Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Ms Anne-Marie Roberts, a prisoner at HMP Eastwood Park, on 24 July 2021

## 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

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 Anne-Marie Roberts died from diabetic ketoacidosis (a serious complication of diabetes or chronic alcoholism when there is a severe lack of insulin in the body which leads to an excess of ketones) on 24 July 2021 while a prisoner at HMP Eastwood Park. She was 52 years old. I offer my condolences to her family and friends.

However, the clinical reviewer identified that the management and monitoring of Ms Roberts' alcohol withdrawal could be improved.

I am concerned that despite frequent checks on the morning of 24 July, it was only when another prisoner raised concerns about Ms Roberts that staff identified that she had died. While we do not know whether the delay in finding Ms Roberts affected the outcome for her, it is critical that prison staff carry out welfare checks appropriately as early intervention can save lives.

I am also concerned that when Ms Roberts was found, staff did not immediately call an emergency code. This is an issue we have raised in two previous recent investigations into deaths at Eastwood Park, and we now escalate our concerns to the Prison Group Director for the Women's Estate.

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** **October 2022**

# Contents

# Summary

## Events

1. On 12 July 2021, Ms Anne-Marie Roberts was remanded to HMP Eastwood Park, charged with arson.

2. At an initial health screen, staff identified that Ms Roberts had Type 2 diabetes, drank heavily and had a history of mental health concerns. Healthcare staff prescribed relevant medications and referred her to the prison's mental health and substance misuse teams.

3. On 14 July, a prison GP reviewed Ms Roberts' blood test results which showed slightly high blood glucose levels. The GP arranged for her to be reviewed on 27 July and recommended that she should repeat the blood tests in three months.

4. At around 9.23am on 24 July, a prisoner raised concerns with staff about Ms Roberts' welfare. Officers unlocked her cell and found her unresponsive. They called for medical assistance and nurses tried to resuscitate her. However, they stopped attempts after seeking external advice.

## Findings

5. The clinical reviewer concluded that the care that Ms Roberts received at Eastwood Park was of a standard reasonably expected and was generally equivalent to that which she could have expected to receive in the community.

6. However, the clinical reviewer made a number of recommendations which the Head of Healthcare will need to address.

7. Despite frequent checks on the morning of 24 July, we are concerned that it was not until another prisoner raised concerns about Ms Roberts' welfare that staff identified that she had died. We are also concerned that staff did not call an emergency code when Ms Roberts was found unresponsive.

8. The clinical reviewer also concluded that emergency response nurses should be trained to recognise when it is inappropriate to attempt resuscitation.

## Recommendations

- **The Head of Healthcare should ensure that all patients undertaking alcohol withdrawal are clinically monitored in line with local procedures.**

- **The Head of Healthcare should ensure that when the procedures for when not to perform CPR is published, all healthcare staff have the opportunity to attend additional training.**

- **The Governor should ensure that staff are aware that when a prisoner is not due to be unlocked until later in the morning, staff satisfy themselves of the prisoner's safety, if there are concerns about the prisoner's wellbeing, by obtaining a response during the morning roll check.**

- **The Governor should ensure that subject to a dynamic risk assessment, staff enter a cell as quickly as possible, where there is a risk to life or concerns about a prisoner's welfare.**

- **The Governor should ensure that all staff understand their responsibilities during medical emergencies, including calling an immediate emergency code when there is a threat to life, in line with PSI 03/2013.**

- **The Prison Group Director for the Women's Estate should satisfy herself that staff at Eastwood Park understand their responsibilities during medical emergencies, including the use of emergency codes, and should write to the Ombudsman when she has done this.**

# The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Eastwood Park informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator obtained copies of relevant extracts from Ms Roberts' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Ms Roberts' clinical care at the prison.

12. The investigator interviewed eight members of prison staff and one prisoner at Eastwood Park. The clinical reviewer also interviewed healthcare staff at the prison.

13. We informed HM Coroner for Avon of the investigation. She provided us with a copy of the post-mortem and toxicology reports. We have sent her a copy of this report.

