Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. B

Mater Misericordiae University Hospital in the Custody of Arbour Hill Prison

10 March 2020

Submission Date to Minister: 9 August 2022

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GLOSSARY

Act	Prison Act 2007
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CO	Chief Officer
GP	General Practitioner
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
NO	Nurse Officer
Office	Office of the Inspector of Prisons
P19	Form to complete when prisoners are disciplined
PHMS	Prisoner Health Management System
PO	Prison Officer

INTRODUCTION

1. Preface

1.1 The Office of the Inspector of Prisons (OIP) was established by the Department of Justice under the Prisons Act 2007 (the Act). Since 2012, the Minister has instructed the Inspector of Prisons to investigate deaths in prison custody. This includes the death of any person which occurs within one month of their temporary release from prison custody. The OIP also carry out regular inspections of prisons.The Office is independent of the Irish Prison Service (IPS). The Inspector of Prisons and staff of the OIP are independent of the Department of Justice in the performance of statutory functions.

1.2 The OIP can 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 public transparency, to promote best practice in the care of prisoners.

2. Objectives

2.1 The objectives for investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the Irish Prison Service (IPS);
- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in the 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;
- Assist the Coroner's investigation and the States 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; and
- Identify areas that may be pivotal in achieving or obstructing progress of the Department of Justice 2021 to 2023 Strategy Statement to create a 'Safe, Fair and Inclusive Ireland' (Goals 2 and 3).

3. Methodology

3.1 Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, next of kin (NoK); 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.

3.2 This report is structured to detail the events leading up to Mr. B's death in prison on Tuesday 10 March 2020 and management of the events associated to his death.

4. Administration of Investigation

4.1 The OIP was notified of Mr. B's death on, Wednesday 11 March 2020. A standardised checklist of information requirements from the IPS to assist an investigation into deaths in custody is in place. The IPS Director of Operations provided the OIP with all relevant information requested.

4.2 The cause of death is a matter for the Coroner.

5. Family Liaison

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

5.2 The OIP contacted Mr. B's NoK, his uncle, on Tuesday 18 August 2020. The family were very complimentary of the prison's management and staff. The NoK's son also wrote to the Governor of Arbour Hill to express the family's gratitude.

5.3 Although this report is for the Minister for Justice, it will also inform several interested parties. It is written primarily with Mr. B's family in mind.

5.4 The OIP is grateful to Mr. B's family for their contributions to this investigation and we offer our sincere condolences on their loss.

6. Arbour Hill Prison

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

6.2 Mr. B was the first death of an Arbour Hill prisoner in 2020; and the second death in IPS custody that year which met the criteria for investigation by the OIP.

7. Family Concerns

7.1 On Tuesday 18 August 2020, the OIP contacted Mr. B's NoK regarding any family concerns about the death. The family did not raise any issues of concern and were very complimentary of prison management and staff.

8. Background

8.1 Mr. B was 63 years old when he passed away at the Mater Misericordiae University Hospital in the custody of Arbour Hill Prison. He was from Ulster and was survived by his elderly mother.

8.2 Mr. B was remanded on Saturday 30 November 2002 and sentenced to life imprisonment on Tuesday 4 May 2004 to Mountjoy Prison. He was transferred to Arbour Hill Prison on Wednesday 30 June 2004.

8.3 Mr. B was on the enhanced level of the prison's Incentivised Regime[1] and regularly attended the prison school.

8.4 Mr. B had no P19s (disciplinary issues) during the entire period of his time in custody.

8.5 Mr. B had family visits while in prison.

9. Medical Issues

9.1 Mr. B was a heavy-set man with complex health issues including hypertension, diabetes mellitus, chronic kidney disease, and liver steatosis. He had a recent history of recurrent falls and poor mobility.

9.2 Due to the recent mobility issues, Mr. B had been moved from the cell he occupied from the time he was in custody to another single cell to allow him easier access (East 1 Cell 1).

9.3 During his time in prison, officers showed concern for Mr. B's wellbeing and took action to support him. There are many records of healthcare intervention whilst he was in prison. Examples include: Nurse Officer A recorded in the Prisoner Health Management System (PHMS) on Sunday 16 February 2020: "Seen in cell. Pain less today. Encouraged to mobilise".

[1] There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level. All prisoners enter the system at standard regime level and have the opportunity to become eligible for the enhanced regime status once they have met the required criteria for the preceding two months. Incentivised regimes (irishprisons.ie).

On Monday 17 February 2020, Nurse Officer B recorded: “Seen in cell this [morning,] medication issued and supervised for S/A of insulin. [Mr. B] advised to have a shower and put on clean clothes and to take frequent walks [up] and down landing throughout the day”.

