OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr I 2018

AGED 53

at St James's Hospital while in the custody of the Midlands Prison

on 14th June 2018.

[Date finalised: 18th June 2020]

[Date published: 12th August 2020]

Office of the Inspector of Prisons
24 Cecil Walk
Kenyon Street
Nenagh
Co. Tipperary
Tel: + 353 67 42210

Office Ref: Mr I /2018

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GLOSSARY

ACO	Assistant Chief Officer
AGS	An Garda Síochána
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CO	Class Officer
Doctor	Registered Medical Practitioner
Dr	Doctor
HSE	Health Service Executive
IoP	Inspector of Prisons
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PIMS	Prisoner Information Management System
SOP	Standard Operating Procedure
SSO	Staff Support Officer
UAL	Unlawfully At Large

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 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.

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

Objectives

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

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

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. The Office of the Attorney General has informed the IPS and Inspector that the provisions of the Prisons Act 2007 in relation to accessing healthcare /medical records of deceased prisoners in relation to investigations of deaths in custody cannot be relied upon. As an interim arrangement pending legislative amendment, the IPS has agreed to release such records with consent from Nest 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 I'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 I passed.

Administration of the Investigation

The OIP was informed of Mr I's death by email at 07:20 on the morning of his passing, 14th June 2018. On 15th June 2018 I visited the Midlands Prison and received a briefing from Governor A and Assistant Governor A. We agreed the material that would be required for the Death in Custody investigation.

The material was subsequently provided in a timely manner and it has been useful to inform the judgements of my Office. When this Office reviewed the information provided it was found that these reports lacked certain detail. We decided to interview identified staff. Due to staffing resources in this office the earliest opportunity to do so was on 1st November 2018. However due to the lapse of time the officers' recollection was not definitive. This is too long a gap for proper recall. In addition some accounts are of limited value because they are of questionable accuracy, for example one statement to the OIP on 1st November 2018 *"I am nearly sure I spoke to xxx…;"* another *"I do not specifically remember the 12th June 2018…I could well have been contacted by xxxx…."*

Explanations of timings and other important details in general terms can affect the judgements of my Office. This is especially true in deaths where emergency interventions are required, but it can also be important in other respects e.g. in corroborating the accounts of staff.

Recommendation 1
The IPS should instruct all staff that their written records and verbal evidence in respect of Deaths in Custody and other significant incidents must be fully detailed and specific in relation to all factual aspects of the event including timings and job roles.

Family Liaison

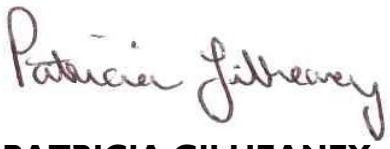
Liaison with the deceased's family is a very important aspect of the Inspector of Prisons role when investigating a death in custody.

Representatives from my office met with Mr I's family on 25th July 2018. Based on their understanding of the facts, the family raised several questions. These questions and my related findings are set out in more detail in this report. In broad terms they related to his diagnosis and care, what happened to his belongings after he passed, and the arrangements and costs of his funeral.

The family also queried why he had spent so long in prison. That matter lies outside the scope of this investigation.

Although this report is prepared at the request of the Minister for Justice and Equality, it is written primarily with Mr I's family in mind. I offer my sincere condolences to them for their sad loss.

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



PATRICIA GILHEANEY
Inspector of Prisons
18TH June 2020

SUMMARY

Mr I died in hospital at the age of 53. He was committed to prison in 1985 and had been transferred around many of Ireland's prisons during his 33 years in custody.

Due to poor health he had been hospitalised on several occasions and was transferred from Shelton Abbey to the Midlands Prison in December 2017. The sole reason for transfer was to improve his access to medical care which was not available at Shelton Abbey.

The most critical finding of this investigation is the IPS' failure to take Mr I to hospital as directed by Doctor A on 12th June 2018. He had been complaining of severe pain and was assessed by Doctor A at 10:40 that morning. Doctor A completed a written referral for the Midlands Regional Hospital, Portlaoise and identified the priority level as urgent.

Nurse Officer A, sent an email at 10:52 on 12th June 2018 to the Chief's Office, the General Office and Detail Office. It stated "*Please be aware that Doctor A (*name stated*) has requested the above-named prisoner attends A&E in PGH as soon as possible* [emphasis added*]."* Nurse Officer A did not explicitly state that Doctor A had categorised the referral as "urgent". She followed up these e-mails by telephone and radio notification.

Seven hours later - around 17:30 - Nurse Officer A's attention was drawn to the fact that Mr I had not yet been taken to the hospital. She therefore contacted the Detail Office again and spoke with Prison Officer A who explained they did not have enough staff to escort him to hospital. Nurse Officer A agreed with the Officer's suggestion that the hospital referral could be deferred until the following morning.

Nurse Officer A did not consult with a doctor before agreeing to this deferral. She acquiesced with the Officer's suggestion because she considered Mr I had not been complaining or in distress. This opinion was at odds with the views of Mr I's two carers who said he was *"not in good shape"* and *"he said his pain was extremely bad"* on 12th June 2018.

The next morning (13th June 2018) at 10.33 Mr I sounded his alarm bell and Class Officer A responded in approximately 25 seconds and observed him sitting on the toilet, complaining of feeling unwell and requesting a nurse. A nurse was called and Nurse Officer A arrived at the cell to find Mr I lying on the floor beside the toilet in distress and pain. At this stage there was still no indication of anyone preparing to take him to hospital, despite indications on the previous day that he would go to hospital "*the next morning*" at 11:00 hours.

