OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr D 2018

AGED 72

In Wheatfield Prison on 4 February 2018.

Date draft report submitted to the Irish Prison Service: 3 February 2021

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GLOSSARY

Act	Prisons Act 2007
ACO	Assistant Chief Officer
AGO	Attorney General's Office
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
IPS	Irish Prison Service
NoK	Next of Kin
OiP	Office of the Inspector of Prisons
PIMS	Prison Information Management System
SOP	Standard Operating Procedure

PREFACE

The Office of Inspector of Prisons (OIP) was established by the Department of Justice under the Prisons Act 2007 (the Act). 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 of Prisons and staff of the OIP are civil servants, however, they are independent of the Department of Justice in the performance of statutory functions.

We make recommendations for improvement where appropriate; and our investigation reports are published by the Minister for Justice 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 the Inspector 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. This was the situation in relation this investigation.

Administration of the Investigation

The OIP was notified of Mr D's passing by way of a telephone call received at 21:25 on 04 February 2018. Staff from the OIP visited Wheatfield Prison on 05 February 2018. Prison staff provided a briefing

and confirmed that CCTV footage from relevant areas of the prison had been saved. Mr D's cell was viewed and information requirements for the investigation were agreed.

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.

The Irish Prison Service was unable to provide up to date contact details for a Nok for Mr D. Prison management informed the Inspectorate that Mr. D's NoK could not be contacted. Therefore, in the absence of consent from Mr D's NoK the Inspector did not meet the requirements of the IPS, based on its legal advices, to request and review Mr D's healthcare records.

There has been communication with this Office and the IPS in relation to access to healthcare records in the context of investigations of deaths in custody since 2015. The IPS, in accordance with its legal advice, informed the Inspector that such records could be released with consent of NoK and this has been the practice over a number of years.

In the absence of consent from the NoK, a requirement of the IPS, we were unable to access and review the relevant records. The OIP sought legal advices. Following receipt of contrary advice to that of the IPS, this Office contacted the Attorney General's Office (AGO) requesting a review of the matter. In reply on 1st February 2019, we were advised that the AGO remains satisfied that the law is clear that the duty of doctor-patient confidentiality does survive death and that the AGO was still of the view that Section 31 of the Act is not sufficiently clear and unambiguous to override the duty. However, the AGO noted that sufficiently clear language could override the duty of confidentiality. The advices received were silent in relation to consent of NoK.

It would seem inconsistent that the duty of confidentiality cannot be overridden by Section 31 of the Prisons Act 2007 but it can be overridden by the consent of a NoK in circumstances where there is no statutory provision which requires the consent of the NoK for the release of a deceased prisoner's medical records.

The IoP wrote to the Minister regarding this matter on 22 October 2019 and in his reply dated 18 November 2019 he expressed the intention to address the matter in legislation as soon as possible.

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

Recommendations

There are four recommendations for improvement. A copy of the final draft of the report, including the recommendations was provided to the Irish Prison Service on 1 February 2021 for review, comments and an Action Plan. A response was received on 19 February 2021. The IPS accepted the four recommendations. An Action Plan was provided and areas of responsibility and timelines were included. Implementation of the Action Plan will be monitored in future inspections and or investigations into deaths in custody.

Patricia Gilheaney
Inspector of Prisons (Chief Inspector)
1 March 2021

SUMMARY

Mr D was a 72 year old man originally from abroad who, prior to his incarceration, resided in the South East of Ireland. He was estranged from his family. The Irish Prison Service endeavoured to identify and make contact with a NoK to no avail. Therefore, we were unable to meet with a NoK in relation to this investigation.

Mr. D was found unresponsive in his cell at 21:05 on 04 February 2018. He was in a single cell on East 1 landing in Wheatfield Prison when he was found by officers on night duty who unlocked his cell following failure to get a response.

We were informed that Mr. D had been diagnosed with cancer for which he underwent surgery and subsequently had to attend many follow up hospital appointments which was evidenced by the IPS External Movements Record.

Mr D was on Special Observation 'for medical purposes' but he was not accommodated in a Special Observation Cell. In accordance with IPS Standard Operating Procedures in place at the time, a Special Observation Prisoner should have been checked every 15 minutes by operational staff and every 2 hours by nursing staff. The CCTV footage viewed showed that Mr. D's cell was master locked at 19:20:55 and the next check of his cell was 21:00:55. There was a period of one hour and 40 minutes from the time Mr. D's cell was master locked to the next check.

General prison records examined, including operational reports of prison personnel on duty during the 24 hours prior to Mr. D's death, indicated that Mr. D was medically unwell. The prison healthcare/medical records would have been of significant importance to this investigation.

