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**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Deborah Purkiss a resident at Ripon House Approved Premises on 31 May 2019

A report by the Prisons and Probation Ombudsman

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.

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.

Ms Deborah Purkiss died from septicaemia (blood poisoning) on 31 May 2019, while a resident at Ripon House Approved Premises. She was 50 years old. I offer my condolences to Ms Purkiss' family and friends.

Ms Purkiss had been at Ripon House for around six weeks when she died. Staff found her unresponsive on the floor of her room during a morning check of residents. Neither they nor ambulance paramedics were able to resuscitate her.

Ms Purkiss had taken all her prescribed medication up to the day before her death. She had not complained of feeling unwell. I am satisfied that there is nothing staff at Ripon House could have done to prevent Ms Purkiss' death.

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

Sue McAllister CB
Prisons and Probation Ombudsman

March 2020

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Summary

Events

1. On 20 May 2016, Ms Deborah Purkiss was sentenced to seven years in prison for violent offences and sent to HMP New Hall. On 16 April 2019, she was released from New Hall to live at Ripon House Approved Premises.
2. Ms Purkiss was prescribed several medications: diazepam (for anxiety), venlafaxine (antidepressant), quetiapine (antipsychotic), propranolol (for heart and blood pressure), pregabalin (for anxiety or pain), lymecycline (an antibiotic prescribed following carpal tunnel surgery), omeprazole (for gastric problems), levothyroxine (for an underactive thyroid) and alendromic acid (to prevent osteoporosis).
3. Records show that Ms Purkiss took all her prescribed medication up to Thursday 30 May.
4. At 7.48am on 31 May, staff carried out a morning check. They got no response when they knocked on Ms Purkiss' door so they opened the door and went in. They found her lying on her back, on the floor, unconscious. Staff called for an ambulance and started cardiopulmonary resuscitation (CPR) until paramedics arrived. The paramedics took over Ms Purkiss' care, but were unable to resuscitate her and pronounced her death at 8.20am.
5. The post-mortem report concluded that Ms Purkiss died from septicaemia (blood poisoning) caused by a pulmonary abscess (bacterial infection in the lung).

Findings

6. Ms Purkiss had not complained of feeling unwell in the lead up to her death. We found that staff at Ripon House could not have foreseen or prevented Ms Purkiss' death.
7. We make no recommendations.
8. However, although it did not play a part in Ms Purkiss' death, we are concerned that residents at Ripon House were able to drink alcohol and share illicit drugs, including crack cocaine, in the garden on 30 May with apparent impunity. This is something the AP managers will need to address.

The Investigation Process

9. The investigator issued notices to staff and residents at Ripon House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator visited Ripon House on 12 June 2019. She obtained copies of relevant extracts from Ms Purkiss' prison, probation and medical records.
11. The investigator interviewed five members of staff and a resident on 27 and 28 June.
12. We informed HM Coroner for West Yorkshire Eastern of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Ms Purkiss' daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked whether her mother had taken Subutex and whether her mother had fallen as her glasses were smashed.
14. The initial report was shared with the Probation Service. They pointed out some factual inaccuracies and this report had been amended accordingly.
15. Ms Purkiss' daughter received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.

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 Approved Premises (AP) in Leeds is owned and operated by the charity Progress to Change. The day to day running is funded by HM Prison and Probation Service. Ripon House has 22 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 Progress to change staff.

