Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Emma Tuff, on 24 October 2025, 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 Emma Tuff died from cocaine and methadone toxicity on 24 October 2025, following her release from HMP Styal a week earlier. She was 36 years old. We offer our condolences to Ms Tuff's family and friends.

5. As Ms Tuff was released from court under a suspended sentence order, it was difficult for prison and probation staff to make accommodation and other community referrals. Nevertheless, healthcare staff at Styal arranged support for Ms Tuff to address her substance use issues in the community post-release. We did not identify any significant learning relating to the pre-release planning for or post-release supervision of Ms Tuff.

6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Ms Tuff's death on 31 October 2025.

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

9. As part of the investigation, the investigator spoke to Ms A, Ms Tuff's community offender manager.

10. We informed HM Coroner for Manchester of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's office contacted Ms Tuff's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of the report.

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

Background Information

HMP Styal

13. HMP Styal is a closed prison which holds convicted and remanded female prisoners. Spectrum Community Health CIC provide physical healthcare services and substance misuse services. Greater Manchester Mental Health NHS Foundation Trust provide mental healthcare services.

Probation Service

14. 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 which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Deaths following release from prison

15. Since September 2021 to the end of February 2026, the PPO started investigations into just over 300 deaths of people who died within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health and substance use issues and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from Styal

16. Ms Tuff was the fourth woman to die within 14 days of release from Styal since we began post-release death investigations and up until March 2026, and the third to have died from drug use. We did not make recommendations in any of these cases.

Key Events

Background

17. On 29 September 2025, Ms Emma Tuff was remanded to HMP Styal for drink driving. It was not her first time in prison.

18. During her initial health screen, Ms Tuff struggled with leg pain, and lay on the floor in Reception, unable to keep still. Ms Tuff denied having thoughts of suicide and self-harm. She tested positive for cannabis, opiates and cocaine. She said she used drugs intravenously and reported a history of daily heroin and crack cocaine use. Healthcare staff added Ms Tuff to the substance misuse service's list of prisoners who needed to be checked daily.

19. On 30 September, the Safer Custody Team conducted a welfare check. Ms Tuff declined to engage as she was withdrawing from drugs. That day, Ms B, a healthcare support worker, saw Ms Tuff in the substance misuse clinic. Ms Tuff agreed to take methadone (an opioid substitution treatment), and she was given advice about minimising the harm from drugs. She agreed to receiving psychosocial support from the substance misuse team.

20. On 2 October, Ms Tuff saw the resettlement team and told them that she would be homeless on release. They noted on the probation information system that her community offender manager should refer Ms Tuff to GMIRS (a wellbeing service, provided by the Big Life Group, which offers a wide variety of services, including mental health and wellbeing support. They do not provide accommodation but may help people navigate housing issues).

21. On 3 October, Ms C from the resettlement team completed a referral to Ingeus (a community service that provides a wide range of support to prison leavers). Ingeus was aware of Ms Tuff's housing issues and told the resettlement team that they would work with GMIRS and Ms Tuff on release.

22. On 8 October, Ms D, a keyworker, saw Ms Tuff and told her that her trial date was scheduled for 17 October. Ms Tuff asked to be prescribed methadone in the community. She told Ms D that she had referred herself to Ashton Change Grow Live (CGL, a community substance misuse service) six weeks before coming into custody.

23. On 9 October, the resettlement team saw Ms Tuff again. She told them that she was interested in applying for accommodation through EMMAUS (a community service that supports prison leavers facing homelessness on release) in Mosley. The resettlement team agreed to let Ingeus know. Ms E, a senior probation officer at HMP Styal, told the investigator that referrals were completed online, leaving no audit trail. Ms Tuff's community offender manager told the investigator that she would have expected the prison's resettlement team to have completed the housing referral as Ms Tuff had not been allocated a community offender manager at the time.

24. On 13 October, healthcare staff gave Ms Tuff training on how to use naloxone (a medication that rapidly reverses an opioid overdose) and she consented to

receiving naloxone to take with her on release. The next day, she was given a release appointment to see her recovery worker at CGL at 4.00pm on 17 October.

