Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. G

Castlerea Prison

14 July 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 ;
- 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[1] footage and phone calls.

3.2 This report is structured to detail the events and actions of the Irish Prison Service from when Mr. G fell unwell and any information that could have foreseen his illness.

4. Administration of Investigation

4.1 On Tuesday 14 July 2020, the Irish Prison Service informed the OIP that Mr. G had died while in detention at Castlerea Prison.

4.2 Castlerea 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 The OIP made contact with Mr. G's NoK, his brother, on Friday 30 July 2021. The role of the OIP in relation to the investigation into his brother's death was explained. Liaison with Mr. G's brother was organised through the Romanian Embassy in Dublin.

5.3 Although this report is for the Minister for Justice it will also inform several interested parties. It is written primarily with Mr. G's family in mind. The OIP offers our sincere condolences to them for their loss.

5.4 The OIP is grateful to Mr. G's brother for his contributions to this investigation.

[1] Closed Circuit Television.

INVESTIGATION

6. Castlerea Prison

6.1 Castlerea Prison is a closed, medium security prison for adult males and has an operational capacity of 340. It is the committal prison for remand and sentenced prisoners in Connaught and also takes committals from counties Cavan, Donegal and Longford.

6.2 Mr. G was the second death of a Castlerea prisoner in 2020 and the seventh death in IPS custody that year which met the criteria for investigation by the OIP.

7. Family Concern

7.1 Mr. G's brother, his Next of Kin, asked the Inspectorate to ascertain why Mr. G was asked to assist moving furniture on Tuesday 14 July 2020 if he was not feeling well.

8. Background

8.1 Mr. G was 33 years old when he was committed to prison on Thursday 21 November 2019. During his committal procedure into Castlerea Prison Mr. G was examined by the Prison Doctor and he provided his medical history. Mr. G disclosed that he was a heavy smoker, but there were no health issues raised. Mr. G was active and appeared in good health throughout his time in prison. Prison medical records show that he had not complained of any health concerns while in prison.

9. Events of 14 July 2020

9.1 On Tuesday 14 July 2020 at 12:45hrs Mr. G carried out cleaning duties involving the collection and disposal of refuse from the landing. He also assisted Work Training Officer[2] (WTO) A moving furniture and did not display any signs of illness or mention feeling unwell. Those who spoke with Mr. G that day, including several inmates, said he appeared to be in good health. Mr. G had a healthy appetite and that night ate his evening meal in his cell in the company of his cellmate. They shared accommodation designed for two inmates, cell 1 on the A1 landing[3].

9.2 His cellmate explained that shortly after dinner on Tuesday 14 July 2020 at 16.30hrs Mr. G complained of feeling unwell and of shortness of breath. Within 25 minutes, Mr. G's condition deteriorated severely and he began vomiting, leading to

[2] Prison Officer with Responsibility for Co-Ordinating Skills and Work Training Programmes.
[3] A Cell Accommodation Area of the Prison.

unconsciousness. CCTV shows that at 16:57hrs, Mr G's cellmate activated the in-cell emergency call bell. CCTV shows Prison Officer A responded within a few seconds, he looked into the cell and immediately returned to the class office to summon assistance.

10. Intervention by Healthcare Staff

10.1 Nurse Officers received notification of the medical emergency at 17:01hrs. At 17:04hrs, the cell door was unlocked and Mr. G was found lying unconscious on the floor. His vital signs were checked and Cardiopulmonary Resuscitation (CPR) was immediately commenced by Chief Nurse Officer (CNO) A and Nurse Officers (NO) A and B.

10.2 At 17:05hrs, the prison control room called an ambulance. CCTV shows that 31 minutes after officers entered the cell National Ambulance Service paramedics arrived. Prison officers had prepared the route in the prison for quick access to the A1 landing. Due to insufficient room to perform CPR in the cell, Mr. G was removed onto the landing.

10.3 Paramedics and nurse officers continued CPR until 18:10hrs when the decision was taken to withdraw first aid as Mr. G's vital signs indicated that he was deceased. The prison was unable to contact a doctor to attend to formally pronounce Mr. G deceased.

