Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Into the Circumstances Surrounding the Death of

Mr R 2019

Submission Date (to Minister) 13 January 2023

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GLOSSARY

ACO	Assistant Chief Officer
ACT	Prisons Act 2007
CCTV	Close Circuit Television
Inspector	Inspector of Prisons
IPS	Irish Prison Service
ICU	Intensive Care Unit
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
P19	Form that is completed alleging breach of discipline by a prisoner
PHMS	Prisoner Healthcare Management System
PICLS	Prison In-reach and Court Liaison Service
PIMS	Prisoner Information Management System
SOP	Standard Operating Procedure

INTRODUCTION

1. Preface

1.1 The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Minister for Justice 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 OIP also carry out regular inspection of prisons. 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.

1.2 The OIP 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.

2. Objectives

2.1 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;
- Assist the Coroner's investigative obligation and contribute to meeting the State's 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 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 The Office of the Attorney General has informed the IPS and the Office of Inspector of Prisons that the provisions of the Act 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 the NoK. This can in some instances lead to a failure to review healthcare/medical records where the NoK is unknown, cannot be located, or refuses to provide consent.

3.3 This report is structured to detail the events leading up to Mr R's death and management of the events associated to his passing.

4. Administration of Investigation

4.1 The OIP was notified of Mr R's passing on the morning of 16 December 2019. Information requirements for the investigation were agreed with Senior Management at Cloverhill Prison. Prison management provided a briefing and confirmed that all CCTV footage for relevant areas of the prison had been saved. However, the OIP was notified at a later stage that CCTV footage of checks conducted on Mr R's cell and Mr R's removal from Cloverhill Prison to hospital could no longer be located.

4.2 As there was a criminal investigation by An Garda Síochána into the death of Mr R, the OIP investigation into the circumstances surrounding his death was placed 'on-hold', pending the outcome of the criminal investigation.

4.3 The cause of death is a matter for the coroner to determine.

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 Since 2015 there has been communication with this Office and the IPS in relation to access to healthcare / medical records in the context of investigations of deaths in custody. The IPS, in accordance with its legal advice, informed the Inspector that such records could be released with the consent of NoK and this has been the practice over a number of years.

5.3 Mr R's NoK was in very poor health at the time of his passing. Several attempts were made to engage with Mr R's NoK without success. In the absence of consent from Mr R's NoK, the Inspectorate did not meet the requirements of the IPS for access to Mr R's healthcare / medical records.

5.4 Although this report will inform the Minister for Justice and several interested parties, it is written primarily with Mr R's family in mind. I offer my sincere condolences to the family for their loss.

INVESTIGATION OVERVIEW

6. Summary

6.1 Mr R was a 38 year old man who, having breached a Barring Order, was remanded into the custody of Cloverhill Prison on the 16 October 2019.

6.2 On the 4 November 2019 at 01:30 Prisoner 1 told the Night Guard, Officer A that he would physically harm Mr R if he remained with him in the cell, alleging that Mr R had attempted to get into bed with him. Officers relocated Prisoner 1 to a nearby cell [see **section 9** for further details].

6.3 Approximately two hours after this incident, Officer A while conducting a check, observed blood on Mr R's head and clothing. Officer A called for assistance and when the cell was unlocked, he found that Mr R had sustained a head injury. Officer A in his statement, reported that having entered the cell with other officers he heard Mr R state that he had fallen out of the bed and sustained a head injury on impact with the cell floor. Officer C reported that "*when asked Prisoner R did not offer an explanation*" on how he sustained the injury. Nurse 1 attended Mr R's cell and provided in-cell healthcare assistance. Mr R was then locked back in the cell for the night. The Officers who had earlier assisted with the relocation of Prisoner 1 all reported that Mr R did not display any injury at the time of the cell relocation.

6.4 At 12 noon on 4 November 2019 Doctor A medically assessed Mr R and referred him for hospital treatment. Mr R was transferred via ambulance to Tallaght University Hospital, escorted by three prison officers. Chaplain A informed Mr R's NoK that he had been hospitalised.

6.5 On 5 November 2019 Mr R was moved from Tallaght University Hospital to Beaumont Hospital. As the OIP did not have access to medical records, we were not in a position to ascertain why Mr R was transferred to Beaumont Hospital.

