

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner F
in the Mater Hospital on
26 July 2014 while in the custody of
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 F
in the Mater Hospital on 26 July 2014 while in the custody of
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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

30 June 2015

Preface

Prisoner F was a 31 year old married man who died in the Mater Hospital on 26 July 2014.

I offer my sincere condolences to the family of the deceased. As part of my investigation I met with the widow of the deceased and have responded, in this Report, to questions and issues raised by her.

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

Judge Michael Reilly
Inspector of Prisons

30 June 2015

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 31 year old married man at the date of his death. He came from the Leinster area. He is survived by his widow, his four young children, his parents, 2 brothers and 2 sisters.
2. The deceased was a drug user from his mid teenage years. He had made various efforts to address his drug addiction.
3. The deceased was committed to prison on 9 June 2014. His release date was to be 18 October 2014.
4. The deceased was referred by the prison doctor to the A&E Department of the Mater Hospital on 24 July 2014.
5. He was not transferred to the Mater Hospital on 24 July. His condition deteriorated on 25 July. He was not transferred to hospital on that day either.
6. The deceased was found slumped in his cell, cell 5 on A2 Landing of Mountjoy Prison at approximately 3.30 am on 26 July 2014. He was moved to the Mater Hospital by Dublin Fire Brigade Ambulance at approximately 3.54 am, where he died shortly afterwards.
7. The cause of death is a matter for the Coroner's Inquest. However, the post mortem, performed by the State Pathologist, revealed that a sealed package in his small intestine was causing an acute obstruction of his bowel.
8. Prison personnel were aware on 25 July that the deceased had stated that he had swallowed drugs sometime prior to that date.
9. I met the deceased's widow at an early stage in my investigation in order to ascertain if she had any particular concerns. In this Report I endeavour to address her concerns.

10. In carrying out my investigation I had unrestricted access to all parts of the prison, to all records, to all staff and to all prisoners. I also had access to CCTV footage. In numbers of paragraphs I refer to timelines. The times referred to are those taken from the CCTV footage.
11. Issues of serious concern are raised in this Report.

My modus operandi

12. It is relevant that I set out briefly my *modus operandi* when investigating all deaths in custody.

As a first step, on being informed of a death of a prisoner in custody, which in all cases happens within hours of a death:-

- (a) I immediately seek a preliminary report on the death from the prison.
 - (b) I ascertain whether or not a criminal investigation is taking place.
 - (c) I visit the scene.
 - (d) I secure CCTV footage.
13. I then meet with the family to hear of any concerns that they may have.
 14. The next part of my investigation entails, *inter alia*, examining the deceased's medical files held by the prison, examining the CCTV, getting statements from prison personnel, interviewing prison personnel, prisoners and others who may be relevant, examining prison records etc. This is not an exhaustive list as each investigation carries its own dynamics.
 15. I submit my report to the Minister but prior to the publication of same I again meet with the family to inform them of the contents of the report.

Matters of immediate concern

16. At 09:04 hours on 26 July 2014, I was informed that the deceased had been discovered at approximately 03.30 hours that morning in an unconscious state by prison staff, that efforts to revive him were unsuccessful, that he was

transferred by ambulance to the Mater Hospital where he was pronounced dead at 05.52 hours that morning.

17. Very early in my investigation I ascertained that on 24 July 2014 the prison doctor referred the deceased to the A&E Department of the Mater Hospital.
18. The deceased was not brought to hospital on either 24 or 25 July 2014 and was found in an unconscious state in his cell in the early hours of 26 July 2014.

Meeting with the deceased's family

19. I met the deceased's widow in her home town. I also had sight of correspondence that her Solicitors had forwarded to the Governor of Mountjoy Prison and the Irish Prison Service.
20. She informed me that her late husband had been a drug user since he was approximately 16 years of age, that for many years he had been a heroin addict and that he had made efforts to give up drugs and was on a methadone programme from time to time.
21. She stated that her husband had spent much of his adult life in prison serving short sentences.
22. She stated that her husband would telephone her every day. She also told me that she visited him at least once a week and sometimes with their children. He was also visited by other members of his family.
23. She also told me that he took drugs, including heroin, while in prison and that she would have to defray the expenses for same at a premium of up to 300%. She explained that she would be informed by telephone by persons unknown as to where to leave the money for the drugs.
24. She stated that her husband had been '*set upon*' by other prisoners in the prison yard of Mountjoy Prison on 23 July. I refer to this incident in greater detail in paragraph 35.

25. She had one major concern – why did her husband die in prison.
26. She had other concerns touching such matters as – who knew what, what did they do with the knowledge, did he get proper treatment in prison, why was he not moved to hospital or at least to another prison.
27. This Report, read in its entirety, addresses all the concerns raised by the deceased's widow referred to in paragraphs 25 and 26.

Profile of the deceased

28. As I have already stated the deceased had spent a significant part of his adult life in prison. He had served his sentences in a number of prisons.
29. He had served relatively short sentences for numbers of offences such as simple possession of drugs, possession of drugs for sale or supply, handling stolen property, public order offences etc.

Status of the deceased in prison

30. He was classed as an ordinary prisoner who was free to mix with other prisoners. He was on the standard incentivised regime.
31. He was not considered suitable for referral to the Community Return Scheme.

