INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr O 2018

AGED 56

AT THE MIDLANDS PRISON

ON 30TH OCTOBER 2018

Date finalised: 22nd June 2020

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

Office Ref: Mr. O/2018

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GLOSSARY

ACO	Assistant Chief Officer
AGS	An Garda Síochána
CCTV	Close Circuit Television
CTR	Compassionate Temporary Release.
HSE	Health Service Executive
IoP	Inspector of Prisons
IPS	Irish Prison Service
OIP	Office of the Inspector of Prisons
Minister	Minister for Justice and Equality
NoK	Next of Kin
PIMS	Prisoner Information Management System

PREFACE

The Office of the 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 (IoP) 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, they are independent of the Department of Justice and Equality in the performance of statutory functions.

The IoP makes recommendations for improvement where appropriate; and 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 O'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 O passed.

Administration of the Investigation

The OIP was notified of Mr O's passing on the evening of 30th October 2018. The Inspector and a colleague visited Midlands Prison on the morning of 31st October 2018. Prison management provided a briefing and confirmed that CCTV footage for relevant areas of the prison had been saved. Mr O's cell was viewed and information requirements for the investigation were agreed.

All information that was requested was provided by the IPS.

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 O's NoK his sister - by letter and also spoke with her by telephone. While she did not want to meet, she raised two important concerns:

- Disappointment that her brother had not been given the opportunity to die in a hospice setting rather than a prison cell;
- She queried how she came to be designated as his NoK. She was not close to Mr O. Associated with this was a concern about her eligibility to pay for/contribute to his funeral expenses in circumstances where she was unable to afford the payment.

I visited Mr O on 30th October at the Midlands Prison, having been made aware of his condition and denial of his Compassionate Temporary Release application. He was in a deep sleep, appeared comfortable and exhibited shallow silent respiratory function. We did not have any conversation.

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

I am grateful to Mr O's family and the Irish Prison Service (IPS) for their contributions to this investigation.

Recommendations

There are **eleven** recommendations for improvement. A copy of the final draft of the report, including the recommendations was provided to the Irish Prison Service on 1st October 2019 for review, comments and an action plan and a response was received on 7th January 2020.

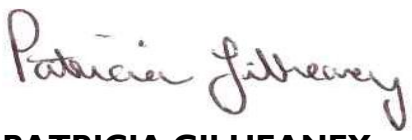
The IPS accepted /part accepted six (6) of the eleven (11) recommendations. An action plan was provided for the recommendations that were accepted and areas of responsibility and

timelines were included in the action plan. Implementation of the action plan will be monitored in future inspections and or investigations into deaths in custody.

The Irish Prison Service did not accept recommendations 1, 3, 4, 6 and 9. As it appeared that the IPS misinterpreted Recommendation 4, an opportunity to revisit this issue was provided on 5th February 2020 and a substantive response was received on 10th June 2020. The recommendations and reasons for unacceptance by the IPS are specified in the following Summary section of the Report.

I am concerned regarding the IPS response to Recommendation 4 in relation to the provision of end of life care in an appropriate clinical setting. It is clear from the chronology of events that the medical recommendation on 23rd October 2018 was for the provision of care "in the appropriate setting, be that in a hospital palliative care bed or a community hospice bed…" A prison cell cannot be equated to hospital or hospice setting.

I am also concerned regarding the IPS response to recommendation 9 in relation to the practical operation of Rule 57 (Prisoner's meeting with officer of Minister) of the Prison Rules 2007-2017. As currently implemented, it would appear that Rule 57 does not achieve the intended objective and may be considered unfit for purpose. It is suggested that the Minister considers amendment or replacement of this Rule so that a prisoner has access to an officer of the Minister who has not already made a decision on the matter that the prisoner wishes to raise.



PATRICIA GILHEANEY
Inspector of Prisons
22nd June 2020

SUMMARY

Mr O was aged 56 when he died from a terminal illness in the Midlands Prison, where he was serving a long sentence.

