OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr Q 2019

AGED 47

At Mater Misericordiae University Hospital

While in the custody of Cloverhill Prison

on 9 December 2019.

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GLOSSARY

ACO	Assistant Chief Officer.
Act	Prisons Act 2007
AGS	An Garda Síochána
CCTV	Close Circuit Television
CO	Chief Officer
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Health Management System
PIMS	Prisoner Information Management System

PREFACE

The Office of the 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 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 Q'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 Q passed.

Administration of the Investigation

The OIP was notified of MR Q's passing on 9 December 2019. Prison management provided a briefing and all information that was requested was provided promptly and fully 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.

A representative from the OIP spoke with Mr Q's sister in August 2020 and in September 2020 Mr Q's sister provided the OIP with a letter in which she raised several issues based on the family's understanding of the facts. These issues and related findings are set out in the report.

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

Recommendations

There are five recommendations for improvement. A copy of the final draft of the report, including the recommendations was provided to the Irish Prison Service on 19 May 2021 for review, comments and an action plan. A response was received on 20 July 2021.

The Irish Prison Service provided an action plan which stated that each of the five recommendations would be considered in the context of the policy and procedure review which was to be completed by the end of September 2021. Having sought an update from the IPS we have been advised that the review ongoing.

PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)
24 November 2021

SUMMARY

Mr Q was aged 47 years when he died in the Mater Misericordiae University Hospital on 9 December 2019, whilst being treated for cancer.

Mr Q was committed to Cloverhill Prison on remand on 21 January 2019, this was his third committal in a 12 month period. He was still a remand prisoner at the time of his passing.

While in prison custody Mr Q was diagnosed with cancer and attended numerous hospital appointments and was admitted as an inpatient to hospital on 9 May 2019.

He had been subject to a three person prison officer escort for seven months in hospital from 9 May 2019 until the time of his death.

Mr Q's family informed the OIP that they were refused visits for a period while he was in hospital as Mr Q was allegedly suspected of taking illicit substances despite being under IPS escort while in the hospital. On review of the entries to the Prison In-Patient Journal it was noted that there were no visits to Mr Q recorded between the 23 September 2019 and the 20 November 2019.

The family reported that Mr Q's urine samples continued to show illicit substance(s) during the period they were not permitted to visit him. They reported that prison staff escorted Mr Q to the perimeter of the hospital to smoke a cigarette but this activity ceased when Mr Q's urine samples were positive for illicit substance(s). Even though Mr Q was not leaving the ward and had no family visits, the family stated that his urine samples continued to show illicit substance(s). The family also stated Mr Q questioned the medical team and they were advised that the pharmacist in the hospital informed Mr Q his medication could have been the cause of the illicit substance(s) showing up in his urine samples. The Inspectorate were not in a position to verify this information with hospital personnel as examination of hospital records is not within the remit of the Inspectorate.

The family did not know who made the decision to deny them visits to Mr Q in hospital. On examination of the Prison In-Patient Journal we noted an entry made by an Officer, whose name is illegible, reporting that the ban on family visits was instigated by the hospital.

The OIP was advised by Assistant Governor A that limitations on visits were imposed by the hospital and Cloverhill Prison management did not ban visits at any stage. It was not possible for the OIP to investigate this further as seeking clarification from hospital staff or viewing hospital records is not, as stated earlier, within the remit of the Inspectorate.

Mr Q could have been released on payment of €100 bail. However, his family informed the OIP that Mr Q would have been homeless if he had paid the bail. His family felt there was pressure put on him by prison officials to take up bail. His solicitor was also contacted on the matter of his bail and on his medical condition. Prison management advised the OIP that it is standard practice to apprise both the person in custody and their solicitor of a bail condition attaching to their custody warrant thereby ensuring the individual fully understood that they could be released on the payment of the specific bail amount. Governor A in their report stated that Mr Q signed a consent form on 29 July 2019 to allow prison management discuss his medical history with his solicitors in relation to bail.

On 8 December 2019 Cloverhill Prison was informed by the Mater Misericordiae University Hospital that Mr Q had been put on a morphine pump and was not expected to live more than a few days. Mr Q died on the 9 December 2019 at 11:40 with his brother present.

RECOMMENDATIONS

1. **IPS should review its procedures in relation to hospital escorts of gravely ill prisoners and particularly the necessity for a three person escort of a prisoner who is in custody pending the payment of a small bail bond of €100**.

   Irish Prison Service Response:

   "*All relevant Policy and procedures in respect of prisoner escorts will be reviewed by end of Q3 2021 in the context of the Policy and procedure review."*

2. **All prison staff should be required to insert their name in block capitals beside their signature when completing all written records including prison journals.**

   Irish Prison Service Response:

   "Feasibility to be assessed. Engagement will take place with Governors/IPSC to give further consideration to this recommendation."

3. **When Next of Kin are notified that their relative/friend has been hospitalised they should be, at that time, advised that only those persons named on the Prisoner's Visitor list will be permitted to visit the person while in hospital.**

   Irish Prison Service Response:

   "*This matter will be considered in the context of the policy and procedure review which will be completed by end Q3 2021*."