RECOMMENDATIONS

Recommendation 1
The lighting on landings should be maintained at a level that makes the viewing of the activity on landings on CCTV footage possible and renders the CCTV system effective for this purpose. [Page 11]

Recommendation 2
IPS Management must ensure that Supervisory staff oversee all required duties, such as checking prisoners, to ensure that such duties are properly undertaken in line with IPS Policy and Standard Operating Procedures and detailed records are recorded in relevant journals. [page 11]

Recommendation 3
IPS Management must ensure that staff are aware of and as far as reasonably practicable comply with any request for information that the Inspector may make in the performance of her functions. Under section 32(7) of the Prison Act 2007. [Page 11]

Recommendation 4
Every effort should be made to ensure that all those involved in an incident participate in the debriefing session(s) thereby ensuring all are afforded an opportunity to process the event and reflect on its impact. [Page 12]

WHEATFIELD PRISON

Wheatfield Prison is a closed, medium security prison for adult males. It had an occupational capacity of 550 beds. There were 437 in the custody of Wheatfield prison on the 04 February 2019.

From 01 January 2018 to 04 February 2018 inclusive there were four deaths for investigation by the OIP. Mr D's was the first death of a Wheatfield prisoner in 2018.

CHAPTER 1: BACKGROUND

Mr D was a 72 year old man originally from abroad who, prior to his incarceration, resided in the South East of Ireland.

Mr D was committed to prison on 03 September 2004 and sentenced to life imprisonment on the 07 November 2006.

Mr D was accommodated on his own in a single cell – cell 5 on East 1 landing in Wheatfield Prison.

Mr D was estranged from his family. He had provided details of a NoK to the IPS but the Governor failed to make contact with the NoK, consequently the OIP did not obtain contact details for a NoK.

Phone and visitor records for the two year period prior to Mr D's death were reviewed. Mr D had no visits during 2016 and he received one pastoral visit in August 2017. According to the IPS phone records Mr D made no phone calls during his last two years in prison.

CHAPTER 2: STATUS OF MR D IN PRISON

Mr D was on the enhanced level of the incentivised regime[1].

At a Multi-disciplinary Prisoner Review meeting held on 07 December 2017, it was recorded that Mr D was refused a transfer to Arbour Hill Prison. The Parole Board recommended that he remain in Wheatfield to attend "Psychology sessions".

CHAPTER 3: EVENTS SURROUNDING THE DEATH OF MR D

On reviewing CCTV footage from E1 landing for the evening of 04 February 2018 it could be seen that all cells were unlocked after tea at about 17:38. Following unlock Mr D left his cell and made his way to the library on the landing. He remained there for about five minutes before returning to his cell. Mr D was visited in his cell by Prisoner 1 who remained there until Nurse Officer A visited Mr D at 18:33. When Nurse Officer A departed Mr D's cell Prisoner 1 re-entered the cell. At 18:54 Prisoner 1 exited Mr D's cell and he closed the cell door as he left. At 19:20 the cells on East 1 landing were

[1] The Incentivised Regime has three levels of privilege – Basic, Standard and Enhanced. Basic level provides the least amount of privileges (number of phone calls permitted, amount daily gratuity paid etc) while the Enhanced level offers the best privileges. All committals are placed on the Standard level of the Incentivised Regime

locked and master locked for the night. When locking Mr D's cell Officer A lifted the viewing flap and looked into the cell.

The Operational Reports submitted by officers on the landing were in line with what was viewed on the CCTV footage from East 1 landing. Officer A's Operational Report stated that as the Class Officer on East 1 landing in Wheatfield *"…on the weekend of the 2nd to 4th February 2018…… was aware of* [Mr D]*'s medical condition, and that* [Mr D] *was tended to regularly by nurses from the surgery"*. Officer A reported that on 04 February 2018 "*at 7:30pm approximately, when I counted my prisoners at lock up. At that time* [Mr D] *was in his bed asleep, cell light off"*. Officer A reported handing over charge "*…to the Night Guard, Officer B."* Officer A also stated that Officer B was informed that Mr D "*…..had been unwell that weekend"*.

