that which he could have received in the community.

Mr Gorst was recalled to prison in June 2021, and was subsequently given a life sentence in February 2023. He was sent to Manchester on 31 March 2023, and at the time, he denied thoughts of suicide or self-harm. During his telephone conversations with his partner, Mr Gorst revealed that he was struggling to come to terms with the length of his sentence and he was unhappy with the regime and environment at Manchester.

In October 2024, following an inspection of Manchester, HM Chief Inspector of Prisons issued an urgent notification to the Secretary of State for Justice in relation to a concerning decline in three of the four healthy prison tests. A number of the concerns HM Inspectorate of Prisons identified are relevant to the matters Mr Gorst raised during his telephone conversations.

We are concerned that when Mr Gorst arrived at Manchester, he was not given a proper induction and he did not receive any key work. Due to the restricted regime at the time, Mr Gorst spent extended periods of time in his cell on his own. It is clear that this had a negative impact on him.

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

Adrian Usher
Prisons and Probation Ombudsman **May 2025**

Contents

Summary

Events

1. In December 2013, Mr Lee Gorst was sentenced to thirteen years and four months in prison for attempted murder and false imprisonment.

2. Mr Gorst was released on licence on 27 January 2020, but was recalled to prison in June 2021, having been charged with further offences, including robbery, unlawful wounding, and threats to kill.

3. On 9 September 2021, Mr Gorst was given a custodial sentence of four and a half years and on 16 February 2023, he was given a life sentence, with a minimum term of five years.

4. Mr Gorst was transferred to HMP Manchester on 31 March 2023.

5. At 3.13pm on 25 April, an officer arrived at Mr Gorst's cell to unlock him for afternoon association and found him hanging. Prison and healthcare staff provided emergency care. Paramedics arrived at 3.33pm and at 3.49pm, pronounced his life extinct.

Findings

6. Mr Gorst did not receive a full induction when he arrived at Manchester, and he did not have any key work sessions. The prison was operating a limited regime which meant that prisoners were spending significant amounts of time in their cells and there were very few opportunities for prisoners to engage in purposeful activities.

7. There was a delay in paramedics attending the emergency. It took prison staff fourteen minutes to conduct security checks and to escort the paramedics through the prison. We note that HMPPS has recently published a new policy for staff which provides guidance on the items with which ambulance staff are permitted to enter the prison.

8. We have read the Secretary of State's response to HM Chief Inspector of Prisons' urgent notification and the associated action plan to address the issues identified. We note that actions have been identified to ensure the safe delivery of regimes and services and that Manchester will receive interim resources to provide additional support.

Recommendations

- **The Governor should outline in the action plan for this report how the actions in the UN action plan have impacted on the amount of key work carried out and the amount of time prisoners have out of their cells.**

The Investigation Process

9. HMPPS notified us of Mr Gorst's death on 25 April 2023.

10. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator visited Manchester on 6 and 7 June 2023. He obtained copies of relevant extracts from Mr Gorst's prison and medical records and documents from the ambulance service.

12. The investigator interviewed two prisoners at Manchester on 3 May. He interviewed ten members of staff at Manchester on 6 and 7 June and he conducted a further four interviews by Microsoft Teams on 19 July 2023.

13. Another investigator took over the investigation in September 2024.

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

15. We informed HM Coroner for Manchester of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology report. We have sent the Coroner a copy of this report.

16. The Ombudsman's office contacted Mr Gorst's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked why Mr Gorst was locked in his cell for twenty-three hours a day.

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

18. Solicitors representing the Gorst family received a copy of the draft report. They did not make any comments.

Background Information

HMP Manchester

19. HMP Manchester is a high security category B training prison, which accepts long-term prisoners. There is a category A unit for prisoners who pose a greater security risk. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care at the prison.

20. The prison comprises of 10 wings. At the time of Mr Gorst's death, 'A' wing housed general population prisoners, as well as the induction wing for newly arrived prisoners. The two cohorts were separated by a sterile area with a gate.

