OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr L /2018

AGED 31

In the custody of Cork Prison on 19 July 2018.

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GLOSSARY

Act	Prisons Act 2007
CCTV	Closed Circuit Television
Class Officer	Officer in Charge on a landing
IOP	Inspector of Prisons
IPS	Irish Prison Service
OIP	Office of Inspector of Prisons
PHMS	Prisoner Health Management System
SAWS	Short Alcohol Withdrawal Scale (a tool to assess the severity of alcohol withdrawal)
SOP	Standard Operating Procedure

Please note throughout this report when referring to time the 24 hour clock is used.

PREFACE

The Office of Inspector of Prisons (OIP) was established 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; 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. This inevitably leads in some instances to a failure to review healthcare/medical records where next-of-kin is unknown, cannot be located, or

refuses to provide consent. Mr L's next-of-kin live outside of Ireland and there were considerable delays in obtaining consent for the Inspector to access his healthcare/medical records for the purposes of this investigation. We extend our appreciation to the Probation Service for their invaluable assistance in this regard and without whom access to pertinent healthcare records would have been denied.

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

At the time of Mr L's death the OIP practice in relation to Death in Custody investigations was to review the IPS internal reports and statements, obtain and review CCTV footage and a range of documentation. The investigation into Mr L's death largely followed existing practice and this report is informed accordingly. In September 2019, following review of Mr L's healthcare records, interviews were also conducted.

Administration of the Investigation

The OIP was notified of Mr L's passing on 19th July 2018. Mr L's cell was not master locked and secured for viewing by the OIP. This resulted from miscommunication within the prison. OIP representatives agreed information requirements for the investigation with management in Cork Prison. Prison management confirmed that CCTV footage for relevant areas of the prison had been saved.

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 committal to prison Mr L provided the name of a friend of no fixed abode as his next-of-kin. However, no contact details were recorded. The IPS informed the Inspector that Mr L's family resided in Poland. The OIP contacted the Embassy of Poland to inform the Diplomatic Mission of our investigation and to request that the contact details of the OIP be provided to Mr L's family with a request for them to make contact if they wished to raise any matter with the OIP. Embassy officials advised that Mr L's brother had some questions and doubts and he would like to obtain some answers. The OIP provided contact details to enable the family make direct contact. However, Mr L's family did not contact the OIP. The Probation Service were in contact with Mr L's family and on June 2019 they assisted the OIP in obtaining next-of-kin consent to review Mr L's prison healthcare records. The relevant records were obtained in July 2019.

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

I am grateful to the Embassy of Poland, Probation Service and Irish Prison Service for their contributions to this investigation.

Recommendations

There are eight recommendations for improvement. A copy of the final draft of the report, including the recommendations was provided to the IPS for review, comments and an action plan.

The IPS accepted/part accepted seven of the eight recommendations. An action plan was provided for the recommendations that were accepted and areas of responsibility and timelines were included in the action plan. Implementation of the action plan will be monitored in future inspections and or investigations into deaths in custody.

PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)

DATE 15 March 2021

SUMMARY

Mr L, a citizen of Poland, was aged 31years. He was committed on remand to Cork Prison on 18th July 2018 to appear at Court on 30th July 2018. Prior to his committal to Cork Prison Mr L was homeless. On the day of his committal the Probation Service informed nursing staff in the prison that Mr H would require immediate medical treatment and observation as he had a history of alcohol addiction, was dehydrated, was prone to seizures and had a heart attack two years previously.

Mr L was reviewed on Committal by nursing staff and was commenced on special observations. Mr L was not placed in a special observation cell and therefore the provisions of Rule 64 of the Prison Rules 2007-2017 did not apply. Rule 64(5) provides that a prisoner *"…shall be observed by a prison officer at least once every 15 minutes while he or she is being accommodated in a special observation cell."* The IPS practice relating to special observation of prisoners who were not accommodated in special observation cells at the time of Mr L's passing was that checks by a prison officer should have been carried out every 15 minutes. Mr L was checked 58 times from 16:12:41 on 18th July 2018 to 08:10 on 19th July 2018. The frequency of checks ranged from less than a minute to 57 minutes with an average of 17 minutes.

