Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Clare Dupree, a prisoner at HMP/YOI Eastwood Park, on 28 December 2022

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.

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.

Ms Clare Dupree died in hospital of hypoxic brain injury, lower respiratory tract infection and multi organ failure as a result of smoke inhalation produced by a fire she set in her cell, on 28 December 2022 while a prisoner at HMP Eastwood Park. She was 48 years old. I offer my condolences to Ms Dupree's family and friends.

Ms Dupree had a history of suicide attempts, substance misuse and mental health issues and after one day at Eastwood Park she made threats to harm herself. Staff appropriately started ACCT procedures but failed to formulate any care plan actions or hold a post-closure review.

HM Chief Inspector of Prisons and the Independent Monitoring Board found that Eastwood Park had the highest rate of self-harm in the women's estate, to the extent it was listed as a prison of concern. We have raised issues about the management of ACCT procedures at Eastwood Park before and are satisfied that HMPPS' Director of the Women's Directorate has implemented a plan to improve practice.

When the fire was detected, an officer radioed for assistance but did not set out the nature of the emergency. The fire panel in the gate house had malfunctioned earlier that day, so staff in the control room were unaware there was a fire. There was a delay before control room staff were alerted to the fire and called the emergency services.

Other regulatory bodies conducted their investigations and found that there were deficiencies in the fire detection and warning system on Ms Dupree's wing.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2024**

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Summary

Events

1. On 19 November 2022, Ms Clare Dupree was sentenced to 52 weeks in prison for assault and threatening behaviour and was sent to HMP Eastwood Park.

2. Ms Dupree had several mental health disorders, a history of substance misuse, suicide attempts and mental health difficulties. She attempted suicide (by hanging) twice in the community. In 2022, Ms Dupree made threats to the police that she would burn a block of flats down, but she had no recorded history of fire setting or arson.

3. On 21 November, a nurse started Prison Service suicide and self-harm prevention procedures known as ACCT, after Ms Dupree said she planned to hang herself. Staff did not formulate a care plan. Ms Dupree was assessed by a psychiatrist who prescribed diazepam and, the following month, an antipsychotic.

4. On 23 November, another psychiatrist referred Ms Dupree to a Psychiatric Intensive Care Unit for assessment. Her mental state deteriorated, but her assessment was delayed because she contracted COVID-19.

5. On 14 December, Ms Dupree was assessed as not suitable for the Psychiatric Intensive Care Unit. Mentally, she was doing much better, and the next day staff stopped ACCT procedures. The decision to end ACCT monitoring should have been reviewed within seven days but was not.

6. On 23 December, a member of the mental health team saw Ms Dupree after staff said they were concerned about her mental state. She was still expressing bizarre ideas but there were no concerns she would harm herself.

7. On the afternoon of 26 December, Ms Dupree was locked in her cell. Later that afternoon, prisoners in nearby cells heard her shouting random abusive words.

8. At 4.39pm, an officer heard the smoke detector alarm outside Ms Dupree's cell. Another officer radioed for assistance but did not say that there was a fire. The fire panel (which alerts the prison that there is a fire) in the gate house was not working so staff did not call the emergency services.

9. Staff on the scene did not immediately tell Gate staff the emergency was a fire, but afterwards followed the protocol to manage the situation. At 4.46pm, they told control room staff that there was a cell fire, and they called the emergency services.

10. At 5.03pm, the fire service arrived at the cell and took over management of the fire. At 5.09pm, paramedics arrived. Officers unlocked the cell and pulled Ms Dupree out.

11. Healthcare staff and paramedics commenced live saving techniques and at 6.14pm, Ms Dupree was taken to hospital, where she was moved to intensive care.

12. At 11.09am on 28 December, Ms Dupree died in hospital.

13. The post-mortem report concluded Ms Dupree died as a result of smoke inhalation.

Findings

14. Ms Dupree had several risk factors for suicide and self-harm. We found weaknesses in the management of ACCT procedures designed to identify her risks and triggers and co-ordinate support for her. Staff did not formulate a care plan and they did not hold a post-closure review.

15. We have raised concerns about ACCT management at Eastwood Park before. In January 2023, we sought assurance from HMPPS' Director of the Women's Directorate that the issues identified were being addressed. We are satisfied that the Director has taken steps to improve the management of ACCT procedures.

16. The officer who detected the fire in Ms Dupree's cell radioed for staff assistance but did not specify that there was a fire and the fire panel in the gatehouse was faulty which led to a delay in control room staff calling the emergency services.