HM Inspectorate of Prisons (HMIP)

21. The most recent inspection of Manchester took place in September 2024. The full report of this inspection was not available at the time of writing. However, on 9 October 2024, HMIP issued an urgent notification to alert the Lord Chancellor and Secretary of State directly about their significant concern about Manchester's performance. The Secretary of State has not yet responded to this. A debriefing paper had been prepared and was publicly available.

22. The inspectors found that there was a concerning decline in three of the four healthy prison tests and the prison was not fulfilling its core function as a training prison. They said that only a third of prisoners surveyed said that a member of staff had talked to them about how they had been getting on in the past week and hardly any prisoners received regular key work sessions.

23. The inspectors noted a steep rise in the rate of self-harm and that the triggers for self-harm included frustration about staff not dealing with their basic needs, boredom, drug use and debt.

24. They found that prisoners were very negative about the short amount of time that they spent out of their cells. Based on their own checks, they found that 38% of prisoners were locked in their cells during the working day, with only 19% leaving the wing to attend purposeful activity. They found that Manchester was running a restricted regime which left many men locked in their cells for most of the day and this was even worse during the weekends, when men would typically spend less than two hours out of their cell.

Independent Monitoring Board

25. 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. The latest annual report covered the year to February 2022, and reported on the ongoing impact of the pandemic.

Previous deaths at HMP Manchester

26. Mr Gorst was the sixteenth prisoner to die at Manchester since April 2020. Of the previous deaths, five were self-inflicted, six were from natural causes and four were from other causes or drug related. Up to the end of October 2024, there have been two further self-inflicted deaths.

Prison regime at Manchester

27. The Deputy Governor, told us that at the time of Mr Gorst's death, Manchester was fully staffed. However, only 67% of staff were actually working in the prison because of sickness, maternity leave and secondments. As a result, the prison was operating a reduced regime which meant that they were not able to carry out all of their functions.

28. Officers told the investigator that typically, prisoners would be let out of their cells for approximately two hours a day, during which time they would have the opportunity to go to the exercise yard, shower and socialise. Prisoners who had enrolled in education would also be unlocked to attend their class (every other week) and all prisoners would be unlocked to collect their meals, and if applicable, their canteen (items that they had bought through the prison catalogue).

29. We were told that the only work available to prisoners on A wing was a cleaning job. If a prisoner wanted to apply for a different job, they had to apply for a transfer to a different wing.

Prison reception process

30. PSI 07/2015 *Early days in custody – reception in, first night in custody and induction to custody* sets out the process and actions that need to be done once a prisoner arrives at the prison. This includes carrying out initial interviews to assess risks, allowing prisoners to make a phone call and providing them with a hot meal, as well as giving them an induction into custody and to the prison.

Key worker scheme

31. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners, and helping people settle into life in prison. Details of how the scheme should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

32. Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key work session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

33. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation.

National Regime Model

34. In 2023, HMPPS introduced the National Regime Model governing how prison regimes are designed, delivered and monitored in every prison. This requires prisons to create a regime plan based on HMPPS's priorities and core service expectations, as well as the individual needs of the prison.

35. The regime plan is approved by an HMPPS Executive Director and Prison Group Director, and a prison's progress is monitored against the agreed deliverables throughout the year.

Key Events

36. On 16 December 2013, Mr Lee Gorst was sentenced to 13 years imprisonment for attempted murder and false imprisonment. He spent time in a number of prisons and was released on licence from HMP Manchester on 27 January 2020.

37. On 29 June 2021, Mr Gorst was recalled and remanded into custody at HMP Forest Bank, charged with robbery.

38. On 9 September 2021, Mr Gorst was convicted and given an extended determinate sentence of seven years, of which four and a half years were to be served in prison.

39. On 18 November 2022, a warrant was issued for Mr Gorst to attend court, charged with robbery, threats to kill and malicious wounding. He was subsequently found guilty and on 16 February 2023, he received a life sentence, with a minimum term to serve of five years before parole could be considered.

40. Later that day, a prison officer spoke to Mr Gorst about the outcome of his trial. He recorded that Mr Gorst had refused his offer to see a nurse and said he was okay and had no thoughts of suicide or self-harm.

