Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sam Lynn, a resident at St Leonard's Approved Premises, on 25 July 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Sam Lynn died in hospital on 25 July 2020, after being found hanging in his room at St Leonard's Approved Premises on 20 July. Mr Lynn was 28 years old. I offer my condolences to his family and friends.

Mr Lynn had only been at St Leonard's for five days before he was discovered hanging in his room. There was nothing in Mr Lynn's behaviour that gave any indication he would take his life. I am satisfied that staff could not have foreseen his actions.

However, I am concerned that there was a delay in staff starting resuscitation attempts when they found Mr Lynn hanging. I cannot say whether the delay made a difference to the outcome, but we know that in a medical emergency a delay of a few minutes may be critical.

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

Sue McAllister CB
Prisons and Probation Ombudsman **March 2021**

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Summary

Events

1. Mr Sam Lynn was sentenced to 56 months in prison in 2017. He was released on licence, to St Leonard's Approved Premises (AP), on 15 July 2020. Mr Lynn would have preferred to stay with his parents on release, rather than live at an AP, but there was concern about his drug use.

2. Mr Lynn's risk of self-harm was assessed as low during his induction at the AP. He had only harmed himself once, in 2017, protesting about a transfer to a different prison. All residents at the AP were checked three times during the night and morning. Mr Lynn had an additional check due to his previous substance misuse.

3. Staff found Mr Lynn bathing his feet in a bathroom during the early hours of 18 July. He had been walking a lot in shoes that were too small for him. Mr Lynn was told to visit hospital, where he was treated for cellulitis. He was prescribed antibiotics and painkillers and returned to the AP later that day. He spent all the next day, Sunday 19 July, in his room and mostly in bed, which was unusual for him. Mr Lynn told staff he felt tired and did not want to take any medication.

4. During a welfare check at 3.00am on 20 July, staff found Mr Lynn hanging from a ligature attached to a window catch in his room. Staff called an ambulance immediately, but they did not start cardiopulmonary resuscitation (CPR) until paramedics arrived. The paramedic recovered a pulse and Mr Lynn was taken to hospital but died on 25 July.

Findings

5. We are satisfied that staff assessed Mr Lynn's risk of suicide and self-harm appropriately and that they could not have foreseen his actions.

6. We are concerned that staff did not start CPR when they found Mr Lynn hanging. We cannot say whether the delay affected the outcome for Mr Lynn but we know that in a medical emergency, a delay of a few minutes may be critical.

Recommendations

- The Approved Premises manager should ensure that all staff understand the Probation Service's policy on resuscitation in Approved Premises.

The Investigation Process

7. The investigator issued notices to staff and residents at St Leonard's Approved Premises (AP) informing them of the investigation and asking anyone with relevant information to contact her. No one contacted her.

8. The investigator obtained copies of relevant extracts from Mr Lynn's prison and AP records.

9. The investigator interviewed three members of staff at St Leonards, and Mr Lynn's Offender Manager.

10. We informed HM Coroner for Berkshire of the investigation. The Coroner did not request a post-mortem or request samples for a toxicology test. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Lynn's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Lynn's family did not raise any issues.

12. We shared our initial report with Mr Lynn's mother. She raised no factual inaccuracies.

13. We provided Mr Lynn's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

St Leonard's Approved Premises

14. Approved premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.

15. St Leonard's is an approved premises in Reading managed by the Thames Valley Probation Trust. It can accommodate up to 22 residents. Staffing at St Leonard's includes managers, offender supervisors (previously known as keyworkers) and support staff, with two staff on duty at night. Residents are always required to sign in and out of the premises and all are subject to standard curfew conditions over night. During the day, residents are free to go out unaccompanied, although they must state where they are going. Alcohol and drugs are strictly forbidden in the AP but residents can consume alcohol when they are out.

16. Residents are required to attend a morning meeting at 10.00am each day, which is followed by in-house projects on topics such as job hunting, finding accommodation and home domestics.