17. The clinical reviewer concluded that the care Ms Dupree received at Eastwood Park was good. However, Ms Dupree did not collect her medication on the morning of the fire and there is no evidence that healthcare staff followed this up or alerted the mental health team in line with local policy.

18. The Crown Premises' Fire Safety Inspectorate conducted an investigation and found deficiencies in Eastwood Park's smoke detection system.

Recommendations

- The Governor should ensure staff are prepared and confident of their responsibilities in the event of a fire, including raising the alarm correctly, by running regular emergency planning exercises.

- The Principal Pharmacist should undertake regular clinical audits to ensure that the policy for managing omitted doses of medication is complied with and prescribers are alerted to any non-compliance.

The Investigation Process

19. HMPPS notified us of Ms Dupree's death on 28 December 2022.

20. 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 her. One prisoner responded citing her own experiences of Eastwood Park.

21. The investigator obtained copies of relevant extracts from Ms Dupree's prison and medical records. She obtained the HMPPS Early Learning Review. She was not able to view the prison's CCTV and body worn video camera (BWVC) footage due to technical issues at the prison.

22. The investigator interviewed nine members of staff and one prisoner at Eastwood Park in May and June 2023. The interviews were carried out in person and by video conference.

23. NHS England commissioned a clinical reviewer to review Ms Dupree's clinical care at the prison. She conducted joint healthcare interviews with the investigator.

24. The investigator liaised with Avon Fire Service, Crown Premises' Fire Safety Inspectorate (CPFSI), who investigated the smoke detection system, and HMPPS Fire Service. Our investigation was suspended between May 2023 and March 2024, while we awaited the outcome of these investigations and the clinical review report. CPFSI and HMPPS Fire Service sent us a copy of their investigation reports.

25. We informed HM Coroner for Avon of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

26. The Ombudsman's office liaised with Ms Dupree's family through their legal representative. Ms Dupree's family asked the following questions:

- The letters Ms Dupree sent showed a significant decline in her mental health over her time at HMP Eastwood Park. How did Ms Dupree come to be in such a desperate state? Was this picked up by staff and what was done to help her?
- Was she receiving her medication and the support she needed for her mental health and substance misuse?
- Was there a delay in Ms Dupree's letter to them being sent out by the prison?
- How was the fire started and what was done to put it out?
- Was there any delay in staff reaching Ms Dupree?
- What were the actions staff took once they were alerted to the fire and reached Ms Dupree's cell?
- Were the fire safety equipment and processes at the prison up to standard?

We have answered Ms Dupree's family's questions in this report and in the clinical review.

27. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS highlighted some minor factual inaccuracies, which have been amended.

28. Ms Dupree's family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies and omissions. The report has been amended accordingly. They also raised a number of questions or matters that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP/YOI Eastwood Park

29. HMP Eastwood Park is a closed prison for women in Gloucestershire. It has 10 residential wings, two of which provide specialist substance misuse services. Practice Plus Group provides integrated healthcare services and Avon and Wiltshire Mental Health Partnership NHS Trust provides psychosocial and mental health services.

HM Inspectorate of Prisons

30. The most recent published inspection report of HMP Eastwood Park followed an inspection in October 2022. Inspectors found that safety had declined considerably and gave it their lowest judgment of 'poor'.

31. Inspectors carried out a review in September 2023. They found that the prison had the highest rate of self-harm in the women's estate, but incidents were slowly starting to reduce. There was some improvement in how ACCTs were carried out (such as more consistent case management), but some women remained frustrated at how difficult it was to get basic requests dealt with. Staffing levels on residential units had improved giving women more time out of their cells with staff able to deliver more regime.

Independent Monitoring Board

32. 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 2023, the IMB reported that compared to the last reporting year, self-harm had risen by 128%, with a small number of prisoners contributing to a large proportion of incidents. A strategy to identify drivers for self-harm was introduced and more support was offered. Staffing levels at the beginning of the reporting period were low and considered to have impacted staff-prisoner relationships and time out of cell.

33. The Board noted that prisoners awaiting transfer to a secure mental health hospital had to wait far too long for placements, with the recommended target of 28 days exceeded for 40% of prisoners. The Board was pleased to report that the complex needs wing had been completely refurbished. The brighter environment and dedicated therapeutic support had a positive impact on the women housed on the wing.

Previous deaths at HMP/YOI Eastwood Park

34. Ms Dupree was the fourth prisoner to die at Eastwood Park since July 2021. Of the previous deaths, two were self-inflicted and one was natural causes. Up to the end of May 2024, there had been one (drug-related) death at the prison since Ms Dupree's.