Relevant events prior to 23 July 2014

32. On 11 July 2014 the deceased attended Carlow District Court. On their return from Carlow District Court Prison Officers from PSEC reported to the prison authorities in Mountjoy Prison that they had intelligence that the deceased had ingested a prohibited article. As a result he was placed in a Close Supervision Cell on C1 Landing from 18.30 hours on 11 July until 11.10 hours on 12 July. He was then returned to his cell on A2 Landing. There is no documentation to outline any satisfactory conclusion to this action save that he spent approximately 17 hours in a Close Supervision Cell.

33. The intelligence referred to in paragraph 32 is contained in statements of Officers A and B who escorted the deceased to the toilet in Carlow Courthouse. He used the toilet, washed and dried his hands. Before he was returned to the prison van the officers proceeded to effect a pat down search of him. They stated that they detected that he had something in his pocket. They asked him to remove it. He put his hand into his pocket, brought his head to his hand and placed whatever article he had in his mouth and swallowed it immediately. They did not see the article. On being asked what he had swallowed the deceased replied that it was a sweet. The officers reported this when they returned the deceased to Mountjoy Prison that evening.
34. On 19 July 2014 the deceased had a visit from his brother and father in the visiting box of Mountjoy Prison at 11.31.49. At 11.32.43 his brother can be seen, on CCTV, handing the deceased what appears to be a passport. The deceased can be seen taking something out of the passport and secreting same either in the back of his underwear or in his person. This was not seen by the prison personnel who were monitoring the visit. Two officers were on duty. One was standing and the other was sitting but neither were looking at the prisoner or his visitors. The deceased handed back the passport to his brother. The visit ended at 12.03.26.

Relevant events on 23 July 2014

35. At 18.28.05 the deceased can be seen, on CCTV, running across the prison yard being pursued by two prisoners. As the two assailants catch up with the deceased they punch him and he falls to the ground. One of the assailants falls on top of him and the other seems to be striking him. The first assailant gets to his feet and can be seen punching the deceased. The first assailant is dragged away by another prisoner. The second assailant then kicks the deceased in the back of the head and walks away. The deceased gets up off the ground and holds the back of his head. This was a significant altercation.
36. At 18.29.24 ACO A can be seen taking the deceased away from the scene.

37. At 18.32.57 the deceased enters Reception where ACO A ensures he (the deceased) was attended to by Nurse Officer A at 18.35.04. The following are the medical notes entered by the nurse officer on the PHMS:-

“(The deceased) down in reception post assault. Bruising around upper body and upper right arm. Graze to right arm and left knee. Head injury advice given and all grazes cleaned and dressed with Mepore dressing. (The deceased) claimed that he was FW and did not need any of the treatment but he did let me treat him”.

The deceased was a reluctant patient and did not refer to the recent assault or make any issue regarding same.

38. The nurse officer placed the deceased on the doctor’s list for review the following morning.
39. At 18.37.25 the deceased was placed in a holding cell in Reception and was then brought to and locked into his own cell – cell 5 on A2 landing at 19.28.17.

Relevant events on 24 July 2014

40. After breakfast unlock ACO A was proactive in bringing the deceased and his two assailants of the previous evening together. He observed them shake hands and was satisfied that whatever feud had precipitated the altercation the previous evening was now over.
41. At 11.59 approximately the deceased attended the prison doctor – Dr. A. The doctor’s notes read as follows:-

“Assaulted last night and this morning. Jumped by another prisoner all over. Complaints of intermittent abdominal pain, nauseated. Bruised all over back, chest, face. Pale looking. ?abdominal trauma. Plan – referral to AE”.

42. I interviewed Dr. A. I asked what he meant by – “*referral to AE*”. He explained that the deceased was to go to the A&E Department of the hospital. I asked him if the referral was urgent and he informed me that he had ticked the relevant box on the referral form as “urgent”. I asked the doctor when he expected the prisoner would go to A&E and he stated that he expected him to go as soon as practicable that day but could understand some delay while the authorities were assembling an escort as he understood that three officers were required for such escort. In other words he did not require an ambulance. He explained this in the following terms: - “*it was not a matter of sirens and lights but also it was not to be left*”. I asked him if the transfer could be delayed to the following day and he explained that A&E meant Accident and Emergency and that he would not have referred him to the hospital if this was neither an accident nor an emergency.
43. The referral form referred to in paragraph 42 was classed in the priority section as “urgent”. The referral form reads as follows:-
- “Thank you very much for seeing the above mentioned inmate who was assaulted by other prisoners yesterday and today. Jumped on his chest and abdomen. Bruised all over, severe intermittent abdominal pain and nausea. Looks pale. Abdomen – soft, normal bowel sounds, rebound – negative. ? abdominal trauma. Please admit for further investigations and management”*
44. Despite exhaustive enquiries and interviews with prisoners and the two assailants of the previous evening I could not find any evidence that the deceased was in an altercation on the morning of 24 July 2014 referred to in the prison doctor’s notes of that morning. However, this is not to suggest that the deceased was not involved in an incident on the morning of 24 July.
45. Dr. A handed the referral form to PASO A who entered the appointment on the PHMS computer system. He opened the PIMS computer system and had the movement to the hospital approved on the system. The details of this approval are listed in paragraph 46. The deceased was, from that time, on a discharge

docket. In other words no one would have had to seek further permission to take the deceased to the hospital.

