A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner E on 9 April 2015 in Midlands Prison

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

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A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner E on 9 April 2015 in Midlands Prison

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

Judge Michael Reilly
Inspector of Prisons

28 July 2015

Preface

Prisoner E was a 52 year old single man who died in Midlands Prison on 9 April 2015.

My Report is divided into seven sections.

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

Judge Michael Reilly
Inspector of Prisons

28 July 2015

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 52 year old single man who had lived in England for many years. At the time of entering prison he was of no fixed abode.

2. The deceased was remanded to Cloverhill Prison on 24 October 2012, was sentenced to a term of imprisonment on 19 May 2014 and transferred to the Midlands Prison on 20 May 2014. His remission date was to be 11 October 2022.

3. From 18 March 2015 to the date of his death the deceased shared a double cell – cell 11 on E3 Landing with Prisoner A.

4. I did not meet the family of the deceased. I was informed that the deceased was estranged from his family for many years.

5. As will become apparent from reading this report the deceased was a fit man who worked hard in the gym, displayed no symptoms of ill health and died suddenly on 9 April 2015.

6. In carrying out my investigation I had unrestricted access to all parts of the prison, to all records and CCTV. I received total co-operation from all persons while carrying out this investigation.

Status of the deceased in prison

7. The deceased was a protection prisoner on the enhanced privilege level.

8. The deceased was well thought of by both prison personnel and his fellow prisoners.

9. The deceased worked out in the gym on a daily basis and could be described as a very fit man who displayed no signs of having any medical problem.

Relevant medical history

10. The deceased was assessed by medical personnel in each prison that he was accommodated in. The notes of such assessments were to the effect that the deceased did not suffer from any underlying medical problems.

11. The deceased had been shot and suffered significant pain from metal fragments embedded in his thigh. He also had an old wrist injury which caused him pain.

12. The deceased received medication for pain relief.

13. The deceased was on no other medication.

14. There is a reference in the medical notes that the deceased attended at the pharmacy on 8 October 2013 and complained that he had dizzy spells.

15. Between 8 October 2013 and the date of his death the deceased had many consultations with prison doctors in connection with his medication for his pain referred to in paragraph 12 but on no occasion did he complain of having dizzy spells.

Sequence of Events on 9 April 2015

16. In this section of my report I refer to timelines. These times are taken from CCTV footage that was available to me.

17. On 9 April 2015 the deceased worked out vigorously in the gym. He then spent some time in the exercise yard before returning to his cell - cell 11 on E3 Landing at 11.55.54.

18. At 12.10.46 Prisoner A with whom the deceased shared the cell returned to the cell. Prisoner A described the deceased's demeanour in the following terms:-

> *"When I went into the cell he was sitting sideways on the top bunk with his feet hanging over the ladder. I asked him what was wrong. He*

said he was not feeling well. I was concerned as he looked very pale (gray). He was unwell, agitated and in a lot of stress/pain. I chatted to (the deceased) *for a few minutes and asked him how he was. His main complaint was that he had a massive heartburn in the middle of his chest. He said he never had felt a pain like this before, this pain was different. He told me he had done an extra heavy workout in the gym. I asked him did he want me to call the medics. He said no. I said to* (the deceased) *that he was only human and that if he needed help that he should get it. At that point he said ok call the medics. I was standing near the door so I went to ring the ordinary bell the one over the worktop. He said no to ring the emergency bell. He was in a lot of distress at this stage.*

19. The above is a small portion of the statement that Prisoner A made in the course of my investigation. He went on to explain that having rung the call bell the officers opened the door virtually immediately and that two 'medics' arrived within a couple of minutes. The officers opened the cell door at 12.26.40. Nurse Officers A and B entered the cell at 12.33.19 and left the cell at 12.42.05.

20. In the course of his statement Prisoner A referred to the conversation between the deceased and the nurse officers in the following terms:-

"He explained to the medics about his gym workout and that he may have pushed himself a little harder that particular day with less time between reps. He told them he went to the yard after his workout but did not feel well. He said on his way in from the yard he had to hold onto the fence as he felt faint. He told them he had to hold onto the railing going up the stairs as he felt faint".

21. I examined the CCTV which covered the stairs referred to in paragraph 20 and can confirm that the deceased had his hand on the banister railing while climbing the stairs. However, it did not appear as though he was having difficulty walking up the stairs.

22. The contemporaneous note in the computer medical notes entered at 12.57 pm by Nurse Officer A reads:-

> *"Called to cell by class officer as patient complaining of chest pain. On examination: Colour good. No breathlessness. Complaining of epigastric pain as a burning sensation. No left arm or shoulder radiation. Blood pressure 120/100. Pulse 88. Reps 17. Reassured and will provide Gaviscon. To see GP 2 pm".*

23. Nurse Officers A and B elaborated on the detail in the medical notes referred to in paragraph 22 in the following terms:-

> *"On arrival at the cell, the prisoner was sitting in a hardback chair. On examination he complained of and pointed to epigastric pain and not chest pain. He described the pain as a burning sensation in this area. He had no left sided chest pain and no radiation of pain or pins and needles in his left shoulder and arm.*
>
> *Blood pressure was 120/100 and pulse 88. His respiration rate was 17/min and O2 Sates of 98%. He said that he was working out as usual in the Gym but had been particularly active today. His colour was good and there was no sweating or clamminess of appearance.*
>
> *Since the presentation appeared to be about a burning pain in the epigastrium and not typically cardiac, it seemed likely that he had some kind of gastric reflux and we put him on the doctor's list for first consultation with the GP at 14.00 today. He was reassured and told that the doctor would see him at 2 pm".*

