OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr P

AGED 47

AT THE MIDLANDS PRISON

ON 14th NOVEMBER 2018

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Office of the Inspector of Prisons
24 Cecil Walk
Kenyon Street
Nenagh
Co. Tipperary
Tel: + 353 67 4221

GLOSSARY

AGS	An Garda Síochána
The Act	Prisons Act 2007
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
CT Scan	Computed Tomography Scan
CTR	Compassionate Temporary Release.
DG	Director General
DiC	Death in Custody
ECR	Emergency Control Room
GP	General Practitioner
HCA	Health Care Assistant
HSE	Health Service Executive
IoP	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of Inspector of Prisons
PIMS	Prisoner Information Management System
SSO	Staff Support Officer

PREFACE

The Office of Inspector of Prisons (OIP) was established by the Department of Justice and Equality under the Prisons Act (2007). Since 2012, the Minister has requested the Inspector of Prisons to investigate deaths in prison custody. In 2018, clarification was received that the Inspector is also requested to investigate the death of any person which occurs within one month of their temporary release from prison custody. The Office is completely independent of the Irish Prison Service (IPS). The Inspector and staff of the OIP are civil servants, however, we are independent of the Department of Justice and Equality in the performance of statutory functions.

We make recommendations for improvement where appropriate; and our investigation reports are published by the Minister for Justice and Equality, subject to the provisions of the Act, in order that investigation findings and recommendations are disseminated in the interest of transparency, and in order to promote best practice in the care of prisoners.

Objectives

The objectives for Inspector of Prisons investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the IPS;
- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- Assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. The Office of the Attorney General has informed the IPS and Inspector that the provisions of the Prisons Act 2007 in relation to accessing healthcare /medical records of deceased prisoners in relation to investigations of deaths in custody cannot be relied upon. As an interim arrangement pending legislative amendment, the IPS has agreed to release such records with consent from Next of Kin (NoK). This inevitably leads in some instances to a failure to review healthcare/medical records where NoK is unknown, cannot be located, or refuses to provide consent. Mr P's NoK provided consent to the Inspector to access his healthcare/medical records for the purposes of this investigation.

This report is structured to detail the events leading up to, and the response after Mr P passed.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Inspector of Prisons role when investigating a death in custody.

My office contacted Mr P's NoK - his sister - by letter and also spoke with her by telephone. While she did not want to meet, she raised an important concern about why her brother had not been given the opportunity to die in a hospice setting rather than a prison cell. She felt this was very unfair.

Although this report will inform the Minister for Justice and Equality and several interested parties, it is written primarily with Mr P's family in mind. I offer my sincere condolences to them for their sad loss.

I am grateful to Mr P's family and the Irish Prison Service for their contributions to this investigation.

PATRICIA GILHEANEY
Inspector of Prisons
20 February 2020

SUMMARY

Mr P was aged 47 when he died in the Midlands Prison on 14th November 2018. His illness had been diagnosed four months earlier - in July 2018 - just over a year after he was sent to prison.

The end of life care that Mr P received in the Midlands Prison was commendable. Every effort was made to make him comfortable and he was treated with as much compassion and respect as was possible on a busy prison wing. This was challenging for staff:

- They did not have the necessary equipment or personal care materials to care for a dying man;
- Palliative carers were brought in from the community;
- Mr P's family were brought in to visit just before he passed. They could only see him in his cell, which meant the visit could only take place when some 50 other prisoners on the wing were locked in their cells. His brother, who was also in the Midlands Prison, was brought to see him and was present when Mr P passed.

These practical burdens on IPS staff and the family would have been unnecessary if Mr P had been afforded the opportunity to die in a hospice, rather than in prison.

Mr P's sister raised one query as follows:

Why Mr P was not been given the opportunity to die in a hospice setting rather than a prison cell. She felt this was very unfair.

Ministerial approval for hospice care was granted, however Mr P remained and died in prison. On 15th October 2019, the IPS informed the OiP that following Ministerial approval for Mr P to receive hospice care he continued to be cared for in Portlaoise General Hospital until his discharge back to the Midlands Prison on 8th November 2018. Nurse Manager A reported that there was discussion between the Community Palliative Care Team and Portlaoise General Hospital regarding Mr P's requirement for hospice care and while this discourse was taking place he remained in hospital. Ultimately, Consultant A's clinical opinion was that Mr P did not require an acute hospital bed. IPS National Nurse Manager A attended the hospital on 7th November 2018 and advised that he spoke with Consultant A by phone. Nurse Manager A reported that he was informed that the Palliative Care Consultant did not have admission rights to Portlaoise General Hospital and as Mr P did not require the services of an acute hospital place he was being discharged back to the Midlands Prison that afternoon.