46. At 14.14.29 PASO A electronically approved a hospital medical appointment with the following details:-

- | | |
|-------------------|--------------------------------|
| (a) Decision | Emergency operations approval. |
| (b) Decision date | 24-7-2014. |
| (c) Details | As per doctor's instructions. |
| (d) Decision by | Surgery |

This automatically created a hospital/medical movement with a planned departure time of 24-7-2014 at 15.00 hours.

47. At 14.25.00 on 24 July PASO A emailed the following - Chief Nurse Officer Mountjoy, MJOY Detail and MJOY Chief as follows:-

“Dr. A wants to send the above to A&E for further investigations when ever possible after being assaulted yesterday and today”.

48. After his examination by the doctor referred to in paragraph 41 the deceased was returned to his accommodation on A2 Landing.
49. The Details Section is responsible for, *inter alia*, arranging escorts for prisoners to hospitals, to courts, to other prisons etc. An ACO is in charge of the Details' Office and personnel.
50. I interviewed ACO B who was the ACO in charge of Details in relation to the events of 24 and 25 July 2014 as they related to the deceased. He confirmed that he was aware of the email referred to in paragraph 47.
51. ACO B accepted that the deceased was on the list in the afternoon of 24 July for escort to hospital. He was queued on this list. Two other prisoners had injuries which necessitated transfer to hospital. Therefore, the deceased was

- relegated to third place on the queue. He explained that if there was a queue which was not cleared by handover time to the night staff the Acting Chief Officer in charge of the prison for the night would be told and it would be his responsibility to get “*them out*”. I asked how the night guard would know that a prisoner was due for escort. He explained that an escort sheet would be in the prison and also the Acting Chief Officer would be verbally briefed.
52. ACO B accepted that he knew, when going off duty at approximately 20.00 hours on 24 July, that the deceased had not gone to hospital. He informed me that the deceased would have been included on the escort sheet for the following day – 25 July.
53. ACO B did not remember whether or not he had communicated the fact that the deceased was to go to hospital to the Acting Chief Officer when he, ACO B was going off duty on 24 July.
54. I examined relevant documentation and can confirm that the deceased’s name appears on the details sheet for 24 July. I accept that this entry was made at some time during the day of 24 July.
55. An escort sheet for all prisoners leaving the prison under escort on 25 July was prepared by officers in the Details Section on 24 July. The deceased’s name appears on this list. I cannot say at what time his name was placed on the list as the officers that I interviewed were unable to assist me.
56. Names of other prisoners who had been referred to hospital on 24 and 25 July appear on the escort lists referred to in paragraphs 54 and 55. I enquired as to the procedure for getting these prisoners to hospital. I was informed that prisoners for hospital went into a queuing system and would be brought to hospital in rotation. They would be prioritised and sometimes would not go if staff were not available.

57. There is no evidence that any of the recipients of the email referred to in paragraph 47 took any direct or indirect steps to ensure that the referral by the prison doctor of the deceased to hospital took place on 24 July 2014.
58. After being returned to his cell from the surgery around midday on 24 July the deceased had no further contact with the medical services on that date or until approximately 14.00 hours on 25 July when he was assessed by Nurse Officer B.
59. The deceased was not taken to hospital on 24 July 2014.

Relevant events on 25 July 2014

60. At 11.19.32 the deceased was visited by his wife in the prisoners' visiting box in Mountjoy Prison.
61. At 11.34.10 the visit terminated. The deceased was taken back to A2 Landing.
62. During the visit the deceased can be seen on CCTV pointing to various parts of his body.
63. In her statement to me the deceased's widow stated that her husband was in a distressed state when she saw him and that he said "*he could not hold anything down and asked to get him medical treatment*". She stated that it was obvious that he had been injured. She stated that he had to shorten the visit as he was feeling unwell.
64. Officer C stated that she observed the deceased after his visit with his wife and prior to his return to A2 Landing and described him in the following terms:-

"Even though he did not speak to anyone he did appear somewhat confused and a little dazed".

65. When the deceased left the visiting box he was returned to his accommodation on A2 Landing. At approximately 11.50 hours the deceased approached Officer D and “*requested to go back to his cell as he was unwell*”.
66. When the visit terminated the deceased’s wife asked to see a Governor. ACO C who was in charge of the A Division spoke to her at the prison gate. She expressed her concerns for her husband’s health, asked to have him medically examined and to arrange his immediate transfer to another prison. This version of events is confirmed by ACO C.
67. ACO C informed me that he spoke to Acting Chief Officer A and informed him of the deceased’s wife’s concerns, the deceased’s illness and what she had said in relation to same. In my interview with Acting Chief Officer A he stated that he did not recollect this conversation.
68. ACO C then spoke to Chief Nurse Officer A and relayed the deceased’s wife’s concerns. He asked the Class Officer on the landing to bring the deceased to the Class Office where Chief Nurse Officer A would examine him.
69. The Class Officer went to the deceased’s cell but the deceased refused to go to the Class Office to be examined.
70. At approximately 13.30 hours Officer E noticed the activation of the call bell light outside cell 5. This was during dinner lock down. He went to investigate. The deceased told him that he was feeling unwell and requested medical attention. Officer E contacted Nurse Officer B. He also contacted ACO D as he needed to unlock the cell to admit the nurse officer when she arrived.
71. Nurse Officer B confirmed that having received the call from Officer E she immediately went to cell 5 where the deceased complained of stomach pains. He also informed her that “*he had swallowed drugs a week ago and that he was assaulted a couple of days ago*”. The nurse officer checked his blood pressure which was normal. She checked his stomach area. She was “*perplexed*” and wanted to check his medical notes. She concluded that there