6.6 An anonymous letter was sent to the IPS alleging that Mr R fell out of his hospital bed resulting in another head injury. It was further alleged in the anonymous letter that Prison Officers supervising Mr R didn't pay adequate attention to him in failing to notify the nursing station when Mr R attempted to get out of his bed and allowed him to do so unassisted. This matter is further referred to in **section 10**.

6.7 According to operational reports and statements on 13 November 2019, Mr R's condition was considered stable and he was transferred back to Tallaght University Hospital. On 19 November 2019 Mr R's condition deteriorated and according to the reports Mr R was only responding to pain. On 21 November 2019 Mr R was transferred to the Intensive Care Unit (ICU) where he remained stable but did not respond to treatment.

6.8 On the 15 December 2019, the decision was made by Mr R's NoK to remove life support. Mr R was pronounced dead at 04:50 on 16 December 2019 at Tallaght University Hospital.

7. Cloverhill Prison

7.1 Cloverhill Prison is a closed, medium security prison for adult males, which primarily caters for remand prisoners committed from the Leinster area. Cloverhill Prison has an occupational capacity of 431 beds. Mr R was the third death of a Cloverhill prisoner in 2019, and the 18 death in IPS custody that year, which met the criteria for investigation by the OIP.

FINDINGS

8. Background

8.1 Mr R was committed to Cloverhill Prison on 16 October 2019 and placed on a standard level of the Incentivised Regime[1] as are all new committals. A Nurses committal assessment was completed on 16 October 2019 and Doctor A completed a committal medical assessment on Mr R on 17 October 2019.

8. 2 Mr R was allocated a cell on D2 wing where he was the sole occupant of the cell. He was moved to A2 landing, cell 10 on 17 October 2019 where he shared the cell with one other prisoner until 22 October 2019 when he was moved to cell 14, which he shared with a different prisoner. The Prisoner Information Management System (PIMS) does not provide information as to why Mr R was moved on 22 October 2019.

8.3 Mr R was moved back to D2 landing on 26 October 2019 and remained there until 29 October 2019. The move from A2 landing to D2 occurred following a medical assessment by the Prison Doctor A, and according to the statements received, Mr R was also assessed by the Prison In-reach and Court Liaison Service (PICLS) team while on D wing. The main objective of the PICLS team is to improve the identification of people suffering from mental health issues when they are remanded to prison. The scheme aims to assist patients, the criminal justice system and local psychiatric services by ensuring a rapid response and by systematically identifying prisoners with a primary diagnosis of psychotic illness. Those prisoners accommodated on D2 landing are assessed and monitored by the PICLS In-reach team.

8.4 It is likely that the Prisoner Healthcare Management System (PHMS) and hard copy medical records has additional notes as to why Mr R was initially accommodated on D2 landing and following a short period in the general prisoner population, why he was moved back to D2 landing. PHMS should contain details of the assessments on Mr R's physical and mental health at that time. As explained earlier, the OIP could not access these entries. Therefore, we cannot comment further, except to state that healthcare / medical records would have provided important evidence to assist our investigation into the circumstances surrounding the death of Mr R.

8.5 Mr R moved to C1 landing cell 11 on 29 October 2019 where he shared a cell with Prisoner 1. On the 4 November 2019, Prisoner 1 alleged that Mr R had tried to climb into bed with him. After this alleged incident, Prisoner 1 was relocated and Mr R remained in cell 11 on C1 landing. According to reports and statements received from prison staff Mr R displayed *'unusual behaviour'* while accommodated on C landing such as hitting his head of the wall. As the OIP has not had access to the clinical records, we cannot comment further on healthcare intervention.

[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.

9. Incident 4 November 2019

9.1 On 4 November 2019 at 01:30 Prisoner 1 pressed the cell call button which was responded to by Officer B. Prisoner 1 alleged that Mr R had attempted to climb into his bed with him. Prisoner 1 reported to Officer B that he would cause physical harm to Mr R if he was not relocated to a different cell. Officer B called Assistant Chief Officer 1 (ACO) for assistance. ACO 1 arrived at cell 11 with Officers A and C and relocated Prisoner 1 to another cell on the same landing. Prisoner 1 was also placed on a disciplinary report (P19) for threatening to assault his Mr R.