41. On 26 March, during a key work session, a prison officer asked Mr Gorst if he had any concerns. He said he did not. He confirmed that he had no thoughts of suicide or self-harm and that he was in contact with his family and support network.

HMP Manchester

42. On 31 March, Mr Gorst was transferred to HMP Manchester and arrived at 4.40pm.

43. A prison reception officer completed a cell sharing risk assessment for Mr Gorst who was assessed as high risk and not suitable to share a cell. The officer told the investigator that he did not have access to the system to view Mr Gorst's digital person escort record (dPER, which records and communicates risk information between police, courts and prisons as a prisoner travels between them) but he obtained information from Mr Gorst's prison record.

44. At 5.10pm, the reception officer carried out Mr Gorst's reception screen and began completing the early days in custody record. However, he did not complete all sections of the form. He recorded that Mr Gorst had told him he had no thoughts of suicide or self-harm.

45. At 5.45pm, a nurse saw Mr Gorst for his initial health screen. She recorded that he said he felt okay and had no concerns about his mental or physical health. She noted he was fit and well, was not prescribed any medications and had no depression or anxiety. She asked Mr Gorst about a previous self-harm incident (which had happened outside of prison) but he did not want to talk about it. The nurse referred Mr Gorst to the mental health inreach team (MHIRT) and the drugs and alcohol recovery service (DARS).

46. The first night interview form (a document used to identify, record and assess all known risk factors) was not completed for Mr Gorst. The reception officer told the

investigator that induction staff complete the first night interview once a prisoner moved to the induction wing. However, an officer who worked on the induction wing, said that reception staff complete it before a prisoner is taken to the wing. A Supervising Officer (SO) told the investigator that officers finished at 5.30pm on a Friday and if Mr Gorst had not made it to the wing while officers were still there, the first night interview would not take place. (We know Mr Gorst was still in reception at 5.10pm and consider it unlikely he reached the induction wing before 5.30pm.)

47. Mr Gorst was allocated a single cell in the induction unit on A wing. The night officer checked on him three times during his first night and noted no concerns.

48. On 1 April, a nurse from DARS spoke to Mr Gorst through his cell door. She recorded that Mr Gorst had said he did not want to engage with DARS.

49. Later that day, a mental health nurse from MHIRT met Mr Gorst to carry out a psychiatric review. He recorded that he engaged well, and he had no concerns about his mood or mental state. He noted that Mr Gorst had said that he did not need anything from MHIRT but knew how to access the service. Mr Gorst told the nurse that he was aware of the available support services. The nurse said that Mr Gorst declined a PHQ-9 assessment (used to screen for and measure the severity of depression).

50. Mr Gorst's day two induction interview was due on Saturday 1 April, but it was not done. An induction officer told the investigator that if a prisoner arrived on a Friday, the day two interview was completed on Monday because of a lack of staff at the weekend. The SO confirmed this and said that because of reduced staff levels, particularly over the weekend, officers struggled to provide a regime and prisoners got no time out of their cells. She said that if they had only three staff on the wing, induction activity did not take place.

51. On 4 April, an officer noted in Mr Gorst's prison record that his education induction had been completed. There is no evidence that Mr Gorst received any other induction, and the day two induction interview did not take place.

52. On 5 April, Mr Gorst spoke to his partner by phone. He talked about applying for an offending behaviour course so that he could be re-categorised from category B to category C and transfer to a different prison. (Security categorisations determine the type of prison that a prisoner is held in.)

53. On 6 April, Mr Gorst spoke to his partner. He said he had signed up for the offending behaviour course and he had applied for a job to show that he was making positive progress.

54. On 11 April, Mr Gorst was moved from the induction part of A wing to the general population side.

55. At 11.30am on 17 April, a prison GP saw Mr Gorst for a routine appointment following his arrival. He recorded that Mr Gorst denied physical or mental health problems and was well, apart from a broken tooth.

56. Later that day, Mr Gorst spoke to his partner by phone. He told her that he was very depressed, he did not want to be in prison, Manchester was a dump and he hated it.

