OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr K 2019

AGED 46 years

In Midlands Prison on 27 July 2019.

Date draft report submitted to the Irish Prison Service: 23 February 2021

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

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GLOSSARY

Act	Prisons Act 2007
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
HCA	Health Care Assistant
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
NRC	National Rehabilitation Centre
OIP	Office of Inspector of Prisons
PIMS	Prisoner 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 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 K's brother 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 K passed.

Administration of the Investigation

The OIP was notified of Mr K's passing on the afternoon of 27 July 2019. An OIP representative visited Midlands Prison the next day. Prison management provided a briefing and confirmed that CCTV footage for relevant areas of the prison had been saved and requirements for the investigation were agreed. Statements were obtained from relevant staff who were on duty.

All information that was requested was provided by the IPS.

Family Liaison

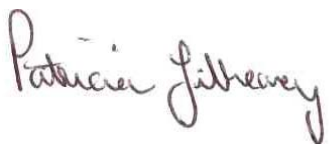
Liaison with the deceased's family is a very important aspect of the Inspector of Prisons role when investigating a death in custody.

On 26 August 2019 the Inspectorate wrote to Mr K's NoK to explain our role and sought consent to access clinical records. On 30 August 2019 a phone call was received from the NoK and all aspects of the investigation were explained. The NoK was complimentary of the Midlands prison staff and especially the assistance they received from Chaplin A. The NoK had no concerns on how Mr K was treated while in Midlands prison and acknowledged that staff had been very kind and had done everything to make Mr K comfortable despite his physical difficulties.

The NoK chose not to accept an invitation to meet with the Inspectorate but said they would be pleased to receive the investigation report in due course and gave consent in writing for the IoP to access Mr K's clinical records.

Although this report is for the Minister for Justice it will also inform several interested parties. It is written primarily with Mr K's family in mind. My colleagues and I offer our sincere condolences to them for their sad loss.

There is one recommendation for improvement. A copy of the final draft of the report, including the recommendation was provided to the Irish Prison Service on 23 February 2021 for review, comments and an action plan. A response was received on 10 March 2021. The IPS accepted the recommendation. An action plan was provided for the recommendation 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)
19 MARCH 2021

SUMMARY

Mr K was a 46 year old man who was committed to prison on the 30 April 2019 and was serving a two year sentence.

Mr K was accommodated in a cell which had been adapted to accommodate a wheelchair, with a hospital type bed. When he was in bed the cell door was left open as Mr K was not able to reach the call bell button.

Mr K had been discharged from the National Rehabilitation Centre (NRC) on the morning of his committal. He required assistance transferring in and out of bed but when in his wheelchair he was able to move around independently. Health Care Assistants (HCA) were employed by the IPS to assist staff in supporting Mr K with his personal care needs.

The records showed that Mr K did not have any special dietary requirements. A report to the IPS from the NRC noted that Mr K was on a normal diet and had been seen by a dietitian. This report also included a 24 hour nursing care plan which noted that Mr K "*can feed himself, may need assistance with setting the meal up.'*

Mr K was found unresponsive in his cell at 14:15 on 27 July 2019. The alarm was raised and the medical team were on hand immediately and commenced CPR. Prison Doctor A arrived at the scene shortly after the alarm was raised and assisted with the resuscitation attempt. A HSE Cardiac Paramedic team also attended and continued to attempt to resuscitate Mr K but were unsuccessful. Doctor A pronounced the death of Mr K at 14:44.

The cause of death is a matter for the Coroner.

RECOMMENDATION

A portable alert device should be available to prisoners who are incapacitated and incapable of reaching the in-cell call bell alert system. [Page 9]

MIDLANDS PRISON

Midlands Prison is a closed, medium security prison for adult males. It is the committal prison for Counties Carlow, Kildare, Kilkenny, Laois, Offaly and Westmeath. It has an occupational capacity of 845 beds. On 27 July 2019 it accommodated 891 prisoners.

Mr K was the third death of a Midlands prisoner in 2019 and the 11th death in IPS custody that year which met the criteria for investigation by the OIP.

CHAPTER 1: BACKGROUND

Mr K was committed to prison on the 30 April 2019 and was serving a two year sentence. His release date with remission would have been 28 October 2020.

Mr K had been discharged from the National Rehabilitation Centre (NRC) just prior to committal. Chief Nurse Officer (CNO) A met with Mr K in the NRC and reported that the NRC gave intensive training in relation to the high level of care required by Mr K. Health Care Assistants (HCA) were employed by the IPS to assist staff in meeting his personal needs.

CHAPTER 2: TIME IN CUSTODY

Mr K was on the standard level of the incentivized regime.[1] IPS records show that Mr K had a good disciplinary record.

He was accommodated in cell 1 on G1 landing which had been specially adapted and could accommodate a wheelchair and a hospital type bed. When Mr K was in bed the cell door was left open as Mr K was not able to reach the in-cell call bell button.

Recommendation 1
A portable alert device should be available to prisoners who are incapacitated and incapable of reaching the in-cell call bell alert system.

Mr K required assistance from HCA's to get in and out of bed and required intermittent assistance to complete personal care needs. When Mr K was in his wheelchair he was able to move around the landing independently.

Mr K made 30 phone calls in the four month period before his death, 19 personal calls and 11 calls to his solicitor. He had one visit from his solicitor, within this timeframe.

