A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner P on 5 September 2015 in Midland Regional Hospital, Portlaoise while in the custody of Midlands Prison

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

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

Judge Michael Reilly
Inspector of Prisons

18 May 2016

Preface

Prisoner P was a 65 year old man who died on 5 September 2015 in Midland Regional Hospital, Portlaoise while in the custody of the Midlands Prison.

I did not meet members of the deceased's family but I offer my sincere condolences to them.

While issues of concern are raised in this Report they were not in any way relevant to the death of the deceased.

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

Judge Michael Reilly
Inspector of Prisons

18 May 2016

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 65 year old single man who came from the Leinster area.

2. He is survived by his sister and extended family.

3. The deceased was a remand prisoner awaiting trial. He was initially remanded to Cloverhill Prison on 16 May 2013. He was transferred to the Midlands Prison on 24 June 2013.

4. The deceased shared a double cell with a fellow prisoner.

5. The deceased collapsed in his cell – cell 22 on E1 landing on 5 September 2015 at approximately 9.30 am. He was attended to by medical staff and removed to Midland Regional Hospital, Portlaoise where he was pronounced dead at 10.07 am.

6. As part of my investigation I visited the Midlands Prison on Sunday 6 September 2015. I was briefed by prison management on the circumstances surrounding the death of the deceased. I gave directions as to the documentation that I required and the CCTV that was to be saved. I visited the deceased's cell.

Status of the deceased in Prison

7. The deceased had occupied cell 22 on E1 landing since 14 September 2013.

8. Cell 22 on E1 landing was a double cell which the deceased shared with Prisoner A.

9. The deceased was not subject to any disciplinary sanctions during his time in prison.

10. The deceased was a member of the Prison Church Choir and was a reader in Church. He had also worked as a helper in the library and as an organiser of the Prison Magazine to which he contributed articles.

11. The deceased had poor mobility and did not use the exercise yards. Most of the time he was confined to his landing and cell. He was able to attend the servery for his meals.

12. The deceased was on the Standard Incentivised Regime at the time of his death.

13. He made a written complaint which was categorised as a Category C complaint on 6 May 2015. He complained that he had lost his Enhanced Incentivised Regime status. He stated that he had spent *"a lot of time"* in organising the library on E2, organising the magazine and contributing articles to same. He stated that he offered to be trained as a 'listener' but had heard nothing. He stated that he was unwell and that his walking was impaired. He stated that his lack of involvement was due solely and completely to his ill health. He asked that the authorities should reconsider his status as *"the one thing that keeps me going are my two phone calls each day"*.

14. The deceased was a *'special observation'* prisoner from 7 April 2015. As a *'special observation'* prisoner he should have been checked every 15 minutes during periods of lock down in accordance with Standard Operating Procedures.

Deceased's contact with medical service

15. Prior to his remand to prison the deceased suffered from a number of serious medical conditions. He had a complex medical history and was on a number of medications.

16. He suffered from, *inter alia*, severe cardiac disease and his life prognosis was poor.

17. He had approximately 380 contacts with the prison medical services since his transfer to the Midlands Prison in June 2013.

18. He attended various hospitals on numerous occasions, at times as an out patient and at others as an in patient, his latest being the week before he died.

19. For privacy reasons I do not intend giving further details as to the deceased's condition or his contacts with the prison medical services. Such information would add nothing further to this Report.

Events of 4/5 September 2015

20. All activity on E1 landing is covered by CCTV cameras. I examined the CCTV from just before midnight on 4 September to the deceased's removal from his cell by the ambulance crew on the morning of 5 September 2015 for all activity relevant to cell 22 and/or the deceased. The following are relevant times taken from the CCTV:

23.52.56	Cell checked by officer. When cells are checked an officer lifts the observation hatch and looks into the cell.
00.53.26	Cell checked.
01.53.59	Cell checked.
02.54.02	Cell checked.
03.53.25	Cell checked.
04.52.14	Cell checked.
05.54.27	Cell checked.
06.40.39	Officer unlocked the master locks of the cell. Did not check the cell.
06.50.18	Cell checked.
07.45.39	Cell checked.
08.13.50	Officer unlocked cell door.
08.13.57	Prisoner A exited the cell.
08.14.28	Deceased exited cell.

08.15.02	Prisoner A returned to and entered the cell with his breakfast. After a moment he re-emerged and stood in the cell doorway.
08.19.52	The deceased returned to and entered the cell with his breakfast.
08.21.05	Prisoner A entered the cell and closed the door.
09.33.48	Two officers went to the door of the cell and looked through the viewing hatch.
09.34.05	The officers entered the cell.
09.34.25	Prisoner A was removed from the cell.
09.35.22	Nurses arrived at the cell and entered.
09.49.03	Ambulance crew arrived and entered the cell.
09.52.26	The deceased was removed from the cell and placed on an ambulance trolley.