14. The Ombudsman's family liaison officer wrote to Ms Roberts family to explain our investigation and to ask if they had any matters they wanted us to consider. They asked what medication Ms Roberts was prescribed, what the medication was for and if Ms Roberts was taking it. They also asked what mental health support Ms Roberts received at Eastwood Park.

15. Ms Roberts' family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

# Background Information

## HMP Eastwood Park

16. HMP Eastwood Park is a closed prison in Gloucestershire which holds up to 442 women. It has ten residential wings, two of which specialise in addressing substance misuse. Healthcare services at Eastwood Park are provided by Inspire Better Health (part of Avon and Wiltshire Mental Health Partnership NHS Trust), and they provide an integrated health services, including the delivery of primary care, mental health, and substance misuse services. Healthcare is provided 24 hours a day.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Eastwood Park was in May 2019. Inspectors reported that relationships between staff and prisoners remained a strength, and prisoners reported that staff were supportive.

18. Inspectors noted that healthcare services were well-led, supported by skilled clinical leads, and they observed conscientious staff who knew their patients well. Inspectors reported that new prisoners received a comprehensive initial health screen which focused on risks and immediate needs, including those relating to substance use withdrawal, mental health and self-harm and that secondary health screens were booked promptly. Inspectors noted good liaison with community healthcare services which helped to ensure continuity of care.

19. Inspectors reported that healthcare staff responded to all emergencies, had received life support training, officers were familiar with the emergency codes protocol and emergency ambulances were called promptly.

## Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to October 2020, the IMB reported that staff worked with prisoners in a highly professional and caring way. They reported that healthcare provided a range of both clinical and non-clinical interventions and in general, prisoners' health needs were well met.

## Previous deaths at HMP Eastwood Park

21. Since January 2018, there have been two deaths from natural causes and two drug-related deaths at Eastwood Park. In our investigations into the deaths of women at the prison in October 2018 and November 2019, we identified that staff did not immediately call an emergency code when they found the prisoners unresponsive.

# Key Events

22. On 12 July 2021, Ms Anne-Marie Roberts was remanded to HMP Eastwood Park, charged with arson.

23. A nurse carried out an initial health screen. She identified that Ms Roberts had Type 2 diabetes, which Ms Roberts told her was well-controlled. The nurse did not take a blood glucose reading but noted that Ms Roberts' clinical observations were stable. She also noted Ms Roberts' history of mental health concerns and that she drank heavily.

24. Ms Roberts brought to the prison her prescribed medications, including diabetic medication, antipsychotics and antidepressants. The nurse assessed that nurses should administer Ms Roberts' medication.

25. Ms Roberts told the nurse that she felt depressed and suicidal but denied thoughts of self-harm. (Ms Roberts had previously tried to take her life by taking an overdose around eighteen months earlier.) Staff started suicide and self-harm monitoring procedures, known as ACCT, and referred Ms Roberts to the mental health team.

26. A prison GP reviewed Ms Roberts and noted her significant mental health history and that she was vague about her alcohol use. The GP competed an alcohol withdrawal assessment, which indicated that Ms Roberts had minimal withdrawal symptoms but that her possible alcohol withdrawal should be monitored.

27. Ms Roberts lived in the prison's substance misuse and detoxification unit.

28. On 13 July, Ms Roberts declined to attend her first ACCT case review, and it was therefore agreed that the mental health team would continue to monitor her.

29. On 14 July, a prison GP noted that Ms Roberts' blood glucose levels were slightly high. He arranged to review her on 27 July and for the blood tests to be repeated in three months.

30. Ms Roberts declined to participate in her secondary health screen on 16 July, and it was rearranged for 19 July.

31. On 16 July, two mental health support assistants assessed Ms Roberts. They noted that it was difficult to hold a conversation with her and that she was unable to give an accurate picture of her mental health. It was decided that Ms Roberts would be given further support through mental health keywork.

32. On 19 July, Ms Roberts again declined to take part in her secondary health screen.

33. That day, Ms Roberts attended an ACCT case review and told an officer that she could not keep her medication down. There is no evidence that this information was passed to healthcare staff.

34. Ms Roberts was compliant with her prescribed medication, apart from on 20 July when she refused to take her diabetic medication but did not provide a reason why.