- would be enhanced medical access and facilities for observation if the deceased was in Reception. She ordered that he be brought to Reception.
72. ACO D, Officer E and Nurse Officer B escorted the deceased to Reception arriving at 13.57.40.
 73. At 14.01.46 the deceased, having been searched, was placed in Holding Cell 2 by Officer F who was in charge of the Reception Area. This was a small holding cell with a short narrow bench. It did not have a window or any form of sanitation or running water.
 74. Officer F made entries in the relevant journal which is named – *Prisoners detained in Reception for a short duration (with the exception of committals and discharges)*. In the section marked – “*Reason for placing in holding cell*” the officer noted “*Claims he swallowed substance*”. At interview the officer could not recall who told him that the substance referred to drugs. He also informed me that he was told that the deceased had been assaulted but did not write this down as it was not the reason for placing the deceased in the holding cell.
 75. Nurse Officer B left the Reception to check the deceased’s medical notes. She returned and told ACO D that the deceased had been referred to the hospital the day before by Dr. A and that he was to go to the hospital “post” the assault. Nurse Officer B’s opinion at that time was that the deceased “*did not strike me as being in a great deal of pain*”.
 76. ACO D informed me that he informed Acting Chief Officer A that the deceased had been taken from A2 Landing and brought to Reception as detailed in paragraph 72. He stated that he informed him that “*he was sick and may have to go to hospital*”. At interview Acting Chief Officer A stated that he did not recollect this conversation.

77. The deceased was checked at 14.21.01 while in holding cell 2. A uniformed officer looked through the viewing hatch. He was again checked in similar manner at 14.28.40.
78. At 14.36.00 Officer F checked the deceased in the cell. He opened the door and talked to him for 39 seconds. The deceased complained of pain in his stomach. The officer called for a medic.
79. At 14.53.56 the deceased was again checked by a uniformed officer by looking through the viewing hatch.
80. At 15.11.40 Nurse Officer B returned to the Reception area accompanied by Nurse Officer C.
81. At 15.12.00 both nurse officers entered holding cell 2. The nursing notes on the PHMS read as follows:-
- “Asked to review in reception. States he is feeling worse. Aggitates O/E – urinated on the floor because he wanted to. BP 163/112 HR 120. Cold and clammy – apyrexial. Referral letter for ae done. CO A aware – for t/f on the reserve”.*
82. I wish to point out at this juncture that the nursing note was generated at 16.10 hours on 25 July. The significance of this time is that it was a contemporaneous note which corroborates the statements made by Nurse Officers B and C referred to in paragraphs 89, 91 and 93.
83. I interviewed Nurse Officers B and C. They were both fully co-operative with my investigation.
84. Nurse Officer B stated, at interview, that she examined the deceased in the holding cell. His blood pressure was high. His pulse was high. He was sweating. He did not have a temperature. He was:-

“more unwell at this stage – his condition had deteriorated and he had to go to hospital now”

85. She stated that he had urinated on the floor but in her opinion this was not as a result of his condition.
86. Nurse Officer C, at interview, corroborated the account given by Nurse Officer B. She also stated that the deceased was quite aggressive. When asked by me if the deceased required an ambulance to get to hospital her reply was – *“he could go by car or walk”*. She explained that she meant that he did not necessarily require an ambulance.
87. I should point out at this juncture that the relevant hospital was the Mater Hospital which is directly across the road from Mountjoy Prison. This hospital is one of the major hospitals in Dublin and its A&E Department operates on a 24/7 basis.
88. Both nurse officers left the Reception area at 15.18.00.
89. Nurse Officer B stated that subsequent to leaving the Reception Area she spoke to Chief Officer A and to an officer in the Details Office and explained the deceased’s condition to them and that he was to go to hospital. The nurse officer was then diverted to another incident in the prison involving a serious head injury to a prisoner which necessitated calling an ambulance.
90. Chief Officer A was the senior uniformed officer in the prison on 25 July. Acting Chief Officer A was also a senior uniformed officer on that day.
91. Nurse Officer C, at interview, stated that she went to Chief Officer A and told him that he was *“going to have to”* send the deceased to hospital and also told him that he (the deceased) was supposed to go out the previous day. She stated that Chief Officer A asked when did the deceased have to go to which she replied *“now”*.

92. Nurse Officer C then attended to the incident referred to at paragraph 89. The injured prisoner in this incident was taken to hospital by ambulance escorted by prison officers.
93. According to Nurse Officers B and C they had a conversation with Chief Officer A subsequent to the transfer of the prisoner to hospital referred to in paragraph 92. They stated that Chief Officer A asked if it would be in order if the deceased was taken to hospital during the Reserve Period, ie, between 5 and 8 pm. Both nurses stated that they accepted this as a compromise as the Chief Officer had explained that he had staff issues that day *“with 30 to 40 staff absent from the prison”*.
94. Chief Officer A, at interview, when asked if he had received the email referred to in paragraph 47 stated:-
- “I can’t say 100%. I probably did”*.
95. I should point out at this juncture that the Chief Officer was not on duty on 24 July.
96. Chief Officer A stated that the first he heard of the deceased having to go to hospital was on the afternoon of 25 July when he was approached by Nurse Officer B at approximately 15.00 hours and was not aware of anything relating to the previous day. The Chief Officer stated that it was not explained to him that it was an emergency. He stated that if he felt it was a *“real”* emergency he would have got the deceased to hospital even if he had to close down a section of the prison in order to release officers for the escort.
97. In the event the deceased was not transferred to hospital during the Reserve Period but remained in holding cell 2 in Reception until 19.24.13 when he was returned to his cell – cell 5 on A2 Landing. He had been in the holding cell, described in paragraph 73, for almost five and a half hours.