57. At 4.57pm on 18 April, Mr Gorst spoke to his partner again. He told her that he was alright, but she said he sounded *'shit'*. He complained that officers had taken his razors from him but had not given him an electric razor and they had forgotten to let him out of his cell for food (which he said happened regularly).

58. At 4.31pm on 20 April, Mr Gorst spoke to his partner. He asked her if she had called the prison as education staff had visited him and asked if he wanted to do art and to move to E wing. (E wing holds category A, B and escape list prisoners.) Mr Gorst said it was strange that they had visited him, and it was as if someone had told the prison that he was not feeling great. She said she had not called the prison.

59. The SO told the investigator that she recalled offering Mr Gorst a move to E wing because it was more settled. She said that he had told her he was happy to stay where he was. There is no record of this conversation.

60. Later that day, Mr Gorst called his partner again. He told her that the alarms had gone off as something was happening and there were lots of knives in the prison which were coming in by drones every night. Mr Gorst said that he hated the prison, and everything was getting on top of him. He said he had watched a television programme called 'Parole' (a BBC documentary series focusing on the work of the Parole Board), and he thought it was going to be very hard for him to get released at the first opportunity. He said that he was only getting an hour and half out of the cell each day and he spent the rest of the time lying on his bed.

61. At 2.00pm on 22 April, Mr Gorst wrote a letter to his mother and partner which he called his suicide letter (the letter was found in his cell after he died). Mr Gorst wrote about how the reality of his life sentence had sunk in and how it would take him years after he served the minimum five years before he would be released. He said that it was a lonely, hard existence, he was locked in his cell alone for twenty-two and a half hours a day, with every minute of his life controlled and he did not have a release date to look forward to. Mr Gorst wrote that he knew he could not do the sentence.

62. Prisoner A, who knew Mr Gorst, told the investigator that there had been a violent incident on the wing on 24 April, which had involved some young prisoners with knives. He told the investigator that Mr Gorst had seen what happened and he thought that it had shocked him. He told the investigator that Mr Gorst had said he was not happy at Manchester because there were no jobs. He had said that Mr Gorst wanted to go back to Forest Bank.

Events of 25 April

63. An officer told the investigator that on the morning of 25 April, staff had discussed offering Mr Gorst a cleaning job as they had noticed that he was not as sociable following his move to the general population part of the wing. He said that all the officers got on with him as he was very pleasant and did what he needed to do.

64. During the morning, a trainee psychological wellbeing practitioner at HMP Forest Bank met Mr Gorst's brother, a prisoner at Forest Bank. She told the investigator that at the end of her session, Mr Gorst's brother told her that he was worried that Mr Gorst was feeling low. He said that Mr Gorst had previously served a long sentence and he was worried about how he would cope with another long sentence.

In her statement, she said that Mr Gorst's brother was calm and delivered the information in such a way that there was no indication that Mr Gorst was at immediate risk of suicide.

65. At 12.04pm on 25 April, an officer unlocked Mr Gorst's cell for lunch. Mr Gorst left his cell. Prisoner A told the investigator that he saw Mr Gorst when he was collecting his lunch and Mr Gorst had asked him if he was okay (after the incident the day before). He said he told Mr Gorst he was alright, and he would speak to him later. Mr Gorst returned to his cell at 12.07pm. Thirty seconds later, an officer locked his cell. At 12.22pm, CCTV footage shows that an officer was undertaking the routine roll check and looked into Mr Gorst's cell. The officer told the investigator that he could not recall what Mr Gorst was doing at the time.

66. At approximately 12.30pm, the wellbeing practitioner returned to her office and, after a discussion with a colleague, she tried to contact the safer custody team at Manchester to request a welfare check for Mr Gorst. She said that when she got through to the answering machine, it directed her to ring the main switchboard if there was an immediate threat to life or to leave a message on the answerphone. It said they could not say when the message would be picked up due to staffing levels. She told the investigator that she tried to call the safer custody team four times and because she could not get through, she spoke to a colleague who gave her a number for the Head of Safer Custody and Equalities. She said that she called the Head, but there was no answer, so she rang the main switchboard at 1.52pm and was put through to the MHIRT.

