Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Sabrina Lyttle, on 30 November 2024, following her release from HMP Styal

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

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 investigated 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 Sabrina Lyttle died from mixed drug toxicity (multiple drugs used simultaneously) on 30 November 2024 following her release from HMP Styal on 27 November. She was 47 years old. We offer our condolences to those who knew her.

5. Ms Lyttle had significant alcohol and substance misuse issues, including a history of heroin and crack cocaine use. Although she was in prison for only three weeks, prison, probation and healthcare staff provided substance misuse support prior to her release. They arranged for several community agencies to work with Ms Lyttle and for this to continue in the community after release. This included staff from one agency meeting Ms Lyttle outside the prison on release and supporting her at her first-day appointments.

6. We do not think that prison and probation staff could have done any more to support Ms Lyttle in the short time from when she was sent to prison until her death. We make no recommendations.

The Investigation Process

7. We were notified of Ms Lyttle's death on 11 December 2024.

8. The PPO investigator obtained copies of relevant extracts from Ms Lyttle's prison and probation records.

9. We informed HM Coroner for Blackpool of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

10. The Ombudsman's office contacted Ms Lyttle's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

11. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS pointed out five factual inaccuracies and we have amended this report accordingly.

Background Information

HMP Styal

12. HMP Styal holds women in a variety of residential units, with 16 separate houses each holding about 20 women. Spectrum Community Health provides healthcare services at the prison. Greater Manchester West Mental Health NHS Foundation Trust provides mental health services. The prison has 24-hour nursing cover.

Probation Service

13. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, 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 supervises people throughout their licence period and post-sentence supervision.

Key Events

14. On 5 November 2024, Ms Sabrina Lyttle was convicted of theft and sentenced to eight weeks in prison. She was sent to HMP Styal. Ms Lyttle had been to prison several times before (although not for over a year) and had a history of substance misuse.

15. At the reception health screening, Ms Lyttle said that she smoked heroin and crack cocaine daily and also misused diazepam (a benzodiazepine commonly known by the brand name Valium that is prescribed for conditions including anxiety and alcohol withdrawal). Healthcare staff identified that she was withdrawing from drugs and alcohol, but she initially refused opiate substitution treatment. Ms Lyttle said that she had previously been prescribed mirtazapine (an antidepressant) but had not collected this for some time. (The prescription was not continued in prison.)

16. On 6 November, Ms Lyttle started a methadone maintenance programme. (Methadone is a prescription medication used to treat opiate withdrawal.) She told healthcare staff she last used drugs and alcohol approximately three days prior to prison. Ms Lyttle asked to speak with mental health team (MHT). MHT staff saw Ms Lyttle in her cell, but she said she was not feeling well and did not wish to engage as she was detoxing. Staff agreed to review her the next day.

17. On 7 November, Ms Lyttle attended substance misuse services. Healthcare staff did recovery checkups on Ms Lyttle and agreed regular clinical observations on her. They contacted Blackpool Horizon (community drug and rehabilitation services) and waited for their appointment details for Ms Lyttle. The medical records did not say if Ms Lyttle was seen by MHT as requested by her the previous day.

18. On 11 November, healthcare staff referred Ms Lyttle to the MHT. Substance misuse service staff also met Ms Lyttle to complete her pre-release substance misuse assessment. They told Ms Lyttle she was required to attend Blackpool Horizon at 3.00pm on the day of her release. Blackpool Horizon staff said they would meet Ms Lyttle at the prison gate when she was released.

19. On 12 November, substance misuse staff referred Ms Lyttle to Reconnect Cheshire (a national programme which is designed to assist individuals leaving prison by providing support, including to access health needs). Reconnect Cheshire staff booked an appointment to see Ms Lyttle at 9.00am on 26 November via videolink.

20. On 13 November, pre-release prison staff completed a needs assessment for Ms Lyttle. Staff raised accommodation issues and completed a Duty to Refer (public authorities have a duty to refer those whom they believe to be homeless or threatened with homelessness - for example, if it is likely they will become homeless within 56 days) to Blackpool Housing for Ms Lyttle.

21. On the same day, the prison offender manager (POM) introduced himself to Ms Lyttle. He was familiar with Ms Lyttle as she knew him in his former role as a prison officer. The POM noted that Ms Lyttle had settled on the wing and was feeling much better. She was due for release on 27 November and had now been referred to Lancashire Women (a charity supporting women with employment, mental health and wellbeing support). This referral was undertaken by the COM on 19 November.

22. On 14 November, healthcare staff met Ms Lyttle to complete release planning and gave her a release appointment letter. Blackpool Horizon staff had sent healthcare staff details of the nearest pharmacy where Ms Lyttle could collect her methadone prescription. Healthcare staff gave Ms Lyttle harm reduction advice and explained tolerance and overdose awareness. They also gave Ms Lyttle training on using a naloxone pack ahead of her release. (Naloxone is used to reverse or reduce the effects of an opioid overdose.)

23. On 19 November, Ms Lyttle was due to attend a Reconnect assessment, but did not attend. (The reason Ms Lyttle did not attend this or a later assessment was not recorded.)