17. Residents register at one of two local GP surgeries. Most prescribed medications are held by premises staff and issued to residents each day. Residents are risk-assessed and allowed to hold medication in their own possession if staff are satisfied that it is safe for them to do so, apart from certain excluded classes of medication which cannot be held by residents. These medicines are always retained by staff and issued to residents according to the prescription. For residents whose risk assessment concludes that they should not retain possession, all their medicines are retained by staff.

Previous deaths at St Leonard's Approved Premises

18. Mr Lynn's death was the fourth at St Leonard's since the Ombudsman took on the responsibility for the investigation of deaths in custody in April 2004. The last death was in 2013.

Key Events

19. On 6 January 2017, Mr Sam Lynn was sentenced to 56 months in prison for robbery and assault. His conditional release date was 7 August 2020, and his licence expiry date was 22 October 2023. This was not his first time in prison.

20. On 16 July 2017, Mr Lynn refused to transfer from HMP Bullingdon to HMP Stocken and cut his arm in protest. This was Mr Lynn's only reported act of self-harm while in custody. Staff started suicide and self-harm prevention procedures (known as ACCT) but they were stopped the next day. Mr Lynn was moved to Stocken a week later. He was moved to Woodhill in 2018, and then returned to Bullingdon on 25 March 2019.

21. Mr Lynn was released on licence from Bullingdon on 15 July 2020, three weeks earlier than expected due to a sentence recalculation. Mr Lynn would have preferred to live with his parents, but because he was considered a high-risk prisoner who would need increased monitoring, and because of his drug use, it was decided he would be released to live at St Leonard's Approved Premises (AP). Mr Lynn had told prison staff he was keen to leave prison, but nervous about staying at an AP. He expressed concern about living with other residents who had also been released from custody.

22. Mr Lynn reported to St Leonard's AP at 12.00pm on 15 July. He could leave there freely if he abided by his 8.00pm to 8.00am curfew and signed in at 2.00pm, every day. AP staff carried out an additional night welfare check on Mr Lynn, as well as three standard checks at 11.00pm, 12.00am, and 7.30am, due to his substance misuse. Mr Lynn had a history of drug taking and alcohol issues both in prison and in the community. The AP Manager, told the investigator that staff were not allowed to search residents but could search their room if they had reasonable suspicion the resident might have something unauthorised, for example illicit drugs.

23. During a comprehensive induction to the AP, Mr Lynn said he was expecting to start work and had saved money for a deposit on a flat. Mr Lynn acknowledged this was the "best chance" he had, was happy to be released and said he had no issues and already knew several residents at the AP. Mr Lynn was told about how COVID-19 restrictions would affect him, including no group work or purposeful activity.

24. Staff completed a self-harm risk assessment with Mr Lynn during his induction. Mr Lynn spoke about his one incident of self-harm in 2017, but said he had no current concerns, had not been treated for depression or any other mental health issues, had never been on any medication for mental health issues, had never attempted suicide and that his family was his protective factor. Mr Lynn spoke about his previous cocaine and heroin use. Staff assessed Mr Lynn as being at low risk of self-harm. They noted that to ensure he remained safe, he would have random drug and alcohol tests, and his room would be searched if there was suspicion he had been taking illicit drugs.

25. There were no issues during any of Mr Lynn's welfare checks overnight on 15 July.

26. Mr Lynn spoke to his offender manager, on the telephone the next day, 16 July. He told his offender manager he had settled in better than he had expected. Mr Lynn completed an application for Universal Credit, was given an advance payment of £300, and agreed to let the offender manager know if he started to have any issues with illicit drug use. They agreed to meet, in person, on 20 July.

27. Mr Lynn's welfare checks were completed as scheduled on 16 and 17 July. There were no issues at any checks. At 2.20am, on the morning of 17 July, Mr Lynn went to the AP office to request painkillers as he had toothache. Staff were not permitted to give him any but gave him a bag of frozen fruit to try to ease the pain. Mr Lynn did not complain about this again.