35. In January 2023, we made recommendations about poor ACCT processes at Eastwood Park. The Director of the Women's Directorate responded and set out a number of improvement measures that had been implemented at Eastwood Park and assurance that quality checks were being completed every 12 weeks.

Assessment, Care in Custody and Teamwork

36. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

37. Part of the ACCT process involves assessing immediate needs and drawing up a support plan to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

38. On 19 November 2022, Ms Clare Dupree was sentenced to 52 weeks in prison for assault and threatening behaviour and was sent to HMP/YOI Eastwood Park. It was not her first time in prison or at Eastwood Park.

39. Ms Dupree had a history of substance misuse, mental health difficulties, suicide attempts and self-harm; she had attempted suicide by consuming weed killer and said that she had attempted to hang herself from a tree in the community. Ms Dupree had no history of arson, but it was recorded that in 2022, she told the police she would set a block of flats on fire.

40. Ms Dupree had a diagnosis of bipolar disorder, paranoid psychosis, schizophrenia, mixed personality disorder, anxiety and depression. She had contact with mental health services in the community and her last admission to a psychiatric hospital was in 2022, when she was detained under the Mental Health Act.

41. When Ms Dupree arrived at Eastwood Park, staff carried out the initial reception screen. Ms Dupree was pleasant and compliant throughout the process. She was provided with a vape pack and offered some phone credit to make a phone call, but she declined.

42. A nurse carried out the first night screen. She noted Ms Dupree's mental health diagnoses and referred her to the prison's mental health team. Ms Dupree's clinical observations were within the normal range, and she tested positive for cocaine, amphetamine, buprenorphine (Subutex, an opiate substitute) and opiates. The nurse considered Ms Dupree was mildly withdrawing from opiates, benzodiazepine and alcohol. Ms Dupree declined to be referred to the prison's substance misuse service. Ms Dupree said that she did not have any thoughts of suicide or self-harm and that she was not on any prescribed medication in the community.

43. Staff housed Ms Dupree on residential wing eight, an induction wing. Healthcare staff saw her regularly and monitored her withdrawal symptoms. They did not identify any clinical concerns or withdrawal problems.

44. On 20 November, a Recovery Support Worker noted that staff were concerned about Ms Dupree's behaviour as she was wandering into other people's cells and shouting at the medication hatch for treatment. She noted that Ms Dupree had suffered with psychosis during her last time in prison and more information would be obtained from the Community Mental Health Team. It was planned that the prison's Crisis Team would see her.

45. At around the same time, Ms Dupree wrote a letter to her mother. In it, she apologised for a previous argument they had had and expressed hope that one day she would be a good mother, daughter and sibling.

46. On 21 November, a nurse carried out a mental health assessment. She recorded that Ms Dupree was distressed, frustrated and sad. She noted that she was presenting with symptoms of psychosis with preoccupied thoughts about her family. Ms Dupree said that the police had hurt her family, and as a result, she was suicidal and planned to hang herself so that she could be reunited with them. She did not want to take any medication or receive help from the mental health team. Ms

Dupree said that she had stopped taking her prescribed medication in the community because they gave her unwanted side effects. The nurse started Prison Service suicide and self-harm prevention procedures (known as ACCT).

47. A Supervising Officer (SO) completed the Immediate Action Plan. Ms Dupree was aware of the Listeners scheme (prisoners trained by the Samaritans to offer support) but had no phone numbers on her prison phone account and said she did not want to talk to anyone. An officer noted that Ms Dupree had been referred to the mental health team for assessment, staff were not to remove any items from Ms Dupree's cell, and she was given distraction packs. The SO set hourly observations with three conversations a day. Ms Dupree was to move to residential wing four which was dedicated to providing increased mental health support (the team visited daily).

48. On 22 November, an officer carried out the ACCT assessment. He described Ms Dupree as having rapid mood swings and hearing voices telling her to kill herself. She said that she wanted to develop her relationship with her four children, get some education and leave prison without the need for probation supervision.

49. That day at 11.55am, a SO chaired the first case review. An officer, a student psychosocial substance misuse worker and a nurse attended. Ms Dupree also attended and engaged but her verbal contributions were not always relevant to the questions being asked. She appeared mentally unwell and was unmedicated. It was noted that she was due to see a psychiatrist that day. Ms Dupree said that she felt better than she had the day before and that trying to kill herself in prison was pointless. She said she would speak to staff if she felt like killing herself again. The staff were concerned and raised her observations to two an hour and three conversations a day.