There was no request from healthcare staff for Mr L to be accommodated in a Special Observation Cell. During the course of this investigation Assistant Governor A confirmed that there was a Special Observation Cell vacant on B1 landing throughout the night.

The OIP was informed that due to overcrowding Mr L was placed on a mattress on the floor in a single occupancy cell that was already occupied by another prisoner. However, in response to a query from the OIP, Assistant Governor A confirmed on 13th September 2019 that the adjoining cell was unoccupied at the time Mr L was found to be unresponsive.

On 18th July 2018 at 17:35 medication for alcohol withdrawal was commenced and the dose administered was in accordance with IPS policy and IPS protocol for the emergency use of chlordiazepoxide. Although the aforementioned protocol provides for the administration of a limited number of further doses at eight hourly intervals where clinically indicated, no further doses of medication were administered during the night.

When carrying out checks of cells during the night, a prison officer requested the assistance of the nurse on duty on three occasions as Mr L appeared to be having a seizure. The nurse attended Mr L on each occasion and reported that while he was confused at first he appeared to recover and was aware of his name and surroundings. The nurse's clinical opinion was that further administration of chlordiazepoxide as per protocol was not indicated.

Mr L had spent just under seventeen hours in custody when he was found unresponsive in his cell at 08:10 on 19th July 2018. CPR was commenced by nursing staff and subsequently continued by ambulance paramedic personnel on their arrival to the cell at 08:30. At 08:50 Mr L was removed by ambulance to the Emergency Department in Mercy Hospital. His death was pronounced in the Mercy Hospital at 09:25 on 19th July 2018.

Several learning points arise from this investigation. Eight recommendations for improvement are made. The recommendations are provided in the next section. Where a recommendation was not accepted (Recommendation two) or part accepted (Recommendations four) by the IPS the reasons are provided in italics.

RECOMMENDATIONS

1. A person committed to prison should be accommodated in a bed unless otherwise contraindicated in exceptional circumstances. If a bed is available and it is decided not to avail of it, the decision and the associated reason(s) for the decision should be clearly documented. (Page 16)

2. Consideration should be given to using a Special Observation Cell in circumstances where the IPS Protocol for the Emergency Use of Chlordiazepoxide is initiated.(Page 17)

   Not accepted by the IPS for the following reason: There is no clinical rationale for the placement of a person in an SOC if when they are in withdrawals or have been administered Chlordiazepoxide under protocol. Indeed the use of the SOC in such circumstances would be clinically inappropriate and contravene the SOC Policy and all clinical best practice. The criteria for SOC placement are clear, and are solely for the risk to self and/or others, and does not, nor should not, include commencement on protocol meds or undergoing alcohol withdrawals.

3. Significant information relating to handover of nursing care, should be documented in writing in the relevant sections of PHMS and also communicated verbally ensuring appropriate exchange of relevant information at the handover of nursing shifts. (Page 17)

4. Entry to records should be made contemporaneously. If for a particular reason this is not possible, the reason should be explicitly stated and the entry countersigned by the person's line manager. (Page 17)

   *It is expected that all clinicians will enter contemporaneous notes. If a note cannot be entered in a timely manner, then it should be entered as soon as possible, with a clearly stated reason for the delayed entry. It is inappropriate that a manager would be expected to countersign an entry for a professionally qualified and accountable person. Individual professional accountability is one of the m*ainstays of a professionally qualified clinician irrespective of discipline.

5. Chapter 18 and Appendix XIX of The IPS Clinical Drug Treatment & Policies Manual V 01 07 2012 requires updating to clearly address the issues identified at sections 6.6 and 6.7 of this report. The policies and procedures should take into consideration lone working nursing staff at night and provide appropriate guidance in such circumstances, including when transfer to hospital for emergency care is indicated. (Page 18)

6. The IPS Protocol for the Emergency Use of Chlordiazepoxide provides that "*the patient*

must be seen by a doctor within 24 hrs". This provision also requires review to incorporate earlier assessment/review by a registered medical practitioner. (Page 18)

7. The Irish Prison Service Epilepsy Management Protocol is silent in relation to situations where two or more seizures of less than 5 minutes duration occur within a specified period of time. It is recommended that the policy is reviewed to address this issue. (Page 18)

8. Handwritten notes of prisoner's vital signs should be contemporaneously entered into the record in the area of the PHMS designated for this purpose. (Page 18)

CORK PRISON

Cork Prison is a closed, medium security prison for adult men and is the main committal prison for Cork, Kerry and Waterford. On 18th July 2018 Cork Prison accommodated 297 prisoners.