His illness had been diagnosed in February 2018, over three years after he went into prison. A view was sought from An Garda Síochána (AGS) in May 2018 to help assess whether Mr O was a suitable candidate for Compassionate Temporary Release (CTR) so that he could die in a hospice. The AGS response in July 2018 set out the facts of his serious offending history. It did not object to CTR.

Even though a hospice bed was available, Mr O's CTR application was refused on October 25th 2018 by the IPS Operations Directorate. This was contrary to medical advice. It was also at odds with the views of the Midlands Prison managers and pastoral team. By that stage Mr O was immobile and the Governor had offered further tangible measures to ensure he could not reoffend, if granted CTR. He had never posed any problem during 27 external hospital appointments and in-patient stays.

CTR denial was compounded by an e-mail about Mr O that the IPS Operations Directorate Official A issued internally to managers two days before Mr O died. The timing and content of this e-mail reflected poorly on its author. When concerns regarding the content of the email were raised by the OIP the author apologised stating that at the time of issue it was their understanding that Mr O had already passed away.

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

1. They did not have the necessary equipment or personal care materials. They had to store and administer oxygen and morphine, which was not desirable on a prison wing;
2. Mr O was a big man, yet there was no hoist to move him around;
3. Palliative carers were brought in and other prisoner friends also helped look after him;
4. One man who had suffered a stroke forfeited his cell with a hospital bed because Mr O's needs were greater;
5. It was challenging to arrange for Mr O's sister to visit at the end: she could only see him in his cell, which meant it could only be facilitated when the other prisoners in the wing were locked back in their cells.

These practical burdens on IPS staff would have been unnecessary if Mr O had been permitted the dignity of CTR to die in a hospice, rather than in prison.

The recommendations are provided in the next section. Where a recommendation was not accepted by the IPS the reasons for unacceptance are provided in italics:

RECOMMENDATIONS

1. **When it is known that death is imminent, the IPS should clarify with a prisoner's Next-of-Kin that they accept that status and fully understand the implications. [section 1.7]**

   Not accepted by the IPS for the following reason: *"There are no implications of being nominated as "next-of-kin" as there is no legal definition within Irish Law for a next of kin. There is no obligation on a person designated as next of kin to pay funeral expenses. As a general rule, whomever arranges the funeral, usually covers the cost. I should highlight that in this case the next of kin did arrange the funeral however, the Irish Prison Service covered in full the cost relating to the funeral."*

2. **Clarification in relation to Referral letters from Registered Medical Practitioners to the Operations Directorate requesting Compassionate Temporary Release for a prisoner on the grounds of health should be sought from the Registered Medical Practitioner who authored the letter, or, if unavailable, by another Registered Medical Practitioner following examination of the prisoner concerned. [section 2.26]**

3. **End of Life Care for prisoners is not a frequent occurrence. It is recommended that the decision-maker in each case should visit and speak directly with the prisoner concerned, relevant medical, nursing and other healthcare personnel providing care and treatment in the prison and also prison management and chaplaincy. [section 2.31]**

   Not accepted by the IPS for the following reason: *"It is the role of local prison management to speak and engage directly with the prisoner. All relevant information is made available to the decision maker in relation to an individual case. It is not considered a necessary or appropriate role for the decision maker to meet the prisoner in respect to whom they are required to make the decision. Such decisions are made in accordance with the relevant protocol and legislation. Irish Prison Service policy is that the identity of decision makers is not disclosed to any prisoner for security and operational reasons."*

4. **In situations where the decision-maker is in receipt of conflicting healthcare advices the medical view should take precedence as s/he is the clinician with ultimate responsibility for the healthcare and treatment of the prisoner concerned. [section 2.30/2.31]**

   Not accepted by the IPS for the following reason: *"The Irish Prison Service do not believe that there were conflicting healthcare advices in this case. Both Dr A and National Nurse Manager A confirmed that the prisoner's illness was terminal and that the prisoner would pass within 4 weeks. Irish Prison Service policies and procedures confirm that the prison doctor is the lead clinician in the primary care team."*

