

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Lynch, a prisoner at HMP/YOI Moorland on 19 October 2024

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 | 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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Peter Lynch was found hanged in his cell on 19 October 2024 at HMP Moorland. He was 61 years old. I offer my condolences to Mr Lynch's family and friends.

Mr Lynch was the first prisoner to take his own life at Moorland in three years. The last self-inflicted death was in December 2016.

This was Mr Lynch's first time in prison and he was clearly upset and frustrated about his sentence. Mr Lynch felt well supported by his family and he was able to spend time with his son, who was also at Moorland. The investigation found that there was little to indicate that Mr Lynch was in crisis, or at heightened risk of suicide and that staff could not have foreseen his actions.

The clinical reviewer found that healthcare staff appropriately assessed Mr Lynch's physical and mental health needs.

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

June 2025

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	11

Summary

Events

1. On 12 August 2024, Mr Peter Lynch was remanded to HMP Doncaster charged with violent disorder. On 22 August, he was sentenced to two years and eight months in prison. He transferred to HMP Moorland on 2 September.
2. Mr Lynch had not been in prison before and was upset and frustrated about his sentence. He told the reception officer he had anxiety and difficulty sleeping but denied any thoughts of suicide and self-harm. The reception officer recorded this in Mr Lynch's early days in custody document. The reception nurse noted that Mr Lynch engaged well and concluded that he did not need support from the mental health team.
3. During a mental health triage assessment, Mr Lynch said he felt safe on the house block and had support from his son (who was also at Moorland) and other prisoners. He did not want support from the mental health team and denied any thoughts of suicide and self-harm.
4. Mr Lynch was initially allocated a shared cell with his son on the induction unit. On 5 September, he moved to a single cell on the house block and did not express any concerns to staff that he was no longer sharing with his son.
5. On 17 October, Mr Lynch was placed on report for using threatening, abusive and insulting words or behaviour. At 7.00pm on 18 October, a prison officer gave Mr Lynch a letter which informed him of the date of his disciplinary hearing. She did not have any concerns about Mr Lynch's risk of suicide and self-harm.
6. At 6.23am on 19 October, an operational support grade (OSG) completed a morning routine check and saw Mr Lynch hanged from the TV bracket in his cell. He radioed for assistance but did not use an emergency code. An officer arrived at 6.24am and called a medical emergency code. Two more officers arrived at 6.25am. The staff waited outside Mr Lynch's cell. The night orderly officer (the most senior officer on duty) arrived at 6.29am. He entered Mr Lynch's cell and started cardiopulmonary resuscitation (CPR).
7. At 6.42am, paramedics arrived, assessed Mr Lynch, and pronounced life extinct.

Findings

8. Mr Lynch had been at Moorland for almost seven weeks when he was found hanged in his cell. He had some risk factors for suicide and self-harm but told staff he felt well supported by his family and on the house block. Mr Lynch spent frequent periods of association with his son and was due to start education.
9. The night before he was found hanged, Mr Lynch was given information about the disciplinary hearing he would face. This might have been a trigger for his actions, but he did not share any concerns with staff.

10. We consider that there were no particular indications that Mr Lynch's risk of suicide had increased in the days before his death and staff's decision not to begin ACCT procedures was appropriate.
11. The OSG did not use an emergency code when he found Mr Lynch hanged and unresponsive in his cell. The prison officers, who were part of the response team, did not understand that they could enter a cell at night. There was a six minute delay before staff entered Mr Lynch's cell.
12. The clinical reviewer concluded that Mr Lynch's clinical and mental health care at Moorland was equivalent to what he could have expected to receive in the community. Healthcare staff appropriately assessed Mr Lynch's physical and mental health needs.
13. We are satisfied that staff could not have foreseen his actions. We make no recommendations.