Cork Prison has a Visiting Committee whose role is to frequently visit the prison; meet with prisoners and hear their complaints; report to the Minister on matters of concern. Their 2017 Annual Report was published on 24th May 2018.

Mr L's was the third death of a prisoner in the custody of Cork Prison from the 1st January 2018 to 19th July 2018, one of whom was on Temporary Release and died in the community. His death was the 12th death in IPS custody that year.

The cause of Mr L's death is a matter for the Coroner.

1.0 BACKGROUND

1.1 Mr L was 31 years old when he was remanded in custody to Cork Prison on 18th July 2018. This was his first time in prison. He had been charged with an offence and was due to appear in Court on 30th July 2018.

1.2 Mr L was a citizen of Poland and was homeless prior to his committal to prison. Information from the Probation Service outlined that he had been living on the streets for the previous seven months and attended Simon Day Centre. He had a history of excess alcohol consumption, including on the day of his committal. On committal he provided the name of a friend with no fixed abode as his next-of-kin. No contact details for this person were recorded.

2.0 TIME IN CUSTODY (to when Mr L was found unresponsive in his cell)

Cork Prison 18th -19th July 2018

2.1 On committal to prison on 18th July 2018 at 15:12, Mr L was placed in a holding cell at the main gate. At 15:20 he was taken to reception. Mr L was interviewed and assessed by Nurses A and B in the Reception area. Nurse B translated a number of medical terms that Mr L could not fully understand. It is recorded that Mr L consumed a bottle of vodka on the day of his committal. Mr L's vital signs were recorded. Following the Nursing Committal Interview Mr L was moved to the Committal Unit on B1 landing where he was placed in cell 4, a single cell that was already occupied, and provided with a mattress on the floor.

2.2 On 18th July 2018 at approximately 15:55, Senior Probation Officer A contacted the prison and spoke with Nurse C and verbally advised her of medical concerns regarding Mr L. At the request of Nurse C, the call was followed up with an email which was received at 16:25 on the same date.

2.3 The email received stated that Mr L *"…will require immediate medical treatment and observation. He is physically addicted to alcohol and frequently has seizure"* (sic). Senior Probation Officer A also advised that Mr L *"…had a heart attack two years ago"*. In addition she advised that Mr L *"…is very dehydrated and as mentioned he is very prone to seizures. He is very frightened at the thought of going through alcohol withdrawal."* A mobile phone number for contacting if required was provided.

2.4 Nurse C, in her report to the Governor dated 7 August 2018 advised that in relation to the email received she "*... handed it over to the nurse who had seen this man on committal. I did not make an entry into his nursing file regarding this as it was being addressed by the committal nurse."*

2.5 Nurse A carried out Mr L's nursing assessment on committal to Cork Prison and it included the completion of an Alcohol Use History. The frequency of Mr L's alcohol consumption was outlined as 1 to 2 bottles of vodka daily. It is recorded that Mr L stated his last drink was one bottle of vodka and it was consumed "*today.*" It is recorded that

Mr L had an overall score of 13 on the Short Alcohol Withdrawal Scale (SAWS). SAWS is a tool to assess the severity of alcohol withdrawal.

2.6 Nurse A made an entry at 17:00 on 18th July 2018 in Mr L's PHMS nursing records regarding the email referred to at section 2.3. The substantive content of the email was entered into the records. Nurse A also made a referral at 16:25 for review by the GP the following morning. Nurse A stated they were *"…awaiting unlock to administer Librium as per protocol."*

2.7 The IPS Clinical Drug Treatment & Policies Manual (July 2012) at Chapter 18 addresses the assessment and treatment of alcohol withdrawals. Appendix XIX provides the IPS Protocol for the Emergency Use of Chlordiazepoxide. According to the policy SAWS score "*above 12 require pharmacotherapy*" (IPS Clinical Drug Treatment Policies Manual V 01 07 2012. Appendix XIX, p.188 of 195).