A Code Red was initiated and Doctor B attended. An ambulance was called and Mr I was removed by paramedics to the Midlands Regional Hospital at about 11:10. Around 16:00 he was transferred to St James Hospital in Dublin as he was seriously ill.

In addition to failure to follow the doctor's instruction, several other concerns arise in this case:

- Even when his transfer to hospital was deferred until the following day, nobody appeared to treat it with any degree of urgency;

- The NoK information contact details (address and telephone numbers) were incorrect which delayed notification to them at a critical time;
- The Critical Case Review did not have the correct attendance as those involved in the incident were not present.

Good practice was identified in the recording by ACO A during Mr I's brief period in St James Hospital.

In relation to the queries raised by Mr I's family, our findings are below:

- **Did Mr I have cancer? How was his pain managed as he had complained of being in agony and felt he was not listened to?**

  Mr I's prison healthcare records did not include a diagnosis of cancer. [Medical diagnosis will be provided directly to the Next of Kin by the Inspector of Prisons in advance of publication of the Report].
  Extensive medical files indicate appropriate medical management in the circumstances. It included timely transfer to a more appropriate prison, allocation of a wheelchair cell and carers and a range of treatments including surgery, medication, pain relief and dietary adjustments in accordance with his medical diagnosis. However failure to transfer him urgently to hospital, as directed by the doctor on 12th June 2018 was a major failing.

- **He had no clean clothes while in St Vincent's hospital and another patient's visitor had to lend him pyjamas - why?**

  Mr I had numerous visits and inpatient stays in hospitals during his time in custody. The inpatient stay in St. Vincent's hospital related to a period when he was in the custody of Shelton Abbey prior to his transfer to the Midlands prisons. Management in Shelton Abbey advised that the Chaplain was in regular contact with Mr I while hospitalised and they were not aware of any concerns regarding the lack of clean clothing.

- **His NoK questioned why they were not informed that Mr I was seriously ill and had been removed to hospital?**

  Efforts to inform his NoK proved difficult as one phone number held by the IPS was a wrong number and the other defaulted to an answering machine. The address for his NoK was also inaccurate. However the IPS did not attempt to notify his family for over seven hours, despite requests from hospital staff that they should be notified as soon as he transferred to St James'. Whether due to miscommunication or tardiness, this was poor practice. The family were ultimately notified by their local Gardaí shortly before Mr I passed at 01:40 on 14th June 2018.

- **Why the IPS - who had held Mr I for 33 years - was not prepared to pay for his funeral in circumstances where his daughter - who was his NoK - could not afford to pay the funeral expenses as she had a young family with health issues?**

The IPS contributed the maximum amount specified in its policy in respect of payments towards a prisoner's funeral.

- **The NoK was informed that the family would have to purchase clothes as there was no fund to provide money for such purchases.**

  Governor A informed the OIP that €100 towards the cost of clothes for Mr I's remains had been authorised and they had expected the family to be informed of this. Governor A stated that there appeared to have been a regrettable breakdown in communication of that contribution.

- **The family were upset that no prayers were said at the funeral home. They were grateful to the Chaplain who attended Mr I's funeral but disappointed that, nobody else represented the IPS when he had been in their custody for 33 years.**

  The IPS said every effort is made to have prison management present at the funerals of deceased prisoners. However as prison management were unable to attend on that particular day for operational reasons, the Chaplain attended as the Governor's representative.

- **The family were concerned about the meagre personal effects they received after Mr I passed. They believed he had a television and a stereo player when he was brought to the Midlands Prison. However they only received one speaker which was broken. None of his jewellery nor family photos were returned to them.**

  The IPS provided an inventory of property that was signed out to Mr I's NoK on 12th July 2019. This included a radio and pictures. There was no record of him having a TV in the Midlands Prison since prisoners held there are not allowed personal TVs – they are provided from prison stores.

  Castlerea Prison also advised that they had property belonging to Mr I and relevant contact details were provided to Mr I's NoK so that they could arrange to have the property collected.

Several learning points arise from this investigation. Eleven recommendations for improvement are made. Two of these have previously been made, either directly or in a slightly different format, and accepted by the IPS (see recommendations 2&4 on page 10).

All of the 11 recommendations in this report have been accepted (recommendation 5 part accepted) by the IPS. These will be monitored in future investigations into Deaths in IPS Custody.

The Death in Custody Standard Operating Procedure referenced in point one of the Action Plan was also received.

RECOMMENDATIONS

1. The IPS should instruct all staff that their written records and verbal evidence in respect of Deaths in Custody and other significant incidents must be fully detailed and specific in relation to all factual aspects of the event including timings and job roles. (Preface)

2. The IPS should ensure that all its staff understand professional practice requires adequate recording. The principle* "If it was not recorded, it was not done" *may provide a useful basis for future training and assessment of practice in supervision and appraisals. (Para 2.40**)**

3. The IPS should satisfy itself about the competence of all staff involved in this failure to follow the doctor's orders and take any action necessary to ensure there is no repeat in any prison establishment. (Para 2.43)

4. In circumstances where urgent hospital referrals are deferred, the IPS should immediately apply increased frequency of nursing / medical checks until the transfer takes place. (Para 2.47)