   [Please see Preface section for IoP response]

5. **Prisoner information in relation to external and internal movements should be contemporaneously entered into the PIMS. [section 2.39]**

6. **As the IPS operates on a 24 hour 365 day of the year basis, it should ensure that decisions required from senior management in IPS HQ are available in a timely manner and are addressed with an appropriate level of urgency. [section 2.44]**

   Not accepted by the IPS for the following reason: *"The working hours of the Irish Prison Service HQ administrative staff are set out in DPER Circular 11/2013 Title: "Revision of Working Hours and Flexible Working Arrangements for Civil Servants" and are remunerated accordingly. Prisons operate on a 24/7, 365 basis and prison staff are remunerated accordingly. Operations Directorate provide a 24/7 service for emergencies only, such as hospital transfers, death in custody, major disturbances etc. The Irish Prison Service is currently conducting a review of the out of hour's on-call system and will inform the Inspector of the outcome of that review. It is intended to have this review complete by end May 2020. As any amendments may impact on the terms and conditions of employment of HQ staff the Irish Prison Service is not in a position to commit to accepting the recommendation at this stage.*"

7. **The IPS should ensure that internal communication is at all times respectful and appropriate action taken when this standard is not reached. The development of a Code of Ethics for all IPS personnel (senior management and staff in HQ and prisons) should be expedited for completion and subsequent implementation at the earliest opportunity. [section 2.43]**

8. **Requests for a meeting with a representative of the Minister in accordance with Rule 57 should be addressed in a timely manner. The recipient of the request should make immediate contact with the prison concerned to assess the urgency of the matter. [section 2.44]**

9. **The representative of the Minister that meets with a prisoner under Rule 57 should not be the original decision-maker in a decision that that prisoner may wish to discuss/raise with the representative. The representative should be of sufficient seniority to make appropriate recommendation for decision. [section 2.44]**

   Not accepted by the IPS for the following reason: *"Operations Directorate currently have an Assistant Principal Officer assigned to each prison as the designated official for rule 57 requests and as decision maker. It is not proposed to alter this arrangement as the Officer will be the most familiar with the individual's case and best placed to address any issues raised by an individual prisoner."*

   [Please see Preface section for IoP recommendation to the Minister]

10 A Critical Incident meeting should take place as soon as possible after a death in custody. [section 3.3/3.4]

11 The IPS Critical Incident Policy should be reviewed and consideration given to the inclusion of a cold debrief within 14 days of an incident to provide further opportunity for everyone involved, including prisoners where relevant. The purpose should be to identify learning, support everyone involved and assess progress in relation to actions that were identified at the hot debrief, i.e. the debrief as soon as possible after the incident occurred. [section 3.3/3.4]

THE MIDLANDS PRISON is a closed, medium security prison for adult males. On 30th October 2018 it accommodated 834 prisoners.

Mr O's was the third death of a Midlands prisoner in 2018, (one of whom was in the community on reviewable temporary release at the time of his death) and the 15th death in IPS custody that year which met the criteria for investigation by the OIP.

CHAPTER 1 BACKGROUND & TIME IN THE MIDLANDS PRISON

1.1 Mr O had previously served time in custody in England. He received a 12 year prison sentence in Ireland in November 2014 and would have been due for release in November 2023.

1.2 He had been in continuous custody for four years at the time of his death, spending most of that time in general population on the Midlands Prison's G Wing, which held around 50 prisoners.

1.3 He appears to have been a low-key prisoner who did not make any formal complaints during his time in the Midlands Prison. IPS records also show Mr O had a good disciplinary record.

1.4 Mr O had at least three close friends (fellow prisoners) who cared for him while he was terminally ill.

1.5 Mr O had limited contact with his family. Ten visits were recorded between June 2015 and May 2018. He did not have any visits in 2017 and very little incoming or outgoing mail. He made three domestic phone calls during July and August 2018.