50. The SO did not set a date for the next review because she was the only Induction Unit SO. The Safer Custody Team was required to reallocate the case coordinator role to someone else in the main prison and the new case coordinator would be responsible for setting the next review date. The sources of support section of the case review log listed Ms Dupree's sister as an external source of support. The SO did not formulate any care plan actions to reduce Ms Dupree's risk. At interview, the SO could not recall why.

51. Also, that day, a psychiatrist saw Ms Dupree. He recorded in the ACCT observation log that Ms Dupree told him she had had suicidal thoughts since she was 18 but was not suicidal currently. She denied any thoughts of self-harm but could not give any guarantees about her safety. He recorded that another psychiatrist would review Ms Dupree in the next couple of days.

52. The psychiatrist also noted in the medical record that Ms Dupree appeared to be experiencing psychosis which was possibly drug induced given her positive results when she first arrived in prison. She declined his offer of antipsychotic medication but agreed to take Diazepam (a sedative).

53. On 23 November, the psychiatrist asked Alder Ward Psychiatric Intensive Care Unit to assess Ms Dupree. She described her as psychotic and unwilling to take antipsychotic medication. (Alder Ward is part of University Hospital Llandough and provides short-term admission and treatment for patients in the most acutely

disturbed phase of a serious mental disorder, supporting them in the early stages of their recovery.)

54. On 24 November, a psychosocial substance misuse worker carried out a substance misuse assessment. Ms Dupree gave inconsistent information about herself. He was concerned she did not have the mental capacity to make decisions. He discussed Ms Dupree with a mental health nurse, and they decided to add Ms Dupree to the substance misuse treatment waiting list.

55. On 26 November, Ms Dupree's allocated care coordinator (a mental health nurse and Eastwood Park's mental health lead) saw Ms Dupree. Ms Dupree was pleasant but was rambling and expressing bizarre thoughts. The coordinator documented that Ms Dupree did not express a risk to herself during the consultation.

56. On 28 November, the psychiatrist made an entry in the ACCT observation book. Ms Dupree presented as very mentally unwell and acutely psychotic with muddled speech. She said she had felt suicidal since she was 18. When asked if she had any thoughts of self-harm she would act on, Ms Dupree questioned how she could when she had not had her 'money' since August. This comment did not relate to anything obvious, and the psychiatrist recorded that Ms Dupree had not answered her question.

57. The psychiatrist also made an entry in the medical record and recorded that Ms Dupree was now acutely psychotic with paranoid and persecutory beliefs and no insight. His plan was to await the outcome of the Psychiatric Intensive Care Unit assessment and continue with Diazepam. Ms Dupree continued to refuse antipsychotic medication.

58. On 29 November, Ms Dupree was accepted for a move to residential wing four at the prison and would move when a space became available.

59. The psychiatrist and the allocated care coordinator chased the referral to the Psychiatric Intensive Care Unit as they considered Ms Dupree to be acutely psychotic. Ms Dupree's assessment was booked for 7 December.

60. On 2 December, a psychiatrist saw Ms Dupree and recorded in the ACCT observation book that she had chronic thoughts of self-harm but no current plans to hurt herself. He said she was erratic, thought disordered and her main risks were towards others at that time. He also noted she was confrontational and paranoid, having made threats to punch someone if she did not get an allegedly stolen vape back. Ms Dupree was moved to a different landing on wing eight.

61. On 4 December, a health worker saw Ms Dupree and carried out an assessment of needs. She described Ms Dupree's presentation as very calm, rational and relaxed and throughout the review she expressed no abnormal thoughts or delusional content. Ms Dupree denied any thoughts of suicide or self-harm. The assessment took place through the cell door observation panel as staff shortages meant staff could not open the cell door.

62. On 5 December, Ms Dupree tested positive for COVID-19. Healthcare staff saw her on 7 and 8 December and rebooked the Psychiatric Intensive Care Unit assessment for 14 December.

63. On 8 December, the allocated care coordinator made an entry in the medical record and said that she had held an ACCT case review (the ACCT document contained no record of the meeting). A SO attended, but Ms Dupree did not as she had been diagnosed with COVID-19.

64. The SO told the allocated care coordinator that he had spoken to Ms Dupree that day and she was feeling unwell but okay. He and the coordinator discussed closing the ACCT, but the coordinator felt that as she had not seen Ms Dupree for a few days and she was awaiting a psychiatric assessment, she did not want to close it. The SO agreed and they decided to review the situation after Ms Dupree had been assessed on 14 December.

65. At interview, the SO could not recall if he had completed the care plan, but he did not add details of the psychiatric assessment to it. The prison lost the case review paperwork, so there is no record of what decisions were made about the level of observations. The ACCT observation book indicates that by 9 December, observations had reduced to hourly with three conversations a day.

