OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr H 2019

AGED 37

In CORK PRISON on 24 June 2019.

[Date final report submitted to the Minister for publication: 5 November 2021]

Date published: 4 February 2022

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GLOSSARY

Act	Prisons Act 2007
AED	Automated External Defibrillator
AGS	An Garda Síochána
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
DiC	Death in Custody
GP	General Practitioner
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
P19	Form that is completed when prisoners are reported for alleged breach of disciplined
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 H's Mother 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 H passed.

Administration of the Investigation

The OIP was notified of Mr H's passing on of 24 June 2019. Two OIP representatives visited Cork Prison the next morning. Prison management provided a briefing and confirmed that CCTV footage for relevant areas of the prison had been saved. Mr H's cell was viewed and information requirements for the investigation were agreed.

Two OIP representatives met with Mr H's mother, sister and her friend in July 2019. The family were living abroad and were happy to meet during their short visit to Ireland. The family stated they were not aware that Mr H was in prison until they were notified of his death. We were advised that Mr H had not maintained regular contact with his family. The family were accompanied at the meeting by the Cork Prison Chaplain who was providing support during their short visit.

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.

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

Recommendations

There are two recommendations for improvement. A copy of the final draft of the report, including the recommendations was provided to the Irish Prison Service on 28 June 2021 for review, comments and an action plan. A response was received on 20 July 2021. The IPS accepted both recommendations. An Action Plan was provided for the recommendations that were accepted 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)
3 November 2021

SUMMARY

Mr H was a remand prisoner committed to Cork Prison on 8 June 2019. On committal he was accommodated on the B1 landing and was moved to the A1 landing on 11 June 2019.

Mr H was aged 37 when he was found unresponsive in his cell at 15:21 on 24 June 2018. He was in cell 22, a double cell on A1 landing which he shared with Prisoner 3. At the time he was found unresponsive he was alone in his cell.

Mr H told the Governor that he had issues with other unnamed prisoners and at his own request was placed on protection on 9 June 2019 under Rule 63 of the Prison Rules 2007-2017[1].

At 15:21 on 24 June 2019 Prisoner 1 looked into cell 22 through the viewing hatch and tried to get the attention of Mr H. When Prisoner 1 got no response from Mr H he immediately called for assistance.

Three Officers A, B and C responded. The cell door was opened and these Officers along with Prisoners 1 and 2 entered the cell. Prisoner 1 who was a Red Cross Volunteer[2] trained in First Aid, commenced CPR.

Officer A called Healthcare staff on his radio. Nurse Officers A, B and C responded and administered emergency attention, including Cardio-Pulmonary Resuscitation (CPR). Nurse Officer E called the emergency ambulance service from the Class Office on the landing. At 15:42 Mr H was removed from the cell to the landing in order to enhance access for healthcare personnel and resuscitation equipment.

Nursing staff continued CPR on rotation until the fire brigade Emergency Response Team arrived at approximately 15:35 and took over care. The emergency ambulance service accompanied by Doctor A arrived at 15:40 and continued with CPR. At 15:57 the medical interventions ceased and Mr H's death was pronounced by the Doctor. Mr H was then placed back in the cell which was master locked and An Garda Síochána were notified.

On committal Mr H had provided the name of an acquaintance as his Next of Kin (NoK), no contact details were provided. Management at Cork prison found it difficult to trace Mr H's family. At 16:15 on 25 June 2019 Assistant Governor A made contact by telephone with Mr H's mother who was residing outside of the jurisdiction. Chaplain A subsequently contacted Mr H's mother and acted as a family liaison.

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

[1] Rule 63 of the Prison Rules 2007-2017 states a prisoner may, either at his or her own request or when the Governor considers it necessary, in so far as is practical and subject to the maintenance of good order and safe and secure custody, be kept separate from other prisoners who are reasonably likely to cause significant harm to him or her.

[2] The Red Cross Volunteer Programme was originally designed by the International Federation of the Red Cross and Red Crescent Societies (IFRC) to be facilitated globally in communities. The initiative was introduced into the prisons in Ireland and benefits the prisoner community, prison staff and families of prisoners

RECOMMENDATIONS

Recommendation 1
Every effort should be made to ensure that all those involved in a serious adverse incident resulting in a death participate in the subsequent debriefing sessions to ensure they are afforded an opportunity to process the event and reflect on its impact. [Page 13]

IPS Response: Accepted

Recommendation 2
The IPS should ensure all staff are aware of and implement Prison Rule 4 (Prison Rules 2007-2020) which relates to the recording of prisoner's details. Prison Rule 4 states that particulars relating to the admission of each prisoner shall be recorded by a person designated by the Governor upon his/her admission to a prison. Prison Rule 4 (e) refers to the recording on PIMS of full details of the NoK and states that the following should be included: "…*contact details for either, (i) a parent or lawful guardian of a prisoner under 18 years of age or, (ii) such member of the prisoner's family as the prisoner may nominate, or (iii) such other person as the prisoner may nominate*." [Page 13]

IPS Response: Accepted

CORK PRISON

Cork Prison is a closed, medium security prison for adult males with an operational capacity of 296 beds. It is the committal prison for counties Cork, Kerry and Waterford. On the 24 June 2019 it accommodated 288 prisoners.

