

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Amy Redmond a resident at Ripon House Approved Premises on 29 March 2017

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



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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.

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

Ms Amy Redmond died of mixed drug toxicity on 29 March 2017 while a resident at Ripon House Approved Premises. She was 28 years old. I offer my condolences to her family and friends.

Ms Redmond was at Ripon House for three months before she died and during this time there were missed opportunities to manage her safely. While there were some entries in Ms Redmond's probation records that suggested she was engaging well, Ms Redmond failed to comply with the rules of the approved premises and conditions of her licence on a number of occasions, and proper enforcement action was not taken.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

Events

1. On 10 October 2016, Ms Amy Redmond was released from prison on a Home Detention Curfew (HDC) licence to her mother's address. After she breached her licence conditions, the Probation Service increased her risk level and moved her to Ripon House Approved Premises on 1 February 2017. Her offender supervisor did not review her licence conditions and they remained as standard conditions. She signed a document, confirming that she understood the rules of the approved premises (AP). This included having no drugs or drug paraphernalia on the premises, not going into other resident's rooms, and complying with curfews.
2. Ms Redmond received 85ml of methadone as opiate replacement therapy. On 7 February, she told staff that this was not working and she tested positive for crack cocaine. Although she had breached the rules of the approved premises, no one gave her a formal warning but a key worker advised Ms Redmond to use the opportunity she had at the approved premises to stabilise her drug and alcohol misuse. Over the next three weeks, she appeared settled and engaged with the services available at the approved premises.
3. From 25 February, staff recorded that Ms Redmond drank alcohol in breach of the approved premises' rules, but she was still not given a formal warning. Her alcohol use became worse over time. On 2 March, a key worker found Ms Redmond in another resident's room, smoking cannabis - and staff gave her a first formal warning.
4. Two residents reported that on 5 March, Ms Redmond had been violent to other residents. Staff removed her from residents' rooms a number of times that evening.
5. On 7 March, a key worker searched Ms Redmond's room and found non-prescribed antidepressant medication. They issued a second formal warning. Later that day, Ms Redmond allegedly threatened another resident, and was found drinking alcohol in another resident's room. The AP manager did not instigate a final warning but agreed to give Ms Redmond the opportunity to change her behaviour over the weekend. That weekend, staff found a crack pipe and cannabis in Ms Redmond's possession but took no formal action about the breach of rules.
6. On 14 March, staff found Ms Redmond with cannabis, and she failed to attend a supervision appointment the next day. On 23 March, she returned late to the approved premises and complained that she had not received her methadone because she had missed an appointment with her GP. Staff recorded her behaviour as chaotic over the next few days, and she returned late twice more.
7. On 28 March, Ms Redmond admitted to a key worker that she had taken heroin because she struggled without methadone. She agreed that she had been drinking more alcohol. On 29 March, a GP prescribed her a daily 40ml dose of methadone, though Ms Redmond told staff that this was not enough.

8. At about 11.00pm on 29 March, staff found Ms Redmond unconscious in her room, having vomited. They called an emergency ambulance and tried to resuscitate her. At 11.45pm, paramedics confirmed that Ms Redmond had died. The post-mortem examination revealed that she died of mixed drug toxicity.

Findings

9. When Ms Redmond's risk was noted to have increased and she was moved to an approved premises, her offender manager did not review her licence conditions. Given her change in circumstances and increased risk, staff should have managed Ms Redmond more effectively by reviewing and adding additional licence conditions specifically targeted to her alcohol and drug misuse, both of which are linked to an increased risk of re-offending and self harm.
10. Ms Redmond's behaviour became increasingly chaotic and she breached her licence conditions and the rules of the approved premises a significant number of times: she admitted using heroin, she tested positive for crack cocaine, was found with drugs, drug paraphernalia, alcohol and in other residents' rooms. She also breached her curfew three times before her death. While all these incidents each warranted a formal warning and possible recall to prison, Ms Redmond only received two formal warnings.
11. Ms Redmond spent the week before she died without methadone which put her at an increased risk of harm. Staff failed to put in place measures to manage her risk effectively, and did not advise her of the risk of mixed drug toxicity as they were required to.