CHAPTER 3: EVENTS AFTER MR K WAS FOUND UNRESPONSIVE

On reviewing CCTV footage from GI landing for the 27 July 2019, Mr K could be seen going to the servery in his wheelchair at 12:14. He collected his dinner and then returned to his cell followed by Nurse Officer A who reported giving him pain relief and discussing his medical needs. Officer A closed and locked his cell door at 12:18. CCTV footage showed Officer B on the landing checking cells at 12:38, the Officer lifted the flap on cell 1 and gave a cursory look into Mr K's cell.

At 14:15 CCTV footage showed Officer A approach cell 1, lifting the flap and looking into the cell. Officer A reported that initially he couldn't see Mr K but then noticed him lying on the floor and called to Officer C for assistance. Officer A unlocked the cell door and they both entered the cell. When they failed to get a response from Mr K Officer C called over the radio for nursing assistance.

[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.

The Care Assistants arrived and entered the cell followed by the Nursing staff. Officer A reported that Supervising Officer A, Chief Officer A and Assistant Governor A took over charge.

Officer C corroborated Officer A's account of events and reported being informed by Officer A that Mr K had spinal injuries and should not be moved. Officer C reported being asked to escort the Ambulance Paramedics and the Fire Brigade personnel to the GI landing when they arrived.

HCA A reported returning to the landing after lunch at approximately 14:10 when they heard an Officer call for assistance at G1 Cell 1. HCA A entered the cell and reported seeing Mr K face down on the cell floor. HCA A stated that Mr K was unresponsive so they checked for a pulse and reported that there "*was no palpable redial (sic) pulse".* HCA A reported that Nurse Officer B then arrived and they both repositioned Mr K with Nurse Officer B commencing CPR while HCA A supported Mr K's head and also rotated administration of compressions with Nurse Officer B until Nurse Officer C arrived and took over. The CPR continued until the paramedics arrived. HCA B and HCA C corroborated HCA A's account of events. HCA B added that Mr K's skin was mottled, a red/white colour and vomitus was observed coming from Mr K's mouth, and this was corroborated in Nurse Officer B's report. HCA B reported assisting the nurse and other carers in moving Mr K from under the table so they could commence CPR.

In the medical record Nurse Officer B recorded receiving a call for a nurse to attend G1 at 14:12 approximately. Nurse Officer B noted on arrival at Cell 1 Mr K was lying on the ground in the recovery position with two HCA's in attendance and an ambulance was called. Nurse Officer B reported that Mr K was unresponsive, there was no pulse present, he was not breathing and his colour was mottled and pupils dilated. The Nurse Officer stated that chest compressions commenced immediately and defibrillator pads were attached, the defibrillator indicated to continue CPR but there was no shock required. Nurse Officer B reported that Dr A arrived at approximately 14:22 and CPR continued until the ambulance personnel arrived at approximately 14:30 and took over care. Dr A pronounced the death of Mr K at 14:44. Nurse Officer B noted that Nurse Officer C and Nurse Officer D were also in attendance.

Nurse Officer C corroborated Nurse Officer B's account of events and added that the ambulance crew needed more space to work on Mr K so Nurse Officer C and a paramedic moved Mr K onto the landing so they could provide medical intervention.

Doctor A reported that while in the area between the E and G landing one of the Nurses called for assistance on G1 landing. Doctor A stated that on arrival at cell 1 Mr K was on the floor and the Nursing Staff were in the course of performing CPR. Doctor A reported assisting with CPR until the ambulance paramedics arrived and took charge of CPR. The Doctor reported that as there was no signs of life or recovery Mr K's death was pronounced at 14:44.

Chaplain A stated that at approximately 14:30 they were called to G1 landing and on arrival saw Mr K being attended to by the medical team. The Chaplain reported that when Mr K's death was pronounced, prayers were said with his remains in the cell. Chaplain A then tried to contact the NoK on the landline contact number listed on the Prisoner Information Management System (PIMS) but did not get a reply. A mobile number was sourced from Mr K's phone call history which enabled the Chaplain to notify the NoK but it took some time to obtain that number as access to the prisoner phone card details was restricted to certain personnel.

Chief Officer A reported that when the death of Mr K was pronounced, the death in custody protocols were immediately implemented. The cell was secured and an officer was posted outside the door with instructions to complete an incident log of all movements into the cell.

CHAPTER 4: POST EVENT

Assistant Governor A reported receiving a phone call from Chief Officer A to inform him of the death of Mr K. Assistant Governor A notified Governor A and the OIP by phone and subsequently asked Chaplain A to contact Mr K's NoK. Assistant Governor A and Chaplain A met with Mr K's NoK later that day to offer support and explain the protocols in relation to the release of Mr K's body.

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 30 July 2019. It was attended by four of the Staff who were involved in the incident. There were other staff who were present at the incident who were not present at the debriefing. The meeting was chaired by Governor A.

Those in attendance reported the events that occurred when Mr K was found unresponsive in his cell.

When the NoK were met they were taken to G1 landing, it was reported that they were "*pleased and relieved*" to see where Mr K was accommodated.

The difficulties encountered in contacting the NoK was also discussed. Assistant Governor A reported that the person on duty did not have access to the phone card system and after some time the information was retrieved.

There was one recommendation made that:

- All Chief Officers should have access to the prisoner's phone cards system.

Assistant Governor A confirmed that all Assistant Chief Officers, who cover both day and night shifts, have been given access to the Prisoner Phone Card System.

Governor A commended the staff for the good support that was provided to Mr K while in custody and noted that he was treated with dignity and respect.

There is no evidence that a cold debrief took place.

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 which includes a death in custody**.**