1.6 This was the second case the OIP investigated in 2018 where NoK were taken aback when they received an invoice for funeral expenses. They did not realise the import of being declared NoK by the prisoner. In this instance Mr O had identified his sister as his NoK. However there had been limited contact between them.

1.7 Mr O's sister told the OIP she had not realised she was his NoK. She speculated this status came about because she agreed to be the point of contact for the prison when he was dying; and also because she consented with the undertaker for his remains to be removed to a crematorium.

Recommendation

1. **When it is known that death is imminent, the IPS should clarify with a prisoner's Next of Kin that they accept that status and fully understand the implications.**

CHAPTER 2 END OF LIFE CARE

2.1 Mr O was in good health when he was committed to prison in November 2014. However he was diagnosed with a life limiting illness in February 2018 and had 27 visits to outside hospitals between 14th May 2018 and 24th October 2018. All were day appointments apart from the last which was a two day in-patient stay. His condition deteriorated quickly.

2.2 On 22nd October 2018 the Chief Nurse Officer issued an instruction that it was imperative nobody should smoke in Mr O's cell - including himself - as he was now in receipt of oxygen therapy.

2.3 On 24th October a Chief Officer A issued an Order to enable prompt access to Mr O's cell, if necessary. The cell was not to be master locked at night. 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.

2.4 Mr O was discharged back to the Midlands Prison from Portlaoise Hospital on 26th October 2018 after a two day stay. He returned in a very weak state, receiving continuous oxygen via nasal prongs and requiring assistance into his cell.

2.5 He was placed in a cell with a standard prison bed, but the next day was transferred to the adjoining cell which had a hospital bed. This cell and bed were vacated by a prisoner who had suffered a stroke, since Mr O's needs were considered greater. The local Health Service Executive (HSE) Palliative Care Team assumed responsibility for Mr O's end of life care from 26th October 2018 onwards.

2.6 His condition became critical over the October Bank Holiday weekend. On Sunday 28th October 2018 he became much weaker and it was agreed that Chaplain A would stay with him during the night. The ACO, officers, nurse and carers were all very attentive to Mr O as he required continuous nursing care.

2.7 It is reported that he had a fairly good day on Monday 29th October 2018 and at 19:25 that evening was placed on special observations.

2.8 On Tuesday morning, 30th October 2018 Mr O was very weak. Having been alerted to his condition and refusal of a Compassionate Temporary Release (CTR) application, the IoP visited him in his cell that morning. He was in deep sleep, appeared comfortable and exhibited shallow silent respiratory function, therefore conversation was not possible. The IoP wrote to the then IPS Director General requesting him to give the matter his immediate attention.

2.9 Mr O was reviewed by General Practitioner Dr A at 11.40 that morning. Dr A noted he was comfortable, with no signs of respiratory distress or agitation. Dr A made the following entry in the medical file "*Ideally pt should be in hospice at this stage as he is actively dying.*" This was the second time Dr A had indicated this opinion in writing in relation to Mr O.

2.10 His sister visited Mr O in his cell for half an hour at lunchtime, accompanied by prison chaplain A. She was anxious about coming into the prison, but was appreciative of the welcome and respect afforded to her by the staff. It was unusual to bring a visitor onto a prison wing and awkward for staff and could only be facilitated when the other prisoners were locked in their cells.

2.11 When the night nurse and care assistant reviewed Mr O at 20:00 that evening, he appeared comfortable. His personal care needs were attended to and medication administered. At 20:40 the nurse received a call to review Mr O again. No signs of life were present and a General Practitioner Dr B was contacted. He arrived at 21:10 and pronounced Mr O deceased at 21:15. The Class Officer, Carer and Chaplain were with him when he died.

2.12 Despite difficulty in taking some of his medications, Mr O usually reported being pain-free. All the documentary and written evidence demonstrates that the prison officers, nursing, medical and care staff in the Midlands Prison, along with the HSE Palliative Care Team provided a high standard of care to Mr O in trying and inappropriate circumstances.

