A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner C on 6 March 2017 in Midlands Regional Hospital while in the Custody of Midlands Prison

***Please note that names have been removed to anonymise this Report**

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A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner C on 6 March 2017 in Midlands Regional Hospital while in the Custody of Midlands Prison

Presented to the Minister for Justice and Equality pursuant to Part 5 of the Prisons Act 2007.

This Investigation was conducted and the Report prepared by the undersigned.

Helen Casey
Deputy Inspector of Prisons

20 December 2017

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Preface

The aim of this investigation is to:

- Establish the circumstances surrounding the death;
- Examine whether any changes in operational methods, policy and practice, or management arrangements would help to prevent recurrence of a similar death or serious event; and
- Address any concerns of the family.

The deceased was a 45-year-old man who died on 6 March 2017 while in the custody of Midlands Prison.

I offer my sincere condolences to the family of the deceased.

I would like to point out that names have been removed to anonymise this Report.

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Investigation Report

General Information

1. The deceased was a forty five year old man who came from the Leinster area.

2. He is survived by his wife, sons, daughters and extended family.

3. The deceased had served a number of terms of imprisonment prior to his most recent committal.

4. He was committed to Cloverhill Prison on 1 June 2016 and transferred to Midlands Prison on 7 October 2016.

5. The deceased became ill in his cell on 6 March 2017. He was removed to Midlands Regional Hospital, Portlaoise, where he died later that evening.

6. I met with the next of kin to explain my role and to ascertain if the family had any concerns they wished to raise. I endeavour to respond in this report to concerns raised by them.

7. While carrying out this investigation I had unrestricted access to staff, prisoners and relevant records, including CCTV footage.

Status of the deceased

8. The deceased was an ordinary prisoner on the standard level of the incentivised regime[1].

9. The deceased was sharing a two person cell with Prisoner A, Cell number 18 on D2 landing.

[1] The Incentivised Regime has three levels of privilege – Basic, Standard and Enhanced. Basic level provides the least amount of privileges (number of phone calls permitted, amount of daily gratuity paid etc) while the Enhanced level offers the best privileges. All committals are placed on the Standard level of the Incentivised Regime.

10. It was reported that the deceased had a good rapport with staff and fellow prisoners. We were informed that he was a "*quiet man and caused no issues"* who *"attended school occasionally but didn't engage with any services"*.

11. The cell mate of the deceased, Prisoner A, confirmed that he got on well with the deceased.

Meeting with the deceased's family

12. We met the family at an early stage in our investigation. They told us that the deceased had to cope with "*a lot of stress"* in his life. There was "*a lot of recent bereavements in the family"*.

13. We were informed that while he got on well with everyone in the prison he was finding it hard to serve his sentence. They stated "*at times he was down and suffered some depression"*.

14. The family stated that they heard that the [deceased] was kept in the Reception Area of the prison and was not taken to hospital *"until it was too late".*

15. The family stated that while they had no issues in general regarding the deceased's time in prison, they were concerned about what exactly happened to him. They asked us to look into the following matters which concerned them:-

    a) "How did the deceased have access to medication?"
    b) "Did the prison authorities act correctly when the [deceased] *was found unwell in his cell?"*
    c) "Was the deceased left waiting in Reception while unwell?" and *"What time was the* [deceased] *taken to hospital?"*

Deceased's interaction with Prison Medical Services

16. A committal interview was carried out with the deceased at Cloverhill Prison by Nurse Officer A on 1 June 2016. Nurse Officer A recorded that the deceased *"suffered a heart attack*" the previous year. The deceased informed Nurse Officer A he "*had two stents*" inserted and was on medication for his heart and was on anti-depressants. According to the interview notes, the deceased stated that he filled his prescriptions but admitted that he was non-compliant in taking his medication.

17. According to the Medical Records the deceased also informed the Nurse he had issues with alcohol abuse and had a "*history of depression"* for which he "*had been treated as an inpatient in hospital"*. Nurse Officer A noted the record as follows:- "*feels okay at present, denying any thoughts of self harm*". Nurse Officer A advised the deceased that "*if he feels unwell later, to inform staff".*

18. On 2 June 2016 the deceased was reviewed by Prison Doctor A who recorded that the deceased *"guaranteed his own safety* - denying *any thoughts of self-harm"*. According to the records Doctor A advised the deceased that he would be reviewed if his mood deteriorated. The Doctor, having consulted with the deceased's pharmacy, prescribed medication for the deceased.