Mr H was the second death in Cork prison in 2019 and the eight death in IPS custody that year which met the criteria for investigation by the OIP.

CHAPTER 1: BACKGROUND AND TIME IN CORK PRISON

Mr H was on remand in Cork Prison from 8 June 2019 until the time of his passing on 24 June 2019. On committal he was accommodated on the B1 landing. Mr H was due to appear at Cork District Court on 1 July 2019.

Mr H was in custody previously, his most recent release date from Cork Prison was on 27 May 2019.

On 9 June 2019 Mr H requested to be placed on protection and was placed on a restricted regime under Rule 63 of the Prison Rules 2007-2017. He was moved from B1 to the A1 landing on 11 June 2019.

Mr H was accommodated in cell 22 on the A1 landing when he was found unresponsive on 24 June 2019. Mr H had been in continuous custody for 16 days at the time of his death.

A committal interview was conducted by Nurse Officer D on Saturday 8 June 2019. The Nurse Officer noted that Mr H denied substance abuse and mental illness and guaranteed his own safety. Mr H had a committal review with Doctor B on Monday 10 June 2019 and there were no concerns noted. Prison Rule 11 requires each prisoner to be also examined by a doctor on the day of his or her admission to a prison save in the most exceptional circumstances when a doctor is not available which is provided for in Rule 11(2). The records examined did not record exceptional circumstance giving rise to Mr. H's medical assessment two days after his committal to prison.

According to IPS records examined, Mr H did not request to see Healthcare staff throughout this time in custody.

Mr H had no cash or property on committal. Following a request to the Governor he was given a loan of €20 which was lodged into his account. Mr H sought a second loan on the morning of his passing advising ACO A that he required the money for tobacco and toiletries. The request for the second loan was refused as Mr H was on remand and had already received a loan. Records showed that €20 was lodged to Mr H's account from a contact outside of the prison. On the morning of his death Mr H had €29.40 in his account and spent €19.20 on his visit to the tuck shop.

Mr H was on the standard level of the Incentivised Regime[3]. He was known to be a quiet man who caused no issues for prison staff although records showed that he had one breach of discipline. Mr H was the subject of a P19 disciplinary report for abusing a prison phone. A hearing was convened at which he admitted the breach of prison discipline and he was cautioned about his future behaviour. No sanction was imposed.

[3] 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.

According to IPS records, Mr H did not receive visits, phone calls or letters while in custody.

Mr H's cellmate Prisoner 3 stated that Mr H would not leave the cell to take exercise. Prisoner 3 also stated that he did not know who Mr H was afraid of but he appeared to be afraid of someone. He informed the Inspectorate that Mr H would only go to the landing to collect tea bags.

CHAPTER 2: SEQUENCE OF EVENTS ON 24 JUNE

Mr H's cellmate Prisoner 3 had a court appearance on 24 June 2019. He informed the OIP that prior to leaving the cell for court on the morning of 24 June 2019, Mr H had been in "*poor form*" but had said nothing to raise concern for his wellbeing.

Officer A stated that Mr H declined exercise during the morning and remained in his cell. It was reported to be normal for Mr H to decline exercise as he didn't usually go to the yard.

Officer A recalled that Mr H was within a small group escorted to the Tuck shop on A2 at 10:15 on the 24 June 2019. The tuck shop records showed that Mr H spent €19.20 at 10:25. Mr H then returned to his cell. Dinner was delivered to Mr H at around 11.55.

Following lunch Officer A unlocked Mr H's cell at 14:15 and Prisoner 4 collected Mr H's dinner plate. Officer A recalled Mr H standing in the cell at the time and didn't make any comment other than to acknowledge them. Mr H remained in his cell. CCTV footage showed Prisoner 5 lift the flap on the viewing hatch of Mr H's cell at 14:25. There is no further activity at the cell until Prisoner 1 lifts the flap of the cell door at 15.21.