5. The IPS should review the application of its Compassionate Temporary Release Policy to ensure that prisoners who are terminally ill are appropriately released on licence in order to avoid the indignity of dying in prison. (Para 2.49)

6. The IPS Protocol for Chaplaincy and Next of Kin Notification dated 25/05/2017 at Section 2.3 makes provision for informing next of kin in cases of grave illness. The IPS should monitor implementation of the Protocol and take appropriate action if there is non-compliance. (Para 3.18)

7. The IPS should apply the following rationale for Critical Incident Reviews:
"The purpose is to provide staff and any prisoners <u>who were involved</u> 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."
Critical Incident Reviews should therefore be arranged to facilitate the attendance of those who were centrally involved, including prisoners, carers and staff from support agencies (Para 3.29)

8. Critical Incident Review minutes should reflect action points and responsibilities so that all relevant personnel understand what is required. This is especially true when key players did not attend the Review. (Para 3.32)

9. The IPS should ensure all referrals to outside hospital are prioritised when a doctor designates them as "Urgent". (Para 3.35)

10. The IPS should ensure that all staff are cared for after a critical incident, including those who are experienced and appear to cope well at the time. (Para 3.41)

11. The IPS should consider the introduction of a 'cold debrief' within 14 days of a critical 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'.

THE MIDLANDS PRISON

The Midlands Prison is a closed, medium security prison for adult males. On 13th June 2018 the Midlands Prison held a total of 817 prisoners.

The Prison Visiting Committee is charged with visiting the prison at frequent interval and carry out its functions in accordance with the Prisons (Visiting Committees) Act, 1925. Their 2017 Annual Report[1] highlighted two issues that are relevant to Mr I:

- The committee noted that their previous concerns about adequacy of medical staff numbers had been addressed (Page 6);
- In relation to missing clothing and other property, the committee heard complaints from prisoners whose clothing and other personal articles were misplaced or lost, often involving inter-prison transfers. "*Following discussion and investigation by the prison authorities, the missing items have now been either located or replaced*." (Para 2.4).

[1] http://iop.gov.ie/en/JELR/Midlands_Prison_Visiting_Committee_Annual_Report_2017.pdf/Files/Midlands_Prison_Visiting_Committee_Annual_Report_2017.pdf

CHAPTER I BACKGROUND

1.1 Mr I was committed to custody on 20th June 1985 at the age of 20. In November 2016 the Parole Board had recommended a transfer to Shelton Abbey and a further review in 18 months. The transfer to Shelton Abbey did take place and he was transferred back to Midlands Prison due to his physical ill health. His death occurred within the aforementioned 18 month period.

1.2 During his 33 years in custody he had a total of 29 moves between Mountjoy, Arbour Hill, the Training Unit, Limerick (to facilitate family contact), Wheatfield, Castlerea, Shelton Abbey and Loughan House Prisons.

1.3 Mr I attempted to take his own life on 1st January 2011. There were no subsequent concerns in this regard. 2014 Parole Board records show he *"made progress in developing some relationship with his estranged family. It would appear that he has made serious efforts since the death of his mother."*

1.4 He had seven reviews by the Sentence Review Group between 1993-2001; and a further eight reviews by the Parole Board between 2002-2014.

1.5 Throughout his time in custody Mr I had a good disciplinary history. He was a trustee cleaner in staff areas and was described [in an unattributed report] as *"A well behaved prisoner who was on the enhanced level of the incentivised regime…. Engages positively with staff and management."*

1.6 Efforts made to achieve release on licence were unsuccessful. The family struggled to reconcile these failures with his ability to live in a low supervision facility like Shelton Abbey, be accorded "Trustee" status, and recognised as a model prisoner.

1.7 However there were obvious setbacks along the way. 2014 Parole Board records indicate *"A few Temporary Releases went astray."* He breached the conditions of Temporary Release on a number of occasions when incidents of aggressive behaviour and alcohol abuse were reported; and he was Unlawfully at Large (UAL) between 22nd-24th November 2017.

1.8 Despite these difficulties, recent external movement records showed Mr I had day visits to residential addresses in October 2016, May and August 2017, and to the Wicklow coast in March 2017. He also had three escorted visits to his mother's grave.

Family Interaction

1.9 Mr I had two brothers, four sisters and a daughter. His daughter was his designated NoK, though had limited contact with Mr I as she was only a baby when he was sent to prison. Their relationship was not very close but she had visited on a few occasions and also had phone contact with him.

1.10 It is reported that family relationships diminished after his mother's death in 2012 and subsequent contact with them was mainly via telephone calls.

1.11 His daughter and friends had visited six times between July-August 2014 while he was in Limerick Prison. There was then a gap until March 2017 when he only had a few professional visits. The last visit from his daughter was on 8th June 2018.

1.12 Phone records show Mr I had two short calls of around five minutes duration on 7th June 2018. However they also show a further six calls after he passed - three on 14th June 2018 and three on 15th June 2018, all categorised as "Domestic." Two of these calls were of 00.00 seconds duration.

1.13 These calls were able to be made because after Mr I passed, he was not marked off the Prisoner Information Management System (PIMS) until 18.06 on the 15th June. This allowed another prisoner who knew his PIN number to make a call on his account. The governor had the matter investigated and received a report which showed the calls were made by a single prisoner to Mr I's daughter/NoK. Their discussions were about the loss of Mr I, funeral arrangements, his property and family matters.