19. The deceased was transferred to Midlands Prison on 7 October 2016. On 8 October 2016, a committal interview and review was conducted by Doctor B who noted on the Medical Record the deceased's medical history of deliberate self-harm. Doctor B further noted on record "*no suicidal ideas at present, but looks in stress"*.

20. The Nursing Staff, noted on 20 November 2016, that the deceased was not attending regularly for his medications and they were concerned for his welfare.

21. Nurse Officer B encouraged the deceased to collect his medications regularly, advised him of the importance of taking his medication.

22. On 24 November 2016 Doctor C reviewed the deceased and also stressed to him the importance of taking his medication regularly. Doctor C highlighted the dangers of non-compliance. It is recorded that the deceased undertook to take his medication regularly and was satisfied the he could keep his medication in his possession. The deceased informed the Doctor that he was feeling upset and worried about an upcoming Court case, but denied any thoughts of deliberate self-harm or suicide.

23. While in custody the deceased continued to be reviewed by the Prison Doctor and Nursing Staff on a regular basis and was treated for minor ailments not relevant to this investigation

24. A Risk Assessment was carried out by the Prison Doctors who concluded that the deceased was suitable to have his heart medication "*in possession"* (I.P.).

25. According to the Nursing Notes the deceased was given his prescribed medication weekly and the empty packets were collected from him.

26. On 26 January 2017, Doctor C again reviewed the deceased who was presenting as "*very stressed and agitated especially at night time"*. There was a note on the medical record that the deceased's sister had passed away the previous week. It is further recorded that the deceased informed Doctor C that he "*feels paranoid that people are talking about him and his family"*. He was worried about his sons and was "v*ery nervous and stressed"* but denied thoughts of self-harm. The Doctor prescribed additional night medication to help the deceased relax.

27. On 2 March 2017 the deceased was again reviewed by Doctor C. The Doctor recorded that the deceased did not find the new medication helpful, he "*felt drowsy*". The Doctor also recorded that the deceased presented with *"some degree of social phobia"*. The Doctor changed the prescription to see if different medication would have better results.

28. In the medical records for 5 March 2017 the Nurse recorded that the deceased was "*given his medication in possession pack"* and *"empty pack returned".*

29. The deceased had no interaction with the prison Psychology or Psychiatric Services in Midlands Prison.

Sequence of events on 6 March 2017

30. At 11:48 the deceased can be seen on CCTV footage speaking with prisoners on D2 landing. At midday he can be seen going down the stairs, collecting his dinner at the servery and returning to his cell.

31. At 12:24 the CCTV footage showed an officer locking all cells for dinner.

32. Prisoner A, who shared the double cell with the deceased in his statement stated that he "*shared a cell for a couple of months and got on well".* He stated that the deceased *"ate his dinner and was in his usual good form".*

33. Prisoner A informed us that the deceased lay down for a rest after the dinner. He reported that at 14:00 an officer unlocked D2 landing and prisoners were free to mix again. Prisoner A, when interviewed, stated that he thought that the deceased *"didn't look very well, he didn't like his colour*". Prisoner A stated he "*knew the deceased had a heart condition and had tablets for it".* He further reported that he had seen the deceased with tablets but he "*didn't get involved*". Prisoner A stated he "*went up to the Class Office and told the officers* (the deceased) *was ill.* He stated the staff responded very quickly – *"only a couple of minutes and the nurses and officers were at the cell".*

34. Officer A reported that Prisoner A came to the Class Office at 14:30, informed them that the deceased was unwell in his cell and required medical attention. Officer A contacted the surgery and Nurse Officers C and D responded immediately. Officer A accompanied the Nurse Officers to the cell where the Nurses assessed the deceased and directed that he immediately be taken to see the Prison Doctor.

35. On 6 March 2017 Nurse Officer C recorded on the medical file that the "*Class officer on D2"* raised concerns about the deceased health. Nurse Officer C reported that "*upon arrival at cell* [the deceased] *was sitting at side of bed visibly trembling. Deceased stated that he felt terrible"*.