2.13 In addition to permitting his sister to visit, there was plentiful evidence of compassion at local level. Chief A's report says he visited Mr O in his cell on four occasions during his tour of duty on Tuesday 30th October 2018. By that stage he had been unresponsive for the previous two days.

2.14 Three prisoner friends cared for Mr O and kept him company.

2.15 Mr O was a tall man, yet there was no hoist available. He was incontinent towards the end, and his personal care needs were attended to in an environment where it was challenging to do so: for example the administering of morphine and oxygen on a prison wing was not without risk.

2.16 Chaplain A's detailed report on Mr O's final days is a good example of how a report should be written. She described the positive local response well: "*Special appreciation and commendation must be given to the prison staff… They reached out in every way possible to support Mr O along with their other duties. They deserve the highest recognition for the care and support afforded to Mr O in very unsuitable conditions…. The prisoners who accompanied and supported him since his diagnosis were especially attentive… They carried a large part of the support and care that a family would give if he were in a hospital or hospice situation… They epitomised human kindness and goodness.*"

2.17 Chaplain A also graphically illustrated the implications for other people of looking after Mr O: *"I expressed my concerns (to the IoP) in regard to the lack of humanity towards a man having to die in his prison cell even though there was a hospice bed available for his end of life care. I mentioned the inappropriateness of trying to care for a dying man in a working prison…. He was on a landing with at least 50 other prisoners. Facilities were not adequate, no supply of bed linen, no proper bed or lifting supports, no sluice room, no privacy etc….. The care he was getting from the prisoners, the staff and medical team could not be faulted… They did their utmost in the circumstances…. There was no provision for extra staff support put in place for this very intensive care situation during the day or night…"*

Compassionate Temporary Release application

2.18 The possibility of Compassionate Temporary Release for Mr O appears to have been first mooted in May 2018. On 8 May 2018 the IPS Operations Directorate requested An Garda Síochána to indicate their views about a CTR application. This request was re-iterated on 14th May 2018.

2.19 AGS responded on 18th July 2018. They set out Mr O's previous criminal history and serious current offences which were exacerbated by abuse of trust; and his return from another jurisdiction to Ireland in March 2011 on the basis of a European Arrest Warrant. Their response also identified a risk of offending via social media. However they did not object to release and the OIP opinion is that the risks they identified could have been easily managed by the measures identified at Para 2.30.

2.20 On 23rd October 2018 the IPS National Nurse Manager A e-mailed Governors in the Midlands Prison. While apologising for premature timing, he thought it important that the likelihood of a hospice bed for Mr O be shared as early as possible.

2.21 The IPS National Nurse Manager A referred to a letter by General practitioner Dr A. The letter was to be sent *"…. with Governors support to Operations first thing in the morning…. The Palliative Care Team advised it is likely a bed in the hospice in XXX will be available tomorrow…The Palliative Care team have been enormously supportive and helpful in this case and I would like to reciprocate with early advice on whether this option will be approved."*

2.22 General Practitioner Dr A's letter also said Mr O's main requirement in the coming days would be for pain relief administered via a syringe driver. He considered his life span was unlikely to be more than four weeks and concluded *"He will not live until the expiration of his sentence. Therefore I recommend Mr O be transferred to a clinical setting where he can be managed appropriately as per IPS Compassionate Temporary Release on Grounds of Health & Capacity Policy 2017."*

2.23 On 24th October at 10.40am Governor A e-mailed Operations Directorate Official B and copied the Operations Directorate Official A and others, asking for Mr O's case to be treated urgently. Governor A's e-mail stated: *"Dr XXX states that Prisoner O is coming towards the end of life stage due to him suffering from XXXX and that he requires the ongoing care of a specialist palliative care team in an appropriate setting…. There are risks as Mr O is serving a lengthy sentence which is not due to expire until 2023. However his mobility is very restricted….. We are recommending temporary release for Mr O so that he receives the appropriate palliative care and so that he may not die in prison. We would recommend that he be tagged so as to monitor his movements. If it is decided to have him escorted, then support will be required."*

2.24 On 25th October 2018 at 09:28 Operations Directorate Official A sent an email to IPS National Nurse Manager A referring to the application for CTR on 24th October 2018 at

10:40 and sought advice/clarification from IPS Care and Rehabilitation Directorate regarding the following:

" 1. What care (medical) will the prisoner receive '….in the appropriate setting…' that he cannot receive in the prison?