The IPS informed the OiP that at that time there was no community hospice bed available and the only dignified response it could afford to Mr P was to make the best possible arrangements for him to be nursed in the Midlands Prison. The following arrangements were then put in place – Community Palliative Care Team, extra nursing/healthcare assistant supports on nights. Nurse Manger A informed the OiP that the Community Palliative Care Team continued to make efforts to secure a hospice bed, however, as no bed became available Mr P had to be nursed to end of life in the Midlands Prison.

There were two recommendations for improvement in the draft report provided to the IPS for review and comments. Additional information was subsequently provided to the OIP and changes were made to the final report to reflect the information received. There is one recommendation for improvement in this report.

The recommendation in this report has been accepted by the IPS. Its implementation will be monitored in future investigations into deaths in custody.

RECOMMENDATIONS

Recommendation

The IPS should consider introducing a policy that would require written consent by a prisoner to confirm their wish not to be resuscitated. Appropriate safeguards should be put in place to ensure that such consent is fully informed and provided freely.

THE MIDLANDS PRISON is a closed, medium security prison for adult males. It has a population in excess of 800.

On 14th November 2018 the Midlands Prison held a total of 816 prisoners.

Mr P's was the 4th death of a Midlands prisoner in 2018; and the 16th death in IPS custody that year.

CHAPTER 1 BACKGROUND & TIME IN THE MIDLANDS PRISON

1.1 Mr P was committed to prison on 18th May 2017 and arrived at the Midlands Prison the next day. He was serving a long sentence and lived on G1 wing where he had Enhanced status.

1.2 He was recorded as having to be kept apart from two other named prisoners but otherwise appears to have been a low-key prisoner.

1.3 His brother was also a sentenced prisoner in the Midlands Prison and a sister was nominated as his NoK.

1.4 Mr P' spending history within the prison tuck shop was unremarkable.

CHAPTER 2 END OF LIFE CARE

2.1 Mr P was a heavy smoker and had previously been a heavy drinker. Following a previous insignificant medical history, he presented to Portlaoise A&E in July 2018. A Computed Tomography (CT) scan was conducted on 24th July and carcinoma was diagnosed. His course of treatment was a combination of chemotherapy and radiation, commencing the following week.

2.2 Mr P had 14 attendances as a day patient at an outside hospital and four inpatient stays at Portlaoise General Hospital (PGH):

1. 24th July – 2nd August 2018;
2. 23rd September – 10th October 2018;
3. 12th October – 17th October 2018. The Discharge Summary noted *"Mr P was extremely non-compliant as an inpatient, refusing both meds and bloods to be taken. Long discussion had and scans reviewed and good response to treatment noted. Mr P wishes to continue chemotherapy…"*
4. 25th October – 8th November 2018.

2.3 On 11th October 2018 a case conference was held following Mr Ps return from hospital the previous day. At that stage medical opinion considered he had between two and three weeks to live. He was very frail and required a single cell.

2.4 This case conference represented a positive planning event. In addition to the primary reason of considering how to care for Mr P, there was a wider agenda: the Midlands Prison now had 35 prisoners on their Care Assistant list. More single cells were required on G1 to accommodate elderly, frail and unwell prisoners.

2.5 Available documentary evidence suggests Mr P had stated he did not want to be resuscitated. There was no Do Not Resuscitate (DNR) policy in the prison; and he had not signed anything to confirm this important wish. This caused anxiety for healthcare staff as their role was about preservation of life.

Recommendation

The IPS should consider introducing a policy that would require written consent by a prisoner to confirm their wish not to be resuscitated. Appropriate safeguards should be put in place to ensure that such consent is fully informed and provided freely.

2.6 Consequently a business case was to be sent to the IPS Healthcare Department in relation to DNR and other issues relating to the age profile of the population. These included consideration to automatic pooled hours when the staffing requirement was elevated by such situations.

2.7 The case conference attendees agreed that a query should be raised about the possibility of a hospice place for Mr P. His family had wanted him to go straight from Portlaoise General Hospital to a hospice.

2.8 On 24th October 2018 Chief Officer A issued an Order to enable prompt access to Mr P's cell, if necessary. The cell was not to be masterlocked at night and arrangements were made for the class key to be left with the night guard to allow rapid entry to the cell. This was commendable proactivity by the Chief Officer.