66. Ms Dupree's family told us through their legal representative that around this time, Ms Dupree's sister received a letter from Ms Dupree. She enquired about the family and asked for some money for vapes.

67. On 9 December, a psychiatrist carried out a psychiatric review and noted that Ms Dupree was doing much better. He noted she appeared much less thought disordered. She recognised she was mentally unwell and was willing to take medication. She denied any thoughts of self-harm or harming others. He recorded he had no acute concerns. They discussed her historical issues and various medications and talked about prescribing Aripiprazole (an antipsychotic) which she had not tried before. He provided Ms Dupree with a patient information leaflet about this medication. They also discussed reducing her Diazepam and she agreed that he could reduce the lunchtime dosage.

68. Overnight, Ms Dupree was disruptive and unsettled and had trashed her cell. She said that her family had gone missing. Records indicate that she had been spitting at staff during the ACCT checks while she was still COVID-19 positive.

69. On 12 December, a psychiatrist made an entry in the ACCT observation book noting that he had been unable to review Ms Dupree because her wing was noisy, and she was in COVID-19 isolation. He noticed she was reasonably well-kempt but had smashed up her television. He recorded he would try and review her later on in the week. In the medical record, he noted that officers said they found Ms Dupree a little chaotic and she would often ask quite random questions, but they were not concerned about her. He noted that it sounded as if her mental state had taken a dip and wondered whether it might be better to defer the Psychiatric Intensive Care Unit assessment until they had been able to fully assess her themselves, and another psychiatrist was going to email a consultant from the Psychiatric Intensive Care Unit about this. Ms Dupree's medication at this point was 10mg of Aripiprazole and 10mg of Diazepam. She was compliant with taking her medications.

70. On 14 December, the consultant assessed Ms Dupree. His early indications were that he did not think she was suitable for transfer to their unit. Staff also concluded she no longer met the criteria for a move to residential wing four at the prison.

71. On 15 December, the SO and the allocated care coordinator held a case review (the review paperwork is missing from the ACCT document). The coordinator said Ms Dupree was presenting well and denied thoughts of suicide and self-harm. They decided to close the ACCT. The SO set a post-closure review date for 23 December. In the meantime, staff were to keep a record of any notable observations, but all formal observations would stop. Staff did not record any notable observations over the following days.

72. On 19 December, the consultant formally told the prison he would not be offering Ms Dupree a bed at his hospital as she seemed better, but that he was happy to discuss this again if her presentation changed.

73. On 23 December, the allocated care coordinator recorded that the Nelson Trust (an organisation dealing with resettlement issues) had met Ms Dupree and reported concerns about her mental state. She went to see her in her cell and found her to be reasonably kempt. She recorded that Ms Dupree was still expressing unusual thoughts but felt better since taking Aripiprazole. They discussed her release plan (Ms Dupree was due for release in May 2023), and she had no concerns about her.

74. That day, Ms Dupree moved to residential wing six. The ACCT post-closure review did not take place.

75. On 24 and 25 December, staff did not record any concerns about Ms Dupree. Other prisoners said that she was happy and dancing on Christmas Day, but that she was still expressing bizarre thoughts.

76. On an unknown date, Ms Dupree wrote a letter to her mother and sister which they received after Christmas. Ms Dupree seemed generally paranoid and described herself as suicidal because of the lack of contact with her daughters. She felt she should be in hospital not prison. On another unknown date, Ms Dupree sent a letter to her sister. She expressed some unusual thoughts and said she was desperate for vapes. A further letter, also sent to her sister and received in January, was generally abusive, Ms Dupree asked for money and said she had COVID-19.

77. The prison told us that they only record letters being sent from prisoners who are subject to public protection restrictions. Ms Dupree was not in this category so there is no record of when her letters were posted. In December 2022, there was a series of nationwide postal strikes.

Events of 26 December

78. As the investigator was unable to view CCTV footage for Ms Dupree's unit on 26 December (due to technical issues at the prison), the following account is formed from the police report, staff interviews and documentary evidence.

79. On the morning of 26 December, Ms Dupree did not attend the medication hatch to collect her medication. There is no evidence that the pharmacist asked anyone to get her or that the pharmacist alerted the mental health team in line with local policy.

80. At 12.45pm, an OSG started his shift in the control room (which is co-located with the gate house). He noticed that the fire panel in the gate house was lit up red indicating that there was a fire on residential wing nine. He asked the staff already

on duty in the control room what was happening. They told him that it was a fault and that they had been unable to re-set it themselves. They had already called the Works Department who had sent the maintenance person to deal with it, but he was a plumber and had not been able to help. He believed that a maintenance person would be coming back the next day to fix the fault.