9.4 On Friday 27 December 2019, Mr. B complained of pain across his back during an appointment to see the General Practitioner (GP) at the Prison Surgery. On Wednesday 22 January 2020 another GP entry in the PHMS indicated Mr. B complained of back pain and requested medication. His back pain complaints became more regular.

9.5 On Thursday 30 January 2020, Mr. B had a routine consultation with a psychiatrist. He had been diagnosed as schizophrenic while on admission to the Central Medical Hospital in 2002. He complained of the back pain during the consultation and mentioned he had not received any visitors recently.

9.6 During the afternoon of Tuesday 11 February 2020, NO B wrote that Mr. B complained of severe pain on his right side and lower back and was due to see the GP in the morning. The GP referred him to hospital for assessment after the scheduled consultation.

9.7 Mr. B was escorted to the Accident and Emergency Department of the Mater Misericordiae University Hospital on Wednesday 12 February 2020 at 22.30hrs. Shortly after arriving at hospital he complained of worsening back pain and increased lower limb swelling. X-rays performed for the referral revealed no acute fractures and he was discharged back to Arbour Hill Prison at 02.15hrs. While in the hospital, Mr. B grazed the right side of his forehead during a fall.

9.8 The Chief Nurse Officer (CNO) wrote in her statement to the OIP Inspector that Mr. B was reviewed by the Prison GP seven times in 2020 and had 43 documented interactions with Nursing Officers outside medication administration in 2019.

9.9 Within the 29 weeks leading up to his admission on Tuesday 18 February 2020, Mr. B was escorted to hospital 27 times for a variety of health issues.

10. Immediate Events Prior to Incident

10.1 On Tuesday 18 February 2020 Mr. B was scheduled for an appointment at the Warfarin Clinic at the Mater Misericordiae University Hospital. At approximately 07:30hrs, while getting ready in his cell, he had an unwitnessed fall from a sitting position as his legs felt weak. In his own words “I fell to the floor on my bum and no head banging” (PHMS entry by NO C). Prison Officer A (PO A) found Mr. B lying on the floor and entered with PO B to lift him back into his chair. Nursing staff were informed and NO C attended. NO C wrote in his report that “no bleeding nor swelling [was] noted then”.

10.2 CNO A later went into his cell for review to ensure he was fit to attend the planned outpatient appointment that morning. She suggested the use of a wheelchair for the hospital escort.

10.3 Mr. B was subsequently referred by a hospital order to attend the Accident and Emergency Department of Mater Misericordiae University Hospital for assessment as he was already there for his outpatient appointment at the Warfarin Clinic. The Prison Surgery faxed the supporting

documentation to the Triage Nurse and Mr. B was admitted as an inpatient after the medical assessment for tests and treatment.

10.4 The hospital made contact with the prison on numerous occasions for a discharge plan due to severe pressure for space due to COVID-19 planning; the last request was made less than two hours before Mr. B passed away. At 19:40hrs on Tuesday 10 March 2020 Mr. B went into cardiac arrest at the hospital and a medical team commenced resuscitation efforts. He was pronounced dead at 20.23hrs.

10.5 At 20.56hrs, the Assistant Governor informed Mr. B's for NoK that he was deceased.

11. Critical Incident Review

11.1 A Critical Incident Review Meeting[2] and debrief took place online involving the Assistant Governor, a Chief Officer and the CNO.

11.2 Two issues were raised by the IPS during the Critical Incident Review: (1) to examine medical resources required to support prisoners with complex medical needs[3] and (2) to provide a dedicated in-patient pack to staff on in-patient duty (which was put in place shortly after this incident).

12. Recommendations

12.1 There are no recommendations in this report.

13. Closing

13.1 The IPS followed all procedures correctly from Mr. B's removal to hospital until his NoK and other authorities were informed.

13.2 The healthcare and operational staff of Arbour Hill Prison should be commended for the duty of care afforded Mr B. who was battling complex medical issues while in custody.

13.3 The Office of the Inspector is satisfied with the duty of care and professionalism of Arbour Hill Prison staff. The issues raised during the Critical Incident Review Meeting will be explored and examined during future inspections of Arbour Hill and with the IPS Senior Management.

14. Support Organisations

14.1 Those who are affected by a death in custody can obtain assistance or advice from a number of charities and support groups. The Office of the Inspector of Prisons has an information pamphlet for relatives and friends of someone who dies in the custody of a prison. Further information can be found on the OIP website at www.oip.ie.

[2] This meeting is between prison management and all prison staff who were involved in the incident of who may have relevant information. These are conducted to identify good practice, potential shortcomings and to address any welfare needs. In this case no issues of concern were raised or identified.

[3] In February 2022 the IPS introduced an End of Life Palliative Care Policy.