The Investigation Process

14. HMPPS notified us of Mr Lynch's death on 21 October 2024.
15. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. The investigator visited Moorland on 7 November. She obtained copies of relevant extracts from Mr Lynch's prison and medical records and viewed CCTV footage and body worn camera footage. She also listened to the last telephone calls that Mr Lynch made. She obtained the HMPPS early learning review and relevant policy documents. She spoke to Mr Lynch's son.
17. NHS England commissioned a clinical reviewer to review Mr Lynch's clinical care at the prison.
18. The investigator interviewed 14 members of staff at Moorland between November 2024 and February 2025. She and the clinical reviewer jointly interviewed healthcare staff and the prison staff involved in the emergency response.
19. We informed HM Coroner for Yorkshire Southeast of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
20. The Ombudsman's office contacted Mr Lynch's family to explain the investigation and ask if they had any matters they wanted us to consider. Mr Lynch's family did not ask any questions but requested a copy of the report.
21. We shared the initial report with Mr Lynch's family. They asked a question that does not impact on the factual accuracy of this report and which we have addressed through separate correspondence.
22. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and we have amended this report accordingly.

Background Information

HMP/YOI Moorland

23. HMP/YOI Moorland is a category C training and resettlement prison. Practice Plus Group runs healthcare services at the prison, including primary care, mental health and substance misuse services. Healthcare services are provided between the hours of 7.30am and 7.30pm, Monday to Friday.

HM Inspectorate of Prisons

24. The most recent inspection of HMP/YOI Moorland was in March 2023. Inspectors found that the safer custody department had worked hard to train their case managers in the new version of suicide and self-harm (ACCT) case management. A quality assurance process identified learning points for continuous improvement. The weekly multidisciplinary safety intervention meeting provided an effective forum for staff to plan and monitor the care provided to prisoners needing additional support, including those at risk of self-harm.

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. In its latest annual report, for the year to February 2024, the IMB reported that there was an increase in the number of ACCT documents opened during the reporting year. The safer custody team undertook live ACCT checks on observation and conversation records. The IMB found that the quality of documentation had become more consistent.

Previous deaths at HMP Moorland

26. Mr Lynch was the thirteenth prisoner to die at Moorland since October 2021. Of the previous deaths 11 were from natural causes and one was drug related. Mr Lynch was the first prisoner to take his life at Moorland since 2016. Up to the end of March 2025, there have been two deaths at Moorland since Mr Lynch's death, both were from natural causes.

Assessment, Care in Custody and Teamwork (ACCT)

27. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners 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 care plan to identify the prisoner's most urgent issues and how they will be met.

28. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. When Mr Lynch was at Moorland, guidance on ACCT procedures was set out in the Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody). From January 2025, this was superseded by the Prison Safety Policy Framework, in which the principles of how an ACCT is managed remain largely unchanged.

Key Events

29. On 12 August 2024, Mr Peter Lynch was remanded to HMP Doncaster charged with violent disorder having been involved in rioting in Rotherham. On 22 August, he was sentenced to two years and eight months in prison. (As with other individuals charged with offences related to the riots in the summer of 2024, his case was fast tracked through the courts.) This was his first time in prison.
30. Mr Lynch had pre-existing medical conditions for which he was prescribed medication.
31. The PER (Person Escort Record, which accompanies the individual from police custody to court and to prison and records details about risk) did not indicate any concerns about Mr Lynch's risk of suicide and self-harm.
32. Mr Lynch did not disclose any thoughts of suicide and self-harm at Doncaster. He was not managed under Prison Service suicide and self-harm prevention measures (known as ACCT) while he was there.
33. Mr Lynch's son was also convicted of violent disorder and spent time with Mr Lynch at Doncaster and Moorland.

HMP Moorland

34. On 30 August, the Head of Safer Custody and Equalities chaired the safety intervention meeting (SIM). The SIM discussed the arrival of prisoners involved in the summer riots (referred to as civil disorder prisoners in the minutes) and the potential impact on the prison. The SIM agreed that future meetings would discuss each prisoner's location and their custodial management. The SIM agreed to evaluate security intelligence related to the prisoners' impact on the prison and if they continued to demonstrate behaviours related to their offence. The safer custody team agreed to meet with all prisoners involved in the riots to identify their concerns and offer support (there is no evidence that this took place with Mr Lynch). The SIM recorded that the equalities manager would discuss the civil disorder prisoners in the protected characteristics forums to ensure that good order and discipline was maintained in the prison. (The equalities manager held a forum on each houseblock and outlined the sources of support available to prisoners with protected characteristics.)
35. On 2 September, Mr Lynch transferred to Moorland.
36. When Mr Lynch arrived at Moorland, escort staff took him to the reception area and handed staff the PERs. The PER did not indicate that Mr Lynch was at risk of suicide and self-harm. Mr Lynch telephoned his wife while he was in reception.
37. A prison officer completed Mr Lynch's reception interview. In the early days in custody document, she noted that Mr Lynch said he did not have any thoughts of suicide or self-harm and did not present as vulnerable. She recorded that he had anxiety and was struggling to sleep. At interview, she said that Mr Lynch was laughing and joking and did not appear low in mood. She assessed his risk of suicide and self-harm and decided he did not need to be monitored under ACCT.