1.14 Apart from information that Mr I had a cousin on G1 landing in the Midlands Prison, who assisted with delivery of some of his meals when he was unwell, his interaction with other prisoners is not known.

Chapter 2 MEDICAL HISTORY

2.1 Much of Mr I's later period in custody was dominated by declining health. He had been receiving medication for his condition prior to his passing. He had been transferred from Shelton Abbey Prison to hospital by ambulance on seven occasions during 2017.

2.2 On 7th October 2017 he underwent abdominal surgery in St Vincent's Hospital, Dublin. He was discharged on 12th October 2017 and returned to Shelton Abbey.

2.3 His daughter informed the Inspectorate that while in St. Vincent's he was on the phone to her, crying. He complained that he was given no clean clothes nor pyjamas; and that another patient's visitor gave him clothes which belonged to her husband.

2.4 The IPS was unable to explain the accuracy of this view since Mr I was in the custody of the Governor of Shelton Abbey while he was in St. Vincent's Hospital. We were informed by management in Shelton Abbey that Mr. I had regular contact with the Chaplain while hospitalised and they were not aware of any issue regarding clean pyjamas.

2.5 On 23rd October 2017 Mr I was unwell - vomiting and dehydrated. He was again sent by ambulance to St Vincent's Hospital where he remained until 28th October 2017. He once more returned to Shelton Abbey and was in good form.

2.6 On 13th November 2017 Mr I was complaining of severe pain around his abdominal incision site and was again transferred by ambulance to St Vincent's Hospital. He was having difficulty tolerating solid foods and was on a liquid diet. He was also referred to Psychiatric Services and the Chronic Pain Management Team in St. Vincent's.

2.7 On 5th December 2017 he was discharged back to Shelton Abbey. He was expected to be on liquid foods from then on and was prescribed analgesia (pain relief).

2.8 On 6th December 2017 Mr I was reviewed by Addiction Counsellor A who recorded that Mr I had been told in hospital that there was no cure for his condition and they could only keep him comfortable with pain relief.

2.9 On 6th December 2017 Nurse Officer B in Shelton Abbey, summarised the situation:
"I have spoken with [xxx] team in St Vincent's who have stated that Mr I's condition is incurable and surgery is not an option…He is in constant pain, confined to bed at present and unable to walk without assistance."

2.10 At this stage Dr C, in consultation with the IPS Chief Pharmacist suggested Shelton Abbey was not suitable for Mr I in view of his medical diagnosis. Dr C recommended he be transferred to a prison which could provide 24 hour medical care.

Transfer from Shelton Abbey to the Midlands Prison

2.11 Accordingly on 7th December 2017 Mr I was transferred to the Midlands Prison in Portlaoise. Nurse Officer C recorded the details of his diagnosis and surgical history on his committal PHMS . *"A letter from Doctor C advised this man is terminal."*

2.12 Dr C's letter 7th December 2017: *"He is terminal and only getting palliative care – he is on a morphine patch and codeine…He needs 24 hour medical care which we cannot provide in Shelton…"*

2.13 Medical notes and continuation sheets indicate considerable engagement thereafter with a variety of medical disciplines. Mr I was allocated carers in the Midlands Prison. He continually complained of pain and requested stronger pain killers. He sometimes used a wheelchair to move around and was accommodated in a wheelchair-accessible cell.

2.14 On 13th December 2017 Dr D noted *"Abdominal pain not well controlled… Massive weight loss…"* She ticked an "Estimated Prognosis" box that indicated "Months" (as opposed to "Days" or "Weeks"). Her record also indicated the patient and his family were not aware of the diagnosis or prognosis, but he was aware of his referral to palliative care.

2.15 Mr I continued to suffer chronic pain and was often unhappy with the food he was receiving. He was occasionally abusive to medical staff and threatened not to take medication or prescribed drinks. He was given Ensure shakes to supplement his nutrition, though at times refused them. He would eat small amounts of food.

2.16 On 22nd January 2018 Mr I was referred to the Pain Management Clinic at the Midlands Regional Hospital under Mr A.

2.17 On 25th January 2018 he was admitted to the Emergency Department at Midlands Regional Hospital for assessment due to his deteriorating status.

2.18 On 2nd February 2018 he was discharged from hospital back to the Midlands Prisons, and referred for vascular review at St. James's Hospital in Dublin on 7th February 2018.

2.19 Following this review Mr I was scheduled for further surgery on 28th February 2018 at Tullamore General Hospital. However severe adverse weather made safe travel impossible, so this appointment - along with all other operations in Tullamore that day - was cancelled by the HSE on 27th February 2018.

2.20 Mr I continued to receive pain medication and was regularly reviewed by prison doctors. He was seen by the dietician in St. Vincent's Hospital on 18th April 2018 and was reviewed by Doctor E at the Midlands Regional Hospital on 24th April 2018. Essentially however his transfers to hospital were only able to relieve symptoms rather than cure the cause; and his condition caused his appetite to be reduced. At the time of his passing Mr I was prescribed 14 different medications.

12th June 2018

2.21 Shortly after he passed Mr I's daughter and NoK reported that *"When Dad phoned in recent weeks he was crying in pain."* She advised him to go into his cell and talk to the Governor. He said he was in agony and was very distraught. He asked his daughter to call the Governor but she declined as she did not wish to interfere.