21. Officer A was the night guard for 4/5 September. He noted in the Night Guard Journal the following:

> *"7.30 pm reported for duty. Checked and took charge of E1 and E2.... 9.00 pm commenced watch tours. Patrolled the landing throughout the night checking.....with extra care to those on spl obs and found all correct.... 6.30 am removed master locks. 7.30 am day staff on duty. Gave over charge correct...."*.

The master locks on cell 22 were removed at 6.40.39 as observed on CCTV and referred to in paragraph 20.

22. Officer B came on duty on the morning of 5 September. He described his involvement as follows:

> *"When I arrived on E1, I took charge of the landing. After all prisoners had received their breakfast and medication I checked and locked all prisoners safe, secure and correct in cells. Reported no's correct and gave over charge correct to breakfast guard....."*.

23. Officer C noted in the Breakfast Guard Report Journal the following:

> *"8.30. Reported for duty. Checked and took charge of E Div finding 124 prisoners secure in custody. E1 – 27 + 4CL + 1L = 32, E2 – 42 + 2CL +1L + 3M = 48, E3 – 38 +3L + 4M = 45. Reported numbers correct to ACO A i/c prison. Patrolled landings throughout the break and checked on all prisoners as required. Found all to be correct. Maintained radio contact with console via E1 class radio.*
>
> *9.15. Staff back on duty. Gave over charge correct".*

24. Officer C completed an operational report for his Governor on 7 September 2015 in which he detailed his involvement as follows:

> *"When I arrived over to take up charge of my breakfast duty, I was rather unwell and nauseous, but thought that I could manage fine in my duties. I started to feel unwell and sick from the night before, where I vomited and had diarrhoea but had thought it was something I had eaten.*
>
> *I wrote out my report in the breakfast guard report book on good fate that I was going to check the prisoners during the break, but when I stood up from the chair to go and start my checks, I got very dizzy and had to sit back down. Immediately I started to sweat profusely and my nausea got worse and I had a tightness in my chest. I held onto the sink and vomited into it a few times. Bye the time I pulled myself together and cleaned the sink, the staff were back on duty.*
>
> *I gave over charge correct and went to the visits, thinking now I would be fine and that it would pass. I wasn't getting any better so I informed ACO A that I was going to the Surgery".*

Officer C went on to relate that he was checked by Nurse Officer A who checked his blood pressure and gave him Motilium. He stated that the nurse told him that his blood pressure was very high and recommended that he see a doctor as soon as possible. He stated that he saw the prison doctor who, not happy with his symptoms and blood pressure, referred him to the Midland Regional Hospital.

25. Prisoner A who shared cell 22 with the deceased described what happened on the morning of 5 September in the following terms:

> *"I got up at 8 o'clock, the door was unlocked. I went out first for breakfast and medication. I got my milk and bottle of water. He was always up in the morning but went back to bed afterwards for a rest. At approx. 9.25 am, he asked me "do you want me to help to clean out the cell". I said "no I'll do it myself". He was sitting on the side of the bed. Next minute I heard a bang. I turned and saw* (the deceased) *lying against the wall of the bed. I checked his pulse and I don't know if I got one or not. He was breathing real hard. I panicked and I ran to put on the emergency cell call and started banging the door. The officers opened the door very quickly and came into the cell. Officer B asked me to leave the cell.* (The deceased) *never spoke once he fell against the wall".*

26. Officer B, already referred to in paragraph 22, described his further involvement as follows:

> *"At approx 9.30 am, I began unlocking. A couple of mins later Officer D calls out to me and inform me that there is a problem in cell 22. Realising it was serious, I ran down the landing and immediately opened the cell door.... Inmate Prisoner A approached me and informed me that inmate* (the deceased) *had fallen back and banged his head off the wall".*

27. Officer D described his involvement as follows:

"At approximately 9.30 am as I was assisting E1, I observed that the emergency cell call in 22 had been activated.

Upon answering the cell call I observed (through the observation panel) prisoner (the deceased) *slumped on his bed. I called Class Officer B who was further down the landing and he immediately opened the cell.*

Prisoner A (the deceased's) *cellmate who activated the emergency cell call was removed from the cell.*

Upon entering the cell, I observed that (the deceased) *was unresponsive and immediately called for medical assistance.*

Within minutes nursing staff arrived and began treating (the deceased)".

28. The account given by Officer D referred to in paragraph 27 was corroborated by a number of other prison officers.

29. I checked the computer records of cell call activations from cell 22 and can confirm that the emergency cell call was activated on the morning of 5 September and was answered 17 seconds later.

30. Nurse Officer B with Nurse Officers C and D responded to Officer D's call for medical assistance.

31. The nurses, referred to in paragraph 30, described the deceased as being slumped on his bed, cyanosed, gasping and having no pulse. They described calling a cardiac ambulance immediately and rendering medical assistance which included CPR and the application of AED.

32. The statements of the nurses, referred to in paragraph 30, are comprehensive. The detail in such statements is more relevant to the Coroner's Inquest.