2.8 Cell 4 on B1 landing is a single occupancy cell. Mr L shared this cell with another male prisoner – Mr A. Mr L's sleeping arrangements consisted of a mattress placed on the floor of the cell. Mr A reported that Mr L had broken English and they watched television. It is also recorded that he (Mr A) did not press the call bell. As Mr L was on a mattress on the floor he was not within reach of the call bell in the cell. On each occasion staff entered the cell during the night it was because they observed Mr L having a seizure. The OIP was informed that Mr L was sharing the cell due to overcrowding. In response to a query from the OIP regarding the person(s) occupying Cell 5 (adjoining cell) on the night of 18th July 2018, Assistant Governor A informed the OIP on 13th September 2019 that the adjoining cell was unoccupied at the time.

2.9 Mr L was placed on 'special observations' by Nurse A at the Committal interview. Mr L was not accommodated in a designated 'Special Observation Cell', nor was a special observation cell recommended / requested. In July 2018 the IPS practice for the frequency of prison officer checks on prisoners placed on special observations who were not accommodated in a special observation cell, was every 15 minutes.

2.10 On 18th July 2018 at 16:12:41 the cell door was closed and locked. An entry in the nursing notes by Nurse A noted an email from the general office of the prison stating that Mr L was under the care of a named doctor in the community and that he was *"…prone to frequent seizures and is dehydrated at present. Awaiting unlock to administer Librium as per protocol."*

2.11 At 17:41 Nurse A visited cell 4 and made the following entry on PHMS *"I reviewed* [Mr L] *in his cell on the B1 landing at 17:45 and issued him with detox medication"*. His vital signs were recorded at 17:45.

2.12 The IPS Protocol for the Emergency Use of Chlordiazepoxide was followed by Nurse A. Mr L fulfilled the criteria for administration of Chlordiazepoxide and 20mgs was administered at 17:45. The protocol makes provision for Chlordiazepoxide 10mg-20mg to be administered every eight hours with a maximum daily dose of 60mgs. The protocol further provides that "*No more than three doses of maximum 20mg per dose may be given, before referral to a doctor.*" The protocol further states "*If the healthcare staff member is satisfied that in his/her opinion administration is appropriate, s/he may administer*

Chlordiazepoxide as per this protocol." Mr L did not receive any further dose of Chlordiazepoxide. The nurse on night duty informed the IOP that in his clinical opinion further administration of Chlordiazepoxide in accordance with IPS Protocol was not indicated.

2.13 The OIP was informed that nursing handover at the end of shift includes a verbal handover and also entries may be made in two section of the PHMS – Nurse Handover Clinic and Nurse Led Clinic if there is specific information that needs to be passed on. There were no entries relating to Mr L in either of the above sections of the system for the evening of 18th July 2019, i.e. from handover of day nursing staff to night nurse. The nurse notes section of the system was completed by Nurse Officer A. Withdrawal from severe alcohol dependence in persons with comorbidities of a history of seizures and cardiac issues coupled with dehydration in a vulnerable person who was homeless prior to committal to prison requires early review by a registered medical practitioner so that decisions as to the appropriate setting for detoxification from alcohol can be made. As there was no registered medical practitioner available at night in Cork Prison referral was made for review by a registered medical practitioner the following morning. Mr L was not sent to an Emergency Department in a General Hospital for medical review.

2.14 On three occasions during the night Nurse on Duty – Nurse D was called to the B1 landing to check on Mr L as he appeared to be having a seizure. Nurse D informed the IOP that he followed the IPS SOP Epilepsy Management Protocol. The aforementioned protocol provides a procedure for first response to a seizure. In accordance with the procedure *"…if the seizure continues for longer than five minutes, call an ambulance."* Nurse D informed the IOP that the duration threshold for calling an ambulance was not reached on any of the three occasions during the night that he was called to review Mr L.

2.15 Nurse D provided an operational report to the IPS, a copy of which was made available to the OIP which outlines contacts with Mr L during the night and early morning when called by the Night Guard on three occasions to check on Mr L as he was having what appeared to be a seizure. On each occasion the nurse officer spoke to Mr L and reported that while he was confused at first he appeared to recover and was aware of his name and surroundings and his observations were within normal range. No medication was administered on each occasion as Nurse D did not deem it to be clinically indicated.