11. Gardaí, Doctor and Governor Attendance

11.1 As is routine following any death in a prison, members of An Garda Síochána arrived at the prison at approximately 19:00hrs and called a doctor who attended at 20:00hrs and pronounced Mr. G deceased.

11.2 That evening, Assistant Governor A attended the prison and met with personnel who were involved or assisted in the incident.

12. Critical Incident Review

12.1 A Critical Incident Review took place on Thursday 23 July 2020 where procuring a chest compression machine and examining the availability of locum doctors were raised by staff who dealt with the incident. These issues are now contained in two of the four recommendations of this report. The issue of non-availability of a doctor at Castlerea Prison was previously raised in Mr. N's 2015 death in custody report.[4]

13. Cell Access

13.1 OIP inspectors asked prison management to confirm the process, the distance and how long it would take to access keys to open cell 1 on A1 landing in an emergency. It was confirmed that access to keys would require an officer to radio the Assistant Chief Officer in charge and advise that they are drawing the keys. Entrance to the key room requires an officer to supply their biometric information which is also requisite to

[4] https://www.oip.ie/wp-content/uploads/2019/11/Report-into-the-death-of-Prisoner-N-2015.pdf. Recommendations states 'The difficulty in securing a Doctor to pronounce death should be taken up with the relevant authority.'

draw the keys. Once the keys have been obtained, the officer has to descend three flights of stairs and pass through two independent Audio Visual gates and thereafter two Atlas doors[5]. Prison management explained that the Atlas doors are kept open during an emergency to minimise delays. The distance from the key room to cell 1 on A1 landing was calculated at 100 yards. An officer completed a reconstruction of the route including passing security measures in 6 minutes and 50 seconds, consistent with the times in the CCTV footage of the response to Mr. G on Tuesday 14 July 2020. The time period to open the cell door is outside the health advice on administering CPR of within 4 minutes. Prison officers acted promptly and correctly but the location of the keys and the barriers it was necessary to navigate to open the cell, diminished 'potential' opportunities for lifesaving interventions. The importance of quick CPR intervention is well established and has been the subject of research by the European Resuscitation Council (ERC)[6]. It is unknown whether administering immediate CPR would have made any difference in this case, but access to cells in any emergency situation should be in the shortest possible time.

14. Family Questions Response

14.1 Mr. G's brother asked why he had been asked to assist in moving furniture that day if he was unwell. It has been established that Mr. G appeared in good health throughout his time in prison and did not display any symptoms of illness until he finished his dinner on Thursday 14 July 2020. WTO A, whom he was assisting on that day, nor anyone else observed any indication that Mr. G was feeling unwell.

15. Recommendations

1. The Irish Prison Service should review the availability of a doctor for unexpected emergencies at Castlerea Prison.

2. The Irish Prison Service should explore the viability of providing 'chest compression machines' to assist staff who are administering CPR.[7]

3. The Irish Prison Service should examine emergency access to all cells, such as a 'code red' alert[8], to minimise the amount of time between a request for first aid or assistance and entry being made. Each prison should have a protocol in place aimed at reducing emergency access times to a cell to four minutes or below. If it is identified that access to a cell in an emergency is beyond four minutes, measures should be put in place to rectify this.

4. Prison Governors should include oversight and effectiveness of emergency access to cells during their routine inspections of a prison.

[5] Prison security doors.
[6] https://www.erc.edu/assets/documents/RESUS-8995-Exec-Summary_copy.pdf
[7] (Castlerea Prison is in a remote location and in this case arrival of paramedics took over 25 minutes from the time of being called. There are limited numbers trained on CPR in any prison).
[8] Prison code for an urgent medical situation – requiring medical staff and equipment.

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.

16. Closing

16.1 Prior to Mr. G collapsing in his cell, there was no medical history or symptoms to suggest he was feeling unwell or required any medical assistance. The OIP is satisfied all prison staff acted in accordance with policy and in the best interests of Mr. G when they were alerted that he was in need of assistance.

16.2 Mr. G was well regarded by fellow prisoners and prison officers. He was a good worker and contributed to the upkeep of the prison through cleaning duties and assisting staff when requested.

17. Support Organisations

17.1 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.