98. In the period between 15.18.00, when the nurse officers left the Reception area, and 19.24.13, when the deceased was relocated to his cell, Officer F and his uniformed colleagues checked the deceased in holding cell 2 in Reception at the following times:-

- 15.19.05 Officer looked through the viewing panel.
- 15.43.11 Officer looked through the viewing panel.
- 16.08.07 Officer conversed with the deceased through the open door.
- 16.09.21 Officer opened the cell door and handed in a carton of milk.
- 17.13.02 Officer looked through the viewing panel.
- 17.41.07 Officer looked through the viewing panel.
- 17.50.10 Officer looked through the viewing panel.
- 17.50.28 Officer unlocked the cell – deceased allowed walk to the toilet.
- 17.52.24 Deceased returned to his cell and door locked.
- 18.39.14 Officer looked through the viewing panel.
- 19.16.10 Officer looked through the viewing panel.

99. At 18.33.00 a nurse officer can be seen in the Reception Area talking to a prisoner in the cell adjacent to cell 2 but does not go to holding cell 2.

100. The Reception Area of Mountjoy Prison normally closes at approximately 19.30 hours. If there are prisoners there at that stage they are, if possible, moved back to their cells.

101. In his operational report dealing with the events of 25 July Chief Officer A stated that:-

“At 7 pm approximately I ordered that (the deceased) was returned to his cell to await escort as there was no staff to keep him in Reception”.

102. However, when being interviewed by me, the Chief Officer did not recall giving the order to return the deceased to his cell on A2 Landing. On being shown his operational report he stated – *“If I wrote that I will stand over it”*.
103. In compliance with Chief Officer A’s instruction the deceased was taken from the holding cell at 19.24.13 for transfer to his cell on A2 Landing.
104. The deceased was locked in his cell – cell 5 on A2 Landing at 19.28.17 having been returned from Reception. He did not leave this cell again. I viewed the CCTV footage for all activities on A2 Landing from 19.28.17 to the time that the deceased was taken from his cell by ambulance personnel that were relevant to the deceased or his cell. The following are accurate times for all relevant activity:-

19.28.17	Deceased locked in cell.
19.30.00	Cell checked and master locked.
20.05.21	Officer checked cell.
20.13.12	Officer checked cell.
21.05.22	Officer checked cell.
21.29.16	Officer G visited the cell and spoke to the deceased. See paragraph 125.
21.50.12	Officer H and another officer entered the cell. See paragraph 126.
21.58.37	Officer checked cell.
22.10.26	Officer H enters cell 5 carrying a sheet of paper. See paragraph 126.
22.11.03	Officer H exited the cell.
22.44.01	Two officers and Nurse Officer D walked down A2 Landing but did not stop at the deceased’s cell.
22.45.19	The two officers and the nurse officer again walked past the deceased’s cell but did not stop at the deceased’s cell.

- 23.09.48 Officer checked cell.
- 00.21.20 Officer checked cell.
- 01.21.16 Officer checked cell.
- 02.18.09 Officer checked cell.
- 03.28.37 Officer checked cell and remains at the door for a number of seconds. Other officers arrive at the door. See paragraph 134.
- 03.31.32 Two officers enter cell 5. A third officer remains on the landing outside the door. See paragraph 136.

There is considerable activity on the landing with officers entering and exiting cell 5.

- 03.36.41 Nurse Officer D entered the cell. See paragraph 138.
- 03.48.57 Nurse Officer E entered the cell.
- 03.50.30 Ambulance personnel enter the cell.
- 03.54.10 The deceased is taken from the landing and brought to the Mater Hospital.

- 105. At approximately 19.30 hours on 25 July Nurse Officer D entered the prison as she was rostered for the night shift.

- 106. At interview Nurse Officer D stated that on her way into the prison she met Chief Officer A in the hallway and that he asked her if the deceased had to go to hospital. She knew nothing of the deceased at that time. In order to express a view she went and met Nurse Officers B and C who she was taking over duty from. She stated that she asked both nurses if the deceased had to go to hospital and that they replied “*absolutely*”. She stated that both nurses were “*shocked*” that the deceased still had not gone to hospital as their understanding was that he should have gone on the Reserve. She stated that she then telephoned Chief Officer A and told him that the deceased had to go to hospital.

- 107. At interview I asked Nurse Officer B if she recalled Nurse Officer D enquiring as to whether the deceased had to go to hospital sometime after 19.30 hours. She stated:-

“I was absolutely incredulous, totally horrified he wasn’t gone at this stage, I couldn’t believe it”.