Prisoner 1 informed the OIP that there was no light on in the cell so he switched on the light and saw Mr H. Prisoner 1 stated that he kicked the bottom of the door to get the attention of Mr H but got no response and realised something was wrong. Prisoner 1 reported that he then shouted to Officer A who was on the landing. Officer A ran to cell 22 and opened the door at 15:21:55.

Prisoner 1 also informed the OIP that Officer B and Officer C were standing on the landing and they responded and entered the cell with Officer A. Prisoner 1 reported that he assisted Officer B to lift Mr H while Officer A and Officer C undid a ligature and they placed Mr H on the floor where Prisoner 1 commenced CPR. Prisoner 1 told the inspectorate that he was a trained Red Cross First Aider. Prisoner 1 recalled Officers calling "*the medics*" on their radio and stated that the Nurses arrived "*very fast and took over*" CPR. The CCTV footage showed four Nurses entering the cell at 15:22.

Prisoner 2 reported entering the cell with Prisoner 1 and assisting in lifting Mr H and placing him on the floor where Prisoner 1 commenced CPR. Prisoner 2 stated that he left the cell when the medics arrived.

Officer A reported responding promptly to Prisoner 1's shout for assistance and unlocking the cell door. He stated that Officer C and Officer B were on the landing and ran to the cell. Officer A recalled Officer B and Officer C lifting Mr H while he undid the ligature and they then laid Mr H on the floor of the cell. Officer A stated that Officer C called the surgery on his radio to alert them to an emergency and he informed the OIP that the Nurses responded promptly.

Officer C's account of events corresponds with Officer A's account. Officer C also stated that on entering the cell with Officer A and Officer B they attempted to lift Mr H but were unable to do so and

called for the assistance of Prisoner 1 and 2. Officer C stated that they placed Mr H on the ground and then Prisoner 1 commenced CPR.

Officer B reported that Mr H was cold when touched, his face was a darkish colour and he was not responsive. Officer B stated that when surgery staff arrived and took over, he left the cell. Officer B commended Prisoner 1 and Prisoner 2 for their actions and assistance on the day.

Nurse Officer C reported that at about 15:18 while in the Surgery with Nurse Officer A and B a radio call was received to attend to a medical emergency on A1 landing. Nurse Officer C reported grabbing the emergency medical kit while the other two nurses ran ahead unlocking the doors leading to the Al landing. It took them about a minute to get to the cell.

Nurse Officer A corroborated Nurse C's account reporting hearing an emergency call over the radio for medics to attend to A1 landing and immediately left the surgery with Nurse B and C. Nurse Officer A reported opening the gates and doors along the way and Nurse Officer C brought the emergency bag.

Nurse Officer C noted, on entering cell 22, seeing prisoner 1 administering chest compressions to Mr H who was lying on the floor of the cell with his head towards the door.

Nurse Officer C reported assessing Mr H and could not feel a pulse at his carotid artery, his lips and tongue were blue, he was cold to the touch, his eyes were fixed and he was not breathing. Nurse Officer C also reported that Nurse Officer A began to open the AED while Nurse Officer B commenced chest compressions and Nurse Officer C opened Mr H's airways and administered oxygen. Nurse Officer C recalled an Officer asking prisoners 1 and prisoner 2 to leave the cell. Nurse Officer C stated that they continued administering CPR alternating positons until the arrival of the Fire Brigade personnel who took over care of Mr H at 15:30.

Nurse Officer C noted being present when Doctor A pronounced Mr H's death at 15:57. Nurse Officer C reported that in the course of assisting Mr H he was removed from the cell on to the landing to allow more space for the emergency services. After the emergency services had left Nurse Officer C assisted in moving Mr H's remains back into the cell. Nurse Officer C stated that Nurse Officer E coordinated the calling of the ambulance and escorted the paramedics to the landing.

Nurse Officer B also reported attending the cell of Mr H with Nurse Officer C and Nurse Officer A and saw Mr H was on the floor with Prisoner 1 carrying out CPR and Prisoner 2 present. Nurse Officer B stated that the Nursing staff took over CPR and the prisoners left the cell. Nurse Officer B also reported that Mr H was unresponsive, peripheral cyanosis noted, lips cyanosed, no respiratory output present, no palpable pulse present and a defibrillator was attached and CPR continued until "*the fire crew arrived*" at 15:37. They took over resuscitation and continued CPR until 15:57 when Mr H was pronounced dead.