4. **Where a decision is made to disallow hospital visits, the patient should be informed as to the reason why the visit(s) is/are disallowed and whether the decision was made by hospital or prison personnel so that s/he, if they wish, may inform their relatives/friends.**

   Irish Prison Service Response:

   "*This matter will be considered in the context of the policy and procedure review which will be completed by end Q3 2021*."

5. **A Critical Incident debrief should be convened following all deaths of persons in prison custody who are on a Hospital Order to review any issue(s) which arose during the persons time in hospital.**

   Irish Prison Service Response:

   "*This matter will be considered in the context of the policy and procedure review which will be completed by end Q3 2021*."

CLOVERHILL PRISON

Cloverhill Prison is a closed, medium security prison for adult males, which primarily caters for remand prisoners committed from the Leinster area. Cloverhill has an operational capacity of 431 beds. On the 9 December 2019 it accommodated 380 prisoners.

Mr Q was the 2nd death of a Cloverhill prisoner in 2019; and the 17th death in IPS custody that year which met the criteria for investigation by the OIP.

CHAPTER 1: BACKGROUND

Mr Q was committed on remand to Cloverhill Prison on 21 January 2019.

Mr Q had three committals into Cloverhill Prison in a twelve month period. The initial committal was from 2 February 2018 until 30 May 2018, his second committal was from 2 October 2018 until 15 November 2018 and his third committal was from 21 January 2019 until the date of his death

During Mr Q's second committal he was advised of his diagnosis of cancer. He attended appointments and was provided with treatment in the Mater Misericordiae University Hospital and Beaumont Hospital throughout this and his subsequent time in custody.

Mr Q was on the enhanced level of the IPS Incentivised Regime[1].

Mr Q was on a methadone maintenance programme during his time in custody.

CHAPTER 2: MEDICAL HISTORY

Mr Q was under the care of the Mater Misericordiae University Hospital for radiation and chemotherapy. He attended ten medical appointments in the oncology clinic on the following dates: 27 February 2019, 07 March 2019, 21 March 2019, 27 March 2019, 29 March 2019, 18 April 2019, 29 April 2019, 1 May 2019, 2 May 2019 and 9 May 2019.

Mr Q was admitted to hospital on 9 May 2019 following his outpatient appointment. On 18 June 2019 Mr Q was discharged from hospital back to Cloverhill Prison. On his return to prison Mr Q was assessed by Nurse Officer A who was concerned for his wellbeing as he was very unwell. Nurse Officer A discussed Mr Q's condition with Chief Nurse Officer A and they liaised with other healthcare personnel including National Nurse Manager A and Mr Q's Oncology team in the Mater Misericordiae University Hospital. Mr Q was re-admitted to the Hospital on the same day. The OIP is not in a position to comment on the decision to discharge Mr Q from hospital in circumstances where on his reception back to prison he was assessed by nursing staff as being very unwell to such extent that his re-admission to hospital on the same day was required.

CHAPTER 3: EVENTS AFTER MR Q WAS HOSPITALISED

Chief Nurse Officer A reported receiving almost daily phone updates from the hospital team who cared for Mr Q regarding Mr Q's condition. On 23 July Mr Q's hospital medical team informed Chief Nurse Officer A that Mr Q required palliative care and palliative chemotherapy.

On 26 July Chief Nurse Officer A. received a call from the Ward Manager advising them that following emergency surgical intervention Mr Q's prognosis was less than 6 months.

On 29 July 2019 Chief Nurse Officer A discussed pending discharge plans by the Mater Misericordiae University Hospital with Prison Doctor A, National Nurse Manager A and the Prison Governors. Chief Nurse Officer A subsequently visited the Hospital to discuss with Mr Q and his medical team Mr Q's discharge plans and expressed concerns regarding availability of appropriate care equipment upon Mr

[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.

Q's return to custody. Chief Nurse Officer A updated National Nurse Manager A and Official A from the IPS Operations Directorate following the visit.

Governor A in their report recorded that Mr Q signed a consent form on 29 July 2019 to allow prison management discuss his medical history with his solicitor in relation to bail. Prison management informed the OIP that Mr Q's Solicitor was contacted and his bail condition was discussed.

The Mater Misericordaie University Hospital contacted Cloverhill Prison on 19 August 2019 to inform them Mr Q would be discharged back to Cloverhill Prison that week, however, Mr Q's condition continued to deteriorate and he remained in hospital under an IPS three person prison officer hospital escort until his death on 9 December 2019.

Recommendation 1
IPS should review its procedures in relation to hospital escorts of gravely ill prisoners and particularly the necessity for a three person escort of a prisoner who is in custody pending the payment of a small bail bond of €100.

Hospital Visits
An entry in the Prison In-Patient Journal which was maintained while Mr Q was in hospital, recorded on 9 September 2019 that Mr Q's sister was refused a visit. The Officer made the following record in the inpatient journal *'*visit ban was instigated by the hospital, when lifted then normal protocols will apply again.' The officer's signature was illegible. Later that day the Officer recorded that Mr Q was allowed visits again. It was also recorded that Prison staff were to liaise with Nurses on duty regarding any relaxation going forward.

