A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner C on 29 January 2018 in Cork Prison

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

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A report by the Office of Inspector of Prisons
into the circumstances surrounding the death of Prisoner C
on 29 January 2018 in Cork Prison

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

The Investigation was conducted and this Report prepared by the undersigned.

Helen Casey
Deputy Inspector of Prisons

20 July 2018

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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 29 January 2018 while in the custody of Cork 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

1.0 General Information

1.1 The deceased was a 45 year old man who resided in the Munster Region. He is survived by his wife and two children.

1.2 The deceased was remanded in custody to Cork Prison on 29 January 2018 and was due to appear before the Court again on 31 January 2018.

1.3 The deceased was committed to Cork Prison at 14:54 on 29 January 2018 and placed in Cell 5 on B1 Landing at 15:35. He was found unresponsive with a ligature around his neck and lying on the floor at 19:00 on 29 January 2018.

1.4 Efforts to resuscitate the deceased were not successful and he was pronounced dead at 19:57 on 29 January 2018.

1.5 We met with the wife and daughter of the deceased at an early stage in the investigation to explain our role and to ascertain if they had any concerns. They raised no concerns regarding his time in custody.

2.0 Status of the deceased

2.1 The deceased was a remand prisoner who was placed on the standard level[1] of the incentivised regime.

2.2 As a new committal to prison the deceased was placed on the Special Observation list [2]

[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 daily gratuity paid etc) while the Enhanced level offers the best privileges. All committals are placed on the Standard level of the Incentivised Regime.

[2] Special Observation prisoners, according to Irish Prison Service policy, must be checked every 15 minute

3.0 **Interaction with prison medical staff**

3.1 On committal to Cork Prison the deceased was processed through the Reception area of the prison. A committal interview was conducted by Nurse Officer A who made the following notes on the Prisoner Health Management System (PHMS):-

"*Assaulted Saturday night and taken to ho*spital *by Gardaí"*.

The injuries sustained by the deceased were also recorded. The Nurse Officer noted that the deceased had *"Very poor English"* and an *"interpreter booked for tomorrow"*. Nurse Officer A placed the deceased "*on Special obs.*"

4.0 **Sequence of Events**

4.1 The deceased was lodged by members of An Garda Síochána to Cork Prison at 14:54 on 29 January 2018 on foot of a warrant. He was remanded in custody to appear at Court in Cork on 31 January 2018.

4.2 On entry to Cork Prison the deceased was met by Work Training Officer (WTO) A who stated that *"Despite the fact that* [the deceased's] *grasp of English did not appear to be good I was able to inform him"* that he was due to appear in Court again on 31 January 2018 *"which he acknowledged"*. WTO A stated in his report that *"the deceased had visible injuries to his face and head"* and further reported that he *"escorted the deceased to Reception accompanied by Officer A.*.

4.3 At 15:32 when Nurse Officer A had completed the committal medical interview. WTO A and Officer A escorted the deceased "*to the Committal Unit on B1 landing where he was placed in cell 5"*.

4.4 Officer C, who was in charge of the committal landing, stated in his report that the deceased arrived "*at 3:35pm and placed in cell number 5. At 3.40 p.m. I placed the cell card*[3] *on his door and at 3.45 p.m. while giving him his tea he was issued with bread, jam, butter and milk.* I *explained to* [deceased] *where*

[3]Details of prisoner occupying the cell

the kettle was along with tea bags and sugar. The deceased seemed to be content with this information".

4.5 Officer C further reported that he was busy dealing with other committals that evening, including allowing prisoners out of their cells to go to the yard for exercise and make phone calls. Officer C stated that he checked the deceased in his cell at 18:40 "*and everything seemed normal at this time"*.

4.6 Officer B in his operational report stated he "*was detailed to work 8am to 8pm as officer in charge of the Vulnerable Person Unit.* Officer B reported that *"while master-locking B1 I came upon cell 5 on the committal landing which was occupied by the deceased. The time was approximately 7pm. At this time I was unable to see the prisoner in the cell so I opened the door. It was then that I observed the prisoner lying on the floor."* Officer B stated that he *"immediately raised the alarm by contacting the surgery."*

4.7 WTO B stated that he responded to Officer B's request for assistance and has reported that "*On Monday evening January 29 at approximately 7pm …….I observed Officer B …… running towards the Class Office calling for assistance"* and immediately went to *"the Committal Unit followed Officer B to cell 5 which we entered along with Officer D"*. He reported that they *"checked for a pulse which we didn't find"*. WTO B stated that *"Nurse Officer B then began CPR assisted by ACO A and myself taking turns with chest compressions. Nurse Officer C arrived with the resus bag"*. WTO B further reported that he attached "*the defib. (AED) which advised no shock*". He stated that "*CPR continued until the HSE Paramedics arrived who then took charge"* and he left the cell.