35. On 21 July, a substance misuse worker tried to assess Ms Roberts' alcohol dependence and to explain the support available from the substance misuse team. Ms Roberts declined to be assessed. The mental health team confirmed that Ms Roberts had mental capacity and the substance misuse worker therefore discharged her.

36. On 22 July, it was noted in Ms Roberts' ACCT document that she complained of stomach pain but did not want paracetamol.

37. On 23 July, a nurse introduced herself to Ms Roberts as her mental health keyworker and arranged an appointment for the following week.

38. That day, Ms Roberts finished her daily exercise early after she told staff that she was not feeling well, felt hot and had a headache. Ms Roberts was noted as being slightly out of breath, but she became more settled after she returned to her cell and did not complain further of feeling unwell.

39. CCTV footage shows that Ms Roberts was checked regularly throughout the night as part of her ACCT observations. (We have based our timings on the prison's communications room log of events and adapted the recorded CCTV times in this report accordingly.)

40. Officer A said that she recalled speaking to Ms Roberts at around 10.00pm, when she was watching television. The officer recalled that Ms Roberts did not engage in conversation or raise any concerns.

## Events of 24 July

41. Officer A said when she checked on Ms Roberts during the night as part of ACCT monitoring, she could hear her snoring lightly at times. She checked on her at around 3.30am and tried to engage with her but Ms Roberts did not look up or speak. Officer B also said that when she checked on Ms Roberts in the early hours of the morning, she too could hear that Ms Roberts was breathing.

42. Officer A said that when she checked on Ms Roberts at around 6.04am, she appeared to have changed sleeping position, with her feet on the floor and lying on her left side. At around 6.08am, she completed the early morning roll check. She said that Ms Roberts remained in the same position and said that she could hear and see Ms Roberts breathing. She said that she had no concerns and checked Ms Roberts again at 6.30am.

43. At around 7.23am, Officer C carried out his roll check. He looked into Ms Roberts' cell for around forty seconds. He said that he thought that Ms Roberts was sleeping and believed that she was breathing but that this was quite shallow. He described her as being in a 'weird' position, with her feet on the floor and leaning to her left side, with her shoulder on the bed. He said that it looked as if Ms Roberts had fallen asleep, and that it was not unusual for prisoners to sleep in 'weird' positions.

44. After the roll check, Officer C returned to the wing office and told Officer B and Officer A how Ms Roberts was sleeping. They discussed how she had been sleeping awkwardly all week and how she regularly slept in unusual positions.

45. Officer C checked on Ms Roberts again at around 7.54am (for 40 seconds) and 7.55am (for 20 seconds) and found her in the same position. He checked on her again at around 8.05am, and she remained in the same position. He asked Officer D for a second opinion and the officers checked on her at around 8.07am (for 40 seconds). Officer D agreed with Officer C that Ms Roberts looked as though she was breathing but that it was shallow. She remained in the same position.

46. At 8.42 am and 9.12am, Officer C checked on Ms Roberts again. He said that Ms Roberts remained in the same position and that he could see her breathing.

47. At 9.13am, a prisoner who worked as a prison orderly went to Ms Roberts' cell to offer her hot water as the wing had not yet been unlocked due to Covid-19 restrictions and as it was the weekend. She looked into Ms Roberts' cell and saw her sitting up, with both feet on the floor, but slouched to the side. She tried to get a response from Ms Roberts but could not. Concerned about her, she told Officer E, who arrived at the cell around thirty seconds later.

48. Officer E called out to Ms Roberts and asked for Officer C's help when she could not get a response. The officers went into the cell and found that Ms Roberts was unresponsive and not breathing. Officer C, who said that Ms Roberts felt warm to the touch, checked for a pulse but found none so radioed for healthcare staff to attend.

49. At around 9.15am, a nurse arrived at the cell, assessed her and called a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties). The control room called an ambulance. The nurse could not find any signs of life and noted that rigor mortis was present, that her skin was mottled but that she was still warm. The nurse started cardiopulmonary resuscitation (CPR).