9.2 Officer B stated that Mr R was regularly checked during their tour of duty. At 03:30 Officer B noticed blood on Mr R's head and clothes and called ACO 1 and Nurse 1. At the request of ACO 1, Officers A and C also attended Mr R's cell. Officers A, B, C and ACO 1 who attended cell 11 earlier to assist in relocating Prisoner 1 had seen Mr R and all reported that Mr R had no visible injury at that time.

9.3 Officer A reported that, when he entered the cell to assist Mr R he heard him state that he had fallen out of the bunk bed and struck his head on the cell floor. Officer C reported that "*when asked Prisoner R did not offer an explanation*" on how he sustained the injury. Officer C also reported seeing blood and vomit on the cell floor and this was corroborated by Nurse 1.

9.4 Mr R was treated in the cell by Nurse 1 for a cut to the rear of his head and according to the reports received, Mr R refused pain relief. Mr R was provided with a change of clothes before being locked back in his cell. The Night Guard reported monitoring Mr R hourly for the remainder of their tour of duty. As CCTV footage was not saved continuously from the time of the incident to the time Mr R was removed to hospital, the OIP are not in a positon to verify how frequently Mr R was checked by operational and/or healthcare personnel.

9.5 At 12 noon on 4 November 2019 Doctor A examined Mr R in his cell. According to Governor A's report, Doctor A observed that Mr R was confused, disorientated, shaking and incoherent in his speech at this time. Doctor A requested an ambulance stating that Mr R required hospital assessment and treatment. The ambulance arrived at 12:55 and Mr R was removed to Tallaght University Hospital escorted by three officers.

9.6 Mr R had been in custody a total of 19 days when he was transferred from Cloverhill Prison to Tallaght University Hospital.

10. Hospitalisation and Death of Mr R

10.1 On 5 November 2019 Mr R was transferred from Tallaght University Hospital to Beaumont Hospital. Mr R had a three officer hospital escort.

10.2 In the material received from the IPS, there was an anonymised report purporting to be from a member of Beaumont Hospital nursing staff. The report was critical of Prison Officers who formed part of Mr R's prisoner escort on the night of the 10 November 2019. The report claims Mr R fell out of his bed resulting in further injury to his head and the removal of a catheter. It was alleged that Prison Officers didn't pay adequate attention to Mr R. The letter stated that hospital nursing staff had asked the escort officers to contact the Nursing Station should Mr R attempt to get out of his bed. According to the letter nursing staff were not notified and Mr R, who was unassisted when he got out of bed, fell sustaining another head injury.

10.3 The OIP interviewed two of the Officers who formed part of the escort on the night of 10 November 2019, Officers D and E. The third escort officer had retired prior to the commencement of this investigation. Officers D and E stated that they were not asked to contact the Nurses Station if Mr R attempted to get out of his bed and further stated that such a request would be highly irregular.

10.4 Officer E recalled Mr R standing up from his bed and walking towards the bathroom. Officer E stated that Mr R's tripod caught on the rail at the end of his bed resulting in the catheter becoming dislodged and caused Mr R to stumble onto the bathroom floor. Officer E stated that nursing staff were immediately called and they assisted in helping Mr R to his feet. Officer E reported that at no point did Mr R hit his head. Officer E also pointed out that the bed rails were not raised to prevent Mr R exiting the bed.

10.5 Following the fall in the hospital, Mr R's condition deteriorated requiring two nurses to assist with his mobility. On 11 November 2019 Mr R was admitted to the High Dependency Unit at Beaumont Hospital.

10.6 The prison clinical records would have been extremely beneficial to establish the circumstances surrounding the fall in the hospital as a detailed clinical report would normally be provided by the hospital staff to the healthcare prison staff in relation to a patient. As explained in section 3.2 and 5.2 of this report, the OIP did not have the consent of the NoK to access the healthcare records of Mr R and therefore, are unable to comment further.

10.7 On 13 November 2019 Mr R was transferred back to Tallaght University Hospital. On 19 November 2019 Mr R's condition deteriorated further. As there was no available bed in Tallaght ICU, Mr R was placed in the Post-Anaesthesia Care Unit. It was reported that at that time he was responding to pain only. On 21 November 2019 Mr R was moved to the ICU Unit in Tallaght University Hospital where he remained stable but did not respond to treatment.

10.8 On 13 December 2019 Mr R's NoK informed Chaplain A that they had met the hospital doctors to discuss Mr R's prognosis and consideration was given to withdrawing Mr R's life support.