108. Nurse Officer B corroborated Nurse Officer D’s statement that she (Nurse Officer D) telephoned Chief Officer A and told him that the deceased had to go to hospital.
109. At interview Chief Officer A stated that he did not recall the conversation with Nurse Officer D in the terms as referred to in paragraph 106. His recollection was that he had informed Nurse Officer D that there *“was one to go to hospital”*.
110. Nurse Officers B and C informed me, at interview, that they were unaware when they were going off duty on 25 July that the deceased had been moved from Reception to his cell on A2 Landing.
111. In his operational statement referred to in paragraph 101 Chief Officer A outlined his difficulty in getting the deceased to the hospital on 25 July in the following terms:-

“We were not in a position to send (the deceased) on the Reserve Period to the Mater Hospital due to shortage of staff. This escort was to be carried out after 8 pm by Night Guards as I was not informed that the illness was of a serious nature. I informed Acting Chief Officer B, ACO I/C Nights that (the deceased) had to go to the Mater and he informed me that he would organise the escort with the night duty officers”.

112. Chief Officer A handed over control of the prison to Acting Chief Officer B between 19.30 and 20.00 hours on 25 July.
113. At interview Chief Officer A stated that when he handed over control of the prison to Acting Chief Officer B he gave him a verbal briefing on issues that

- would be of relevance to him (the Acting Chief Officer) in carrying out his night duties which included an order to transfer the deceased to hospital. He also stated that the handover form would have corroborated his verbal briefing. He stated that he informed the Acting Chief Officer of the identity of the Governor on call for the night shift should he need to contact him.
114. I examined the handover form referred to in paragraph 113. There is no reference to the deceased on this form or any mention of the fact that a prisoner was to go to hospital during the night.
115. Chief Officer A stated, at interview, that he did not discuss the situation of the deceased with any governor at any time on 25 July.
116. Subsequent to the handover of duties referred to in paragraph 112 Acting Chief Officer B was the senior officer in charge of the prison from 20.00 hours on 25 July and his duty was due to end at 08.00 hours on 26 July.
117. In his Operational Report Acting Chief Officer B describes the handover of the prison to him by Chief Officer A in the following terms:-
- “On arrival C.O. A met me at the front steps and informed me that a prisoner (the deceased) was to be brought to the hospital, that I was to organise the escort as there was no staff to take him during the day”.*
118. When interviewed by me Acting Chief Officer B elaborated on his operational report. He stated that Chief Officer A had told him that at the time of handover the jail was fairly quiet and one was to go to hospital.
119. Acting Chief Officer B informed me that shortly after taking up duty on 25 July he had to deal with a serious incident.
120. At interview Acting Chief Officer B informed me that the prison officer numbers were depleted in the prison on the night of 25 July and that he was reluctant to strip officers from other tasks to facilitate an escort to the hospital

for the deceased. He decided to enquire if any officers, who had gone off duty at 20.00 hours, but still in the environs of the prison, would be prepared to come back on duty for the purpose of escorting the deceased to hospital. He contacted the Officers' Mess to make this enquiry.

121. The Acting Chief Officer stated that he informed Nurse Officer D that the deceased had to go to hospital. At 21.15.52 she created an application for a hospital appointment for the deceased. This appointment was also automatically saved on the PIMS with details as follows:-

- | | |
|------------------------|--------------------------------------|
| (a) Appointment type | A&E. |
| (b) Reason | Following assault, doctor's request. |
| (c) Appointment doctor | None. |
| (d) Clinic | A&E. |
| (e) Hospital | Mater. |
| (f) Appointment date | 25/7/2014. |
| (g) Appointment time | 22.00. |

122. At 21.25.33 Acting Chief Officer B approved the movement to the hospital. This was also automatically saved with details as follows:-

- | | |
|--------------------|--|
| (a) Recommendation | Recommended. |
| (b) Recommended by | Dr. A. |
| (c) Comments | Doctor recommended today. No staff to take till now. |
| (d) Decision | Emergency Operations Approval. |
| (e) Decision date | 25/7/2014 |
| (f) Details | Doctor recommended today, no staff to take till now. |
| (g) Decision by | Acting Chief Officer B |

123. Officer G who had gone off duty at 20.00 hours responded to the enquiry referred to in paragraph 120 and made himself available as one on the escort required to take the deceased to hospital.
124. Acting Chief Officer B instructed Officer G to go to cell 5 on A2 Landing to inform the deceased that he was to prepare to go to hospital.
125. Officer G went to cell 5 at 21.29.16. He spoke to the deceased and reported back to the Acting Chief Officer that the deceased declined to get ready to go to hospital.
126. Officer H was the Class Officer in charge of A1 and A2 Landings on the night of 25 July. On learning that the deceased had refused to go to hospital he wished to satisfy himself that this was in fact the situation. At 21.50.12 he entered cell 5 and has stated that he spoke to the deceased who told him that he did not want to go to the hospital and to get out of his cell. He reported this to Acting Chief Officer B who instructed him to return to the deceased and to get him to sign a form stating his refusal of hospital treatment. He brought a pre-prepared form to the deceased in his cell at 22.10.26. The deceased signed the form and the officer left the cell at 22.11.03. The form reads as follows:-

“Mountjoy Prison

NCR

Dublin 7

Governor Sir

I (deceased) off A2 Landing was offered a hospital escort for medical treatment on 25/7/14 at 9.15 pm. I refused to go on this escort.