2.16 Nurse D informed the Inspector that Mr L's pulse and oxygen saturation levels were checked on each of the three occasions he attended him during the night. Documentary evidence of a handwritten note with the relevant findings was made available during the course of the investigation.

2.17 There is a section on PHMS for the recording of "*Clinical Details – Selected Observations – Vital signs*". There are only two entries in relation to Mr L at 16:45 and 17:45 on 18th July 2018. There is no entry of vital signs in the PHMS for Mr L during the night or for early the following morning.

2.18 A review of PHMS records show three entries by Nurse Officer D in relation to Mr L for the night of 18th /19th July 2018. One of the entries was made retrospectively. The entries were as follows:

- 19th July 2018 at 02:11

  "ats post seizure
  collateral from cell mate that Mr L had a seizure lasting 2-3 mins
  appears fine now – no injuries
  aware of name and surroundings
  for dr mane"

- 19th July 2018 at 05:33

  "ats
  having seizure
  lasted apprx 2-3 minutes
  orientated to time and place afterwards"

- 20th July 2018 at 12:01

  "retrospective note for 18/july (sic) 2019@0330hrs
  Ats post seizure
  Confused at first
  Became lucid after 1 minute
  Appears fine now
  Aware of name and surroundings"

2.19 The officers on duty checked the cell occupants throughout the evening and night. They lifted the viewing flap and looked into the cell. 58 checks were carried out between 16:12:41 on 18th July 2018 to 08:10:30 on 19th July 2018 when Mr L was found to be unresponsive on a mattress on the floor. In accordance with IPS practice at that time 64 checks should have been completed. The frequency of checks ranged from less than a minute to 57 minutes, with an average of 17 minutes.

3.0 EVENTS FOLLOWING MR L BEING FOUND UNRESPONSIVE IN HIS CELL

3.1 At 08:10 on 19th July 2018, Officer A who was Class Officer on B1 landing, went to cell 4 accompanied by Nurse A who was administering medications, and unlocked the cell. Nurse A entered the cell.

3.2 Mr L was lying on his back on the mattress on the floor of the cell, covered by a duvet. Nurse A tried to engage with Mr L and found that he was unresponsive to verbal commands.

3.3 Mr A, the cell mate of Mr L, told Nurse A that "*he has been having fits all night"*. Apart from the three occasions that the nurse was requested to attend Mr L's cell there was no further evidence to corroborate Mr A's statement. Nurse A reported that a full clinical assessment was carried out and medical assistance and an ambulance was requested.

3.4 Mr A was removed from the cell and placed in adjacent Cell 5 (a double occupancy cell) on B1 landing. The OIP was informed that Mr L was accommodated on a mattress on the floor in Cell 4 on B1 landing because of overcrowding. However, Cell 5 on B1 is a double occupancy cell and during the course of this investigation it was confirmed that when Mr A was removed to Cell No.5 it was unoccupied and had been cleaned out with no belongings of the previous occupant remaining.

3.5 CPR was commenced with the assistance of Nurse E.

3.6 Ambulance Paramedics arrived at 08:30 and took over care of Mr L. At 08:50 they removed him to the Emergency Department, Mercy Hospital. A prison escort was provided.

3.7 Mr L's death was pronounced at 09:25 on 19th July 2018 in the Mercy Hospital, Cork.

4.0 CONTACT WITH NEXT OF KIN

4.1 Mr L was a Polish citizen and was not known to have any family in Ireland. He did not provide contact details for next-of-kin on committal.

4.2 The OIP was informed that Cork Prison contacted the Embassy of Poland to seek their assistance in contacting Mr L's brother in Poland. The OIP subsequently contacted the Embassy on 10th September 2018 to inform the Diplomatic Mission of its investigation and to request contact with the family of Mr L in Poland, subject to their consent.

4.3 On 11th September 2018 the Embassy of Poland confirmed that they had contacted Mr L's brother and on our behalf, asked if he would like to contribute in any way to the investigation in relation to his brother's death in custody. Mr L's brother informed the Embassy that he had some questions and doubts and he would like some answers.