10.9 On 14 December 2019 Governor A received a phone call from Chief Officer 1 who advised the Governor of Mr R's poor prognosis. On 15 December 2019 the decision was made by Mr R's NoK to remove life support which was withdrawn at 16:00.

10.10 Governor A contacted Chaplain A who visited Mr R and met his NoK at Tallaght University Hospital. Mr R's NoK remained by his bedside throughout the night until his passing at 04:50 on 16 December 2019. Members of An Garda Síochána arrived from Ronanstown Garda station and took charge of Mr R's remains.

10.11 Chaplain A continued to liaise with and support Mr R's NoK.

11. Critical Incident Review

11.1 A critical incident meeting should take place as soon as possible after a Death in Custody, involving all who were present. The purpose is to provide staff and any prisoners with an opportunity to share views in relation to how the situation was managed, and identify any additional support or learning that could have assisted. In this case, there is no evidence that a critical incident meeting was convened by management of Cloverhill Prison. While this may have seemed unnecessary because Mr R passed away in hospital six weeks after an injury sustained in prison, it is clear there were issues of concern which should have been raised at a Review meeting. A Review meeting might have also identified other concerns and resolutions e.g. the subsequent injury sustained in hospital while being supervised by prison staff.

11.2 In previous investigation reports submitted in 2018 (Mr I and Mr O), The OIP recommended there should be a hot[2] and cold debrief[3]. However, it is pleasing to note that since the death of Mr R and prior to the completion of this investigation report, the Irish Prison Service has 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.

12. CCTV Footage

12.1 The OIP shortly after learning of the passing of Mr R requested that all relevant CCTV be saved and secured for review. The IPS responded stating that "*all relevant CCTV from the night of November 3rd & 4th 2019 has been saved*". CCTV provided to the OIP only captured approximately two hours of footage which related to the removal of Mr R's cellmate and subsequent attendance at Mr R's cell during the early hours of 4 November 2019 when he required healthcare assessment and treatment.

12.2 At no point was Mr R captured on the CCTV footage provided. The footage provided to the OIP was not continuous, therefore the OIP cannot verify if the number of prisoner checks conducted and/or the time period between checks. It is also the case that the footage provided does not capture Doctor A's attendance at the cell, Mr R's removal from his cell or his departure to hospital.

13. Criminal Investigation

13.1 An Garda Síochána conducted an investigation into the incident at Cloverhill Prison on the night of 3/4 November 2019 when Mr R sustained a head injury. The Gardaí submitted a file to the Director of Public Prosecution, no prosecution was recommended.

[2] Hot Debriefs" are interactive, structured team dialogues that take place either immediately or very shortly after a critical incident. They are designed to help the whole team learn from the experience, reflect on what went well, identify difficulties and to consider ways to improve.

[3] Cold "debrief" are normally held within 14 days of the incident to provide further opportunity for everyone involved in the incident to identify learning, provide support and assess progress in relation to actions identified at the hot debrief.

14. Recommendations

14.1 The Office of the Inspector of Prisons has made four recommendations.

1. Pending amending legislation, the Irish Prison Service should conduct a review of the legal advice to see if there are any limited and/or defined circumstances where the necessity to access medical records and conduct a thorough and effective investigation of the circumstances surrounding the death of a person, might outweigh the challenges of obtaining consent from a next-of-kin. It is worth noting that a next-of-kin has no legal basis in law.

2. When a serious incident occurs in a prison, the Irish Prison Service should ensure that CCTV footage is saved in a continuous flow, most particularly when the incident results in hospitalisation or death of a prisoner. The footage should be capture a period of time leading into the incident and the staff response. The footage should continue right through until the ambulance departs the prison or until death is pronounced.

3. The Irish Prison Service should update the Hospital Escort Policy to include the role and responsibility of hospital escort staff in a situation where a prisoner wishes to alight from their hospital bed. The policy should provide guidance on matters such as (a) notification of nursing staff and (b) provision of support/assistance where physical instability is evident.

4. Free text entry on the Prison Information Management System should be an option for staff to provide the reason/further detail for cell movements.

The responses of the Irish Prison Service to these recommendations are set out in the Action Plan prepared by the IPS in response to this report.

15. Support Organisations

15.1 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.