4.8 Nurse Officer B reported that "*at approx. 19:02 while dispensing medications on B2 landing Officer B put out an emergency call for surgery to attend B1. I ran to B1 and met Officer B"* Nurse Officer B further reported that she checked for a pulse but *"no pulse was present"* and she *"started compressions straight away assisted by WTO Officer B and ACO A"* taking turns with the compressions until Nurse Officer C arrived with the emergency bag. It was

further reported that Nurse Officer C applied oxygen while WTO B applied the defibrillator pads. Nurse Officer B concurred with WTO B's, statement which stated that they continued with the "*compression and rescue breaths via bag"* until the Ambulance Paramedics arrived after 8 minutes followed by the Fire Brigade who *"took over care of the deceased"*. Nurse Officer B reported that death was pronounced *"at 19:40 by Dr A"* and *"Fr A gave the deceased his last rites"*.

5.0 **CCTV Footage**

5.1 CCTV footage as saved from a series of cameras in Cork Prison was viewed and the following interactions between staff and the deceased were observed. The times shown are the time recorded on the CCTV footage

15.32:40	Deceased can be seen escorted by two officers as he walked unaided from the Reception area to the B1 Committal landing.
15:35:15	The deceased entered cell 5 on B 1 committal landing. He was carrying a white plastic shopping bag. The cell was locked and the officers left.
15:38:29	Officer placed a card on the cell door[4].
15:45:29	Officers with food trolley arrived at cell 5. Deceased exits cell and took food from trolley. Officers assisted in taking items into the cell. The deceased then locked in cell and officers moved onto other cells.
16:33:18	Officer checked cell 5. Lifted viewing flap and looked in.
16:59:55	Officer checked cell 5. Lifted viewing flap and looked in.

During the following hour and a half officers and prisoners moved along the landing going about their business but the cell 5 was not checked.

18:32:47	Officer checked cell 5. Lifted viewing flap and looked in briefly.

[4] Details of prisoner occupying the cell

19:02:06	Officer lifted viewing flap, looked into the cell as he master locked the cell. This officer unlocked and opened the cell door, looked into the cell but did not enter. He closed the door ran down the landing and immediately returned followed by three officers.
19:02:26	Officer opened the cell door, entered the cell followed by other officers. One officer exited immediately and ran to the Class Office.
19:02:59	This officer ran back from the Class Office to cell 5, entered the cell followed by a Nurse Officer.
19:04:15	Another Nurse Officer entered cell 5 carrying an emergency bag.
19:11:26	Emergency Response Paramedics arrived with equipment and entered cell 5.
19:13:37	Two more paramedics arrived to cell 5.

6.0 **Findings**

6.1 The deceased was a remand prisoner scheduled to appear in Court on 31 January 2018.

6.2 The deceased had sustained injuries prior to his committal to prison and records show the deceased informed Nurse Officer A that he had been taken to hospital by Gardai.

6.3 The deceased was categorised as a 'Special Observation' prisoner by the Nurse Officer who conducted the committal interview.

6.4 The deceased was placed in a single cell, Cell 5 on B1 landing.

6.5 The Irish Prison Service Standard Operating Procedure (SOP) relating to Special Observation Cells provide for 15 minute checks to be performed. Records show that the deceased's cell was checked on five occasions from 15:45 to 19:02. If the terms of the SOP were complied with 14 checks should have been conducted.

6.6 The staff responded quickly when the deceased was found unresponsive in his cell.

6.7 The deceased was pronounced dead in his cell at 19:57 on 29 January 2018.

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

7.0 **Recommendations**

7.1 The Irish Prison Service should develop an appropriate management and governance structure to ensure that Standard Operating Procedures are (a) known to all staff and (b) implemented at all times.

7.2 Supervision by Line Managers is a vital part of implementing policy. The Irish Prison Service should review the level and quality of training to satisfy itself that it is sufficient to equip supervisory grades with the necessary skills to carry out their function.

7.3 Where procedures are breached, appropriate disciplinary investigation should be conducted and those who failed to carry out their duties be held to account.