Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Leanne Lytollis on 13 January 2024, following her release from HMP New Hall

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 l 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. Ms Leanne Lytollis died of multiple drug toxicity on 13 January 2024, following her release from HMP New Hall on 8 January. She was 32 years old. We offer our condolences to those who knew her.

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 Ms Lytollis' death on 16 January 2024.

7. The PPO investigator obtained copies of relevant extracts from Ms Lytollis' prison and probation records.

8. We informed HM Coroner for Northeast Lincolnshire 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 Office contacted Ms Lytollis' family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not have any questions but asked for a copy of our report.

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

11. Ms Lytollis' family received a copy of the initial report. They did not make any comments.

Background Information

HMP New Hall

12. HMP New Hall is a closed prison for female prisoners aged 18 or over who have been convicted. It is managed by HMPPS. Inclusion, Midlands Partnership NHS Foundation Trust provide substance misuse services and. Practice Plus Group, Health in Justice provides physical and mental health care.

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 7 November 2023, Ms Leanne Lytollis was convicted of theft and was sentenced to 16 weeks in prison. She was sent to HMP New Hall. Ms Lytollis was due for release on 5 December.

15. A nurse conducted Ms Lytollis' initial health screen. She noted that Ms Lytollis used crack cocaine and took two pregabalin tablets every day and would drink several alcoholic drinks. In 2020, Ms Lytollis was diagnosed with emotionally unstable personality disorder (EUPD). She was being managed by a GP in the community. She was prescribed sertraline (antidepressant), amitriptyline (also an antidepressant sometimes prescribed for pain relief) and aripiprazole (anti-psychotic). Ms Lytollis tested positive for benzodiazepine, cocaine, and cannabinoids. The nurse referred her to the substance misuse team (SMS) and the alcohol brief intervention service.

16. On 8 November, a member of the substance misuse team noted that Ms Lytollis would be allocated a recovery worker for support. She started methadone therapy and was monitored closely for alcohol and benzodiazepine withdrawal.

17. On 13 November, a recovery worker from the substance misuse team completed an assessment with Ms Lytollis. They discussed the risks of mixing drugs, medication and alcohol and Ms Lytollis said she was fully aware of the risks. Ms Lytollis was also trained in the use of naloxone (a medication to reverse an opioid overdose) and said she would take a kit with her on release. Ms Lytollis said she was engaging with the community drug and alcohol service in the community, so the recovery worker referred her to We Are With You (WAWY- a charity that supports people who have challenges with drugs, alcohol or mental health).

18. On 4 December, a recovery worker of the substance misuse team gave Ms Lytollis the details of her initial appointment with WAWY. She could attend their office any time before 4.00pm on the day of release or at 11.00am on 6 December. There is no evidence Ms Lytollis attended her initial appointment with WAWY.

19. On 5 December, Ms Lytollis was released from HMP New Hall on Home Detention Curfew. (HDC - a scheme which allows some prisoners to be released early if they have suitable accommodation.) She was released to private rented accommodation, and she was issued with a naloxone kit.

20. On 8 December, Ms Lytollis attended an appointment with her Community Offender Manager (COM). Ms Lytollis appeared to be intoxicated and admitted that she had drunk an alcoholic drink before the appointment, and the previous day. They discussed how Ms Lytollis could keep herself safe and minimise the impact of her drinking. Ms Lytollis told the COM that the previous night she visited her uncle in hospital and that she did not get home in time for her curfew.

21. On 11 December, Ms Lytollis was recalled to prison because she breached her HDC curfew. She was unlawfully at large (UAL is when a person fails to take all necessary steps to return to prison after their licence has been revoked) for 10 days.

22. On 21 December, Ms Lytollis was convicted of theft and sentenced to one day in prison. While at court, the police arrested her for breaching her licence and she was sent back to New Hall. The one-day sentence ran concurrently with her recall to prison. She was due to be released on 8 January 2024.

23. A nurse completed Ms Lytollis' initial health screen, and she tested positive for cannabinoids, benzodiazepines and cocaine. Ms Lytollis said that she was using £50 of crack and £30 of heroin daily, prior to being recalled. Ms Lytollis said she was ok with being back in prison because it was better than where she was in the community.

24. Ms Lytollis started methadone maintenance therapy and was monitored closely by the SMS team.

Pre-release planning

25. On 22 December, a recovery worker from the substance misuse team referred Ms Lytollis to WAWY so that she could continue to be supported in the community. Ms Lytollis was advised about the use of naloxone, potential overdose and the impact of mixing drugs, medication, and alcohol. The recovery worker also informed Ms Lytollis that she did not need an appointment for WAWY, she could attend their office on the day of release.

26. On 28 December, a member of the resettlement team at New Hall completed Ms Lytollis' basic custody screening. She referred Ms Lytollis to Together Women Project (a charity who provide holistic support women with complex needs). This referral was initially for accommodation, but when a worker from Together Women completed Ms Lytollis' assessment the following day, it was evident Ms Lytollis needed support with other areas including substance misuse. The member of the resettlement team was aware that Ms Lytollis was already receiving support from the substance misuse team in prison. She did not refer Ms Lytollis to the community drug and alcohol service because this had already been done.

27. On 8 January 2024, Ms Lytollis was released on licence. She was released with a naloxone kit and enough medication to last until she was able to get an appointment with her community GP. Ms Lytollis had secured private accommodation.

Post-release management

28. Following her release, Ms Lytollis attended her initial appointment with her COM. They discussed her licence conditions, and the COM reminded her to attend her first appointment with WAWY.

29. The next day, Ms Lytollis attended her initial appointment with WAWY. A recovery worker completed her initial assessment. Ms Lytollis started methadone therapy but asked for buprenorphine (also known as Subutex - used to treat opiate addictions) or Espranor (another medication for opiate addictions) as soon as possible. He told her she would need to discuss this with the non-medical prescriber. An appointment was booked for Ms Lytollis to see the non-medical prescriber on 15 January. Ms Lytollis did not attend this appointment.

Circumstances of Ms Lytollis' death

30. On 13 January, Ms Lytollis was found unresponsive in her friends' property. When the police arrived, the paramedics had already confirmed that she had died. The police found empty packets of nitrazepam (a type of benzodiazepine), pregabalin, and carbocisteine tablets (both medications not prescribed to Ms Lytollis) and a small amount of cannabis. The police did not suspect any third-party involvement.

Post-mortem report

31. The post-mortem report concluded that Ms Lytollis died of multiple drug toxicity.

Findings

Substance misuse services

32. Ms Lytollis had a history of substance misuse. While she was in prison, she was promptly referred to the SMS team, who monitored her closely, placed her on a detoxification therapy and warned her about the risks and dangers of taking drugs. The SMS team in prison ensured they referred her to community drug services and community organisations to support women with a range of needs and vulnerabilities, ensuring she would still get the necessary support once she was released. Ms Lytollis was also trained in the use of naloxone and was released with a supply of this. We are satisfied that both the prison and probation services did all they could to manage the risks associated with her substance misuse.

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

At the inquest held on 25 October 2024, the coroner conclude Ms Lytollis' 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 l 020 7633 4100