2. If that care is not available in the prison, can it be in-sourced?

3. is there any indication as to what is meant by 'coming towards end of life stage? I appreciate that of course nobody can put a precise date on the matter, however this is insufficiently vague to assist in the Minister's consideration given the other issues and risks alluded to in the Governor's covering email.

4. There is reference to limited mobility in his prison cell. Would transfer to an outside facility increase his mobility?"

2.25 On 25th October 2018 at 09:36, IPS National Nurse Manager A replied as follows:

"1 In reality we can afford Mr XX the same care he would receive in a hospice in the Midlands Prison. This is down to the fact that the local HSE Palliative care team are more than willing to engage very positively with us and attend the prison as required.[emphasis added]

2. As above.

3. Mr XX is in the end stages of his life and there is no prospect of him recovering or his health improving at all. His health will continue to deteriorate, however, at what pace we don't know, but all professional estimates are he will pass away in the coming 2-4 weeks.

4. Irrespective of his location, his mobility will not improve at all. The only change will be a deterioration in mobility and ability to communicate, interact with others and also to his level of consciousness."

This email would appear to be at variance with IPS National Nurse Manager A's previous email on 23rd October 2018 referred to in section 2.20 and 2.21.

2.26 Operations Directorate Official A did not contact General Practitioner Dr A for clarification of points raised in her medical referral letter and instead sought the view of a senior nurse manager. It would appear that the view of the IPS National Nurse Manager A trumped that of General Practitioner Dr A who on 23rd October 2018 in a letter to Governor B and copied to Chief Nurse Officer A, IPS Care and Rehabilitation Directorate Official A and IPS National Nurse Manager A stated:

"..Mr XX requires the ongoing care of a specialist palliative Care team ***in the appropriate setting,*** *be that in a hospital palliative care bed or a community Hospice bed whichever becomes available first through our colleagues in the HSE.* [emphasis added].

Therefore, I am making a submission under Rule 105 of the Prison Rules for Mr XX to be granted Temporary Release for End of Life care in an ***appropriate clinical setting****"* [emphasis added].

This position was supported by Governor A, Governor B and Chaplain A.

Recommendation:

2. **Clarification in relation to Referral letters from Registered Medical Practitioners to the Operations Directorate requesting Compassionate Temporary Release for a prisoner on the grounds of health should be sought from the Registered Medical Practitioner who authored the letter, or, if unavailable, by another Registered Medical Practitioner following examination of the prisoner concerned.**

2.27 On 25th October 2018 the IPS Operations Directorate Official A wrote to Governor A and others. He refused the CTR application on the following grounds:

- Nature and gravity of the offence;
- Length of time left to serve and the fact that Mr O was only mid-way through his sentence;
- Potential threat to the safety and security of members plus AGS concerns about risk to the public; and
- Mr O's offending history.

2.28 Operations Directorate Official A also said the IPS National Nurse Manager A had advised that Mr O could receive the same level of care that he would receive in a hospice since the HSE Palliative Care Team were willing to attend the prison as required. Operations Directorate Official A also pointed out that *"In the event of a serious deterioration which renders his condition unmanageable in the prison setting the matter can be revisited."*

2.29 The referral by General Practitioner A, the views of prison management, nursing staff and chaplain contradicts the advice of the National Nurse Manager that Mr O could receive the same level of care that he would receive in a hospice setting. It is also difficult to understand how revisiting the matter might have been of any benefit given the rapid deterioration and advancing end of life in Mr O's condition. Transfer at a later date would not have been in Mr O's best interests and/or feasible.