Officer B informed the Critical Incident meeting held on 13 February 2018, that on taking up Night Guard Duty, Officer A reported to him that all was "*good except for [Mr D], but advised that [Mr D] seemed to be in better form today".* Officer B reported that "*at approximately 09:05pm while doing my check and activating my recoding clocks, I observed prisoner* [Mr D], *cell 5, lying prostrate on the floor of his cell on his back. I upon knocking on the door and calling out his name was unable to get a response so, I informed the ACO Room and the Nurse Officer on duty. ACO A, ACO B and Nurse Officer B arrived almost immediately and entered the cell of prisoner* [Mr D]. *The prisoner* [Mr D] *was unresponsive to Nurse Officer B's actions. No pulse was available and all signs of life were gone from prisoner* [Mr D]".

ACO B corroborated Officer B's account of events and reported taking "*… up duty on 04/02/2018 at 07:45pm from [Chief Officer A] "* and responding to a radio call at approximately 21:05 from Officer B who "*could not get a response from* [Mr D]". ACO B informed ACO A and both went to Mr D's cell. ACO B further reported unlocking Mr *D's* cell and entering with ACO A and Officer B who were followed into the cell by Nurse Officer B.

ACO B reported that Mr D was "*lying on his back on the ground, with his legs underneath his body*". ACO A reported that they "*moved* [Mr D's] *legs so he lay flat on the floor so we could start CPR*" until Nurse Officer B took over. ACO B reported locking "*…. down the cell" and "posted [Officer C] outside*" following the advice of Nurse Officer B whom it is reported said they "*could do no more*".

Nurse Officer B reported receiving "*… a radio call at approximately 21:05 hours from Officer B that there was an unresponsive prisoner on the ground.*" Nurse Officer B also reported that on entering the cell Mr D was "*lying in a supine position*" and there was *"No signs of life. Slight lividity noted near neck. CPR was not initiated secondary to lividity. No radial/carotid pulse. Eyes fixed and unresponsive. Cold to touch".*

ACO A reported that the Governor-in-charge and An Garda Síochána were notified of the situation at 21:20.

Doctor A arrived to Cell 5, E1 landing and pronounced Mr. D's death at 22:45. Mr D's body was removed from the prison to the city morgue at 00:50 on 05 February 2018.

The investigation team noted that the CCTV footage of the evening of 04 February 2018 from E 1 landing showed that Mr D had been visited by another prisoner on the evening of his death. This prisoner spent time in M. D's cell. The Inspectorate contacted Prison Management and asked to have this prisoner identified. We were informed that he was Prisoner 1.

Prisoner 1 made a statement in which he acknowledged that he visited Mr D in cell 5 on East 1 landing. He stated that

"*On the 04/02/2018 I was a prisoner in Wheatfield Place of Detention, on West 3. At approx. 18:00 I called to* [Mr D] *Cell because I had Yogurts for him. When I opened his cell, his cell was in darkness and he was lying on his bed fully clothed. I did not want to disturb him as I thought he was asleep so as I was leaving the yogurts on the counter he woke up and asked me to put on the kettle.* [Mr D] *turned*

on his light and sat up in bed leaning against the wall. He asked me for his tobacco. As I handed it to him I noticed he was very pale/ashen. We had a conversation and [Mr D] *spoke about how he had refused any more hospital treatment….. The Nurse came in to* [Mr D]*'s cell and l left to give privacy……. After the Nurse had left I spoke with* [Mr D] *again and made more tea. We spoke about our kids and about* [Mr D]*'s expectations about moving to West 3. I left* [Mr D]*'s cell about 18.50 or 18.55. As I left he asked me to close out the door behind me. When I found out he had passed away the next day I was very shocked"*.

Prison Chaplain A reported meeting with and speaking to Mr D on both the 02 and 03 February, 2018. Chaplain A reported that on 02 February Mr D was "*in bed and very unwell, to the extent that he did not really want to talk, though he did say that the medics were aware of his condition."* Prison Chaplain A visited Mr D again on 03 February 2018 and found him "*slightly improved, but he also voiced and showed that he was in some considerable pain and discomfort with his stomach. Upon enquiring if I could do anything to assist him or indeed call one of the medics, he informed me that our prison doctor, [Doctor B]was on his way to see him*". Prison Chaplain A also reported that directly after speaking to Mr. D they informed Officer A of Mr D's condition who, it is reported stated, they were already aware of Mr. D's condition and were "*monitoring the situation"*.

Prison Records

According to prison records examined in the course of our investigation Mr D was on Special Observation "*for medical purposes*" but he was not accommodated in a Special Observation Cell.

In accordance with Irish Prison Service Standard Operating Procedure in effect at the time of M. D's passing, prisoners on 'Special Observation' were required to be checked every 15 minutes by operational staff and every two hours by nursing staff.