4.4 Mr L's brother was provided with contact details for the OIP. No contact was received. The OIP did not have contact details for Mr L's brother.

4.5 Due to the nature of the information contained in statements received as part of the investigation and also a review of general records, the IOP was of the view that a review of Mr L's relevant prison healthcare records was required in order to complete the investigation. However, in the absence of consent from a next-of-kin, the IPS refuses access in accordance with advices from the Office of the Attorney General.

4.6 In June 2019 the OIP became aware that the Probation Service was in contact with Mr L's brother in Poland. At the request of the OIP, the Probation Service sought family consent for the OIP to access Mr L's healthcare records relating to his time in prison. Consent was received and subsequently provided to Cork Prison on 27th June 2019. A copy of the relevant healthcare records was received by the OIP on 3rd July 2019.

5.0 INVESTIGATION PROCESS

5.1 The OIP was informed of the death of Mr L by Governor A on 19th July 2018.

5.2 The OIP corresponded with Prison Management at Cork Prison and received required reports/statements in line with the agreed protocol between the OIP and the IPS.

5.3 CCTV footage was viewed and all activities occurring in the vicinity of Mr L's cell from the time he was placed in the cell until he was removed by ambulance to hospital the following morning were noted.

5.4 Interviews (via phone or face to face) were conducted.

5.5 The cell was examined by An Garda Síochána Scenes of Crime Unit prior to its release for use.

5.6 The cell was not viewed by the OIP before it was put back in use due to miscommunication within the prison. However this did not have any negative effect on this investigation. The OIP received photographs of the cell which were taken soon after Mr L was removed to hospital.

5.7 Direct contact from Mr L's next-of-kin in Poland was not received. Therefore there was no opportunity to ascertain if they had any concerns.

6.0 FINDINGS

6.1 Mr L was a 31 year old homeless man from Poland who was remanded in Cork prison on 18th July 2019. He had a history of severe alcohol abuse. The Probation Service informed Nurse C on the day of Mr L's committal that he was dehydrated, had a history of seizures, and had a heart attack two years previously. He was also reported to "*…be very frightened at the thought of going through alcohol withdrawal.*"

6.2 Mr L was assessed by Nurse A on committal and the assessment included an assessment of alcohol withdrawal. He was placed on 'Special Observations'. Mr L was accommodated in a single cell which was already occupied so he was provided with a mattress on the floor. The cell adjacent to Mr L's (Number 5 on B1) is a double occupancy cell and was unoccupied. A Safety Observation Cell was available for use on B1 landing on the night of 18th July 2018 and was not utilised.

Recommendation 1: A prisoner should be accommodated in a bed unless otherwise contraindicated in exceptional circumstances. If a bed is available and it is decided not to avail of it, the decision and the associated reason(s) for the decision should be clearly documented.

Recommendation 2: Consideration should be given to including Use of a Safety Observation Cell in circumstances where the IPS Protocol for the Emergency Use of Chlordiazepoxide is initiated.

6.3 The handover of Nursing Care for Mr L did not include any entry in the Nurse Handover Clinic and/or Nurse Led Clinic sections of PHMS and therefore information that Mr L had commenced on the Emergency Protocol for the Use of Chlordiazepoxide was not shared in writing.

Recommendation 3: Significant information should be documented in writing in the relevant sections of PHMS and also communicated verbally ensuring appropriate exchange of relevant information at the handover of nursing shifts.

6.4 Mr L was administered chlordiazepoxide 20mgs at 17:45 on 18th July 2018 in accordance with the IPS Protocol for the Emergency Use of Chlordiazepoxide and a medical referral was made with a request for review the following morning 19th July 2018.

6.5 Nurse D attended Mr L on three occasions during the night as during the course of checks of his cell it was observed that he appeared to be having a seizure on each occasion. One of the records in relation to Nurse Officer D's interaction with Mr L on 18th July 2018 at 03:30 was not made contemporaneously. However, it was clearly stated in the record on 20th July 2018 at 12:01 that it was a retrospective note for the above mentioned date and time.