Recommendations

- Yorkshire Probation Trust should ensure that all case managers enforce national standards so that residents' risks and needs are managed effectively. In particular, they should ensure that licences are appropriately reviewed and enforced in line with national standards and local approved premises' rules.
- The manager of Ripon House Approved Premises should ensure that residents suspected of substance misuse understand the risks of mixed drug toxicity.

The Investigation Process

12. The investigator issued notices to staff and residents at Ripon House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Ms Redmond's probation records, and spoke to relevant members of staff by telephone. She interviewed Ms Redmond's offender manager by telephone.
14. We informed HM Coroner West Yorkshire Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. We shared the initial report with the National Probation Service. There were a number of factual inaccuracies, which we have amended accordingly.

Background Information

Ripon House Approved Premises

16. Approved premises (formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.
17. Ripon House is an approved premises which is funded by the charity Progress to Change. Ripon House has three shared rooms and eighteen single rooms. Breakfast, lunch and evening meals are provided. There is a communal area for dining and socialising and areas for group work. Each resident has a key worker to discuss their progress and wellbeing. The key worker ensures that residents adhere to their individual licence conditions and the rules of the approved premises. Ripon House is staffed 24 hours a day by probation employees.

Previous deaths at Ripon House Approved Premises

18. There have been no previous deaths at Ripon House.

Key Events

Background

19. Ms Redmond was sentenced to 18 months in custody for the offence of wounding with the intent to cause grievous bodily harm on 14 April 2016. On 10 October 2016, Ms Amy Redmond was released from prison on a Home Detention Curfew (HDC) licence to her mother's address. Her offender supervisor explained to Ms Redmond her licence conditions and what was expected of her.
20. The offender supervisor said that Ms Redmond initially engaged well and attended her supervision sessions. However, Ms Redmond spoke to a worker from Together Women's Project (TWP - an organisation that supports women with criminal backgrounds to build a positive future) and told her that, in breach of her licence conditions, she was living in a squat, which was a known address associated with drug misuse, and was a sex worker. On 27 January 2017, the offender supervisor and the TWP worker visited Ms Redmond. She admitted that she had stayed in a squat for a week, where she had used drugs and worked as a sex worker.
21. As a result of the change in her behaviour and because she had lived at an unauthorised address, the offender supervisor and his colleague re-assessed Ms Redmond's risk. They decided that her risk of re-offending and of harm to the public had increased from medium to high. Due to the change in her risk, the colleague became her offender manager and, instead of recalling her to prison, she secured Ms Redmond a place in Ripon House Approved Premises for closer monitoring.

Ripon House Approved Premises

22. On 1 February 2017, Ms Redmond moved to Ripon House. A support worker at Ripon House met her. Her offender manager did not review Ms Redmond's licence and no one put in place additional measures to reflect that Ms Redmond was now living in Ripon House. The support worker reminded her of the standard licence conditions (to comply with the conditions of her HDC and the requirements of probation supervision, including not committing offences). Ms Redmond also had to comply with requirements set by her supervising officer to address her alcohol and drug misuse, which formed part of her sentence plan (an assessment of an individual's offending needs and associated risks, and a plan, the primary purpose of which is to address the identified needs and risks).
23. Ms Redmond signed a document agreeing to comply with the rules of the approved premises, including the requirement to be at Ripon House between 11.00pm and 6.00am. The support worker told Ms Redmond that her room would be randomly checked, and that she would at random be tested for drugs and alcohol. She was not allowed in other residents' rooms, or to let them into her room. She was also not allowed any drugs or drug paraphernalia. Ms Redmond registered with a GP and agreed to take her medication under the supervision of the AP staff. Ms Redmond told staff that she was currently being prescribed 85ml of methadone daily as opiate replacement therapy.