2.30 The CTR application was refused despite explicit medical and other opinions which supported it, Mr O's serious physical limitations, good conduct during 27 hospital visits in recent months and tangible measures - tagging and a possible escort - which Governor A had offered to mitigate any risk of Mr O reoffending.

2.31 In addition to medical and Governors' opinions, other staff contributors to this investigation were of the view that Mr O should have been afforded the opportunity to die in an appropriate setting with appropriate equipment available to assist in delivering end of life care.

Recommendation

3 End of Life Care for prisoners is not a frequent occurrence. It is recommended that the decision-maker in each case should visit and speak directly with the prisoner concerned, relevant medical, nursing and other healthcare personnel providing care and treatment in the prison and also prison management and chaplaincy.

4 In situations where the decision-maker is in receipt of conflicting healthcare advices the medical view should take precedence as s/he is the clinician with ultimate responsibility for the healthcare and treatment of the prisoner concerned.

2.32 Following refusal of CTR, Mr O wrote to the Midlands Governor on 26th O ctober 2018 (Friday of a bank holiday week-end). He acknowledged the care he had received in the prison, but said *"Now as I face my last days before I die and as I become weaker and totally dependent I am terrified and troubled about how I can cope. I am also aware my family cannot be with me if I have to die in prison."* He asked to meet with an officer of the Minister of Justice in accord with Prison Rule 57 as soon as possible in relation to hospice care, saying *"I would like to be able to face death with as much dignity as possible…."* The letter was sent by Chaplain A to Governor A at 18:47 and was sent on to the then Director General and copied to five other persons including Operations Directorate Official A at 19:09, outside of office hours.

2.33 On Sunday 28th October 2018 (a bank holiday weekend and two days before Mr O ultimately passed) Chief Officer B sent an email at 18.26pm to notify IPS Governors and managers that Mr O may pass away that evening, and in that event who would need to be contacted. Governor A forwarded the e-mail to Operations Directorate Official A at 18.53pm.

2.34 Operations Directorate Official A responded to Chief Officer B's email at 22.52 that night.

2.35 On becoming aware of the reply the OIP immediately wrote to ask the then IPS Director General to raise concerns regarding the content of the email along with refusal of Mr O's CTR application by the Operations Directorate.

2.36 The then Director General contacted the IoP and a detailed written reply from Operations Directorate Official A was received on 31st October 2018. It explained that refusal of Mr O's CTR application was

- In accordance with relevant policy and legislation and was considered in the very same way that all such applications had been considered since the Compassionate TR Policy was introduced in the IPS (Policy is dated 2 March 2017); and
- Guided by confirmation from the Care and Rehabilitation Directorate that his medical needs could be provided in the prison setting through in-sourcing of palliative care.

2.37 Operations Directorate Official A also confirmed that the decision to refuse would be revisited in the event of any serious deterioration in Mr O's condition, but said no such request was received - Mr O had sent his letter to the Midlands Governor after being notified of CTR refusal on the Bank Holiday Friday, 26th October 2018. As stated previously the Governor, within minutes of receipt, sent the letter to the then Director General and copied it to a number of people including Operations Directorate Official A.

2.38 Operations Directorate Official A also said they checked Mr O's status on the Prisoner Information Management System (PIMS) shortly after receiving the email from National Nurse Manager A on 25th October 2018 at 09:36 and noted it stated he was in hospital. He stated he requested Operations Directorate Official B to establish how Mr O was and whether he was likely to remain in hospital. Not having received any information to the contrary, they understood that Mr O remained in hospital over the weekend.

2.39 The hard copy book at the Prison Gate records all entries to and exits from the prison. The Prison Gate Book records that Mr O returned to the Midlands Prison from Portlaoise General Hospital on 26th October 2018 at 10:40, however, this movement was not entered into PIMS until 17:31 on 26th October 2018.