2.22 Mr I was living in Cell 5 on G1 landing of the Midlands Prison. IPS records show that he activated his emergency call bell at 11:45 on 11th June 2018 for 21 seconds; and at 02:52 on 12th June 2018 for 1 minute, 27 seconds. He was given pain relief medication on each occasion.

2.23 CCTV and documentary evidence on 12th June 2018 shows him engaging in social interaction with staff, including a Carer, and other prisoners. Two carers expressed concern about Mr I's increasing pain. He told them he did not want to lie down due to pain. Both Carers went to see him throughout the day. They brought him medication and said Mr I was *"not in good shape"* and *"he said his pain was extremely bad."*

2.24 Nurse Officer D provided a statement which indicated she dispensed medication to Mr I at 08:00 and 16:00 on 12th June 2018. At 08:00 he took his medication, but at 16:00 he did not want it as he said it left a bad taste in his mouth. She advised him to take the medication to avoid pain, which he then did. She recorded *"No other complaints voiced at this time."*

2.25 Mr I saw Doctor A at 10:47 on 12th June 2018. She recorded her physical examination of him on the PHMS system. She recorded the plan as
"*"Referred to PGH* (referring to Portlaoise General Hospital) *for further management*."

2.26 Dr A also completed an "IPS Referral Form." The "Priority Urgent" (as opposed to "Priority Routine") box is ticked on this form.

2.27 Dr A phoned Nurse Officer A to notify her of the referral of Mr I to the Emergency Department. Doctor A IPS Referral Form was also received via e-mail by Nurse Officer A.

2.28 Nurse Officer A subsequently sent an e-mail at 10.52 on 12th June 2018 to arrange Mr I's transfer to A&E. The e-mail was sent to the correct locations within the Midlands Prison – all nurses, Detail Office, Chiefs and the General Office.

2.29 The e-mail was extremely brief. It simply said *"Please be aware that Dr A has requested the above-named prisoner attends A&E in PGH as soon as possible [emphasis added]."*

2.30 Nurse Officer A's recorded statement to the Inspectorate on 1st November 2018 said *"….I received a phone call from Dr A stating that she had referred Mr I to the A&E Department of Portlaoise General Hospital. I do not recall that the referral was urgent or required an ambulance. I followed the protocol for sending a prisoner to hospital…."*

2.31 Nurse Officer A's statement makes no reference to the Referral Form completed by Doctor A with the priority for transfer rated as 'urgent'.

2.32 Mr I's cousin, who was also a prisoner on G1 landing, brought him food during the day. There were no reports on file from this prisoner relative, or from NO E, despite the fact that they all had contact with him on 12th June 2018.

2.33 Very limited statements were provided by two prison officers B and C who were on duty on 11th and 12th June 2018. They do not indicate that they realised Mr I was due to go to hospital. This is strange since an impending transfer to outside hospital should be known to staff on a landing. It is also curious that they thought Mr I was in good form, when two carers had formed contrary opinions.

2.34 Ultimately Mr I was not transferred to hospital on 12th June 2018. Nurse Officer A only realised this when Carer A asked her around 18:00 about progress in effecting his transfer. Carer A said Nurse Officer A then phoned the Detail Office twice and was told *"That is the first we have heard of it."*

2.35 ACO B recorded (on 15th June 2018):
"At approximately 11am the Detail office was contacted by NO A informing us that Mr I had to go to A&E at some stage during the day [emphasis added].[2] *We already had a prisoner in A&E so we proposed to send Mr I to A&E when the other prisoner returned.*
At approximately 6pm NO A contacted the Detail Office enquiring about the status of the escort. As we were cutting 20 posts on the reserve that evening we asked if this escort could be sent over the next morning.
NO A informed Prison Officer A that the escort could go over the next day. The movement was cancelled on PIMS and rescheduled for the next day at 11am. At no stage did the Detail advise that this escort could not be actioned."

2.36 Prison Officer A (in a November interview with the IoP) could not recall whether NO A agreed immediately or rang back afterwards. In an e-mail on 14th June 2018 to Governor A he said *"As is common practice when in a staff shortage situation I asked could the escort be deferred until the following morning…"*

2.37 NO A said that, after discussion and having realised Mr I had not been complaining or in distress, she agreed in the circumstances that he could go to hospital the following morning. She informed the night nurse that he was clinically stable and in no distress.

2.38 NO A's written statement about this matter on 15th June 2018 was extremely brief and lacking in detail. It indicates she was requested by Doctor A via a phone call to arrange for Mr I's review at Accident & Emergency Department of the Midlands Hospital. It does not acknowledge Mr I's level of pain nor convey any sense of urgency. Her written statement simply says *"It was agreed that Mr I would attend A&E first thing Wednesday am."* This is at odds with her contemporaneous e-mail which said he should be transferred "*as soon as possible."*

[2] This does not accord with the account of Carer A who said when NO A phoned the Detail Office at approximately 18:00, she was told *"That is the first we have heard of it."*

2.39 Nurse Officer A:

- Did not consult with Doctor A, or with any other doctor, before overriding Doctor A's direction for Mr I to be transferred urgently to hospital;
- Recording is insufficient - it does not indicate who requested the delay nor convey her rationale for deferring the transfer to hospital;
- Comment that Mr I was in no distress is at odds with the accounts of his carers and it subsequently transpired that Mr I in fact did not go to hospital "first thing" the next morning. It was only when he was found in a collapsed state at 10:40 that action was taken.