24. On 21 November, a substance misuse nurse reviewed Ms Lyttle. She reported that she was very excited to be involved in a police scheme (OASIS - aims to create a safer and more secure environment in Blackpool town centre). This meant that she would be supported and provided with accommodation. She would also be supported by Blackpool Horizon (which is connected to the Changing Futures) and under the care of the community drug team. The support from Horizon had been facilitated by a referral from the COM and included Ms Lyttle being picked up at the prison gate on the day of her release. Ms Lyttle was still prescribed methadone. Staff assessed that she had mild withdrawal symptoms, but she said she was otherwise okay.

25. On 22 November, healthcare staff gave Ms Lyttle a release appointment letter. As agreed, Blackpool Horizon staff were to meet her on the morning of release. Staff reminded Ms Lyttle that if this could not go ahead then she was to attend Blackpool Horizon before 3.00pm on the day of release. They requested a naloxone pack, to be given to Ms Lyttle on release. Staff also arranged for Ms Lyttle's methadone prescription to continue once released.

26. On 26 November, Ms Lyttle did not attend her scheduled Reconnect assessment. As she was being released to the Blackpool area, prison staff contacted the Lancashire Reconnect Team to advise that Ms Lyttle did not attend her appointment. Prison staff sent all the information they had, including the referral form for Ms Lyttle, to Lancashire Reconnect and requested they see her in the community within 28 days.

27. Lancashire Reconnect reviewed the referral and advised prison staff that Ms Lyttle had not been accepted. This was because she was already receiving support from Prison Leavers (services that aim to help individuals reintegrate into society, address health needs, and access vital resources like housing, employment, and social support) and Lancashire Women.

28. Ms Lyttle's community offender manager (COM) told us that she did not meet Ms Lyttle prior to her release and did not have telephone contact with her either. As Ms Lyttle was sentenced on 5 November and released on 27 November, she said that there was very little time for her to make contact. (The COM said she was also absent from work for a week during this time.) However, on 26 November she liaised with Housing, POM and Lancashire Women to confirm release plans.

29. On 27 November, Ms Lyttle was released from prison. She was met by Changing Futures staff. (Changing Futures is a government funded programme to help to

stabilise and improve the lives of adults facing multiple disadvantages, including homelessness and substance misuse. We do not know why their staff met Ms Lyttle rather than Blackpool Horizon staff, as had previously been suggested.) Prison staff issued a naloxone pack to Ms Lyttle.

30. Blackpool Housing arranged temporary release accommodation for Ms Lyttle in a hotel.

Post Release

31. On the day of release, Ms Lyttle attended Blackpool Horizon with Changing Futures staff and was assessed as a priority need. Changing Futures staff also accompanied Ms Lyttle to Lancashire Women, where new clothes and a phone were issued to her.

32. Changing Futures staff brought Ms Lyttle to her initial probation induction appointment on 27 November. The COM saw Ms Lyttle and completed the probation induction agreement. They said that Ms Lyttle would have weekly appointments and drug testing for the duration of her licence. Dependent on her presentation at later appointments, Ms Lyttle could have been referred to the First Steps to Change. This is a Probation toolkit delivered 1:1 by the COM which intends to support engagement and compliance throughout a Community Order or period of licence supervision by providing practical activities focused on building skills, strengths and strategies to encourage women to desist from offending and have a positive future.

Circumstances of Ms Lyttle's death

33. On 30 November, Ms Lyttle was found unresponsive in a restaurant toilet in Blackpool. Initial circumstances suggested this was because of drug use. A crack pipe was found on the floor with a number of tablets not identified at the time. Sadly, Ms Lyttle had been in the toilet for two days before being discovered by maintenance staff. Paramedics attended and pronounced life extinct.

Post-mortem report

34. The post-mortem report concluded that Ms Lyttle died from mixed drug toxicity. The toxicology report found that she had used cocaine and taken methadone and diazepam at some time prior to her death.

Findings

35. Ms Lyttle was a vulnerable woman with complex support needs, including a long history of substance misuse and homelessness linked to risk of harm and offending behaviour. After release, she was given temporary accommodation in a hotel. She attended her initial probation induction, but we do not know her whereabouts after this until her death.

36. Prior to her release, prison and probation staff made arrangements to support Ms Lyttle in the community with her substance misuse issues. Her methadone prescription was continued and she was given naloxone on release (and training on how to use this). Arrangements were made with several community support services, including Blackpool Horizon, Changing Futures and Lancashire Women. Staff from these organisations engaged with Ms Lyttle on the day of her release, and it is positive that they were able to meet her at the prison gate and accompany and support her at her initial appointments.

37. Ms Lyttle was released from prison on 27 November, after serving just over three weeks of her sentence. The short time period she spent in prison meant that prison and probation staff had little opportunity to plan, including finding permanent release accommodation for her. Nevertheless, there was some good practice in the utilisation of staff with whom Ms Lyttle was familiar (POM), and regular discussion between professionals on release preparation and risk management for Ms Lyttle in the community. The COM had a good relationship with Ms Lyttle working with her since September 2022. We found evidence that prison and probation staff, in collaboration with community support staff, made consistent efforts to understand her needs and how to address them. They encouraged Ms Lyttle to engage with the support services offered her in the community. We do not think any more could have been done to support Ms Lyttle.

Inquest

38. The inquest into Ms Lyttle's death concluded on the 29 July 2025. The coroner confirmed that Ms Lyttle died of mixed drug toxicity.

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

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