(Deceased signed the form)

Officer H”

127. Officer H stated at interview that, in his opinion, the deceased was fully coherent when he talked to him and when the deceased signed the pre-prepared form on the night of 25 July.
128. Officer H returned the signed form to Acting Chief Officer B in the Keys Office.
129. Acting Chief Officer B, in a short supplementary report, stated that he notified Nurse Officer D by radio, shortly after the event, that the prisoner had refused the escort. This was corroborated by Nurse Officer D at interview and also by her entry in the medical notes at 23.56.00 of the following – “*declined to go to AE*”.
130. Nurse Officer D explained that she was very busy that night in the prison and that was the reason she did not make the entry referred to in paragraph 129 until 23.56 hours.
131. The deceased was found in a collapsed state in his cell at 03.31.32 on 26 July.
132. The circumstances of the discovery of the deceased in his cell at 03.31.32 and his state of health at that time are matters more appropriate for investigation by the Coroner at the Inquest.
133. However, it is appropriate that I refer briefly to the description of the scene in cell 5 as reported by officers and a nurse officer.
134. Officer I stated that while doing his checks at approximately 03.30 he noticed the deceased lying on the floor of his cell. He called for assistance. This statement is corroborated by Officer J.
135. Officer J stated that he asked Officer K to get the keys for the cell.

136. Officer K stated that he got the keys and went immediately to cell 5 accompanied by Acting Chief Officer B. They met Officer J. The door to cell 5 was opened. The deceased was lying on the floor of his cell.
137. Acting Chief Officer B stated that en route to the cell he called Nurse Officer D for medical assistance. He described entering the cell in the following terms:-
- “On entering cell 5 A2 I observed Prisoner (deceased) lying on the floor, breathing deeply. The prisoner was unresponsive”.*
138. Nurse Officer D made the following entry in the Medical Notes:-
- “Asked to see at 03.30 hrs approx. O/E found collapsed on floor, laboured breathing, pale pallor, vommitus +++ of ? bile on floor, unresponsive. As initial assessment was being carried out (deceased) went into cardiac arrest. Emergency call for DFB/ambulance. CPR commenced with the assistance of Nurse Officer E until the arrival of DFB at 03.50 hrs approx. Handover given to DFB who transferred (deceased) to Mater AE”.*
139. The deceased was pronounced dead in the Mater Hospital at 05.52 hours on 26 July 2014.
140. The cause of death is a matter for the Coroner’s Inquest. However, the post mortem, performed by the State Pathologist, revealed that a sealed package in his small intestine was causing an acute obstruction of the deceased’s bowel. I understand that this would cause abdominal pain and vomiting.
141. The package referred to in paragraph 140 was handed to members of An Garda Síochána for investigation. I am not aware of the current status of this investigation.

Telephone calls made to IPS Headquarters and Mountjoy Prison on 25 July

142. In my initial interview with the deceased's widow she informed me that she had telephoned both IPS Headquarters in Longford and Mountjoy Prison subsequent to her visit with her husband on 25 July. In paragraphs 143 to 148, I set out my investigations into this issue.
143. She told me that she telephoned IPS Headquarters in Longford and spoke to a person in Operations. She expressed her grave concerns for her husband.
144. I examined her telephone records for 25 July and can confirm that calls were made by her on her mobile telephone to IPS Headquarters in Longford on that date.
145. The official who took the call in Longford generated the following entry on PIMS:-
- “The partner phoned and was in an awful state and was very concerned for (the deceased's) safety. She said he was jumped on by 7 other prisoners in Mountjoy and is in a very bad way and wants him moved to any prison in the country once it's not Mountjoy. She said he will get killed there if he is not moved by Monday. She said she def going to papers. I told her I discuss his case with senior management”.*
146. I have been informed by the Operations Directorate of the IPS that the content of this note was not brought to the attention of management. It was, however, on PIMS.
147. The deceased's widow stated at interview that she telephoned Mountjoy Prison at approximately 7.30 pm on 25 July. She stated that she expressed her grave concerns. She did not know who she was talking to but stated that she was told that if her husband needed treatment he would get it. Neither this call nor its content were noted or logged in Mountjoy Prison.

148. I again examined her telephone records and can confirm that a call was made from her mobile telephone to Mountjoy Prison at 19.11.32 on 25 July.

However, I am not aware of the contents of this call. All I can say is that the call was made.

Officers' understanding of their obligations to transfer deceased to hospital

149. At interview I specifically asked all uniformed officers of their understanding of their obligations to transfer the deceased to hospital on 24, 25 and 26 July. A number of staff stated that they were not aware that Dr A had referred the deceased to A&E on 24 July. All officers stated that they were unaware of the urgency of the requirement to take the deceased to hospital. Senior staff, namely, those in charge of the Details Section and in charge of the prison stated that had they been aware of the urgency of the situation or the seriousness of the condition of the deceased they would have made immediate arrangements to have him transferred to hospital.

150. In the course of my investigation I interviewed Chief Officer B. He had been one of two Chief Officers on duty on 24 July 2014.

151. He informed me that he had carried out a review of the events of 24 July. He explained that because of procedure failures the deceased was not sent to hospital on 24 July. He identified these as:-

(a) The email referred to in paragraph 47 was only sent to “*some*” of the required parties to inform them of the need to arrange an escort for the deceased in that it failed to include Governor or General Office.