2.40 Nurse Officer E attended Mr I at 03:00 on the night of 11th/12th June 2018 and did not make an entry in the nursing notes section on PMHS. However, a referral was made for review by the Doctor on 12th June 2018.

2.41 The Critical Incident Review minute in relation to the escort not being actioned on 12th June 2018 said: *"…. At approx. 11am the Detail Office was contacted by NO A informing us that Mr I had to go to A&E* at some stage during the day…[emphasis added]. *"* This is another version of events.

Recommendation 2
The IPS should ensure that all its staff understand professional practice requires adequate recording. The principle* "If it was not recorded, it was not done" *may provide a useful basis for future training and assessment of practice in supervision and appraisals.

2.42 The events of 12th June 2018 reflect poor recording and different versions of events. NO A appears to have acquiesced to a request from the Detail Office to defer Mr I's urgent transfer to hospital, without reference to a doctor, having determined that his level of pain was sufficiently low that he could wait until the morning.

2.43 It appears the Detail Office routinely deferred external movements of prisoners when there were staff shortages. The final sentence of ACO B's account presents as an unbecoming attempt to absolve the Detail Office of any blame for this unfortunate matter (see para. 2.35).

Recommendation 3
The IPS should satisfy itself about the competence of all staff involved in this failure to follow the doctor's orders and take any action necessary to ensure there is no repeat in any prison establishment.

2.44 The IPS was asked to comment on cancelled escorts to outside appointments.
Governor A said that "*Where there is a body warrant or holding warrant signed by a judge, then the escort will not be cancelled due to staff shortages. If it is a production request from a Garda, depending on staff resources on a particular day, the escort may be declined. 48 hours' notice is required for Gardai to make such requests*."

2.45 The Governor was not in a position to provide numbers of such production requests which were not met. However he advised that the PIMS showed "*There were 54 medical appointments in the last year that were cancelled due to staff shortages*."

2.46 Mr I's cell was master-locked at 19:20 on 12th June 2018. There were nine checks on him during the night plus a further two by his carer, before the master lock was removed at 07:36 the next morning, 13th June 2018.

2.47 Mr I was checked hourly on the night of June 12th-13th. This was in accordance with IPS SOP. However in view of the fact that he had been referred to hospital and then had his transfer deferred, more frequent medical special observation should have been put in place.

Recommendation 4
In circumstances where urgent hospital referrals are deferred, the IPS should immediately apply increased frequency of nursing / medical checks until the transfer takes place.

13th June 2018

2.48 CCTV and documentary evidence show the 13th June 2018 medication round taking place at 08:37. At 09:50 Mr I was standing at his cell door, dressed, with left hand on his tummy. He re-entered the cell and the door was closed.

2.49 CCTV records show that Mr I activated his call bell at 10:33:54 and CO A responded promptly and arrived at the cell at 10:34:20. Mr I was found on the cell floor beside the toilet in pain. Help was summoned and CO A and NO A attended.

2.50 CCTV footage shows the officer remained in the cell for six seconds, exited and walked up the landing reaching for his radio. This was CO A who found Mr I on the floor and placed a pillow under his head.

2.51 CO A returned at 10:38 and a NO arrived 14 seconds later. Doctor B arrived at 10:49 and a Chief Officer at 10:51. Paramedics arrived at 11:01.

2.52 Nurse Officer A recorded on the PHMS:
"Alerted to Mr I in his cell by CO A on B1[3] 10:40.
When I entered the cell Mr I was on the ground beside the toilet appeared in pain. Assisted by Carer and CO A to lift Mr I from the floor to his wheelchair. I left the cell and got red bag from surgery. When I returned Mr I was unresponsive in the chair with his head slumped. Pale and grey and peripheral cold to touch. Lifted from chair to the bed in his cell.
Code Red called via radio. Dr and Ambulance assistance required."

2.53 Doctor B responded, and recorded as follows:
"*Attended (Red Code)*
Collapsed in his cell
Recovered with basic immediate interventions

[3] This appears to be a typographical error as Mr I was accommodated on G1 not B1.

c/o severe pain abdomen.
Ambulance arrived. Transferred to hospital.
I am very concerned to note as well that he was recommended to be transferred yesterday by medical team to A/E, and was not taken to hospital by prison and today he collapsed and going to hospital by Ambulance! I have informed the management Gov B."

2.54 At 11:09am Mr I was removed from G1 landing at the Midlands Prison by paramedics on a trolley en route to an ambulance bound for the Midlands Hospital.

Recommendation 5
The IPS should review the application of its Compassionate Temporary Release Policy to ensure that prisoners who are terminally ill are appropriately released on licence in order to avoid the indignity of dying in prison.

CHAPTER 3 EVENTS AFTER MR I WAS HOSPITALISED

Notification to the Family

3.1 Prison Officer D who escorted Mr I to the Midlands Regional Hospital on 13th June 2018 was told by nursing staff that he was seriously ill. Around 16:00 a nurse advised the NoK should be informed as arrangements were being made to transfer him to hospital in Dublin.

3.2 Prison Officer D contacted the Midlands Prison Detail Office to request an escort for the transfer. He also contacted the Chief's Office and believed he spoke with Chief Officer A whom he told that Mr I's NoK should be informed.

3.3 Mr I left the Midlands Hospital for St James's Hospital, with an escort around 18:45.

3.4 At 22:45 Prison Officer E phoned ACO A - who was then in charge of the Midlands Prison - to advise him that Mr I's condition was critical, he was going to surgery and he had been advised that the NoK should be informed.