50. More healthcare staff arrived, and staff continued resuscitation efforts. The defibrillator was attached but advised that there was no shockable rhythm. At around 9.28am, an on-call GP was contacted for advice and CPR was stopped at 9.32am. The ambulance was stood down and a prison GP confirmed Ms Roberts' death at 12.45pm.

## Contact with Ms Roberts' family

51. On 24 July, a custodial manager was appointed as the family liaison officer. In line with national instructions on managing the risk of COVID-19 in prisons, she telephoned Ms Roberts' brother, her next of kin, to tell him that Ms Roberts had died and offer her condolences. The prison contributed to the funeral costs in line with national instructions.

## Support for prisoners and staff

52. After Ms Roberts' death, the Head of Residential Services and Safeguarding 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 care team also offered support.

53. The prison posted notices informing other prisoners of Ms Roberts' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by her death.

## Post-mortem report

54. A post-mortem examination established that Ms Roberts died of diabetic ketoacidosis which can occur as a result of diabetes or chronic alcoholism. The report noted that it can be difficult to differentiate between the two causes if a person has both diabetes and alcoholism. The post-mortem examination was unable to identify an underlying condition, such as infection. However, the pathologist reported that because ketoacidosis in alcoholics is poorly understood, it could not be excluded that alcohol withdrawal could have contributed to Ms Roberts' diabetes ketoacidosis as she had diabetes. The post-mortem report noted that Ms Roberts' history of alcohol use was not well documented, and as she had no firm clinical diagnosis, the pathologist did not include chronic alcohol excess in the cause of death.

55. Toxicology tests confirmed the presence of prescribed medications, consistent with therapeutic use. There was no evidence of illicit drug or alcohol use.

# Findings

## Clinical care

56. The clinical reviewer found that the care that Ms Roberts received at Eastwood Park was of a standard reasonably expected and was generally equivalent to that which she could have been expected to receive in the community.

57. However, the clinical reviewer found areas of non-equivalence regarding the management and monitoring of Ms Roberts' alcohol withdrawal period as it did not follow NICE guidance.

58. The clinical reviewer made two recommendations which are not relevant to Ms Roberts' death but which the Governor and Head of Healthcare will need to address.

## Alcohol detoxification

59. The GP who assessed Miss Roberts at reception assessed that she needed to be monitored for symptoms of alcohol withdrawal. The clinical reviewer reported that in line with Eastwood Park's local healthcare policy, healthcare staff should have monitored her for five days, initially every two hours,

60. The clinical reviewer identified that Ms Roberts was not monitored in line with the local policy because the GP did not send a task to the nurses to explain that she needed these observations, and the nurses did not read the GP's notes which said that she needed alcohol withdrawal monitoring. We make the following recommendation:

    **The Head of Healthcare should ensure that all patients undertaking alcohol withdrawal are clinically monitored in line with local procedures.**

## Type 2 diabetes

61. The clinical reviewer reported that the GP's plans were in line with NICE guidelines for managing diabetes. The clinical reviewer noted that there would not have been a requirement for Ms Roberts' blood glucose levels to be monitored outside of these routine tests.

62. The clinical reviewer concluded, and the Head of Healthcare agreed that, while Ms Roberts' diabetes management at Eastwood Park was in line with NICE guidance, the expectations on how to monitor patients with Type 2 diabetes at Eastwood Park were not clear. It would be helpful for Eastwood Park to develop a pathway to manage and monitor Type 2 diabetes, including an additional pathway for those also undertaking an alcohol withdrawal regime.

## Resuscitation

63. When the nurse arrived at Ms Roberts' cell, she found that she did not appear to be breathing, rigor mortis was present in her arms, she had widespread mottled skin

but was still warm. She immediately started CPR. After further advice was sought, the decision was taken to stop CPR.

64. The clinical reviewer noted that the College of Nursing guidance for when not to perform CPR in prison settings (March 2016) includes guidance for when CPR might be futile, such as when rigor mortis is present. The clinical reviewer noted that healthcare professionals faced a difficult decision when deciding not to perform CPR, as they are taught to preserve life. Although not critical of the decision to start CPR, the clinical reviewer concluded that staff needed to feel more confident in making such decisions while taking into account the patient's dignity.

