Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. E
Arbour Hill Prison
10 April 2020

[Submission Date (to Minister)] 25 November 2022

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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 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 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 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 and actions of the Irish Prison Service from when Mr. E was found unconscious and any information that could have foreseen his illness.

4. Administration of Investigation

4.1 On Friday 10 April 2020, the OIP was notified that Mr. E had passed away while in Arbour Hill Prison. That afternoon, the investigation team attended the prison and liaised with all relevant persons who had contact with Mr. E to determine the chain of events that led to his death.

4.2 Arbour Hill Prison Management provided the OIP with all relevant information in accordance with the standardised checklist of required information.

4.3 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 Inspectors communicated with Mr. E's NoK by telephone on, Wednesday 19 August 2020.

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

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

INVESTIGATION

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. E was the second death of a prisoner from Arbour Hill Prison in 2020 and the fifth death in IPS custody that year which met the criteria for investigation by the OIP.

7. Family Concerns

7.1 The family of Mr. E had no issues or concerns regarding the time he spent in the custody of the Irish Prison Service.

8. Background

8.1 Mr. E was 57 years old when he passed away in Arbour Hill Prison. He was originally from Scotland and had resided in the Ulster area.

8.2 On Thursday 18 July 2019 Mr. E was committed to Castlerea Prison to serve a three year sentence with a remission date of Saturday 16 October 2021. On Friday 19 July 2020, Mr. E was transferred to the Midlands Prison and spent five months there. He was subsequently transferred to Arbour Hill Prison on Friday 20 December 2019 to participate in the Building Better Lives Programme.[1]

8.3 During his committal procedure into Castlerea, Midlands and Arbour Hill Prison, Mr. E provided nursing staff with his medical history and was examined by a doctor. Mr. E disclosed that he had health issues that included hypertension, gout and asthma. His blood pressure was taken and on each occasion and the readings were high. Prison medical records show that he had not complained of any other health concerns and was prescribed medication to treat all his known medical issues while in prison.

9. Events of 10 April 2020

9.1 On Friday 10 April 2020 at 11:17hrs CCTV shows Mr. E returning from exercising in the North Yard and walking the short distance to his cell number 21, which is double occupancy type accommodation, shared with his cellmate. Several inmates and prison officers confirmed that on 10 April 2020 Mr. E did not show any signs of illness or disclose feeling unwell.

[1] This is a therapeutic programme for men who acknowledge that they have committed a sexual offence and who have a desire to build a better life for themselves.

9.2 At 11.45hrs his cellmate attempted entry and when he tried to open the cell door he noticed Mr. E collapsed on the floor restricting access. His cellmate immediately raised the alarm with Prison Officer (PO) A who checked the cell to assess Mr. E's condition but was also unable to enter due to Mr. E's position behind the door. PO A went to the circle[2] and a 'Code Red Alert'[3] was immediately called for prison and health care staff to assist. At 11:46hrs, PO B entered the landing and joined PO A at cell 21.

10. Intervention by Healthcare Staff

10.1 At 11:47hrs, Assistant Chief Officer (ACO) A arrived at cell 21 joined by Chief Officer (CO) A and they managed to enter by pushing the door open. Mr. E's vital signs were checked and Cardio Pulmonary Resuscitation (CPR) commenced. At 11:48hrs, Nurse Officer A arrived at cell 21 and immediately left to collect the emergency bag, returning at 11:50hrs.

10.2 CO A called for an ambulance and CCTV shows that 16 minutes after officers entered the cell, National Ambulance Service paramedics arrived. CPR continued until 12:10hrs when the decision was taken to cease attempts as Mr. E's vital signs indicated that he was deceased.

11. Sequence of Events after Incident

11.1 At approximately 12:15hrs Prison Doctor A was contacted and requested to attend Arbour Hill to formally pronounce Mr. E deceased. The doctor was part time at Arbour Hill and also covered Mountjoy Prison. The cell was master locked and a prison officer was assigned to create a log of movements in terms of accessing the cell. Prison management reported the death to An Garda Síochána.

11.2 At 12:30hrs, prisoners in the cells located close to Mr. E's cell were provided with their meals and locked back to preserve the dignity of Mr. E. At 12:58hrs, members of An Garda Síochána arrived and the cell was unlocked. Gardaí left the cell at 13:05hrs. At 13:16hrs, Prison Doctor A attended cell 21 and pronounced Mr. E deceased. At 13:39hrs Garda forensic examiners attended and at 14:14hrs, funeral directors arrived and removed Mr. E's remains.

11.3 Inspectors met with Mr. E's cellmate who explained that all of the prison officers involved in the incident acted quickly and in his opinion with compassion. Following the incident he met the Prison Chaplain and was offered counselling from a Samaritans trained Listener. He was asked if he wanted to move cell, but he wished to return to the same cell. Prison management arranged for the cell to be repainted and professionally cleaned before he returned to this accommodation about three weeks later. The cellmate thought the prison staff went "above and beyond" in considering the impact and effects on him and other prisoners.

[2] Area in prison where landings meet.
[3] Prison code for an urgent medical situation – requiring medical staff and equipment.

12. Critical Incident Review

12.1 On Friday 8 May 2020, a Critical Incident Review Meeting[4] took place, which was outside the 14 days recommended by the IPS 'Standard Operating Procedure'. Attendees included, Assistant Governor A, CO A, ACO A, Chief Nurse Officer A, Nurse Officer A, Chaplain A and a note taker. CO A explained to attendees' that procedures were followed promptly with no immediate improvements identified. Prison Medical staff suggested procuring privacy screens to protect the dignity of the person and to avoid prisoners becoming distressed by a situation.

12.2 Staff communicated several observations which included: (1) training on how to effectively communicate with emergency services, (2) staff training on the use of a defibrillator and first aid, (3) current advice on chest compressions while using a Bag Valve Mask with a viral filter attached and (4) strategically placing additional defibrillators in the prison.

12.3 Recommendations were also made by staff seeking: (1) a chest compressor machine, (2) privacy screens, (3) training for officers on CPR techniques, (4) developing a checklist for emergency situations and (5) radios enabled to make calls to emergency services.

13. Recommendations

13.1 The Office of the Inspector has made four recommendations:

1. The Irish Prison Service should conduct a review of the prison estate to determine a policy for the ratio of emergency first aid trained staff on duty to prisoners, and the availability of defibrillators in addition to those held by health care staff in the 'Red Bag.'.

2. The Irish Prison Service should explore the viability of providing 'chest compression machines' to assist staff who are administering CPR.[5]

3. The Irish Prison Service should examine the policy for responding to medical emergencies and consider the issues raised by Arbour Hill Prison staff during the critical incident review.

4. Critical incident reviews must follow the guidance of the Irish Prison Service agreed protocol.

[4] 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.
[5] As in Mr. G/2020

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.

14. Closing

14.1 The staff of Arbour Hill Prison involved in this incident should be commended for their response to this unexpected emergency and for the care and dignity they demonstrated for Mr. E and other prisoners who were affected by this event.

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.