24. On 7 February, the offender manager, the support worker and Ms Redmond met at Ripon House. Ms Redmond told them that 85ml of methadone was not enough, and that she was using non-prescription drugs in addition to her methadone. The support worker tested Ms Redmond for drugs, which showed that she had been using crack cocaine. The offender manager advised Ms Redmond to use the opportunity she had at Ripon House to access services to stabilise her drug and alcohol misuse but took no further action.
25. Over the next three weeks, Ms Redmond followed the approved premises' rules, attended her supervision sessions and engaged with external agencies to manage her substance misuse issues.
26. On 25 February, Ms Redmond brought alcohol into Ripon House. A key worker confiscated it and noted on the case management system that a referral would be made to Ms Redmond's offender manager to initiate enforcement procedures. The offender manager did not however issue a warning letter.
27. On 28 February, a case manager at Ripon House met Ms Redmond, who said that she had not used illegal drugs for nearly two weeks but had been drinking more alcohol throughout the day. Ms Redmond said that she was not happy living in Leeds and felt that things would be better if she moved closer to her mother. The case manager told her that she could discuss her preferred location during her appointment with a housing organisation scheduled for the next day.
28. On 1 March, Ms Redmond returned to Ripon House with alcohol. A key worker initially confiscated it as it breached approved premises' rules. However, when Ms Redmond said that she would buy more, she returned it to her so that Ms Redmond could drink it outside. No one took action about Ms Redmond bringing alcohol into the approved premises.
29. The next day, Ms Redmond was found in another resident's room, smoking cannabis. Ripon House operates a drug-free environment, and bringing drugs into the hostel and being in a resident's room breached the rules. Staff gave Ms Redmond her first formal warning.
30. On 3 March, the offender manager reviewed Ms Redmond's details on the Offender Assessment System (OASys, which was used to measure the risks and needs of offenders). She recorded that there was no evidence that Ms Redmond had used the thinking skills programme completed while in prison within a community setting and that alcohol and drug use were serious indicators of harm.
31. Later that day, the offender manager contacted the TWP worker to find out if Ms Redmond was still attending appointments with her. The TWP worker said that she was not. She said that she had had spoken to the TWP worker for Leeds and, as Ms Redmond was not engaging with any services at the hostel, she would not accept a referral for her at this stage.
32. On 5 March, a resident reported that Ms Redmond was in another resident's room and that she had heard her hit someone. A key worker recorded in the case management system that she removed Ms Redmond from the other resident's room. She noted that Ms Redmond went to and from other residents' rooms several times and was removed each time. At 12.30am on 6 March, a

- resident reported that Ms Redmond had headbutted another resident, though Ms Redmond denied this. At 1.00am Ms Redmond was again found in another resident's room, and did not leave immediately when asked to do so. She was not given a formal warning.
33. The next week, Ms Redmond tested negative for drugs but entries in the case management system showed that she continued to drink alcohol in excess.
 34. On 7 March, a key worker searched Ms Redmond's room and found amitriptyline tablets (an antidepressant often prescribed for other uses such as treating pain). As Ms Redmond had no prescription for these drugs, the key worker issued a second formal warning. Later that day, a resident said that Ms Redmond allegedly threatened another resident, and was also drinking alcohol in another resident's room. The manager of Ripon House did not start the procedure to recall Ms Redmond to prison, but agreed to give her an opportunity to change her behaviour over the weekend. She told her that if it did not change, her bed at Ripon House would be withdrawn.
 35. While not recorded in the case management system, there was an email exchange between the case manager and the offender manager on 9 March which referred to Ms Redmond being found with a crack pipe and cannabis at Ripon House. The email exchange suggested that this was discussed with Ms Redmond, but staff took no formal action about Ms Redmond's continuing breaches of the approved premises' rules.
 36. The next week, Ms Redmond appeared to stabilise, produced regular negative drug test results, and her probation records indicated that she was engaging with activities and was looking for alternative housing. Despite this, an entry on 14 March in the case management system from an unknown member of staff noted Ms Redmond's "unacceptable behaviour" as she had cannabis in Ripon House. There is no evidence that any action was taken to address the breach of rules.
 37. The next day, Ms Redmond failed to attend her supervision appointment with her offender supervisor. Ms Redmond claimed that she had no record of it. He spoke to staff at Ripon House, who said she had been drinking heavily in the morning but that her behaviour had improved in the last few days. They also confirmed that she was working as a sex worker, and said that this would be having a negative impact on her emotional state. No action was taken to recall Ms Redmond to prison for failing to attend her supervision appointment.
 38. On 23 March, Ms Redmond returned to Ripon House 25 minutes after her curfew time. She told staff that she had not been able to pick up her methadone prescription as she was late for her GP appointment. Her probation records indicated that, without methadone, she was chaotic over the following days.
 39. On 26 and 27 March, Ms Redmond again returned after her curfew time. Staff told the offender manager that she was late but did not start recall procedures.
 40. At 9.00am on 28 March, the case manager saw Ms Redmond for a key work session. Ms Redmond told her that she was struggling without her methadone, and admitted to using heroin as she felt she had no option. She agreed that she