65. The clinical reviewer noted that Inspire Better Health have drafted their own Standard Operating Procedure (SOP) about when not to perform CPR, which is due to be published soon. She concluded that when it is published, staff should receive supplementary training so that they feel supported in making difficult decisions about CPR. We therefore make the following recommendation:

**The Head of Healthcare should ensure that when the procedures for when not to perform CPR is published, all healthcare staff have the opportunity to attend additional training.**

## Discovering Ms Roberts

66. Although staff checked on Ms Roberts hourly throughout the night, it was only when another prisoner could not get a response from her at 9.13am that staff intervened and discovered that she had likely died. Staff told us that when they carried out checks during the night and morning, they could see Ms Roberts breathing, albeit shallowly.

67. However, we are concerned that when staff saw that Ms Roberts was sleeping in an unusual position (she changed from a lying position to a sitting position in the early hours of 24 July), staff did not consider making further efforts to check on her welfare, for example, by calling out her name, shining a torch or by entering the cell. We are also concerned that the staff we interviewed considered it normal for women on the detoxification unit to sleep in unusual positions.

68. We are also concerned that although Officer A, Officer N and Officer C discussed among themselves the 'weird' way that Ms Roberts was sleeping, they did not consider or take further action to check on her. Because it was the weekend and COVID-19 restrictions were in place, Ms Roberts was not expected to have been unlocked from her cell until later that morning.

69. We note that Officer C checked on Ms Roberts a further five times after his first check at around 7.23am, with some checks taking up to 40 seconds. He also sought clarification about Ms Roberts' welfare from Officer D.

70. We accept that the primary purpose of a roll check is to confirm that all prisoners are present and correctly accounted for. However, roll checks are also an opportunity to check on prisoners' wellbeing and to identify any obvious signs that a prisoner may be ill or dead. We accept that roll checks may be carried out very early in the morning and, where that is the case, we do not consider that it is reasonable for staff to wake prisoners up and obtain a response from them to

confirm that they are alive. For example, if a prisoner is in bed covered by bedding during a roll check, we consider that it is reasonable for staff to assume that she is asleep, unless she is lying in an obviously awkward position, which Ms Roberts evidently was.

71. Prison Service Instruction 75/2011 on residential services says that:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
>
> "…there needs to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ...Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example, by obtaining a response during the unlock process."

72. We cannot know whether earlier intervention would have affected the outcome for Ms Roberts, but we do know that a delay of even a few minutes can make a critical difference in a medical emergency, and there were a number of missed opportunities to identify her condition earlier. We make the following recommendations:

**The Governor should ensure that staff are aware that when a prisoner is not due to be unlocked until later in the morning, staff satisfy themselves of the prisoner's safety, if there are concerns about the prisoner's wellbeing, by obtaining a response during the morning roll check.**

**The Governor should ensure that subject to a dynamic risk assessment, staff enter a cell as quickly as possible, where there is a risk to life or concerns about a prisoner's welfare**

## Emergency response

73. PSI 03/2013 on medical emergency response codes requires staff to radio a code blue when a prisoner is unconscious or having breathing difficulties and for the control room then to call an ambulance immediately.

74. When Officers E and Officer C found Ms Roberts, they called for healthcare assistance but did not immediately call a code blue. We recognise that it can be difficult for prison staff to make instant decisions in such distressing circumstances. However, when there is a potentially life-threatening situation, it is essential for them to act quickly and exercise good judgement. However, we are satisfied that they were aware of the emergency code procedures and that they should have a called a code blue immediately. We raised similar concerns about the use of emergency codes into the deaths of women at Eastwood Park in October 2018 and November 2019. We make the following recommendation:

**The Governor should ensure that all staff understand their responsibilities during medical emergencies, including calling an immediate emergency code when there is a threat to life, in line with PSI 03/2013.**

**The Prison Group Director for the Women's Estate should satisfy herself that staff at Eastwood Park understand their responsibilities during medical emergencies, including the use of emergency codes, and should write to the Ombudsman when she has done this.**

## Inquest

The inquest, held on 27 February 2024 concluded that Ms Anne-Marie Roberts died from natural causes.

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