36. Nurse Officer C noted on the record that on checking his vital signs found the deceased to be "*disorientated to person, place and time"*. Nurse Officer C further recorded that the deceased *"Stated he wanted to end his life. Not able to cope with prison anymore*. *….. admitted to having taken his full card of 'In Possession' medication for the week plus a handful of zocs[2]"*. According to the report of Nurse Officer C the deceased was unable to clarify the amount of tablets he had taken. The Nurse Officer directed that the deceased be taken to the surgery for review by the Doctor.

37. The deceased was seen by Doctor C who also recorded that the deceased had confirmed that he took his full week supply of medication. The Doctor further recorded that the deceased was "*confused*", "*drowsy*" and stated that he "*wants to kill himself*". A urine sample was taken - it showed positive for unprescribed drugs. The deceased was immediately referred to the Midlands Hospital, Portlaoise by Doctor C for further observation. Care was handed over to Ambulance Paramedics at 15:30 and he was immediately transferred to the hospital

38. Chief Officer A reported that "*at 18:30 I contacted the escorting staff in PGH[3] to receive an update on* (the deceased)'s *condition. I was informed that the medical team were waiting on the results of blood tests and x-rays and it had been decided that he was to be admitted to the hospital for 24 hours observation"*.

39. At 21:50 ACO A, who was in charge of Midlands Prison, received a telephone call from Officer B, who was in charge of the escort at Midlands Regional Hospital. Officer B reported that a Doctor had pronounced the death at 21:45.

[2] Slang term used for Zimmovane tablets.
[3] Midlands Regional Hospital, Portlaoise – Formerly known as Portlaoise General Hospital

ACO A reported that he immediately notified the Governor who directed that the next of kin be contacted.

CCTV Footage

40. I viewed the following CCTV footage which corroborates the sequence of events on 6 March 2017 as outlined by staff:-

14:46	Prisoner A can be seen on CCTV footage going into the Class Office.
14:53	Two Nurse Officers arrived on the landing, meet the Class Officer and go to cell 18.
15:04	The deceased was escorted off the landing to the surgery.
15:35	Paramedics arrived at 15:00 and the deceased was taken immediately by ambulance to Midlands Regional Hospital, Portlaoise for treatment.

Responding to the concerns of the family

41. I will use the same sequence as at paragraph 15 to respond to the concerns raised by the family.

a) "How did the deceased have access to medication?"

According to Prison Medical Records the deceased was risk assessed by Prison Doctors and deemed suitable to be in possession of his medication. Details are provided in paragraphs 21 to 24.

b) "Did the prison authorities act correctly when the deceased was found unwell in his cell?"

Our investigation found that the Prison Staff responded promptly when the alarm was raised. He was assessed in his cell by the Nurse Officers, then taken to the Prison Surgery to see the Doctor and removed to hospital. Details are provided in paragraphs 33 to 37.

c) *"Was the deceased left in Reception while unwell?"* and
"What time was the deceased taken to hospital?"

The deceased was taken to the Prison surgery at 15:04 where he was examined by the Doctor. The Doctor directed the deceased be removed to hospital. The ambulance left the Midlands Prison with the deceased at 15:35. Details are provided at paragraphs 37 and 40.

Findings

42. The deceased was accommodated in a double cell on D2 landing.

43. The deceased shared the cell with a Prisoner with whom he got on well.

44. The deceased was a well behaved prisoner who was on the standard level of incentivised regime.

45. The deceased admitted, inter alia, a history of depression but denied thoughts of self-harm.

46. The deceased was regularly reviewed by the Prison Medical Services.

47. The deceased was not attending the Psychology or Psychiatric Services in Midlands Prison.

48. The deceased had been assessed as suitable by Prison Doctors to be in possession of his prescribed medications.

49. The deceased admitted self-administering all the medications in his 'In Possession Pack' on 6 March 2017 and also admitted taking illicit substances.

50. The deceased had given no indication to either his cell mate or to staff of his intention to self-harm.

51. Prisoner A is to be commended for taking prompt action in alerting the Class Officer when he became aware that the deceased was unwell.

52. The operational and medical staff responded promptly when alerted that the deceased was unwell.

53. The deceased was removed from Midlands Prison to Midlands Regional Hospital, Portlaoise at 15:35 on 6 March 2017.

54. The deceased was pronounced dead at 21:45 at Midlands Regional Hospital, Portlaoise on 6 March 2017.

55. The cause of death is a matter for the Coroner.