She said she spoke to the reception nurse and made her aware of Mr Lynch's anxiety and sleeping difficulties.

38. A nurse completed Mr Lynch's reception health screen. She noted Mr Lynch's clinical history and made a referral to the long-term conditions nurse. (Mr Lynch did not attend his appointment with the long-term conditions nurse on 11 October). At interview, the nurse said that she remembered her interaction with Mr Lynch, and he was fed up but not tearful. She could not remember an officer telling her that Mr Lynch had anxiety and difficulty sleeping and he did not tell her this. She did not refer Mr Lynch to the mental health team because Mr Lynch engaged well, and he did not have any current thoughts of suicide and self-harm.
39. An officer completed Mr Lynch's first night induction and cell sharing risk assessment (CSRA, which assesses whether a prisoner poses a risk to other prisoners and can safely share a cell). He assessed Mr Lynch as a high risk of sharing a cell due to his offence and active alerts (racist, homophobic), but recorded he could share a cell with a prisoner of the same ethnicity. Mr Lynch was allocated a double cell on the induction unit which he shared with his son.
40. On 5 September, Mr Lynch moved to a single cell on houseblock 2, a general population wing, after completing the induction process. At interview, the officer said that Mr Lynch was happy to be in a single cell and he was able to see his son during association (social time). Mr Lynch was not allocated a keyworker.
41. On 6 September, a SIM was held to discuss the civil disorder prisoners including Mr Lynch and no concerns were raised. The SIM continued to discuss this cohort of prisoners on a weekly basis.
42. Between 3 and 24 September, Mr Lynch tried to call his family from the in-cell telephone, but the calls were blocked so he could not get through. On 21 September, Mr Lynch spoke to prison staff and said he was still unable to make telephone calls from his cell. Staff informed him that he needed to apply to have his telephone numbers approved. The prison arranged for Mr Lynch to telephone his wife. The same day, Mr Lynch submitted his telephone numbers for approval. At interview, the Head of Safer Custody & Equalities said that Mr Lynch's approved telephone numbers were not automatically transferred to Moorland because Doncaster (a contracted prison, operated by Serco) operates a telephone system which is not compatible with public sector prisons. Each telephone number is also subject to public protection screening before it is authorised.
43. On 24 September, mental health nurse completed a mental health triage assessment. She noted that Mr Lynch was tearful because he was frustrated about being in prison and said he felt a strong sense of injustice related to his offence. Mr Lynch said he felt safe on the house block and had support from other prisoners. He did not want to speak to the mental health team or consider medication and was aware that he could contact the mental health team if this changed. She recorded that Mr Lynch did not have any thoughts of suicide or self-harm.
44. On 25 September, Mr Lynch's telephone numbers were approved.
45. On 8 October, Mr Lynch made an application for work or education. He was due to start English education on 21 October.