was drinking more alcohol but said this was because she did not have methadone.

Events of 29 March

41. At 9.45am on 29 March, Ms Redmond's GP prescribed her 40 ml of methadone to be increased daily by 10ml. A key worker recorded that Ms Redmond returned to Ripon House at 7.50pm, and complained that the amount of methadone she had been prescribed was not enough. She went outside immediately to drink alcohol that she had left outside the premises, and returned shortly afterwards to clean her room.
42. At around 9.50pm, the key worker completed a handover with the night staff. She told them that she was not sure if Ms Redmond was in the approved premises as she had been in and out all day. The night staff described seeing a woman with pink hair at 10.45pm on CCTV footage. They believed this was Ms Redmond, as she was the only resident with pink hair.
43. At 11.00pm, the night staff began the resident curfew check, completing the ground floor first, and making their way to the first floor, where Ms Redmond lived. One night staff told us that when Ms Redmond did not respond when she knocked on her door, she went into her room with her colleague and found her on the floor in a foetal position. They initially believed that Ms Redmond was intoxicated but when they tried unsuccessfully to wake her, they realised that she was unconscious.
44. The night staff said that she checked for Ms Redmond's pulse, and thought she felt a weak pulse. Both members of staff then moved Ms Redmond, and they noticed she had vomited. She immediately called for an emergency ambulance at 11.06pm, while her colleague opened Ms Redmond's airways. The night staff then started cardiopulmonary resuscitation while her colleague went downstairs to wait for the paramedics. She continued resuscitation efforts for around five minutes before the paramedics arrived and took over. Paramedics confirmed Ms Redmond's death at 11.45pm.

Contact with Ms Redmond's family

45. After Ms Redmond's death, the police told Ms Redmond's mother of her death. On 4 April, the manager of Ripon House contacted Ms Redmond's mother to offer her condolences and to offer her the opportunity to visit Ripon House. Ms Redmond's mother was undecided at that stage, so the manager agreed that she would bring Ms Redmond's belongings to her address. The National Probation Service offered a contribution towards the cost of Ms Redmond's funeral in line with national instructions.

Support for residents

46. After Ms Redmond's death, staff at Ripon House individually spoke to all residents and members of staff, and a counsellor was made available in early April to talk to any staff or residents affected by her death. The manager of Ripon House gave both members of staff involved in the emergency response additional individual support. When she realised that one member of staff was particularly affected, she arranged for further psychological support.

Post-mortem report

47. The doctor who completed the post-mortem examination concluded that Ms Redmond died of mixed drugs toxicity. The toxicology tests detected a significant number of illicit drugs in Ms Redmond's system, including methadone, cocaine, ethanol, morphine (likely from illicit heroin), fentanyl (an opioid analgesic) and synthetic fentanyls (new drugs in the UK). The toxicologist concluded that in combination, the illicit drugs detected were likely to have caused Ms Redmond's death.