24. Prisoner A in his statement then described subsequent events in the following terms:-

"(The deceased) *and I chatted after they left. He could not get comfortable no matter what he did. He then lay on the bed (my bottom bunk) to try to get some relief and asked me to massage his left arm but this gave no relief. He got out of bed after a few minutes and walked around again. He went back into bed again for a second time just a few minutes later. I covered his legs with his own duvet from the top bunk. He turned into the wall for the first 5 minutes. Then he turned out and pulled the duvet up. He seemed to be settling. I was sitting on the chair. I thought I heard him snoring but when I looked I noticed he was gasping for breath. He made a second sound and gasp straight away".*

25. Prisoner A immediately rang the emergency call bell.

26. At 13.31.33 Officer A responded to the emergency cell bell from the deceased's cell as he was the Dinner Guard in charge of E Division. He called for immediate medical assistance. He contacted Officer B and asked him to bring the keys from the Keys Office.

27. Nurse Officer C responded to the emergency call and entered the deceased's cell at 13.37.58. She found the deceased lying on his right side, unresponsive, not breathing. She commenced CPR immediately and was assisted by Prisoner A.

28. Nurse Officer C detailed her actions in the medical notes in the following terms:-

"Called to cell at 13.30 hrs approx, to emergency call to E3 Cell 11. On entering the cell prisoner (deceased) *lying on the bed on his right side, unresponsive and cyanosed unable to palpate pulse. I immediately requested an ambulance. I transferred* (deceased) *to the floor and commenced CPR immediately. Breathing laboured and infrequent. Assisted by* (deceased's) *cell mate who took over chest compressions while I connected the AED, carried out instructions as*

per AED, three shocks given while continuing chest compressions. O2 given and airway maintained. Relieved by Nurse Officers B and A".

29. At 13.53.12 Nurse Officer B entered the deceased's cell followed at 13.53.45 by Nurse Officer A. They took over from Nurse Officer C and continued CPR.

30. Nurse Officer A detailed the actions taken by him and Nurse Officer B in the medical notes in the following terms:-

> *"On return from lunch Nurse Officer B and myself were told that* (deceased) *had suffered a cardiac arrest.*
>
> *On arrival at the cell we found the patient on the floor with NO C in charge with paddles attached to the prisoner and carrying out CPR.....She was assisted by the patient's cell mate. I immediately took over heart compressions and NO B managed the airway. We shocked the patient a fourth time.*
>
> *Shortly after this the ambulance personnel/paramedics arrived on the scene and took over leadership of the situation. When appropriate the patient was transferred onto the ambulance stretcher and moved to the ambulance from where he was transferred to hospital.*
>
> *Throughout the transfer of the patient from the cell to the ambulance, heart compressions were continued throughout as well as bagging the airway. On leaving the prison he appeared to have a pulse".*

31. At 13.54.31 ambulance personnel arrived at the cell. They took over charge of the scene.

32. At 14.08.30 the deceased was taken from the cell by ambulance personnel and brought to the Midlands Regional Hospital, Portlaoise where he was pronounced dead at approximately 15.30 hours.

Findings

33. The deceased was a fit and healthy man up to the morning of 9 April 2015.

34. The deceased complained to his cell mate that he was unwell in the minutes following 12.10.46.

35. The deceased's cell mate immediately raised the alarm. Prison personnel and nurse officers responded.

36. The nurse officers carried out a full assessment on the prisoner and concluded, in their professional opinion, that he had some kind of gastric reflux.

37. The deceased was to be seen by the doctor at 14.00 hours.

38. The deceased continued to be unwell and his cell mate again raised the alarm. Prison personnel and nurse officers again responded.

39. The nurse officers worked professionally on the deceased until the ambulance medical personnel arrived and took charge of the situation.

40. The deceased's cell mate assisted in every way he could by alerting others to the plight of the deceased and by assisting the nurses particularly with CPR.

41. While it is a matter for the Coroner all the indications are that the deceased died following a cardiac arrest.

Comment

42. Prisoner A gave considerable assistance to the nurse officers. He assisted with CPR throughout much of the fraught period. He also saw his friend die. He described his feelings post the event as follows:-

> *"I am very upset and traumatized by what I witnessed. It was the first time I was so close to a person that was dying before my eyes. I am*

haunted by the thought of what if the emergency response unit/ambulance was called when the medics first came to the cell to attend to (the deceased) . *Would he be alive today? I continue to punish myself for not putting more pressure on the medics to call an ambulance at that point and get him to the hospital. I guess that will always haunt me".*

43. I enquired of the prison authorities as to the support that was given to this prisoner. I accept that many prison personnel including the psychologist, a governor, the chaplain and others visited this prisoner and were concerned for his welfare.

44. However, in a prison setting, a prisoner, who has been traumatised by an event such as in the instant case, must get over this trauma in an artificial setting where he must spend long hours on his own or in the company of cell mates who may not be sympathetic. Prisoners are not entitled to the luxury of being able to 'take time out' to deal with the emotional turmoil that follows a traumatic event as in the instant case.

45. I interviewed Prisoner A shortly before finalising this report. He was still suffering the effects of the trauma that he experienced.

Recommendation

1 Prison authorities must at all times be conscious of persons, be they prison personnel or prisoners, who are or may be affected by a traumatic event, as in the instant case. All appropriate immediate and follow up support must be given to such persons.