28. On 18 July, at 2.45am, a recovery worker saw Mr Lynn bathing his feet in the bathroom. He told her he had been wearing trainers that were too small, and had resulted in blisters, sores and he had lost toenails. The recovery worker telephoned 111 for advice and was told Mr Lynn needed to attend the Accident and Emergency department at The Royal Berkshire Hospital (RBH) within the hour. The recovery worker arranged a taxi to take Mr Lynn to hospital. He returned at 7.00am, having been prescribed antibiotics and codeine painkillers. Hospital staff had drawn a line on one of Mr Lynn's legs, which was red and swollen and hospital records noted he had cellulitis. Mr Lynn was told to return to hospital if the redness travelled outside of the mark, and he had a follow up appointment for Monday 20 July.

29. On Sunday 19 July, Mr Lynn stayed in bed most of the day, which was unusual for him. The recovery worker spoke to Mr Lynn during a welfare check at 11.00pm, when she asked whether he was going to take any of his medication, as he had not taken any that day. Mr Lynn replied that he felt too tired. Ms Ibironke thought this could be true, as he had not slept much the previous day, because of the pain in his feet and trip to hospital. The recovery worker asked Mr Lynn again at the next welfare check at 12.00pm. Mr Lynn replied that he did not want to take any medication. The recovery worker reported this in line with AP regulations. Mr Lynn was checked again (his additional welfare check) at 3.00am, and he responded to staff. Closed Circuit Television (CCTV) showed that apart from staff, nobody entered or left Mr Lynn's room throughout the night, including Mr Lynn.

30. At 7.30am on 20 July, a residential assistant and the recovery worker began their morning welfare check. They had checked ten rooms before arriving at Mr Lynn's. The residential assistant who was leading the checks that morning, was dressed in full protective clothing. He unlocked the door and looked in, before quickly closing the door again. He spoke quietly so as not to alert the residents, and told the recovery worker that Mr Lynn was hanging. They both immediately went into Mr Lynn's room where they could see he was suspended by straps from a rucksack, to a metal bar used to restrict the opening of the skylight. The residential assistant held Mr Lynn while the recovery worker cut the ligature. They both gently lowered him to the floor.

31. At 7.31am, the recovery worker telephoned 999 for an ambulance while the residential assistant checked Mr Lynn's wrist for a pulse. He could not find one. The residential assistant said Mr Lynn appeared blue in colour and felt cold.

32. The investigator listened to the 999 call. The ambulance operator told the recovery worker they would be on the scene quickly, so residential assistant went to the front door to let them in, while the operator instructed the recovery worker to check Mr Lynn again, which she did.

33. Initially the recovery worker told the ambulance operator that Mr Lynn was not breathing and felt cold. The operator asked several questions and asked her to carry out further checks, at which point the recovery worker realised Mr Lynn's back felt warm. The recovery worker rolled him onto his back, with some difficulty, and started massaging him to try to bring about some movement. After another minute, at 7.36am, the operator asked whether the recovery worker had access to a defibrillator. The recovery worker said she had and would get it. At this point paramedics can be heard arriving at the AP and took over Mr Lynn's care. They checked Mr Lynn and instructed the residential assistant to begin cardiopulmonary resuscitation (CPR), which he did. A paramedic gave Mr Lynn an injection and then took over CPR.

34. A Helicopter Emergency Medical Service (HEMS) crew arrived a few minutes later and took over Mr Lynn's care. They managed to establish an output and, at 8.15am, they took Mr Lynn to hospital.

35. A police officer searched Mr Lynn's room. She found a used crack pipe and Brillo scouring pad used to smoke drugs, and three mobile telephones. The last sent message on one of the phones said that Mr Lynn was sorry for his actions, but his head was "fucked up right now" and he did not want to be here anymore. Mr Lynn wrote that he hated his life.

36. On 27 July, police told the AP Manager that Mr Lynn had died in hospital on 25 July, at 10.57pm.

Contact with Mr Lynn's family

37. The AP Manager telephoned Mr Lynn's mother to inform her that her son had been taken to hospital in a serious condition. AP and probation staff telephoned the hospital regularly for updates on Mr Lynn's condition, but the family asked for no further contact from any probation staff. The Probation Service offered to contribute to Mr Lynn's funeral in line with national guidelines.