33. The deceased was removed by ambulance personnel at 09.52.36 for transfer to the Midland Regional Hospital, Portlaoise. The nurses noted that while on route to the ambulance the deceased suffered another cardiac arrest.

34. The deceased was pronounced dead in the Midland Regional Hospital, Portlaoise at 10.07 hours on 5 September 2015.

Findings

35. The deceased had a complex medical history for which he was receiving treatment both in prison and in hospital when so referred.

36. The deceased, because of his medical condition, was unable to engage in structured activity in the prison which involved physical exertion.

37. The deceased was a *'special observation'* prisoner and as such should have been checked every 15 minutes approximately during periods of lock down.

38. The deceased was <u>not checked</u> every 15 minutes in accordance with Standard Operating Procedures during the night of 4/5 September 2015.

39. The note of the duties carried out by the Breakfast Guard set out in the Breakfast Guard's Journal referred to in paragraph 23 **<u>is not correct</u>**. The explanation for these entries is given in paragraph 24. I have not investigated nor addressed any of the issues relating to the accuracy of any of the entries in the Breakfast Guard's Journal nor the conflicting accounts as these do not fall within my mandate. However I refer again to these issues in paragraph 48.

40. The deceased was last observed on CCTV at 08.19.52 when he entered his cell having collected his breakfast from the servery.

41. Prisoner A has given a truthful account of the events of the morning of 5 September 2015 where he described the deceased suddenly becoming ill.

42. Prisoner A immediately called for assistance by activating the cell call bell and by banging on the cell door.

43. There was an immediate response by prison officers to the call for assistance from Prisoner A.

44. There was an immediate response by the nursing staff on the morning of 5 September 2015.

45. Both prison officers and nursing staff acted appropriately in responding to the emergency on 5 September 2015.

46. While the cause of death is a matter for the Coroner I understand that due to the severity of the deceased's cardiac disease he would have been predisposed to the risk of sudden death at any time.

47. While it is a matter for the Coroner it appears that the substance of my findings referred to in paragraphs 38 and 39 did not contribute to the deceased's death.

Recommendations

48. The Governor must review all issues raised in this Report and must comprehensively address those outlined in paragraphs 23, 24, 38 and 39 of this Report.

49. The Governor of the Midlands Prison must ensure that a functioning line management structure is in place to oversee the implementation of Standard Operating Procedures.

50. Prison staff must understand that it is a serious matter to generate official documents that are misleading and/or inaccurate.

Issue of concern

51. In paragraph 13, I referred to a complaint lodged by the deceased on 6 May 2015 and to the substance of such complaint.

52. I have been informed that on 4 May 2015 the deceased was reduced from the enhanced regime to standard regime under the Incentivised Regimes Policy as he was deemed *"unfit for work"*.

53. I have been further informed that every prisoner who is reduced from a higher level has the opportunity to appeal the decision and that these appeals are processed on an individual basis.

54. In the instant case the deceased did appeal by way of his complaint referred to in paragraph 13.

55. The deceased's complaint was categorised by Assistant Governor A as a Category C Complaint on 6 May 2015 and referred for investigation.

56. I have been informed that no investigation file exists, that no statements were taken and that no letters of findings issued to the complainant/deceased or to any other party.

57. I am advised that the Incentivised Regimes Policy has been applied more strictly in the recent past and that the intent of the Higher Enhanced Regimes Level is to reward those prisoners who are exceptional in both their level of engagement with services on a regular and consistent basis and in displaying positive behaviour.

58. I am further advised the policy states, in relation to structured activity:

> *"At the enhanced level, prisoners must participate actively in structured activities in education, work/training and/or offender programmes for at least defined periods a week (unless circumstances outside their control prevent this level of engagement).*
>
> *Engagement with services includes consistent participation in education activities, work/training activities, offender programmes; activities provided by the Psychology or Probation Services and/or approved in-reach services"*.

59. However, I also understand that prison management in many prisons, including the Midlands Prison, were advised by IPS Headquarters that the numbers of prisoners on the enhanced level were to be reduced and that targets were to be set for incremental reductions in status of those prisoners who did not meet the criteria for the enhanced regime. It would seem that the reduction in status of the deceased and many more old and infirm prisoners on the same landing and at the same time had more to do with this advice from IPS Headquarters than from consideration of the deceased's and other prisoners' particular circumstances.

60. The deceased was entitled to have his complaint investigated and to be provided with answers to his legitimate queries. By failing to investigate this complaint the Irish Prison Service was in breach of its own Complaints Procedure.

61. Old and infirm prisoners are, in many cases, unable to engage in the structured activities, education, work/training and/or offender programmes as envisaged in the scheme referred to above. It is not their fault. Therefore, it would appear to me that they are being discriminated against because of their age and/or infirmity. This is not only my view but is that of the many people who work with and have contact with such prisoners on a daily basis and of the prisoners themselves.

62. **I wish to make it clear that this issue is not in any way relevant to the death of the deceased.**