81. At 3.47pm, Ms Dupree came out of her cell for her evening meal. An officer accompanied her back to her cell. In his written statement, he said that it had been quiet on the wing that day with no issues. Ms Dupree was with another prisoner (Prisoner A) outside of her cell briefly before an officer locked them in their cells at 3.52pm. Prisoner A said Ms Dupree seemed quite happy but a little erratic.

82. Prisoner A told the police that at some point after being locked in their cell (the exact timings have not been established), Ms Dupree was shouting the word 'paedophile'. Around 15 minutes later, Ms Dupree was shouting that she was on fire; smoke started to fill Prisoner A's cell. Another prisoner (Prisoner B) was in the cell below (downstairs) and could hear Ms Dupree shouting too. Prisoner A and Prisoner B did not agree to be interviewed as part of this investigation.

83. Officer A had arrived at Ms Dupree's wing to help with medication and to lock the prisoners in their cells. At 4.39pm, the officer heard the smoke detector alarm outside Ms Dupree's cell on the second landing and went up the stairs to find out which cell it related to. Officer B was by Ms Dupree's cell door and told her there was a fire. Officer A tried to raise the alarm using her radio, but the battery was dead. Officer B made the radio call and asked for assistance on residential wing six. She did not say that there was a fire. (Officer B was on extended leave from the prison and we were unable to interview her.)

84. Because the fire panel was faulty and Officer B did not specify there was a fire, staff in the control room did not call for the fire service. The OSG who was also in the control room, said that the fire panel had beeped, but it still showed an issue on residential wing nine which they knew was incorrect. He said that he and a colleague decided to wait for a staff call confirming a fire before alerting the emergency services.

85. Officer B started to inundate the cell with water through the inundation port (a hole in the cell door which can be opened to insert a fire hose). When the officers called Ms Dupree and kicked the cell door, she did not respond. The observation panel was covered so they could not see in the cell.

86. At 4.40pm, Prisoner C activated the fire alarm and a Custodial Manager (CM) arrived and took over the inundation. She told staff to collect Respiratory Protective Equipment hoods. Because the fire panel was faulty, staff in the control room still did not know that there was a fire on residential wing six.

87. At 4.42pm, Officer B and another officer put the hoods on and took over inundation. A member of staff radioed for the senior manager in charge that day to attend the wing.

88. At 4.46pm, an officer phoned the control room and confirmed that there was a cell fire, and a prisoner was inside the cell.

89. When control room staff received the call, they thought the fire was on residential wing nine because that was what the fire panel was showing. They called the Fire Service at 4.46pm followed by the ambulance service at 4.47pm. Another officer came to the gate and told them that the fire was on residential wing six. Control room staff informed the fire service and told them to go straight there.

90. At 4.50pm, the duty governor arrived on residential wing six. The CM told him the fire was in Ms Dupree's cell and that the observation panel was blocked. Two officers put on smoke hoods and took over cell inundation.

91. Staff continued with inundation for 33 minutes until the fire service arrived on the wing at 5.03pm and took over management of the fire.

92. At 5.09pm, paramedics arrived on the wing. At 5.12pm, once the fire was considered to be under control, staff unlocked the cell door and fire-fighters pulled Ms Dupree, who was lying unconscious on the floor near the cell door, out of the cell. Medical staff and paramedics started CPR.

93. At 6.14pm, Ms Dupree was taken to hospital. She remained in intensive care, where she died at 11.09am on 28 December.

Contact with Ms Dupree's family

94. On 26 December, the prison appointed a family liaison officer (FLO). There were no telephone numbers for Ms Dupree's next of kin recorded anywhere on the prison system. The FLO contacted the police for more information. The police provided telephone numbers but when the FLO called the numbers, they did not connect. The police attended the next of kin's address and informed them that Ms Dupree had been taken to hospital. On 27 December, the FLO met Ms Dupree's family at the hospital and offered her support. She remained at the hospital with them until Ms Dupree's death. She continued to offer support.

95. The prison contributed to the costs of the funeral in line with prison policy.

Support for prisoners and staff

96. After the incident, the duty 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 care team also offered support. Officer A was selected as a hospital escort and accompanied Ms Dupree to hospital.

97. The prison posted notices informing other prisoners of Ms Dupree's 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 Ms Dupree's death.

Post-mortem report

98. The post-mortem report gave Ms Dupree's cause of death as hypoxic brain injury, lower respiratory tract infection and multi organ failure as a result of inhaling fumes produced by a fire.