(b) Upon receipt of the email referred to above the deceased was queued for discharge. The Chief Officer explained this procedure as follows:- “*This would be normal procedure in the detail office. ‘Queuing’ is usually required due to the fact that critical success factors involved in discharging an unexpected, or unscheduled escort from the prison is dependant on the number of staff available to perform such an escort. The required amount of staff are drawn from posts within the prison. How and when they are*

*deployed is also dependent on a number of factors – how serious the situation is and the amount of staff available to staff the escort”. The Chief Officer explained that at approximately 16.00 hours on 24 July a serious incident occurred which necessitated a hospital escort. He explained that this incident had now overtaken the referral from Dr. A. He stated that the wording in the email of “*whenever possible*” whilst “*important was not a high priority escort*”.*

- (c) No member of the healthcare team made contact with the Detail Office in relation to the deceased on 24 July.
- (d) There was no notification to healthcare of the non transfer of the deceased to hospital. The Chief Officer explained that when a hospital referral is cancelled for operational reasons such as no escort staff, high security risk etc or where a hospital escort is delayed or postponed a form must be filled out by the Detail Staff and the Chief Officer stating the reasons for the delay or cancellation. A further healthcare plan would then be put in place and the prisoner would be scheduled to see the doctor at the next clinic.
- (e) The Chief Officer drew my attention to the protocol to be observed by healthcare if an escort was delayed or cancelled. However, the notification referred to at (d) above was not prepared or sent.

152. Chief Officer B concluded:-

“Having reviewed the steps taken, protocols adopted and in some instances, protocols missed or not adhered to, it is clear that (deceased’s) non discharge to hospital on that date was not due to any of these factors, but due to the fact that another incident deemed to be of a more serious nature, with a greater risk to health and welfare to persons in custody had occurred on that date”.

153. Chief Officer B stated, at interview, that in the event of the Details Office having difficulty in assembling staff for an escort the office would contact a Chief Officer on duty and he (the Chief Officer) would order the deployment of officers from other duties to facilitate such an escort. He would be the member of staff who could make such a decision.

154. ACO B accepted, at interview, that if he did not have sufficient officers for an escort the Chief Officer on duty would have to be contacted as he had authority to deploy officers from other duties to form the escort.

Findings

155. The Irish Prison Service failed in its duty of care to the deceased in that, despite being referred to hospital by the prison doctor at approximately 12 noon on 24 July, seeking medical attention on two occasions on 25 July and a deterioration in his medical condition at approximately 15.30 hours on 25 July the deceased was not transferred to hospital until found in his cell in an unresponsive state at 03.31.30 on 26 July 2014.

156. My finding referred to in paragraph 155 is supported by the following findings in paragraphs 157 to 178.

157. The deceased was referred by the prison doctor to the A&E Department of the Mater Hospital at approximately 12 noon on 24 July 2014.

158. Senior operational officers in Mountjoy Prison, tasked with the organisation of prison escorts to, *inter alia*, hospitals or with operational oversight of the prison were aware of the referral referred to in paragraph 157.

159. An application for the discharge of the deceased to hospital was created and approved on 24 July 2014.

160. The deceased was not transferred to hospital on 24 July 2014.

161. Senior operational officers in Mountjoy Prison, tasked with the organisation of prison escorts to, *inter alia*, hospitals or with operational oversight of the prison knew on 25 July that the deceased was to be escorted to hospital on that date.

162. The deterioration in the deceased's medical condition at 15.15 hours on 25 July 2014 and the imperative to have him transferred to hospital was communicated to relevant senior officers.
163. The imperative to have the deceased transferred to hospital was again communicated to the relevant officer at approximately 19.30 hours on 25 July 2014.
164. The deceased was transferred from Reception to his cell at approximately 19.30 hours on 25 July 2014 on orders from the relevant operations officer.
165. The deceased was not transferred to hospital during the day duty shift which ended at 20.00 hours on 25 July 2014.
166. The senior officer in charge of the prison from 20.00 hours on 25 July was aware that the deceased was to be transferred to hospital by the night guards on the night of 25 July 2014.
167. The senior officer, referred to in paragraph 166, organised an escort for the deceased at approximately 21.00 hours on 25 July 2014.
168. An application for the discharge of the deceased to hospital was created and approved during the night shift on 25 July 2014.
169. At 21.15 hours approximately the deceased was told to prepare to go to hospital. He refused.
170. At 22.10 hours approximately the deceased signed a pre-prepared form to confirm that he had refused to go on a hospital escort.
171. No medical clinical assessment was carried out prior to or subsequent to 22.10 hours on 25 July 2014.
172. The deceased was not transferred to hospital during the night of 25 July 2014.

173. Different members of the medical team in Mountjoy Prison were aware at different periods of time of the referral of the deceased to hospital and of his deteriorating medical condition.
174. The deceased was not seen by any member of the medical staff after 15.18 hours on 25 July 2014.
175. The deceased was found lying on the floor of his cell, in an unresponsive state, at approximately 03.30 hours on 26 July 2014. He was breathing but went into cardiac arrest soon after. He was pronounced dead in the Mater Hospital at approximately 05.52 hours on 26 July 2014.
176. The deceased's widow made a telephone call to Mountjoy Prison at approximately 19.15 hours on 25 July 2014 to express her grave concerns for her husband.
177. The deceased's widow expressed her grave concerns for her husband's wellbeing on three occasions on 25 July 2014.
178. While the cause of death is a matter for the Coroner I understand that the deceased died as a result of "*inhalation of gastric contents due to acute obstruction of bowel due to foreign body in small intestine*".

Recommendation

The provision of healthcare to prisoners must be the sole responsibility of the medical professionals and must not be dependent on operational considerations.