2.9 On 1st November 2018 Dr A wrote to the Midlands Prison governor saying *"Mr P was transferred to PGH on 25th October transferred by ambulance to Portlaoise General Hospital, and this episode of care continues. Further he has not been deemed medically fit for a return to prison at this time…. He is now at the end of life stage of cancer and following a review by the Palliative care Consultant, it was recommended from a clinical perspective that he remain in PGH, awaiting a bed in a hospice facility…. life span is a very short period indeed…. He will not live until his planned release date of 16/8/2025…. At this stage of treatment, the hospital clinicians advise that further hospital care or hospice care is indicated due to the complexities of the interventions required and the Midlands Prison are not in a position to meet his care needs…. Therefore I am making a recommendation under Rule 105 of the Prison Rules that Mr P be granted Temporary Release as per IPS Compassionate Temporary Release on grounds of Health and Capacity Policy, 2017."*

2.10 The next day, 2nd November 2018, the governor received an e-mail from Assistant Principal A to say the Minister had approved hospice care for Mr P and 'things had been set in motion to make this happen'.

2.11 Mr P was not transferred to a hospice or a nursing home.

2.12 On 8th November 2018 at 08.07 IPS National Nurse Manager A sent an e-mail to Midlands Governors: *"After much discussion yesterday Mr P will be returning to the Midlands Prison today at about 10am…."* The e-mail set out various practical arrangements: a special mattress and a profile bed were to be provided, prescriptions were in place; an agency was supplying a Healthcare Assistant (HCA) on a 24 hour a day basis and the Palliative Care Team were also available when required.

2.13 Governor B replied at 08.14 : "*As discussed yesterday, I do not believe that it is appropriate that this man dies in prison and I would be grateful if you and your team make whatever arrangements are necessary to have him transferred to a more suitable palliative setting in advance of him dying. A death in prison is hugely distressful on all involved – the man himself, his family, the other prisoners on his landing and the prison's staff. It should be avoided if at all possible."* This was a compassionate and sensible suggestion.

2.14 Despite the doctor's and governor's view, Mr P returned to the Midlands Prison from Portlaoise General Hospital on Thursday 8th November, at which stage the local Health

Service Executive (HSE) Palliative Care Team assumed responsibility for his care. Four Health Care Assistants (HCAs) subsequently contributed to looking after him.

2.15 Mr P's brother dictated a report which said that on Tuesday 13th November 2018 at 14.30 he was brought over from C2 wing in the Midlands Prison (where he was a prisoner) to see Mr P. He stayed for 30 minutes. By that stage Mr P was unable to communicate with him.

2.16 Governor B was made aware on Tuesday evening, 13th November 2018 that the end was imminent. He asked Chaplain A to inform Mr P's family and invite them in to see him that evening. His father, a brother and sister came in at 19:30. Although it is reported that they were uncomfortable being in a cell, they spent approximately 35 minutes with him.

2.17 On Wednesday morning 14th November 2018, Governor B visited Mr P in his cell. Mr P was unconscious and his breathing was laboured. He again requested an assessment by the Palliative Care Team to determine whether Mr P could be moved to hospice care.

2.18 Mr P's brother was again brought to see him at 13.30 that day.

2.19 At 14.30 he was very close to death and at 14.50 it appeared he had passed away. His brother, Chief Officer A, two nurses, a chaplain and two healthcare assistants were with him as he passed away. A doctor was called and confirmed death at 15.00. Chaplain A contacted Mr Ps NoK to confirm that he had passed.

2.20 Chief Officer A's informative, factual report said "*…I do not think it is appropriate to have any prisoner at end of life to be held in custody. This situation is not fair on any of the stakeholders that encounter this situation. It is vitally important that these people are moved to a unit that is designed to meet the medical and emotional needs of the patient and his loved ones."*

2.21 The OIP acknowledges that the reports which were supplied in particular by the Chief Nurse Officer A, Officers A and B and Chaplain A, provided context, were factual and sufficiently detailed to explain their roles and analysis of the situation. However, important information regarding transfer to hospice care was not provided by IPS until 15th October 2019.

CHAPTER 3 POST EVENT

Hot and cold debrief meetings

3.1 A hot debrief should take place as soon as possible after a Death in Custody, involving all who were present. The purpose should be to provide staff and prisoners with an opportunity to share views in relation to how the situation was managed, and identify any additional support or learning that could have assisted.

3.2 A Critical Incident Review took place at 3pm on November 16th. It was chaired by the Midlands Prison governor. Relevant operational managers, medical personnel, Staff Support Officer and chaplain also attended.