67. The Head of Safer Custody and Equalities told the investigator that there was a process in place for staff to listen to voice messages and action them at least once a day when there was a safer custody officer on duty. However, this did not always happen on the days when the safer custody officer was redeployed to other areas in the prison due to staff absences.

68. The wellbeing practitioner told the investigator that she spoke to a nurse and told him that her client at Forest Bank had raised concerns that Mr Gorst was low in mood and may be feeling like he had had enough. She said her client was unsure if Mr Gorst was suicidal but had asked for him to have a welfare check.

69. The nurse told the investigator that he took the call at 2.00pm and was told that Mr Gorst's brother had reported that Mr Gorst felt low but was unsure if he had any suicidal ideation. He said he wrote a note of his conversation with the wellbeing practitioner in his notepad and had intended to add Mr Gorst to the list for a welfare check and to update his medical record once he had completed the other tasks he was scheduled to complete that afternoon. He said that based on his conversation with her, he did not think that the check needed to happen immediately.

70. At 3.00pm, Officer A arrived on A wing and, at 3.13pm, she unlocked Mr Gorst's door. (She was not interviewed as she was on long term sick absence during the investigation.) Officer B told us that normally, prisoners were unlocked at 2.00pm but that day, the unlock had been delayed as a security move was being carried out.

71. Officer B told the investigator that he was unlocking prisoners on another landing when he heard Officer A scream for staff. He said he ran straight upstairs.

72. CCTV footage showed that Officer B arrived at Mr Gorst's cell approximately twelve seconds after it had been unlocked. On arrival, he switched on his body-worn video camera. He said that he saw Mr Gorst hanging and noticed that his skin was starting to discolour. He said he took out his anti-ligature knife to cut the ligature (a torn bed sheet which had been attached to pipework at the top of the cell) and Mr Gorst was limp in his arms. He said he moved him to the floor and began cardiopulmonary resuscitation (CPR).

73. Officer B told the investigator that he did not think Mr Gorst was alive. He said he had done his basic life support training the week before and had been trained to start CPR even if he thought the person was dead (just in case there was a chance that they could be revived).

74. CCTV footage showed that the SO arrived at the scene twelve seconds after Officer B. She told the investigator that when she arrived, Officer B was placing Mr Gorst on the floor, and she radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing and triggers the control room to call an emergency ambulance and alerts prison staff of the incident). She said she then assisted Officer B with CPR.

75. An entry in the prison incident log records that the prison called for an ambulance at 3.13pm.

76. A nurse told the investigator that when she heard the code blue, she first went to the clinic room and collected the emergency bags. At 3.16pm, she arrived at Mr Gorst's cell. She said when she arrived, Mr Gorst was not breathing so she inserted an airway (a tube to open the airway) and set up the defibrillator (a machine used to apply an electric charge to restore a normal heartbeat) while the officers continued with CPR.

77. At 3.19pm, a prison GP arrived at Mr Gorst's cell as resuscitation attempts were taking place. He said that the defibrillator was attached but advised no shock. In his statement, he said that Mr Gorst showed no signs of life.

78. The ambulance records state that the paramedics arrived at the prison at 3.19pm and reached Mr Gorst at 3.33pm. The paramedics recorded that there was a delay in them reaching Mr Gorst due to multiple security checks and the opening and closing of the gates and doors to get to the wing. Once they arrived, they took over Mr Gorst's care.

79. At 3.49pm, the paramedics ceased life support and pronounced Mr Gorst's life extinct.

80. At approximately 4.00pm, the nurse was told that Mr Gorst had died.

81. At 4.17pm, the nurse updated Mr Gorst's medical records. He wrote that he had received a call at 2.00pm to say Mr Gorst's brother was concerned for Mr Gorst's welfare, Mr Gorst's brother had reported *"low mood and suicide ideation"* and Forest Bank wanted Mr Gorst to have a welfare check. He told the investigator that this entry was inaccurate, as he had been told that they were unsure whether Mr Gorst had suicidal ideation. He said he had no explanation as to why he had made this error.