3.5 ACO A made immediate efforts to contact the NoK at 22:45. However no effort had been made from 16:00 until 22:45 to contact the NoK, despite the hospital staff request for this to be done.

3.6 On advice from Governor B, ACO A then made several attempts to contact the NoK via two numbers that were held on IPS files. However these were of no use: the first automatically activated an answering machine; and the second turned out to be a wrong number which belonged to someone else.

3.7 At 00:00 Prison Officer E again contacted ACO A to inform him that Mr I was in the Intensive Care Unit and medical staff had told him nothing further could be done. ACO A informed him that efforts were being made to inform the NoK.

3.8 ACO A then contacted Henry Street Garda Station in Limerick at 23:15 and requested that AGS visit the NoK to inform them of the situation. It then transpired that the address on file for Mr I's daughter who was his NoK, was also incorrect. However with assistance from the Gardaí, the correct address was identified.

3.9 At 00:50 on 14th June 2018 ACO A received a call from the Gardaí confirming that contact had been made with Mr I's NoK. They had been informed of his condition and had been given the Midlands Prison phone number.

3.10 At 01:05 ACO A received a call from Mr I's daughter. He updated her on the situation and gave her the phone number for the Intensive Care Unit at St James's Hospital.

3.11 At 01:40 Prison Officer E was informed that Mr I had passed away. He in turn informed ACO A.

3.12 A detailed e-mail account / timeline (from time of transfer of Mr I to St James Hospital at 19:30 on 13th June 2018 to identification of his remains by IPS to AGS at 02:45 on 14th June 2018) was provided by ACO A. This was good practice as it evidenced relevant unfolding events and actions taken, times, who was notified and by whom, including efforts and associated difficulties in contacting Mr I's daughter.

3.13 Chaplain A had been informed by ACO C by phone at about 20:15 on 13th June 2018 of Mr I's removal to the Midlands Hospital, and later onward transfer to St James's Hospital. ACO C told him Mr I was dying and asked if he would be able to inform the NoK should he pass away. Chaplain A confirmed he would be available to do so.

3.14 Chaplain A said at the Critical Incident Review meeting *"I rang ACO C to ask if his family should be contacted. ACO C advised that it might be advisable that they shouldn't be contacted at this stage."*[Emphasis added]

3.15 This contradicts ACO C's account which is contained in an e-mail of 26th December 2018 (six months after the event) to the IoP. He said he phoned Chaplain A to put him on standby in case Mr I's condition deteriorated significantly and therefore may be required to inform the prisoners' family of same. *"My role on the night was to assist ACO A. This was the only function I carried out in relation to the above prisoner's death and as such there was no delay in either ACO A' or my own actions..."*

3.16 There is an obvious discrepancy between the accounts of Chaplain A and ACO C. While this was not material to Mr I's demise, such communication breakdowns become more pointed at a time of high emotion; and they can have practical consequences in terms of timely and accurate notification to a family. Such discrepancies highlight the importance of obtaining detailed, accurate and contemporaneous accounts of events.

3.17 The notification to Mr I's NoK was not as requested by the hospital staff. They wanted the family notified that Mr I was seriously ill before he died; not that someone should inform them after he died. Notwithstanding the inaccurate phone numbers held on file, there was a delay of over seven hours on the part of the IPS. Whether due to miscommunication or tardiness, this was poor practice.

3.18 Governor A provided a copy of an email dated 7th August 2018 that was issued to Midland Prison Chief Officers and ACO's and copied to all governors and chaplains instructing that the Chaplains Office is to be informed of any prisoner that is taken to hospital by ambulance and where the prisoner is gravely ill the provisions of the IPS Chaplaincy and Next of Kin Notification Protocol is to be adhered to.

Recommendation 6
The IPS Protocol for Chaplaincy and Next of Kin Notification dated 25/05/2017 at Section 2.3 makes provision for informing next of kin in cases of grave illness. The IPS should monitor implementation of the Protocol and take appropriate action if there is non-compliance.

Funeral Arrangements

3.19 Mr Is family felt aggrieved that they had to arrange and pay for his funeral. His daughter was only an infant when her father was sent to prison, yet as his nominated NoK she was requested to contribute a significant amount for his funeral expenses.

3.20 The IPS provided a receipt to show they had in fact contributed €2,000 for Mr Is funeral - the maximum amount allowed by policy in respect of prisoners' funerals. Governor A had authorised a further €100 towards the cost of clothing for his remains; and had asked chaplaincy for this information to be conveyed to the NoK. The Governor regretted if a breakdown in communication had meant that contribution was not known to the family and said it would still be available to Mr. I's NoK if she wished to receive it.

3.21 The family were also upset that no prayers were said at the funeral home; and that despite having been in custody for 33 years, the only IPS representative to attend his funeral was the Chaplain.

3.22 The IPS said every effort is made to have prison management present at the funerals of deceased prisoners; and that unfortunately for operational reasons prison management were not in a position to attend on that particular day. The prison chaplain represented the Governor at the funeral of Mr. I.

Personal Effects

3.23 The family had expected more personal effects to be returned to them after Mr I passed. They believed he had a television and a stereo player when he was brought to the Midlands Prison. However they stated that they only received one speaker which was broken; and said none of his jewellery nor family photos were returned to them.