As part of our investigation into all deaths in prison custody the office of the Inspector of Prisons examines relevant prison medical records. The Irish Prison Service requires the Inspectorate to obtain NoK consent for the Inspector to view the medical records of a deceased prisoner. In this case, due to complex family circumstances, the consent was not obtained. It is therefore not possible to comment on the medical care afforded to Mr D. It is noted from the examination of the external movements of Mr D that he was taken to 13 medical appointments outside of the prison during the course of 2017.

General prison records examined and operational reports of prison personnel on duty during the 24 hours prior to Mr D's death would indicate that he was physically unwell. Consequently the prison healthcare, including medical records are of significant importance to this investigation. As these records were not reviewed by the Inspector, this Office can make no further comment as regards healthcare interventions. The Prisoner Information Management System (PIMS) records of external movements show that Mr D attended several hospital appointments on a monthly basis during 2017. It should be noted as mentioned earlier that another prisoner stated that Mr. D told him that "*he had refused any more hospital treatment".*

As explained earlier in this report, the Office of the Attorney General suggested to the Inspector of Prisons that the Minister be advised that legislative amendment is required to clarify access to medical records of deceased prisoners and the request was made on 18 November 2019. The Inspectorate has been informed that its access to records will be addressed in the General Scheme of the Inspection of Places of Detention Bill in 2021.

Request for further Information

The CCTV footage viewed showed that at 19:36 some landing lights on the landing were turned off and the visibility was reduced. All landing lights were turned off at 19:38 and consequently much of the landing was in darkness and visibility was very poor.

At 20:21 an officer could be seen walking down the landing and was visible on camera as far as the dividing gates on the landing. The Officer did not check cells visible on the footage. It was too dark past the gates to see the Officer. The Officer walked back up the landing at 20:22 and did not check cells.

At 21:00 an officer can be seen checking cells vaguely visible on footage and appeared to check Mr D's cell, but the only movement that could be seen was the light of the torch. The Officer returned to the door of cell 5 at 21:03 but left again. An officer returned again at 21:04 and the lights on the landing were turned on. An ACO accompanied by an officer ran towards the cell and all three entered the cell. At 21:05 another officer and a Nurse Officer with a trolley arrived at the cell. All officers including the Nurse Officer left the cell four minutes later and the cell door was locked.

An operational report submitted by an Officer, was lacking detail which was required to complete this investigation report. The Inspectorate submitted a written request for the attention of the Officer concerned seeking factual information.

In reply to the foregoing request for factual information the Inspectorate received a letter from the Officer advising that following counselling to help them cope with the immense trauma they suffered that night that the "*incident no longer forms part of my memory data*" and the report they wrote and submitted at the time should be relied upon. The Officer also stated that they did not know if they "*could cope with the pressure from your department [referring to the office of the Inspector of Prisons] forcing me to recall this absolute horrible experience as its (sic) like living a nightmare over again*." The Officer offered his sympathies to the family of Mr. D.

Recommendation 1
The lighting on landings should be maintained at a level that makes the viewing of the activity on landings on CCTV footage possible and renders the CCTV system effective for this purpose.

Recommendation 2
IPS Management must ensure that Supervisory staff oversee all required duties, such as checking prisoners, to ensure that such duties are properly undertaken in line with IPS Policy and Standard Operating Procedures and detailed records are recorded in relevant journals.

Recommendation 3
IPS Management must ensure that staff are aware of and as far as reasonably practicable comply with any request for information that the Inspector may make in the performance of her functions. Under section 32(7) of the Prison Act 2007.

CHAPTER 4: POST EVENT

A debriefing meeting should take place as soon as possible after the incident and involve all who were present. This is usually referred to as a hot debrief. 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.

A Critical Incident Review Meeting took place on 13 February 2018, 9 days after Mr D passed. It was attended by only three of the staff who were directly involved in the incident. The meeting was chaired by Governor A.

The meeting discussed the events as they happened on 04 February 2018 according to the staff involved.

There is no evidence that a hot debrief was held. In previous investigation reports we recommended there should be a hot and cold debrief, for example Mr I 2018 and Mr O 2018. However, we are pleased to note that since the death of Mr. D and prior to the completion of this investigation the Irish Prison Service has reviewed its Critical Incident Policy. The Irish Prison Service Standard Operating Procedure (SOP) titled 'Critical Incident Reporting and Debriefing Procedures' came into effect on 1 July 2020. The new SOP provides for the holding of both a hot and cold debrief following a critical incident such as a death in custody**.**

Recommendation 4
Every effort should be made to ensure that all those involved in the incident participate in the debriefing sessions to ensure they are afforded an opportunity to process the event and reflect on its impact.