46. On 11 October, Mr Lynch met with his prison offender manager (POM) to discuss the sentence planning process. At interview, the POM said that Mr Lynch was upset, emotional and frustrated with his sentence. Despite the POM's best efforts, Mr Lynch did not want to engage. Mr Lynch did not express any thoughts of suicide and self-harm. The POM said he intended to speak to Mr Lynch again within the next couple of weeks (the target for completing a prisoner's sentence plan is 10 weeks after sentencing). He did not consider that Mr Lynch should be monitored under ACCT.
47. On 12 October, Mr Lynch's family visited him. A further visit was arranged for 26 October.
48. On 17 October, staff placed Mr Lynch on report pending a disciplinary hearing for using threatening, abusive and insulting words or behaviour contrary to prison rules. Prison staff reported that Mr Lynch used racist and inflammatory language about migrants.
49. Mr Lynch's son told the investigator that he saw Mr Lynch on the houseblock during the afternoon. He did not have any concerns about Mr Lynch's behaviour but said he seemed quieter than normal. Mr Lynch gave his son a hug and returned to his cell.
50. At around 6.45pm, prison staff completed a routine welfare check and roll check. Mr Lynch was in his cell and did not have any concerns.
51. Mr Lynch made four telephone calls to his family on 18 October. He did not express any thoughts of suicide and self-harm.
52. CCTV shows that at 7.01pm on 18 October, an officer went to Mr Lynch's cell and gave him written details of the disciplinary hearing which would take place the following day. She spoke to Mr Lynch through the observation panel. At interview, she said that Mr Lynch read the document and did not raise any concerns. This was the last time Mr Lynch was seen alive.
53. At 8.00pm, an Operational Support Grade (OSG) completed an evening routine check of cells on Mr Lynch's unit. He checked that Mr Lynch's cell door was locked but did not look inside. At interview, he said that the purpose of the check is to ensure that cell doors are locked, and he was not required to complete a welfare check. Mr Lynch did not press his cell bell during the night.

Events of 19 October

54. The following account has been taken from documentary evidence provided by Moorland, CCTV and Body Worn Video Camera (BWVC) footage, medical records and transcripts of interviews with staff.
55. At 6.23am, the OSG completed the morning routine check of Mr Lynch's cell. At interview, he said he looked through the observation panel and saw that Mr Lynch was not in bed. A white lead was on the bed. He then saw Mr Lynch sitting on the cell floor with ligature around his neck. He said that he turned on the cell light and shouted and banged on the door. Mr Lynch did not respond. He radioed the control room and asked for assistance. He did not use an emergency code. (Codes red (for

blood) and blue (to indicate a prisoner is unconscious or having difficulty breathing) are established means for staff to raise the alarm. On hearing a code call, prison and healthcare staff attend the incident and staff in the control room call for an ambulance.)

56. At 6.24am, an officer from the prison officer response team attended (this is a team of officers who are responsible for attending requests for support from OSGs while the prison is in patrol state). At interview, he said he saw Mr Lynch hanged from the TV bracket. Mr Lynch was grey in colour, and he thought that he was dead. He radioed an emergency code blue and asked the night orderly officer (the manager in charge of the prison during the night) to attend. Control room staff called an ambulance immediately. He said he believed he could not enter the cell without the permission of the night orderly officer. He did not ask the night orderly officer if he could enter the cell.
57. At 6.25am, two further officers (who were also from the prison officer response team) attended. At interview, both officers said they were unaware that they could enter Mr Lynch's cell without the authority of the night orderly officer. They did not radio the night orderly officer again to ask for permission.
58. At 6.29am, a Custodial Manager (CM) arrived at Mr Lynch's cell. (The CM had arrived at the prison early for his day shift at 6.07am. At that point, the night orderly officer had gone off duty and left the prison.) He opened the cell door and entered with the three officers. The CM used his anti-ligature knife to remove the ligature from Mr Lynch's neck. He started CPR. At interview, he said that Mr Lynch was cold to touch and felt stiff. He recognised signs of rigor mortis. He said he understood the circumstances when it was inappropriate to start CPR but he decided to start lifesaving procedures in case he 'got it wrong'.
59. At 6.42am, paramedics arrived and having examined Mr Lynch, pronounced life extinct.
60. Mr Lynch left notes to his family. He asked for forgiveness and spoke about his love for his family. Mr Lynch also spoke about his frustrations around the circumstances of his prison sentence.

Contact with Mr Lynch's family

61. At 8.20am, the prison appointed a family liaison officer (FLO). She went with the Governor and broke the news of Mr Lynch's death to his son. The prison arranged additional family visits.
62. At 10.35am, the FLO and Governor visited Mr Lynch's wife and broke the news of his death. The FLO stayed in contact with Mr Lynch's family to offer advice and support.
63. In line with national policy, the prison contributed towards Mr Lynch's funeral costs.

Support for prisoners and staff

64. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
65. After Mr Lynch's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The Samaritans attended the prison on 22 October and spoke to prisoners and staff.
66. The prison posted notices informing other prisoners of Mr Lynch'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 Lynch's death.
67. Safer custody staff gave prison listeners and the induction unit manager postvention leaflets to share with prisoners and staff.