Other investigations following Ms Dupree's death

99. Following Ms Dupree's death, separate investigations were conducted by Avon Fire Service, Crown Premises' Fire Safety Inspectorate (CPFSI), and HMPPS Fire Service.

Avon Fire Service

100. In their investigation report, Avon Fire Service found that Ms Dupree had most likely deliberately started the fire with a vape pen in the bottom of her wardrobe. Clothes and part of her mattress were found in the bottom of the wardrobe.

Crown Premises Fire Safety Inspectorate (CPFSI)

101. In their investigation report, CPFSI noted that Ms Dupree's history did not flag her as an individual at higher risk from fire and arson in prison. CPFSI reported that it was not possible to establish the time at which Ms Dupree started the fire but noted that she was locked in her cell at 3.52pm and the domestic smoke detector outside her cell went off at 4.39pm, which meant that Ms Dupree was exposed to fire gases and heat for an unknown length of time during those 47 minutes.

102. The use of domestic smoke detectors fitted outside cells was in line with HMPPS' approach to mitigate fire risk. However, the cell window vents were open during the incident, so smoke escaped preventing the detectors sensing the problem sooner.

103. The main fire alarm system for the wing was functioning. However, the fire risk assessment for residential wings five and six noted that a reasonable fire detection and warning system was not provided. The system was not considered to adequately offer life safety to people within that building. Had an in-cell smoke detector instead of outside cell smoke detectors been in place, it would have been more likely to have detected the fire within 120 seconds of ignition, whether or not the cell window was open.

104. CPFSI found no evidence that Ms Dupree pressed her emergency cell bell to draw staffs' attention to the situation sooner.

HMPPS Central Operations Services Directorate

105. The report provides a detailed timeline of events and concludes there were deficiencies with: a) the stacking of fire alarm signals at the main panel b) the process for clearing faults with the fire alarm panel; and c) the process for servicing water misting equipment post-use.

106. In response, an automatic repair request was added to the prison's maintenance system 'Planet FM' to ensure a service request was generated after water misters were used. The prison confirmed that the fire alarm panel was fixed.

Findings

Assessment of Ms Dupree's risk of suicide and self-harm

107. Ms Dupree arrived at Eastwood Park with a number of risk factors. She had a history of substance misuse, attempted suicides, mental ill-health and relationship difficulties. She was not identified as a risk of starting fires but had threatened to set fire to a block of flats when she was arrested by the police in 2022. During both her periods at Eastwood Park, Ms Dupree did not present with any risks relating to fire setting prior to the events of 26 December 2022.

108. Ms Dupree was supported by ACCT procedures a day after she arrived at Eastwood Park, after she told staff she intended to attempt suicide. We found that although the mental health team attended and contributed to ACCT case reviews, there were omissions in the management of the process. Staff did not set a date for the second case review and did not complete the care plan. We were told that the Safer Custody team were responsible for setting the date for the second case review once the first review had taken place. This did not happen in Ms Dupree's case. Since her death, the prison has changed its process to ensure that ACCT procedures are allocated to a case manager straight away, who will hold the first case review and subsequent reviews so that there is consistency with case coordinators.

109. ACCT procedures were stopped despite there being an outstanding referral for Ms Dupree to see a psychiatrist for assessment for the Psychiatric Intensive Care Unit, and although staff had set a date for a post-closure review, it did not take place. A SO told us that the post-closure review did not take place because it had been an extremely busy day, and they were short staffed. He said that there were twelve instances of self-harm that day and he had dealt with five of them. He intended to hold the post-closure review when he was next due at the prison on 27 December.

110. The prison was unable to provide us with Ms Dupree's ACCT case review notes. We note that the prison had also lost the ACCT case review notes in the last self-inflicted case at Eastwood Park before Ms Dupree's death. We made recommendations about the management of ACCT procedures and recommended that the HMPPS Director of the Women's Directorate write to the Ombudsman and set out what action she had taken to satisfy herself that meaningful improvements had been made to the assessment and management of the risk of suicide and self-harm at Eastwood Park. In her response in March 2023, the then Director of the Women's Directorate outlined several measures that had been put in place including:

- Appointing a temporary Head of Safety to focus on improvements to the ACCT process, including case co-ordination, the high number of ACCTs open at any one time at the prison and ensuring that women received the right support.

- Providing extra support visits from the Women's Directorate and the National Safety Team to focus on ACCT processes and procedures, upskilling staff on risks, triggers and protective factors and drawing up an action plan in conjunction with the Governor containing short, medium and long term goals.