82. Officers who attended to secure Mr Gorst's cell noted that on his wall calendar, Mr Gorst had written "my last day" on 22 April. They also found a mobile phone in his room (the police did not analyse the phone).

Contact with Mr Gorst's family

83. The prison appointed a manager at Manchester as the family liaison officer. At 5.45pm, she and the Deputy Governor left the prison to visit Mr Gorst's mother, but no one was at the address. She then tried to reach Mr Gorst's mother by phone and at 7.06pm, they broke the news that Mr Gorst had died.

84. On 4 May, Mr Gorst's family visited Manchester. The prison contributed to the cost of Mr Gorst's funeral in line with national instructions.

Support for prisoners and staff

85. After Mr Gorst's death, the Head of Residence met all the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff were notified of the different support options available to them.

86. The prison posted notices informing other prisoners of Mr Gorst'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 Gorst's death.

Post-mortem report

87. The pathologist concluded that Mr Gorst died from hanging.

Inquest into Mr Gorst's death

88. The inquest into Mr Gorst's death was held on 15 September 2025 and a verdict of suicide was recorded. The coroner concluded that Mr Gorst's death was due to hanging.

Findings

Assessment of risk

89. All staff have a responsibility to identify, manage and support prisoners who are at risk of harm to their self, other and from others. PSI 64/2011 (Managing prisoner safety) which was in place at the time of Mr Gorst's death, since replaced by the Prison Safety Framework, provided guidance to staff around the risks and triggers that may increase a prisoner's risk. These include early days in custody/transfers and sentencing.

90. It is evident from the records that prison and healthcare staff asked Mr Gorst on a number of occasions if he had any thoughts of suicide or self-harm and on each occasion, he stated he did not.

91. While staff had noticed that Mr Gorst appeared less sociable following his move to the general wing, we have not identified anything which may have led them to consider that Mr Gorst was intending to take his own life. However, as detailed in subsequent sections, the limitations of life at Manchester made it much harder for staff to identify risk in prisoners.

Lack of induction

92. The prison records indicate that Mr Gorst was not given a proper induction when he arrived at Manchester. Neither the first night nor second day interviews took place, and his prison record shows that he only received an induction to education. Some of the officers to whom we spoke were unclear who was responsible for the first night interview. The Head of Residence, who was appointed after Mr Gorst's death, told us that they had since reviewed all their local policies.

93. During the interviews, officers told the investigator that A wing did not have enough staff allocated to it and staff from the wing were sometimes redeployed to other areas of the prison. They said that this meant that they could not consistently deliver the induction and no induction activity took place at the weekend.

Action taken since Mr Gorst's death

94. The Head of Residence told the investigator that following Mr Gorst's death, the prison carried out a complete review of the induction process. She said that officers who now work on the induction wing go through an application process and undertake specific training. She said it is made clear to staff that induction activity takes priority over other tasks and it has to be completed within the prescribed timescales.

95. The Head said that they had updated a number of the documents that support the induction process and prisoners now have an induction passport which records when the different elements of the induction are completed. There is also a visible induction tracker in the wing office.

96. The Head explained that induction activity is tracked in a number of different ways and a prisoner does not leave the induction wing until they have completed all parts. She said that a custodial manager completes quality assurance checks and follows up on any identified issues.

97. We recognise that the prison has taken steps to improve the induction process and we therefore make no recommendation.

Restricted regime

98. In his letter to family, Mr Gorst wrote that he was locked in his cell alone for twenty-two and a half hours, seven days a week.

99. At the time of his death, we were told that the prison was operating a reduced regime which meant that prisoners were out of their cells for approximately two hours a day. In terms of employment opportunities, staff told us that the only jobs available on A wing were cleaning roles and for those prisoners who wanted to take part in education, they were only able to support access to education every other week (if there were enough staff to facilitate this).

100. The recent HMIP inspection identified that the restricted regime meant that many men were locked in their cells for 22.5 hours a day, during which time they could not access showers, or association time. They also raised a significant number of concerns about Manchester's provision of education, skills and work activity.