Post-mortem report

68. The post-mortem report gave Mr Lynch's cause of death as hanging. The toxicology report detected the presence of Mr Lynch's prescribed medications in his blood at levels in line with his prescribed doses.

Findings

Assessment of risk

69. Mr Lynch had been at Moorland for almost seven weeks when he was found hanged in his cell. Mr Lynch's son was also at Moorland and Mr Lynch told staff that he had good family support. Mr Lynch had no previous history of attempted suicide and self-harm. Prison Service Instruction (PSI) 64/2011 on safer custody (in place at the time of Mr Lynch's death and now replaced by the Prison Safety Policy Framework), required all staff who had contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. Mr Lynch had some of these risks including that he was convicted of a violent crime, this was his first time in prison, and he felt upset and angry about his sentence.
70. Prisoners in the early days of prison life are at increased risk of suicide and so it is particularly important that staff responsible for assessing them in reception and during induction understand how to identify objective risk factors and make and record considered decisions about whether ACCT monitoring is required. Mr Lynch told the reception officer that he was suffering from anxiety and had difficulty sleeping. Prison staff did not fully explore this with Mr Lynch or record in the early days in custody document what action was taken to reduce his risk.
71. The Head of Safer Custody & Equalities told us that staff's recording of their assessment of Mr Lynch's risk when he arrived at Moorland fell below the expected standard. She said that since Mr Lynch's death, the prison has taken steps to improve the quality of the early days process, with an emphasis on assessing risk. She said that following Mr Lynch's death, additional checks have been introduced to ensure that staff identify those prisoners who may be at an increased risk. With support from the regional safety team, the prison has reviewed the early days process. The early days document now includes additional questions about risk and what action staff must take if they are concerned. Prisoners are also provided with information about the Samaritans and prison Listeners (prisoners trained by the Samaritans to provide support).
72. The Head said that the prison has introduced additional quality assurance checks to ensure that reception staff follow the correct procedures for newly arrived prisoners, including spot checks on early days booklets and identifying staff that need additional training. We welcome these steps. However, experience tells us that upskilling staff in reception and ensuring that they use the information available to them to assess suicide and self-harm risk requires ongoing focus and training. The Governor will want to sustain progress in this area.
73. Despite his upset and frustration about being in prison, Mr Lynch continued to deny any thoughts of suicide and self-harm. Prison staff reported that he interacted well with other prisoners on the house block, and he spent frequent periods of association with his son. He was also due to start education shortly after his death. When Mr Lynch was placed on report, prison staff explained the adjudication process and did not consider that his risk of suicide and self-harm had increased. It is possible that being placed on report was a trigger for Mr Lynch's actions, but he did not express any particular concerns to staff.

74. We are satisfied that there was little evidence that Mr Lynch's risk of suicide had significantly risen in the days before his death and that staff could not have foreseen his actions. We make no recommendation.

Emergency response

75. Our recent Policy into Practice: Emergency Response, published on 29 January 2025, highlights that the HMPPS Internal Security Procedures Policy includes the procedures for staff entering a cell at night. Under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer and cells should not be opened unless a minimum of two/three members of staff are present. However, staff have a duty of care to prisoners, to themselves and to other staff, and the preservation of life takes precedence over these directions. This means that where there appears to be immediate danger to life, staff can enter a cell if they consider it safe to do so (having undertaken a dynamic risk assessment), without first seeking permission from senior staff. The policy emphasises the importance of night staff being regularly briefed on the circumstances in which they can enter a cell. The PPO has made repeat recommendations that Governors should ensure night staff understand this.
76. Our investigation found that the OSG who found Mr Lynch hanged did not use a medical emergency code and prison staff who responded did not understand that they could enter a cell without the authority of the night orderly officer. This led to a delay of six minutes before they entered Mr Lynch's cell, and this only happened when the orderly officer arrived. In addition, staff did not communicate to the night orderly officer that Mr Lynch had hanged himself. We cannot say that the delay affected the outcome for Mr Lynch, but early intervention is crucial to improving the outcome in cases of hanging.
77. Since Mr Lynch's death, the prison has taken steps to ensure staff understand what action must be taken if a prisoner is unresponsive and there is an immediate risk to life. This includes the appropriate use of emergency codes and what information must be shared with the control room to ensure that an ambulance with the correct priority is dispatched and that the night orderly officer is aware of the situation. On 29 October, the prison issued a notice to staff about action to be taken if staff discovered an incident that may present a risk to life during night or patrol state. The prison has also amended their local security strategy to include a video about the procedure that staff must follow when they respond to emergency situations.
78. The night orderly officer is now required to deliver a briefing to all staff on night one of the period of night duties. This includes mandatory instructions to staff about the action they must take in non-emergency and emergency situations. Night staff are required to sign the document to confirm their understanding. The night orderly officer must also confirm to safer custody that they have delivered the briefing. Ms Rose has shared with the investigator evidence of the quality assurance process introduced to ensure that all staff are aware of their responsibilities.
79. In light of the steps taken by Moorland, we do not make a recommendation in relation to entering a cell.