- Implementing a new regime giving women there more access to purposeful activity and greater time out of cell, hopefully leading to more meaningful staff-prisoner relationships.

111. We note that senior managers conduct assurance visits every 12 weeks and to date, there have been no self-inflicted deaths at Eastwood Park since Ms Dupree's. We do not make a recommendation, but the Director of the Women's Directorate and the Governor will want to continue to drive improvements in the prison.

Emergency response

112. HMPPS' document "Cell fire and safe systems of work for cell fires & Respiratory Protection Equipment (RPE) Learners' refresher handbook v.5.2" sets out specific instructions on what staff should do in the event of a fire. It says staff should raise the alarm by pressing the fire alarm call point and inform the control room using the radio net. Eastwood Park's Fire Orders and Evacuation Plan also says that the Communications Officer will need the following information in the event of a fire: location, number of people involved and life at risk.

113. At 4.39pm, staff were first aware there was a fire in Ms Dupree's cell. Officer B called for assistance but did not say over the radio that there was a fire. The officer was not available for interview.

114. Smoke detectors went off at 4.39pm and a prisoner activated the fire alarm at 4.40pm. However, because of the fire panel's fault, staff in the control room did not know there was a real fire until an officer phoned them at 4.46pm.

115. An OSG said that when he came on duty, he was made aware that the fire panel was incorrectly showing a fire on residential wing nine and it had been stuck like that all day. It would not re-set and staff had reported it. However, the on-call maintenance person who arrived was a plumber and could not fix it. We understand HMPPS Fire Service raised the fire panel issue with the prison. The prison told us that the fire alarm panel was repaired.

116. We note that there was a seven minute delay between the fire alarm being activated and the emergency services being called. We do not know what impact the delay had as although the fire service arrived on the wing at 5.03pm, it was still another nine minutes before the cell had been sufficiently inundated to allow staff to open the cell door safely (5.12pm).

117. The investigator asked the Governor and the prison's Senior Health, Safety and Fire Advisor about the delay in calling the emergency services and any action taken at the time to prevent this happening again. They did not respond. We make the following recommendation:

The Governor should ensure staff are prepared and confident of their responsibilities in the event of a fire, including raising the alarm correctly, by running regular emergency planning exercises.

Clinical Care

118. The clinical reviewer concluded that the care Ms Dupree received at Eastwood Park was good. The mental health team, including psychiatrists, regularly reviewed her and mental health nurses attended ACCT meetings. A plan to move Ms Dupree to residential wing four was appropriately considered.

119. She did note, however, that healthcare staff should have requested Ms Dupree's community mental health records to obtain a more comprehensive record of her mental health picture. The prison has put a process in place for obtaining GP records but not mental health records. The clinical reviewer has made a recommendation about this which we do not repeat here but which the Head of Healthcare will wish to address.

120. On 26 December, Ms Dupree did not collect her medication and the mental health team were not aware. The Local Operating Procedure 'Managing omitted doses of medication' should have been initiated. As this omission occurred within hours of Ms Dupree setting the fire, it represents a potential missed opportunity for a member of the mental health team to have visited her at what was clearly a time of crisis. We recommend:

The Principal Pharmacist should undertake regular clinical audits to ensure that the policy for managing omitted doses of medication is complied with and prescribers are alerted to any non-compliance.

Governor to Note

121. The investigator was not able to view CCTV of the incident despite travelling to Eastwood Park to do so. The acting Head of Safety told her there were technical issues despite being assured beforehand that the footage would be available for her visit. The investigator was also told it could not be downloaded to a disc and could only be viewed at the prison. While the investigator was able to get a timeline from the other investigations, it is imperative that the PPO is furnished with the evidence it requires, and in a form that allows for its proper interrogation.

122. After the emergency response, Officer A was sent on an all-night bedwatch with Ms Dupree. Her physical and mental wellbeing was not checked on first. While we appreciate that staffing levels were low, the Governor may wish to consider whether this was appropriate and whether other staff could have been called in to take over the bedwatch duties.

Inquest

123. The inquest hearing into the death of Ms Dupree concluded on 19 February 2026. The Coroner gave Ms Dupree's medical cause of death as hypoxic brain injury caused by inhalation of products of combustion.

124. The Coroner established that factors relevant to Mr Duprees' death included the delay in a PICU assessment which possibly contributed to her death as a timely assessment would have resulted in hospitalisation and appropriate care; and the use of DSDs instead of AFDs also possibly contributed to Ms Dupree's death. The

Coroner concluded that Ms Dupree died from sustained inhalation of smoke due to a delay in detection of fire as a result of arson.

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