Support for residents and staff

38. After Mr Lynn's death, the AP Manager 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 were offered counselling.

39. The AP staff offered support to residents who may have been adversely affected by Mr Lynn's death.

Post-mortem report

40. The Coroner did not request a post-mortem. No toxicology samples were taken.

Findings

Assessment of Mr Lynn's risk

41. During Mr Lynn's induction, staff completed a self-harm risk assessment. The purpose is to identify and manage residents who might be at risk of self-harm, in conjunction with Equip (Managing Risk of Intentional Injury and Risk to Self, Community Process) and PI 32/2014, Approved Premises Manual, and the Approved Premises Reducing Self-Inflicted Deaths Action Plan.

42. The assessment asks about any previous incidents of attempted suicide or self-harm. Mr Lynn reported the incident in 2017, when he cut his arms, but said he had no current concerns. Mr Lynn disclosed previous cocaine and heroin misuse, and said he had the support of family and friends and that helped him to cope with his situation. Mr Lynn's level of risk was assessed as low, although he was put on an extra welfare check each night because of his substance misuse history. An extra welfare check was carried out every night.

43. We are satisfied that staff assessed Mr Lynn's risk of self-harm appropriately, that he gave no sign that he intended to take his life during the short time he was at the AP, and that staff could not have foreseen his actions.

Emergency response

44. The National Probation Service has an Approved Premises Safe Working Practice Document, published in January 2020. The AP also has an updated ligature process policy. Both documents set out what staff should do if they find a resident hanging. The recovery worker and the residential assistant were the only two members of staff on duty that morning, and initially followed the policy. They cut the ligature, laid Mr Lynn carefully on the floor and called for an ambulance within a minute of discovering him. The residential assistant checked Mr Lynn for a pulse but could not find one.

45. The investigator listened to the telephone call to the Ambulance Service. The recovery worker told the ambulance operator Mr Lynn felt cold. The operator said an ambulance was close by and would be at the AP soon, so the residential assistant left the recovery worker with Mr Lynn while he went to the front door to let the paramedics in. The recovery worker remained on the telephone to the operator. It is clear from listening to the telephone call that the recovery worker was upset and initially thought Mr Lynn had died. However, Paragraph 19 of the ligature process policy says, "Always attempt CPR/life support measures – even if the situation seems bleak."

46. At first the operator asked questions about Mr Lynn's location, when he was last seen and general details about him. The recovery worker asked if she could leave Mr Lynn to deal with other residents, but the operator asked her to stay with him.

47. A minute and a half into the call, the operator asked the recovery worker to check Mr Lynn again. The recovery worker replied he was not breathing and did not feel warm. Approximately three minutes into the call, the operator asked the recovery worker if Mr Lynn felt stiff. She said he did not. The operator then

asked if Mr Lynn felt cold. The recovery worker said his back felt "a bit warm". The recovery worker said she had started "massaging" Mr Lynn to try to get some "movement". The operator advised the recovery worker to lay Mr Lynn onto his back, which she did with some difficulty as it was a small space and Mr Lynn felt heavy. Two minutes later the operator asked if the recovery worker had access to a defibrillator. She said she did and stood up to go to get it. At this point, at 7.36am, paramedics can be heard in the background arriving at the AP. They said that Mr Lynn was not receiving chest compressions when they went into his room. They instructed the residential assistant to carry out chest compressions while they assessed Mr Lynn, and then took over his care.

48. Both the recovery worker and the residential assistant had current first aid training. We would have expected them to have started CPR immediately, especially as the AP's policy is to always attempt CPR if a resident is found hanging. We note that the ambulance paramedics were able to recover a pulse. We cannot say whether the delay in starting CPR affected the outcome for Mr Lynn, but we know that in a medical emergency, a delay of a few minutes may be critical. We make the following recommendation:

The Approved Premises manager should ensure that all staff understand the Probation Service's policy on resuscitation in Approved Premises.

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