Delivering keywork

80. The keyworker scheme is intended to allow prison officers more time and flexibility to provide prisoners with the best chance of engaging in rehabilitation. Consistent key work enables good relationships to develop between staff and prisoners, providing support and encouraging positive behaviours.
81. At the time of Mr Lynch's death, keywork at Moorland was targeted at the most vulnerable prisoners, with young offenders who were serving their first custodial sentence being identified as a priority. Prisoners who were identified as vulnerable to violence or bullying were also considered for priority keywork. Staff could refer prisoners who required extra support from a keyworker to the SIM. Mr Lynch was not allocated a keyworker at Moorland, and he did not raise any concerns with prison staff that he needed support. We consider that Mr Lynch, who was serving his first custodial sentence, may have benefitted from additional targeted support from a designated keyworker.
82. In January 2025, the prison introduced a new keyworker policy which states that all prisoners will be allocated a keyworker, who will provide prisoners with consistent support throughout their time at Moorland.
83. We welcome the introduction of keywork to all prisoners and make no recommendation.

Prisoner phone access

84. PSI 49/2011 on prisoner communication services requires prisons to encourage prisoners to maintain contacts in the community and meaningful family ties.
85. When Mr Lynch arrived at Moorland, his telephone numbers did not automatically transfer with him. In normal circumstances, administration of the prison phone accounts system usually takes at least a few days to set up. Mr Lynch (who was not familiar with prison systems) incorrectly assumed that his numbers would automatically transfer with him. He was unable to make a telephone call from his cell for 23 days. This delay would undoubtedly have caused Mr Lynch additional stress and upset.
86. In March 2025, we made a national recommendation that prisons should review the current process for setting up prison phone accounts for newly arrived prisoners (both from court and on transfer).
87. The Head of Safer Custody & Equalities told us that Moorland did not have a process in place to ensure that prisoners who arrived from Doncaster were aware that each of their telephone numbers would require approval before they could access the phone system.
88. Since Mr Lynch's death, reception staff inform prisoners arriving from Doncaster that their phone numbers will not automatically transfer to the phone system, and they are provided with a form to submit numbers for approval. Once approved, the numbers are added as a priority. Prisoners can make a telephone call from the reception area and staff also inform their next of kin (if they are a different contact) that they have arrived at Moorland. The Head provided evidence of the new

process to the investigator. This includes quality assurance checks to ensure that reception staff are following the correct procedures for newly arrived prisoners. We are satisfied that Moorland has taken appropriate steps to improve the process and make no recommendation.

Clinical and mental health care

89. The clinical reviewer concluded that Mr Lynch's clinical care at Moorland was equivalent to what he could have expected to receive in the community. The clinical reviewer made a recommendation to the Head of Healthcare about non-attendance at clinical appointments which they will wish to consider.
90. The clinical reviewer commented that as Mr Lynch's death occurred outside of the healthcare team's hours of provision, healthcare staff did not attend the emergency response on 19 October. When prison staff entered Mr Lynch's cell it was clear that resuscitation attempts would be futile.
91. The clinical reviewer said that healthcare staff appropriately assessed Mr Lynch's physical and mental health needs and that they could not have foreseen his actions.

Inquest

92. At the inquest, which took place between 20th July and 5 August 2026, the Coroner concluded that Mr Lynch died by suicide.



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

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

T | 020 7633 4100