Recommendation

5 Prisoner information in relation to external and internal movements should be contemporaneously entered into the PIMS.

2.40 When Operations Directorate Official A received Chief Officer B's email, they stated they thought it was notification of a Death in Custody. This was because Operational Circulars provide that Operations Directorate Official A is to be contacted out of hours in the event of a death in custody. The relevant Circular is silent in relation to notification in the case of a deterioration in a prisoner's medical condition.

2.41 Operations Directorate Official A explained that they had misread and misunderstood Chief Officer B's email. They suggested their belief that Mr O had passed away was genuine as demonstrated by the fact that they informed the IPS press office (via email dated 30th October 2018 at 16:29), the Director General and the Director of Care and Rehabilitation. It was only upon a phone call from Care and Rehabilitation Directorate Official B on the afternoon of 30th October 2018 that they realised the error they had made.

2.42 Operations Directorate Official A also elaborated to say that, at no time since sending their e-mail of 22:52 on 28th October 2018 did any of the recipients contact them to point out that Mr O had not in fact passed away, or to correct the record.

2.43 Operations Directorate Official A accepted without qualification that the wording of their email was inappropriate.

2.44 In relation to Mr O's request for a visit from an official of the Minister under Prison Rule 57, Operations Directorate Official A noted the request was sent to the then Director General at 19:09 on Friday 26th October 2018, after the Directorate had closed for ordinary

business for the bank holiday weekend. On Tuesday morning at 10.17am the Director General sent an email to Operations Directorate Official A to request that the matter be dealt with. They responded that Mr O had passed away over the weekend, in accordance with their belief at that stage.

2.45 The abovementioned email on Friday 26th October 2018 at 19:09 to the then Director General was also copied to others including Operations Directorate Official A.

Recommendations

6 As the IPS operates on a 24 hour 365 day of the year basis, it should ensure that decisions required from senior management in IPS HQ are available in a timely manner and are addressed with an appropriate level of urgency.

7 The IPS should ensure that internal communication is at all times respectful and appropriate action taken when this standard is not reached. The development of a Code of Ethics for all IPS personnel (senior management and staff in HQ and prisons) should be expedited for completion and subsequent implementation at the earliest opportunity.

8 Requests for a meeting with a representative of the Minister in accordance with Rule 57 should be addressed in a timely manner. The recipient of the request should make immediate contact with the prison concerned to assess the urgency of the matter.

9 The representative of the Minister that meets with a prisoner under Rule 57 should not be the original decision-maker in the decision that that prisoner wishes to discuss/raise with the representative. The representative should be of sufficient seniority to make appropriate recommendation for decision.

CHAPTER 3 POST EVENT

3.1 Chaplain A notified Mr O's NoK when he died; and the next morning a chaplain went into the prison before breakfast unlock to meet with the prisoners who were close to Mr O and inform them of his passing.

Critical Incident Meeting

3.2 A critical incident meeting should take place as soon as possible after a Death in Custody, involving all who were present. The purpose is to provide staff and any 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.

3.3 No debrief was held after Mr O died. While this may have seemed unnecessary because he was receiving end of life care, it is clear there were radically different views between prison

management and staff including chaplaincy, medical/nursing and the Operations Directorate regarding a decision in IPS HQ to refuse CTR. These views should have been aired at a meeting, which might well have identified other concerns and resolutions e.g. about some of the practical aspects of caring for a terminally ill patient in prison.

3.4 Nonetheless, it is positive that ACO A sent an e-mail to all Midlands Prison staff to notify them of Mr O's death and thank everyone who helped on his last night. He also identified a Staff Support Officer who was to receive a list of all staff involved so that he could offer them support.

Recommendation

10 A Critical Incident meeting should take place as soon as possible after a death in custody.

11 The IPS Critical Incident Policy should be reviewed and consideration given to the inclusion of a cold debrief within 14 days of an incident to provide further opportunity for everyone involved, including prisoners where relevant. The purpose should be to identify learning, support everyone involved and assess progress in relation to actions that were identified at the hot debrief, i.e. the debrief as soon as possible after the incident occurred.