3.24 The IPS said there was no record of Mr I having a TV in Midlands Prison and that prisoners are not allowed personal TVs there – they must be provided from prison stores. An inventory of all Mr I's property was provided by the Midlands Prison. It included a list of checked-in items on the 5th February 2018 following his transfer from Shelton Abbey to the Midlands.

3.25 The IPS also provided an inventory of property that was signed out to Mr. I's family on the 12th July 2018. It showed a radio and pictures were signed out on the 12th July.

3.26 Castlerea Prison had also contacted the Midlands subsequent to Mr. I's death to advise that they had property which belonged to him. His NoK details were provided to Castlerea so that they could make necessary arrangements to have the property collected.

3.27 Midlands Governor A could not see items on the PIMS that were checked-out from Castlerea Prison when he was transferred to Shelton Abbey on 18th February 2017. However there was a list of checked-in items on 5th February 2018 following his transfer from Shelton Abbey to Midlands.

Critical Incident Review

3.28 A Critical Incident Review took place at 13:35 on 14th June 2018. It was chaired by the Midlands Prison Governor B, which was the right level of seniority in the circumstances.

3.29 Five others participated: Governor A, Chief Officer B, the CNO A and chaplains A and B. While some of these participants were directly involved in the events of 12th-14th June concerning Mr I, several significant people who were involved did not participate. These included NO A, Doctor A, Detail Office staff, carers, G1 landing staff and other prisoners.

3.30 It is not known if they were invited and did not attend, or were not invited. Their absences undermined the purpose of a Critical Incident Review.

Recommendation 7
The IPS should apply the following rationale for Critical Incident Reviews:
"The purpose is to provide staff and any prisoners who were involved 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."
Critical Incident Reviews should therefore be arranged to facilitate the attendance of those who were centrally involved, including prisoners, carers and staff from support agencies.

3.31 The review examined a timeline of recent events and the emergency response. It noted that his carers were concerned about his rising pain on 12th June 2018. Referral to Emergency Department in Portlaoise General Hospital by Doctor A was noted. Reference was made to the email from NO A to the Detail Office stating that Mr I needed to be transferred as soon as possible. The difficulties in relation to contacting his NoK were discussed and it was recognised that prisoners contact details need to be kept up to date, especially when they are serving long sentences.

3.32 The minutes lack analysis and do not reflect any opinions of the senior participants about the failings in relation to Mr I's non-transfer to hospital as directed by Doctor A. They do not convey a sense that anyone needed to be held accountable. Instead they concentrate on what would be required for the IoP investigation. While appropriate to look at what is required for the OIP investigation, if this is to be a learning exercise as intended, then the review needs to deal with difficult subject matter; and its minutes should reflect the deliberations and conclusions of all involved.

3.33 It is therefore welcome that much clearer action points were contained in Governor A's report which was sent to the IoP on 21st June 2018.

Recommendation 8
Critical Incident Review minutes should reflect action points and responsibilities so that all relevant personnel understand what is required. This is especially true when key players did not attend the Review.

3.34 The following actions were identified as being necessary following the review:

- Standard Operating Procedure (SOP) to be implemented that when a prisoner is critically ill, NoK to be informed;
- NoK details to be updated on a regular basis. Sign to be placed on all landings to advise prisoners of the importance of NoK details being current;
- Chaplaincy to be informed when a prisoner is sent by ambulance to hospital;
- Implement SOP regarding referrals to hospital;
- Governors to contact family;
- CNO to be made aware of hospital/inter hospital transfers;
- SSO to follow up with staff on escort.

3.35 These were all appropriate measures. The IPS subsequently provided evidence to show that SOP 01/2018 was implemented on 21st June 2018. It clarifies procedures for prisoners who need urgent (non-scheduled) medical treatment or review in an external medical clinic.

3.36 However it is concerning to note that (a) Para 3.7 of SOP 01/2018 still allows for the possibility that *"A hospital referral may have to be cancelled for operational reasons e.g. no escort staff….. A hospital escort may be delayed or postponed"* and "*Where there are serious concerns that a delay could have an immediate life threatening effect on a prisoner, Healthcare is to communicate these concerns to the Chief Officer who will in turn bring these concerns to the Governor.*

Recommendation 9
The IPS should ensure all referrals to outside hospital are prioritised when a doctor designates them as "Urgent."

3.37 Midlands Prison SOP 01/2018 includes an instruction on contacting NoK where a prisoner is gravely ill.

3.38 An IPS protocol for Chaplaincy and Next-of-Kin Notification (LP/11/000-P06) was approved and issued by IPS HQ on 25th May 2017.

3.39 On 7th August 2018 a written direction was given by the Governor to all Chief Officers and Assistant Chief Officer in the Midlands Prison to notify the Champlain's office of any prisoner who has been taken to hospital by ambulance.

3.40 A request was also sent to the IPS Information Technology Department to have a report prepared on NoK details so that a census on NoK details could be completed. Governor A confirmed that a Next-of-Kin census for the entire prison was conducted.

3.41 There was no indication that any staff were traumatised following Mr I's demise. Nonetheless staff care should form a core element of the Critical Incident review agenda

Recommendation 10

The IPS should ensure all staff are cared for after a critical incident, including those who are experienced and appear to cope well at the time.

3.42 There is no evidence that a cold debrief was held after Mr I passed. This would have been all the more important in light of the absences of people who played key roles in his care between 12th-14th June 2018.

Recommendation 11

The IPS should consider the introduction of a 'cold debrief' within 14 days of a critical 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.