Release from HMP Styal

25. On 17 October, Ms Tuff attended court and was released directly from court, having received a suspended sentence order. The court gave her a signed induction slip which included details of her initial probation appointment at the probation area's Women's Centre in Stockport at 10.00am on 21 October. She did not have accommodation in place for her release.

26. CGL confirmed by email that Ms Tuff had attended her appointment with them at 4.00pm that day. Ms Meakin told the investigator that Ms Tuff would have received naloxone at that appointment.

27. As Ms Tuff was given a suspended sentence order, she was not subject to a licence but had to receive drug rehabilitation treatment for 18 months as instructed by her community offender manager.

28. On 21 October, Ms Tuff attended Tameside Women's Centre, where a duty probation officer saw her. She told them that she had been released from Styal the previous Friday and was given an appointment at Stockport but had no way to get there. The duty officer gave her a new appointment for 23 October at Stockport and gave her a bus pass.

29. On 22 October, Ms Tuff collected and took her methadone at a Boots pharmacy in Denton.

30. On 23 October, after Ms Tuff did not attend her probation appointment, Ms F, who had been allocated as her community offender manager, sent her an initial warning letter which also gave her a new appointment for 30 October.

31. On 27 October, a probation service officer at Tameside told Ms F that she had information that Ms Tuff might have died. Ms F told the investigator that she contacted the police, Ms Tuff's CGL worker and the Coroner to verify this information.

32. On 30 October, the Coroner's office confirmed to Ms F that Ms Tuff had died.

Circumstances of Ms Tuff's death

33. Since her release from Styal, Ms Tuff had lived at her friend's home in Ashton. On 23 October, Ms Tuff's friend found her lying on the couch, with her leg in an unusual position. Ms Tuff had vomit around her mouth. Her friend called Northwest Ambulance Service and began cardiopulmonary resuscitation (CPR). Paramedics arrived at 3.23pm and continued CPR. Paramedics pronounced life extinct at 4.09pm. Police were called shortly afterwards. They found drug paraphernalia in the room, as well as a number of unidentified pills and two small bags containing white powder.

Post-mortem report

34. The post-mortem report concluded that Ms Tuff died from cocaine and methadone toxicity. Post-mortem toxicology results found a medium concentration of cocaine and its metabolites, at a level lower than those typically associated with fatal toxicity. Post-mortem toxicology results found a concentration of methadone consistent with therapeutic use.

Inquest

35. At an inquest held on 29 January 2026, the Coroner concluded that Ms Tuff's death was drug related.

Findings

36. Ms Tuff was a vulnerable woman with complex support needs, including a long history of substance misuse and homelessness.

37. Ms Tuff was released from court on 17 October, having received a suspended sentence order. She had only been in prison for two and a half weeks on recall. Ms Tuff was homeless on release and had to live with friends. Her brief period in prison and the fact that she was awaiting either sentencing or release from court made it difficult for prison and probation staff to plan effectively for her release, including finding accommodation for her, as they did not know whether she would remain in prison or be released. Ms F told the investigator that if Ms Tuff had attended her probation meeting with her, she would have referred her to community services, including accommodation support.

38. Although Ms Tuff was released homeless, Styal and the Probation Service took reasonable and appropriate steps to manage the risks associated with her substance misuse. Before her release, Ms Tuff had been supported by substance misuse services in the community and healthcare staff had arranged an appointment for her with CGL post-release. CGL gave Ms Tuff her methadone prescription in the community after she was released. Healthcare staff also gave Ms Tuff harm minimisation advice and naloxone training before release but the investigator could not establish if she was given naloxone in the community. The prison resettlement team appropriately referred Ms Tuff to Ingeus in the community for support but as she had not been allocated a community offender manager while in prison (as she was on remand and had not been sentenced), she was not referred to any other support services.

39. This investigation highlights the particular complexities and challenges faced by HMPPS and their stakeholders in finding post-release accommodation and referring prison leavers to services when they have spent very short periods in prison on remand and are released directly from court.

Adrian Usher
Prisons and Probation Ombudsman **July 2026**

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