Findings

Enforcement of licence conditions

48. Probation national standards say that where an offender fails to comply with a community order, suspended sentence order or post sentence supervision period and has not given an acceptable explanation, an offender manager should issue a warning or take appropriate enforcement action within six working days of the last failure to comply. They say that when residents do not comply, staff should respond in a way that is proportionate to the level of risk presented, and that they should investigate the issue, focusing on indicators of increased risk of re-offending likely to cause serious harm. They say that staff should exercise professional judgement to determine whether a reason provided for non-compliance is reasonable, taking into account factors such as a resident's pattern of compliance and their overall response to their sentence.
49. Approved premises' instructions, set out at section 83 of Probation Instruction (PI) 32/14, say that even relatively minor repeated breaches might indicate "underlying attitudes that could give concern over risk" and that offender managers should react quickly, appropriately and consistently when residents breach rules.
50. When Ms Redmond was released from prison, the Probation Service assessed her as a medium risk of harm. They noted that her risk to self and others would increase if she continued to use substances in excess, funded by working as a sex worker. When Ms Redmond initially breached the conditions of her HDC licence, the probation service agreed that they could continue to manage her risk in the community and moved her to Ripon House to monitor her high risk of harm to herself and to the public more closely. Ms Redmond's offender manager told the investigator that a licence can be reviewed, and additional conditions can be added to the risk management plan before recalling someone. Ms Redmond's licence was not however reviewed to reflect the change in her circumstances. The offender manager told the investigator that she felt that it was a constraint in itself that Ms Redmond was living in an approved premises and she did not consider it necessary to review or amend her licence to reflect Ms Redmond's increased risk and change in circumstance.
51. While there is evidence that Ms Redmond managed to remain drug-free for a brief period of time, her alcohol misuse increased and her behaviour became increasingly chaotic. There is also evidence that she was earning money as a sex worker. On at least two occasions, Ms Redmond brought alcohol into the approved premises but staff gave her no warnings, as we would have expected them to. They failed to give her formal warnings when she breached her licence conditions and Ripon House's rules when she went into other residents' rooms, did not attend her supervision appointment, tested positive for crack cocaine, was found with a crack pipe and cannabis and returned after her curfew time on three consecutive days. Only on one occasion when Ms Redmond smoked cannabis and another when she was found with non-prescribed antidepressants was she given formal warnings.

52. We are also concerned that she had no methadone the week before she died, which might have increased her risk of harm and drug and alcohol misuse. Staff should have done more to manage Ms Redmond's increased risk. If staff had issued warnings when she did not comply with the rules and if she had been recalled to prison given the significant number of times she failed to comply, she might not have had access to drugs, which in turn might have changed the outcome for her
53. Ms Redmond had a significant amount of independence and autonomy at Ripon House and while it is clear that most staff knew Ms Redmond well and made decisions with the intention of supporting her and giving her every chance of succeeding in the community, we are concerned that these decisions were not sufficiently robust and that her actions should have resulted in her recall to custody. There were a number of occasions when a formal warning would have been justified, but staff could not consistently explain why a warning was not given, and there were not always entries in the case management system to evidence their decisions. The decisions made did not support Ms Redmond or manage her risk adequately. We make the following recommendation:

The National Probation Service should ensure that all case managers enforce national standards so that residents' risks and needs are managed effectively. In particular, they should ensure that licences are appropriately reviewed and enforced in line with national standards and local approved premises' rules.

Mixed drug toxicity

54. Ms Redmond died of mixed drug toxicity. The Approved Premises Manual says that those who misuse substances are at high risk of self-harm or death, particularly from mixed drug toxicity when individuals simultaneously take a cocktail of drugs. This is often due to reduced tolerance after release from prison, and staff are required to advise residents of this on arrival. Although Ms Redmond did not arrive at Ripon House directly from prison, she had admitted using drugs while at her mother's address and soon after arriving at the approved premises, she tested positive for crack cocaine. We are concerned that no one at Ripon House advised her of the risk of mixed drug toxicity. We make the following recommendation:

The manager of Ripon House Approved Premises should ensure that residents suspected of substance misuse understand the risks of mixed drug toxicity.

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