3.3 The review was valuable in highlighting a range of issues:

- Governor A said Mr P died with dignity and thanked all involved in his care. She said *"Prison is not an appropriate place for someone to die and we hope it will be the last."*
- Chief Officer A said *"This is a horrible place for someone to die, and it's wrong for all staff, healthcare, care assistants and prisoners to witness."*
- National Nurse Manager A said *"There is a great culture in the Midlands Prison in staff support and compassion in these difficult situations…. It is extremely hard for a family to watch their loved one die in prison. This is a prison, not a hospice. Chief [name stated] played a huge leadership role and all healthcare commended and appreciated the Chief's dealings."*
- Practical challenges were identified: e.g. Nurse Officer A said "*Palliative care has issues with not being able to bring in mobile phones etc.*
- Staffing issues were also apparent. The minutes said: "*It was noted there was only one nurse on nights on Monday – it was acknowledged that it is hard for nurses to make decisions when they are on their own. It was acknowledged that we were relying on the goodwill of staff in these situations, which weren't easy to deal with."*
- Governor A also commented that in the future it is likely the IPS "…*will be more open to prisoners going to a hospice."* This is a very important issue for the future care of terminally-ill prisoners in IPS custody;
- The Staff Support Officer (SSO) received a list of staff on duty that day. He would have liked to get them together for tea and a chat after Mr P passed, but acknowledged it could not happen as the staff could not be relieved. He offered to meet on a one to one basis to ascertain coping mechanisms and offer support. An e-mail group was also to be established for staff support and the governor said the boardroom was always available for staff support in such circumstances;
- An actions list was generated. It included clothes to be logged, laundered and bagged for the family; property/PAMS account to be collected from the General Office; and reports acquired from relevant staff.

3.4 The meeting concluded with the Governor reiterating her hope that the death of a terminally ill prisoner would not occur again and that going forward a nursing home or hospice can be arranged.

3.5 There is no evidence that a cold debrief was held. This has been recommended previously for IPS consideration and the IPS has informed the IOP that a policy and procedure is in development.

3.6 The IOP wrote to the Governor A of the Midlands Prison on 9th May 2019 requesting

- The sequence of events following receipt of Ministerial approval for Mr P to receive hospice care;
- The reasons why hospice care did not occur and the efforts that were made to obtain a hospice placement;
- The reason why Mr P did not remain in PGH awaiting a hospice placement in accordance with the information in Dr A's letter of 1st November 2018.

The governor acknowledged this request on 10th May 2019 and said she would respond as soon as possible.

3.7 On 23rd May 2019 the OIP sent a follow up query about progress. Governor A replied and advised that she had contacted Care and Rehabilitation Directorate A and National Nurse Manager A to respond.

3.8 On 10th October 2019 a further reminder issued from the IOP as a substantive response remained outstanding. Governor A again forwarded the IOP request to the relevant parties. National Nurse Manager A responded by return advising that a substantive reply would issue on 14th October 2019.

3.9 On 15th October 2019, the IPS informed the OIP that following Ministerial approval for Mr P to receive hospice care he continued to be cared for in Portlaoise General Hospital until his discharge back to the Midlands Prison on 8th November 2018. The OIP was informed by Nurse Manager A that there was discussion between the Community Palliative Care Team and Portlaoise General Hospital regarding Mr P's requirement for hospice care and while this discourse was taking place he remained in hospital. Ultimately, Consultant A's clinical opinion was that Mr P did not require an acute hospital bed. IPS National Nurse Manager A reported that he attended the hospital on 7th November 2018 and spoke with Consultant A by phone. Nurse Manger A further reported that he was informed that the Palliative Care Consultant did not have admission rights to Portlaoise General Hospital and as Mr P did not require the services of an acute hospital place he was being discharged back to the Midlands Prison that afternoon.

3.10 National Nurse Manager A informed the OiP that at that time there was no community hospice bed available and the only dignified response it could afford to Mr P was to make the best possible arrangements for him to be nursed in the Midlands Prison. The following arrangements were then put in place – Community Palliative Care Team, extra nursing/healthcare assistant supports on nights. The Community Palliative Care Team continued to make efforts to secure a hospice bed, however, as no bed became available Mr P had to be nursed to end of life in the Midlands Prison. The IPS advised that it would appear that the difficulties in this case surround the availability of community hospice beds, the difference of opinion between the Palliative Care Consultant and the Consultant in Portlaoise General Hospital and the responsibility this then placed on the IPS to afford Mr P a dignified and respectful death.