Recommendation 4: Entry to records should be made contemporaneously. If for a particular reason this is not possible, the reason should be explicitly stated and the entry countersigned by the relevant line manager.

6.6 The IPS Protocol for the Emergency Use of Chlordiazepoxide provides that if an IPS healthcare member is satisfied that in her/his opinion administration is appropriate, s/he may administer Chlordiazepoxide as per protocol. Protocol provides that 10mg-20mg may be administered eight hourly. Nurse A was of the opinion it was appropriate and administered 20mgs at 17:45 on 18th July 2018.

6.7 Nurse D was called to see Mr L on three occasions during the night and it is recorded that on two occasions Mr L was post seizure and on one occasion he was having a seizure. Mr L was not administered any medication during the night as Nurse D formed the clinical opinion that withdrawal signs were not present and administration of further medication was not indicated. The IPS Clinical Drug Treatment and Policies Manual at Chapter 18 addresses the Assessment and Treatment of Alcohol Withdrawals. Section 18.6.6 provides the IPS policy position in relation to prophylactic anticonvulsant therapy as follows:

> *"If there is a concern that a patient may be at risk of an alcohol withdrawal seizure then diazepam may be used as a detoxification regime. In addition anticonvulsant prophylaxis may be added such as carbamazepine (and in the case of those on methadone, sodium valproate).*

According to the policy in the case of concern regarding alcohol withdrawal seizure, diazepam may be considered. However, a medical prescription is required.

6.8 Mr L was not transferred to an Emergency Department for urgent medical review. Chapter 18, Section 18.6.8 of the IPS Clinical Drug Treatment and Policies Manual states:

> *"Inpatient admission for the medical treatment of alcohol withdrawals in a hospital setting is recommended when:*
>
> *a) There is a history of severe alcohol dependence, i.e. persistent use of large amounts of alcohol over a long period of time.*
> *b) Severe alcohol withdrawal symptoms*
> *c) History of seizures*
> *d) History and risk of Delirium tremens*
> *e) Cognitive impairment*
> *f) Comatose state*
> *g) Associated acute physical illnesses requiring hospital admission*
> *h) Poor nutritional state*
> *i) Persistent vomiting and dehydration."*

The policy is unclear in that it does not state if one or more of the above criteria are required to be present.

Recommendation 5: Chapter 18 and Appendix XIX of The IPS Clinical Drug Treatment & Policies Manual V 01 07 2012 requires updating to clearly address the issues identified at 6.6 to 6.8 inclusive. The policies and procedures should take in to consideration lone working nursing staff at night and provide appropriate guidance in such circumstances including when transfer to hospital for emergency intervention is indicated.

Recommendation 6: The IPS Protocol for the Emergency Use of Chlordiazepoxide provides that "*the patient must be seen by a doctor within 24 hrs*." This provision requires review to make provision for earlier assessment/review by a registered medical practitioner.

Recommendation 7: The IPS Epilepsy Management Protocol is silent in relation to situations where two or more seizures of less than 5 minutes duration occur within a specified period of time. It is recommended that the policy is reviewed with a view to addressing this issue.

6.9 Nurse D provided a statement to the IPS within which it is recorded that Mr L's vital signs were within normal limits. Mr L's vital signs were not recorded by Nurse D on the PHMS. Documentary evidence in the form of a copy of the handwritten record made by Nurse D on each occasion was reviewed during the course of this investigation.

Recommendation 8: Handwritten notes of prisoner's vital signs should be entered into the record contemporaneously in the area of the PHMS designated for this purpose.

6.10 Mr L was placed on special observations by Nurse A on committal. The practice in the IPS in July 2018 required that he be checked every 15 minutes by prison officers. Mr L was locked back in his cell at 16:12:41 on 18th July 2018 and was found unresponsive at 08:10:30 on 19th July 2018. A total of 58 checks out of 64 were completed. The average time between checks was 17 minutes.

6.11 Nursing staff commenced CPR and continued until they were subsequently relieved by ambulance paramedics at 08:30.

6.12 Mr L was removed by ambulance to the Emergency Department, Mercy Hospital at 08:50 on 19 July 2018.

6.13 The death of Mr L was pronounced on 19th July 2018 at 09:25 in the Mercy Hospital, Cork.