101. The prison's regime plan for the year 2024/25 states that Manchester is committed to expanding education to all of the prison and to increase work attendance. The prison also plans to expand their fresh air target from the current 30 minutes a day to one hour, in line with HMPPS's priorities. We note that one of the actions within the Secretary of State's action plan is for the prison to work with HMPPS Workforce and Capability Team to review its target staffing levels to ensure the safe delivery of regimes and services. We therefore make the following recommendation:

The Governor should outline in the PPO action plan how the actions in the UN action plan have impacted on the amount of key work carried out and the amount of time prisoners have out of their cells.

Lack of key work

102. Mr Gorst was not allocated a key worker during his time at Manchester and there was only one entry in his prison record which indicated that staff had had a notable conversation with him. (Given how little time out of cell Mr Gorst had, we acknowledge that it would have been difficult for staff to have had any meaningful contact with prisoners in their care.) While we cannot be certain that Mr Gorst would have shared his feelings and concerns, if a key work session had taken place, the officer may have picked up that Mr Gorst felt hopeless.

103. Officers gave us different accounts about when a key worker is allocated to a prisoner. Some told us that it happened once the induction was completed, and others said it was when the prisoner had left the induction wing. All officers

interviewed indicated that the 45-minute key work sessions were not taking place because of the lack of staff on the induction wing.

104. A prison manager told the investigator that Manchester was not able to carry out key work with all prisoners due to staffing constraints and a strategic decision had been made to focus on key work for a specific cohort of men. At the time of Mr Gorst's death, only prisoners convicted under the Terrorism Act and high-risk prisoners with mental health issues and those being monitored under suicide and self-harm (ACCT) procedures had key work sessions. This amounted to approximately 15% of the prison's population.

105. In October 2024, the investigator asked the prison for an update on the number of prisoners who were now receiving key work. We were told that key work had been extended and now included prisoners who had been given an indeterminate sentence for public protection and young adults. This amounts to 14.15% of the prison's population.

106. We note from the prison's regime plan for the year 2024/25 that there are no plans to extend key work beyond those prisoners identified as high priority, which is a concern.

107. Lack of key work was one of the issues identified during the recent HMIP inspection. However, we do not know at this stage if the actions set out in the Secretary of State's action plan will lead to an improvement in the provision of key work.

Delay in paramedics reaching Mr Gorst

108. Ambulance records show that the ambulance arrived at the prison at 3.19pm and paramedics were with Mr Gorst at 3.33pm. Paramedics recorded that there was a delay getting to Mr Gorst *"due to multiple security checks, gates and doors to open and close before they could get to the wing".* While we do not consider it would have changed the outcome for Mr Gorst and we recognise the importance of maintaining the prison's security, this was a significant delay.

109. We welcome HMPPS's updates to the policy framework covering emergency services' access (Managing conveyance of unauthorised and illicit items) in September 2024, which contains guidance for staff on ensuring the swift entrance and exit of emergency vehicles, including what items emergency service personnel are permitted to bring into the prison. As a result, we make no recommendation.

Clinical care

105. The clinical reviewer found that the clinical care that Mr Gorst received at HMP Manchester was equivalent to that which he could have expected to receive in the community. However, he was concerned about the difficulties the family liaison officer encountered when trying to pass on pertinent risk information about a prisoner. The clinical reviewer made four recommendations which are not directly linked to Mr Gorst's death but which the Head of Healthcare will want to address.

Governor to note

107. The reception officer told the investigator that he and a number of colleagues did not have access to the dPER. It is essential that all staff working in reception have access to the system and know how to look up a dPER.

108. During the interview with the Head of Safer Custody and Equalities, the investigator raised concerns about the clarity of the safer custody answerphone message and how this could cause callers confusion and delay or prevent communication about risk or safety information. The Head said that she could see there were some *'grey areas'* in the message and that this would be addressed. However, having checked the message in November 2024, we note that has not yet been changed.

109. The conversation with Mr Gorst about moving to a different wing was not recorded in his prison record. The officer told the investigator that she was not expected to record contacts of this nature.

110. The Governor will want to consider the broader learning identified by this investigation.

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