Previous deaths at Ripon House Approved Premises

18. There has been one previous death at Ripon House, in March 2017, which was drug-related.

Key Events

19. On 20 May 2016, Ms Deborah Purkiss was sentenced to seven years in prison for violent offences. She was sent to HMP New Hall.
20. Ms Purkiss had generalised anxiety disorder, recurrent depressive disorder and emotionally unstable personality disorder and had previously been detained under the Mental Health Act for six months.
21. Ms Purkiss was under the care of mental health services in New Hall. She was anxious about leaving the prison and living in an Approved Premises (AP) as she was agoraphobic and worried about having to leave Ripon House unaccompanied for appointments. The prison's mental health team engaged Ms Purkiss in graded exposure therapy to help her address her anxieties about being outside. Ms Purkiss also had a history of self-harm, which included overdosing and cutting herself.
22. Ms Purkiss was prescribed several medications: diazepam (for anxiety), venlafaxine (antidepressant), quetiapine (antipsychotic), propranolol (for heart and blood pressure), pregabalin (for anxiety or pain), lymecycline (an antibiotic prescribed following carpal tunnel surgery), omeprazole (for gastric problems), levothyroxine (for an underactive thyroid) and alendromic acid (to prevent osteoporosis).
23. On 16 April 2019, Ms Purkiss was released from New Hall prison to live, on licence, at Ripon House. Residents usually stay at Ripon House for three months. All residents have a curfew and Ms Purkiss' was 11.00pm. Ms Purkiss met with her key worker who explained Ripon House's rules. One of the conditions was that residents were not permitted to bring alcohol or illicit drugs into Ripon House.
24. Ms Purkiss engaged in groups at the AP and particularly enjoyed art and jewellery making. She became more confident and participated in filming a video about Ripon House for other residents who were reluctant to live there.
25. On 6 May, Ms Purkiss attended an alcohol awareness session. The session looked at the harm alcohol could have on physical and mental health, and risks associated with alcohol use and the help that was available.
26. Medication records show that Ms Purkiss took all her prescribed medication up to Thursday 30 May.
27. On 30 May, Ms Purkiss joined in with the reading group and participated well in reading and discussions. At 9.45pm, Ms Purkiss asked for permission to go to a local convenience store. She said she needed to top up credit on her mobile telephone. She was told that she could go out any time until her curfew. Ms Purkiss asked other residents if they wanted anything from the shop and left on her own.
28. Ms Purkiss' friend and fellow resident told the investigator that Ms Purkiss returned with a half bottle of vodka. Ms Purkiss, her friend and other residents spent the evening in the garden, laughing and joking and Ms Purkiss shared the

vodka. Another resident joined them and, at some point during the evening, gave Ms Purkiss half of a Subutex tablet (an opioid drug prescribed for the treatment of heroin addiction, but which is also abused). Ms Purkiss did not take it immediately, and her friend saw her put it on top of her tobacco tin, with the intention of taking it later in her room. The resident also offered around crack cocaine, but Ms Purkiss declined. Her friend was surprised when Ms Purkiss accepted the Subutex, as she had admitted to using 'Spice' (psychoactive substances - PS) in prison, but nothing else.

29. Ms Purkiss' friend said that she thought this was the first time Ms Purkiss had had alcohol since leaving New Hall, although she later told the investigator that Ms Purkiss only got 'a small bottle each time' indicating this may have happened before.
30. Ms Purkiss' friend rang her when they returned to their rooms, but Ms Purkiss did not answer. Her friend texted her at 12.16am, but received no reply.
31. At 7.48am on 31 May, two members of staff carried out a morning check. They knocked on Ms Purkiss' door, but got no response. They went into Ms Purkiss' room and saw she was lying on her back, on the floor, so pulled their emergency alarm. One member of staff telephoned for an ambulance while the other checked Ms Purkiss for a pulse or breathing. She found neither so started cardiopulmonary resuscitation (CPR) with chest compressions while another member of AP staff gave Ms Purkiss rescue breaths until paramedics arrived approximately four minutes later. The paramedics took over Ms Purkiss' care, but were unable to resuscitate her and pronounced her death at 8.20am.

Contact with Ms Purkiss' family

32. The police told Ms Purkiss' daughter of her death and the AP returned her belongings to her family. The National Probation Service contributed towards Ms Purkiss' funeral, in line with national instructions.

Support for residents and staff

33. After Ms Purkiss' death, staff at Ripon House spoke to all residents, and a counsellor was available to talk to staff and residents.

Post-mortem report

34. The post-mortem report concluded that Ms Purkiss died from septicaemia (blood poisoning), caused by a pulmonary abscess (bacterial infection in the lung). The toxicology report showed that Ms Purkiss had alcohol and her prescribed medication in her system, but there was no trace of any other drugs, including Subutex.

Findings

Ms Purkiss' health

35. Ms Purkiss took all her prescribed medication up until 30 May. She did not complain of feeling unwell in the period leading up to her death. We are satisfied that staff could not have foreseen or prevented her death.
36. Once Ms Purkiss had been discovered, staff complied with Ripon House's emergency response protocol and called for an ambulance and the police immediately. All staff on duty overnight, and on the morning of 31 May, were trained in emergency first aid.
37. We make no recommendations.

Substance misuse in the AP

38. Residents of Ripon House are not permitted to have illicit drugs or alcohol in the AP and may be randomly tested for these substances. However, although it did not play a part in Ms Purkiss' death, we are concerned that residents were able to drink alcohol and share illicit drugs, including crack cocaine, in the garden on 30 May with apparent impunity. This is something the AP managers will need to address.

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