OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr J /2019

AGED 78 years

In Connolly Hospital while in the custody of Arbour Hill Prison

On 10 July 2019

Date draft report submitted to the Irish Prison Service: 24 February 2021

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GLOSSARY

ACO	Assistant Chief Officer
Act	Prisons Act 2007
AGS	An Garda Síochána
CCTV	Closed Circuit Television
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
Office	Office of the Inspector of Prisons
OIP	Office of the Inspector of Prisons

PREFACE

The Office of the 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 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. 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 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. In this case the NOK who resides outside the jurisdiction was made aware of the OIP contact details but did not make contact and therefore consent to review healthcare/medical records was not received.

Administration of the Investigation

The OIP was notified of Mr J's passing by email on the morning of 10 July 2019. Mr J was in hospital several weeks prior to his death so it was not deemed necessary for an OIP representative to visit Arbour Hill Prison and view the cell. Prison management provided a briefing and information required for the investigation was agreed.

All information requested was provided promptly 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. In this instance we did not meet with or speak to the NoK. The NoK, who resided outside of the jurisdiction, were provided with contact details of the Inspectorate by prison management however, the NoK did not contact the Office.

PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)
23 March 2021

SUMMARY

Mr J was aged 78 when his death was pronounced in Connolly Hospital Blanchardstown on 10 July 2019.

Mr J was serving a life sentence in Arbour Hill Prison. On 15 June 2019 Mr J was taken by ambulance from Arbour Hill Prison to the A & E department of the Mater Misericordiae Hospital. On 28 June 2019 Mr J was discharged from hospital back to Arbour Hill Prison. On 29 June 2019 the Nurse Officer on duty in Arbour Hill Prison referred Mr J back to the Mater Misericordiae hospital by ambulance. As there were delays in gaining access to the Mater Misericordiae Hospital the Ambulance crew conveyed Mr J to Connolly Hospital Blanchardstown. It is noted that Mr J was referred back to hospital within 24 hours of his discharge from the hospital. The OIP was unable to look further into this matter as in the absence of NoK consent for the IoP to access medical records of a deceased, the IPS does not release such records.

Mr J was estranged from his family and did not have any contact with them either by phone or visits prior to his transfer to hospital on 29 June 2019. On 3 July 2019 prison healthcare staff were informed by hospital personnel that Mr J was in a critical condition and his NoK was informed by prison management. On the 4 July 2019 Mr J's NoK visited him at Connolly Hospital and informed the Assistant Governor that they did not wish to be contacted again until he had passed.

On 9 July 2019 at 22:25 Assistant Chief Officer A received a phone call from a Staff Nurse in Connolly Hospital advising of the imminent death of Mr J. Assistant Chief Officer B, who was on the hospital escort, was also informed and contacted Assistant Chief Officer A in Arbour Hill Prison.

At 23:57 on 9 July 2019 Assistant Governor A was informed of the passing of Mr J and he made contact with the NoK.

The cause of death is a matter for the Coroner.

RECOMMENDATIONS

There are no recommendations emanating from the investigation of the death in custody of Mr J.

ARBOUR HILL PRISON

Arbour Hill Prison is a closed, medium security prison for adult men. It has an operational capacity of 142. The prisoner profile is largely made up of long term sentenced prisoners.

Mr J's was the only death of an Arbour Hill prisoner in 2019; and the tenth death in IPS custody that year which met the criteria for investigation by the OIP.

CHAPTER 1: BACKGROUND & TIME IN PRISON

Mr J was serving a life sentence and had been committed to prison in 1997.

The prisoner's external movement records showed that between July 2018 and June 2019 he had monthly visits to external hospital appointments.

Mr J was on the enhanced level of the incentivised regime[1]. He was a well behaved prisoner who had a good disciplinary record.

Mr J did not have any contact with family either by phone or visits during his time in Arbour Hill prison. He received a monthly pastoral visit from Sister A.

CHAPTER 2: EVENTS SURROUNDING MR J'S HOSPITALISATION

Mr J had been hospitalised for 14 days when discharged to Arbour Hill prison on 28 June 2019 however, he was referred back to hospital on 29 June 2019 by the Nurse Officer on duty in Arbour Hill Prison. He remained in the care of Connolly Hospital Blanchardstown until his death was pronounced on 10 July 2019.

On 3 July 2019 Connolly Hospital informed the prison healthcare staff that Mr J was in a critical condition and his NoK were informed. On the 4 July Mr J's NoK visited him at Connolly Hospital.

On 9 July 2019 a Staff Nurse at Connolly Hospital contacted the Prison at 22:25 and informed ACO A that Mr J was very poorly and the NoK should be informed. At 22:31 ACO A received a call from ACO B, the Night Guard escort, who also informed ACO A of the situation.

At 22:55 ACO A phoned Assistant Governor A who was in the hospital at the time. Assistant Governor A attended the ward and gave his contact details to the medical personnel and also to the escorting officer, ACO B, and informed them that in the event of Mr J's passing he should be informed and would then contact the NoK. The NoK had informed the Assistant Governor that they did not wish to be contacted prior to his passing.

At 23:57 on 9 July 2029 Assistant Governor A was informed of the passing of Mr J by ACO B. At 23:59 he contacted Blanchardstown Garda Station to inform them of the passing and asked them to attend the hospital. Assistant Governor A then made contact with the NoK and informed them of Mr J's passing.

A doctor on duty in Connolly Hospital pronounced death at 00:24 on 10 July 2019.

At 04:15 on 10 July 2019 a member of An Garda Síochána (AGS) arrived at the hospital and ACO B identified the body of Mr J to AGS. ACO B and Officer A on receiving documentation confirming the death of Mr J left the hospital.

[1] The Incentivised Regimes Programme provides for a differentiation of privileges between prisoners according to their level of engagement with services and behaviour. The objective is to provide tangible incentives to prisoners to participate in structured activities and to reinforce good behaviour, leading to a safer and more secure environment. There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level.

CHAPTER 3: POST EVENT

A critical incident meeting was held at 11:00 on the 29 July 2019. The purpose of the critical incident meeting was to establish the facts and provide an opportunity to share views in relation to how the situation was managed and identify any additional support or learning.

Assistant Governor A briefed the group on the background of Mr J's passing.

Chief Nurse Officer A raised health and safety concerns of using oxygen on a prison landing and asked for this to be examined. We have been advised by Assistant Governor A that a review occurred and in the future warning signs will be placed on the landing and in the cell where oxygen is in use.

Sister B reported that she had been in touch with Mr J's NoK and they were grateful to Assistant Governor A for the manner in which he handled the situation.

Assistant Governor A concluded the meeting by recording that the cause of death is to be decided by the Coroner.