Nurse Officer E reported that on leaving the dispensary on A2 at approximately 15:18 they were alerted by a Prison Officer that medical assistance was required on A1 landing. On arriving at the cell the Nurse Officer reported seeing Mr H lying on the floor of the cell and CPR being administered by Nurse A, B and C . On Nurse A's instruction Nurse Officer E rushed to the A1 Class Office to ring the Emergency Services. The Nurse Officer then informed the main gate that an ambulance would be arriving. When Mr H was pronounced dead Nurse Officer E reported assisting with the relocation of Mr H's body back into the cell.

Assistant Chief Officer A reported responding to a call for a medic to A1 from Officer A at approximately 15:20. On arrival to the landing ACO A stated that he was directed by Officer D and Officer C to cell 22 where Mr H was on the floor being treated by Nurse Officers C, A and B. The ACO reported that Officer A, Officer B as well as Prisoners 1 and 2 were in the cell. ACO A stated that Chief Officer A and Assistant Governor A then arrived at the scene and moments later the first paramedic crew arrived followed by more paramedics. ACO A stated that when the paramedics arrived it was decided to move Mr H from the cell to the landing in order to facilitate the emergency crew as they continued their work. ACO A reported that at approximately 15:58 Mr H was pronounced dead by Doctor A. ACO A stated that Mr H was then returned to his cell. ACO A reported that Trades Officer A blocked the observation glass from the inside of the cell and the cell was master locked by Officer E who was posted at the door to secure the area while awaiting the arrival of An Garda Síochána.

All staff responded quickly when the emergency was raised which is evidenced by the CCTV footage. Prisoner 1 and Prisoner 2 were reported by staff to have been of great assistance and we commend them for their actions. It was noted that both prisoners were referred to and seen by the GP. Both were referred to psychology services. Prisoner 2 was reviewed by a psychiatrist on the day of the incident.

CHAPTER 3: POST EVENT

Critical Incident Review

A critical incident meeting was held on the 25 June 2019. The purpose of a critical incident meeting is to establish the facts, to provide an opportunity to share views in relation to how the situation was managed and identify any additional support or learning.

The meeting was attended by ten staff, four of whom were directly involved in the incident.

Prisoner 1 and Prisoner 2 did not attend a debriefing but were referred to the psychology service and the prison doctor.

The meeting was chaired by Assistant Governor A

Assistant Governor A asked the surgery staff if they had any concerns following the incident that may benefit future responses to a similar incident. Nurse Officer C reported that they were unaware of the nature of the injury until they arrived at the scene. The Nurse Officer stated that it did not affect the treatment afforded to Mr. H but it could be relevant in a future incident. The following matters were raised:

- Surgery radios did not have a private call function;
- Availability of a radio for each member of staff in the surgery;
- Suggestion that a cordless phone be made available to surgery staff to speak to Ambulance Control;
- Concerns at the lack of First Aid training provided to staff.

When drafting this report the OIP made enquiries with the management of Cork Prison as to the current situation regarding the surgery radios. The OIP was advised that a business case was submitted to the Governor of Operations seeking extra radios for the surgery with a private call function. On further reflection the idea of a cordless phone to speak with ambulance control was not considered to be best practice and was therefore not progressed.

The OIP was informed that there has been no provision for the training of prison staff in first aid techniques.

Assistant Governor A and Chief Nurse Officer A agreed to put a plan in place outlining the information that should be provided to Ambulance Control by the Control Room staff. We have been advised by Assistant Governor A that following liaison with Ambulance Control new SOP's have been developed and implemented.

There was no evidence that a cold 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. We are pleased to note that since the death of Mr H and prior to the completion of this investigation the Irish Prison Service had 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 and …"*should include, to the greatest possible extent, all the staff involved in the incident*."

Recommendation 1
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.

On committal Mr H provided the name of an acquaintance as his Next of Kin (NoK) but no contact details were provided and consequently management at Cork prison found it difficult to trace Mr. H's NoK. At 16:15 on 25 June 2019 Assistant Governor A made contact by telephone with Mr H's mother who was residing outside of the jurisdiction.

Recommendation 2
The IPS should ensure all staff are aware of and implement Prison Rule 4 (Prison Rules 2007-2020) which relates to the recording of prisoner's details. Prison Rule 4 states that particulars relating to the admission of each prisoner shall be recorded by a person designated by the Governor upon his/her admission to a prison. Prison Rule 4 (e) refers to the recording on PIMS of full details of the NoK and states that the following should be included: "…contact details for either, (i) a parent or lawful guardian of a prisoner under 18 years of age or, (ii) such member of the prisoner's family as the prisoner may nominate, or (iii) such other person as the prisoner may nominate."

Prison Chaplain A also contacted Mr H's mother and acted as family liaison providing support during their short visit to Ireland.