The In-patient journal entries by prison officers recorded that Mr Q received visits from his family on 10 September, 16 September, 18 September, 20 September and 22 September 2019. There are no visits recorded in the In-patient journal between 23 September and 20 November 2019. On 28 September 2019 there is a note in the In-patient journal recording that *'nurses on duty have reported that there are amphetamines in his samples. No more visits until further notice. Prison staff to liaise with Nurses on duty for any relaxation on this request going forward.'* The entry was made by an ACO whose name was also illegible.

Recommendation 2
All written records including prison journals should require staff to insert their name in block capitals along with their signature.

On 3 October 2019 there was an entry in the In-patient Journal that Mr Q asked if he could get his visits back. Officer A contacted Chief Officer (CO) A in Cloverhill Prison and recorded in the journal '*answer was NO VISITS. Nursing staff informed.*' Officer A informed the hospital nursing staff. The Inspectorate sought clarification from Cloverhill Prison management and was advised by Assistant Governor A that limitations on visits were imposed by the hospital, given Mr Q's status and nature of his illness. Assistant Governor A informed the Inspectorate that Cloverhill management did not ban hospital visits but advised that the only people allowed to visit Mr Q were those on his visitors list.

On 4 October 2019 Officer B noted in the In-patient Journal that clarification was sought in relation to the visiting ban as Mr Q had further questioned the ban. Officer B was informed that the ban had been imposed by the hospital and not by the prison and noted that if hospital staff allowed visits the escort personnel would have to check the Mr Q's Visitor List to ensure the person wishing to visit was on the list.

On 1 November 2019 Governor B wrote to Mr Q's solicitors in response to a letter received on 30 October 2019. Governor B advised the solicitors that there *were 'no instructions to stop visits to [Mr Q], but all of his visitors are restricted to those nominated by him on his visits authorisation form. The names can be changed at his discretion. [Mr Q] has 10 active visitors approved at present. This is a measure to protect [Mr Q] from unwanted visitors.'*

Recommendation 3

When Next of Kin are notified that their relative/friend has been hospitalised they should be, at that time, advised that only those persons named on the Prisoner's Visitor list will be permitted to visit the person while in hospital.

Recommendation 4

Where a decision is made to disallow hospital visits, the patient should be informed as to the reason why the visit(s) is/are disallowed and whether the decision was made by hospital or prison personnel so that s/he, if they wish, may inform their relatives/friends.

On 21 November 2019 it was recorded in the In-patient Journal that Mr Q was visited by his brother and sister. On 24 November 2019 his nephew and his brother visited. On 30 November 2019 Mr Q received visits from his two sisters, his brother, his mother, aunt and his sister's partner. On 6 December 2019 Mr Q's family were informed he only had days to live. His family visited him continuously on the days preceding his death.

CHAPTER 4: EVENTS SURROUNDING THE DEATH OF MR Q

On 8 December 2019 Cloverhill Prison was informed by Mr Q's medical team that he was on a morphine pump and was not expected to live more than a few days.

On 9 December 2019 Cloverhill Prison was informed that Mr Q had slipped into a coma.

Assistant Chief Officer (ACO) A took up duty at 07:00 on 9 December 2019. The ACO reported being advised by Officer C that Mr Q had a restless night and his family were in and out and had spent the night in the Relative's Room. In ACO A's report it was further noted that Governor C and CO B arrived in the hospital at approximately 10:50 and advised the prison officers to use their discretion to give the family more space. ACO A then remained outside the room and asked Officer D and Officer E to leave the immediate area of the room.

ACO A reported being informed of Mr Q's passing at 11:45 and contact was made with CO B and Cloverhill Prison personnel. ACO A also reported that CO C rang to inform the escort personnel that An Garda Síochána (AGS) had been notified. Governor A contacted Chaplain A requesting that the Chaplain visit Mr Q's family. Governor C and CO B both reported that at approximately 10:50 they visited the hospital and were advised by nursing staff that Mr Q was gravely ill and he may pass away at any stage. They reported that they did not enter the room, however Mr Q was visible through the glass panel. They spoke to Mr Q's brother briefly. Shortly after their visit they were informed by ACO A that Mr Q had passed away.

Mr Q passed away at 11:40 on the 9 December 2019, his brother was with him at the time.

Records examined showed that Chaplain A arrived at the hospital at approximately 13:00 and Mr Q's family left the area at approximately 13:20.

The Prison Escort staff remained with Mr Q's remains until members of AGS arrived at the hospital, which was shortly after the family left. In the absence of any family member, AGS asked the prison officers to identify the remains of Mr Q. ACO A identified Mr Q and AGS then took charge. The Prison Escort staff left the hospital and returned to Mountjoy Prison with all associated Prison Hospital Escort equipment.

Critical Incident Review

The OIP was informed by Cloverhill Prison that there was no Critical Incident Review meeting held as Mr Q was in the care of the Mater Misericordiae University Hospital from 18 June 2019 until the time of his death.

Recommendation 4
A Critical Incident debrief should be convened following all deaths of persons in prison custody who are on a Hospital Order to review any issue(s) which arose during the persons time in hospital.