A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner I on 4 October 2014 in the Mater Hospital while serving a sentence in Mountjoy 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 I on 4 October 2014 in the Mater Hospital while serving a sentence in Mountjoy Prison

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

Judge Michael Reilly
Inspector of Prisons

23 March 2015

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Preface

Prisoner I was a 54 year old man who died in the Mater Hospital on 4 October 2014 having been moved there from Mountjoy Prison that afternoon.

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

My report is divided into 5 sections as follows:-

1. General Information.
2. Status of the deceased in prison.
3. Deceased's contact with the Medical Services.
4. Relevant sequence of events in Mountjoy Prison on 4 October 2014.
5. Findings.

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

Judge Michael Reilly
Inspector of Prisons
23 March 2015

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 54 year old man who came from the Dublin area. He had been estranged from his family for many years.

2. The deceased served a number of prison sentences. He was last committed to Mountjoy Prison on 19 December 2012. He was initially accommodated in D Division. In January 2014 he was moved to A Division, where he remained up to the date of his death. His release date was to be 25 August 2016.

3. The deceased was considered a quiet man who kept to himself and did not participate in activities within the prison.

4. On 4 October 2014 at approximately 12.10 pm the deceased was found in a collapsed state having suffered what appeared to be a seizure. Ambulance services were called and he was removed to the Mater Hospital. He was pronounced dead shortly before 4 pm.

5. I did not meet with the family of the deceased.

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

Status of the deceased in prison

7. The deceased was classed as an ordinary prisoner. He was on the standard level of the incentivised regime.

Deceased's contact with the Medical Services

8. I do not intend giving exhaustive details of all contacts the deceased had with the medical services but do set out relevant contacts.

9. On 19 December 2012 the deceased was sentenced to Mountjoy Prison. An appropriate committal assessment was carried out by Dr. A on 20 December 2012. The doctor noted that the deceased had a long history of medical issues.

10. On 21 April 2013 Nurse Officer A attended to the deceased in his cell. The deceased had apparently suffered a seizure and was taken by ambulance to the Mater Hospital where he was seen by Dr. B who prescribed appropriate medication. The doctor noted that, at that time, the deceased was not on medication. He also noted that the hospital records disclosed that the deceased had a history of seizures in the past.

11. On 5 September 2013 Nurse Officer B attended to the deceased in his cell. He was lying on his right side, with blood around his mouth and weakness to his right side. He was taken by ambulance to the Mater Hospital. A referral letter from Dr. C accompanied the prisoner.

12. On 6 September 2013 the deceased underwent an angiogram and ECG in the Mater Hospital. He was prescribed appropriate medication and returned to prison in a stable state. Dr C noted in the medical records that there were *"no other issues or concerns"*. He also noted that the deceased was to be reviewed by a consultant *"in six weeks in Out Patients"*.

13. On 14 November 2013 the deceased attended the Neurovascular Clinic in the Mater Hospital. This was a follow up to his attendance at the hospital on 6 September referred to at paragraph 12. On review his brain scan was negative and the diagnosis was that he had suffered TIAs in the past.

14. Between 14 November 2013 and the day that he died there is no indication in any of the medical records that the deceased was hospitalised for or suffered any seizures such as referred to in paragraphs 10 and 11.

15. Between 14 November and the date of his death the deceased was on constant medication for his ailments.

16. The medication being given to the deceased had to be monitored on a constant basis – at least once a week. This meant that the deceased had to attend at a specific clinic for the purpose of having his blood monitored.

17. On numerous occasions the deceased refused to attend such clinics. It was explained to him by doctors and other medical personnel, in the strongest terms, the necessity of attending such clinics but he still did not attend. It is noted in the records that he did not, at all times, appreciate the necessity of complying with medical advice.

Relevant sequence of events on 4 October 2014

18. On 4 October at approximately 11.55 am the deceased was unlocked for dinner by Officer A. The deceased was seen by officers standing in the doorway of his cell at 11.55 am and this was the last occasion on which he was seen alive.

19. At approximately 12.15 pm Officer A started checking all cells to ensure that prisoners had received their dinners.

20. When Officer A went to the deceased's cell to check that he had received his dinner he found the deceased on the floor of his cell. Officer A immediately called for medical staff on the radio.

21. Nurse Officer C stated she was called to the deceased's cell on A1 at approximately 12.15 pm on 4 October. She stated that the deceased was *"unresponsive to pain but breathing"*. The Nurse Officer placed the deceased *"in the recovery position and O2 therapy commenced*".

22. Nurse Officer D recorded that the deceased was *"found in collapsed state? Petit mal seizure"*.

23. At 12.28 pm the Dublin City Fire Brigade Ambulance personnel arrived and took the deceased to A&E at the Mater Hospital at approximately 12.30 pm.

24. The deceased passed away shortly before 4.00 pm.

Findings

25. The deceased was classed as an ordinary prisoner on the standard level of the incentivised regime.

26. He kept to himself and did not participate in activities in the prison.

27. He suffered from a number of medical conditions for which he was receiving ongoing appropriate medical treatment which necessitated, at times, reviews by hospital consultants.

28. The deceased did not co-operate fully with all his medical treatment.

29. On a number of occasions, having suffered seizures, the deceased was removed to the Mater Hospital, the last being on 5 September 2013, and on each occasion was treated appropriately and returned to the prison.

30. It appears that the deceased suffered a seizure on 4 October 2014.

31. The deceased was pronounced dead shortly before 4 pm on 4 October 2014.

32. The cause of death is a matter for the Inquest.

33. All staff in the prison – both medical and disciplined responded appropriately on 4 October 2014.