



OIFIG AN CHIGIRE PRÍÓSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF
Mr G 2019
AGED 64
In Portlaoise General Hospital
while In the custody of Portlaoise Prison
25 May 2019

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Office of the Inspector of Prisons
24 Cecil Walk
Kenyon Street
Nenagh
Co. Tipperary

Tel: + 353 67 42210

**INSPECTOR OF PRISONS INVESTIGATION REPORT
MR G 2019**

<u>CONTENT</u>	<u>PAGE</u>
GLOSSARY	03
PREFACE	04
SUMMARY	06
RECOMMENDATIONS	07
PORTLAOISE PRISON	07
FINDINGS	
Chapter 1: BACKGROUND	08
Chapter 2: EVENTS RELATED TO MR G ON 25 MAY 2019	09
Chapter 3: CRITICAL INCIDENT REVIEW	11

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

GLOSSARY

Act	Prisons Act 2007
ACO	Assistant Chief Officer
AGS	An Garda Síochána
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
CT scan	Computed Tomography scan
DiC	Death in Custody
GP	General Practitioner
IoP	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PGH	Portlaoise General Hospital
PHMS	Prisoner Health Management System
SSO	Staff Support Officer
SOP	Standard operating procedure

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

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 (IoP) 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 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 of Prisons 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 G's wife who was his NoK, 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 G's death

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

Administration of the Investigation

The OIP was notified of Mr G's passing on Saturday 25 May 2019. The Inspector of Prisons and a colleague visited Portlaoise Prison on the same day. Prison management provided a briefing and confirmed that CCTV footage from the prison had been saved. Mr G's cell was viewed and information requirements for the investigation were agreed.

The IoP interviewed two men in custody on the E2 landing.

Operational reports were sought from relevant staff outlining what had occurred and their respective responses.

CCTV footage was sought and viewed. Unfortunately CCTV is very limited in this area of the prison and there was no CCTV footage available from the E2 landing.

All information that was requested was provided promptly and fully by the IPS.

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.

Mr G's wife was contacted by letter dated 10 June 2019 and subsequently by telephone call and a detailed explanation of the investigation process by the OIP was provided. The requirement to obtain next of kin (NoK) consent to view Mr G's medical records was also explained and agreement was received that written consent would be given. On 12 June 2019 a signed consent for the release of healthcare records held by the IPS was received from the NoK. The NoK did not avail of an invitation to meet with the IoP.

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. My colleagues and I offer our sincere condolences to them for their sad loss.

PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)
2 February 2021

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

SUMMARY

Mr G was 64 years of age when he died at Portlaoise General Hospital (PGH) having been taken there by ambulance from Portlaoise Prison.

Mr G had been committed to Portlaoise Prison on 16 May 2015. He was on the enhanced level of the incentivised regime¹ and had been accommodated in cell 45 on E2 landing.

Mr G received ongoing medical attention while in custody in Portlaoise Prison.

On 25 May 2019 at 11:45 the Cell Call alert in Mr G's cell activated and Officer A who was the assistant Class Officer on E2 landing responded by going to the cell immediately. Officer A found Mr G in a distressed state complaining of severe chest pains. Officer A immediately notified Officer B who was Class Officer on E2 landing that a Medic was required as Mr G was having severe chest pains. Officer A placed Mr G in the recovery position on his bed and remained with him until nursing staff arrived.

Officer B on being told of the situation immediately rang the surgery for medical assistance for Mr G and then went to Mr G's cell.

Acting Chief Officer A who was in charge of A and E blocks heard the emergency calls and immediately contacted the Control Room and directed that an Ambulance be called.

Nurse Officers A and B responded immediately to the emergency call.

Nurse Officer A was the first to arrive at the cell and described finding Mr G lying on his bed in obvious distress, complaining of severe central chest pain radiating down his left arm.

The Nurses assessed his condition and took note of his vital signs and administered medication. Staff were alerted to the urgency of the situation and confirmation was given that an ambulance had been summoned.

Mr G's condition worsened and he became unresponsive. CPR was commenced and continued by the nurses until the Paramedics from the Ambulance Service arrived at the cell at 12:05 and they took over CPR.

The emergency ambulance paramedics responded promptly and were with Mr G within 20 minutes of the alert being raised.

The Garda and Military Escort detail were in position to escort the ambulance at 12:14.

Mr G was placed on a trolley and removed to the ambulance and at 12:37 the ambulance left the prison with the escort detail.

The ambulance went directly to PGH and Mr G was taken into the emergency department as CPR continued.

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.

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

At 12:54 on 25 May 2019, Mr G's death was pronounced by the Doctor on duty in PGH Emergency Department.

The cause of death is a matter for the Coroner.

RECOMMENDATIONS

There are no recommendations emanating from the investigation of the death in custody of Mr G.

PORTLAOISE PRISON

Portlaoise Prison is the sole maximum security prison for adult men in Ireland. It holds both remand and sentenced prisoners. It consists of three separate blocks A, C and E. It has an operational capacity of 291. On 25 May 2019 there were 232 prisoners, 44 of whom were in E block.

Portlaoise prison has a Visiting Committee whose role is to frequently visit the prison; meet with prisoners to hear their complaints and report to the Minister on matters of concern.

Mr G was the sole death of a Portlaoise Prison in 2019. At the time of his death, Mr G was the seventh death in IPS custody that year which met the criteria for an investigation by the OIP.

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

FINDINGS

CHAPTER 1: BACKGROUND:

Mr G was committed to Portlaoise Prison on the 16 May 2015 and he had a date of release with remission of 27 December 2023. He was accommodated in E Block and was on the enhanced regime applicable in that block.

Mr G had no disciplinary issues recorded against him. He associated freely with the other prisoners on E2 landing and received regular visits from family and friends while in prison.

Mr G was active and in general good health when committed to prison.

Healthcare while in Portlaoise Prison

On committal to prison, a medical committal interview and assessment is undertaken by the prison GP, during which the prisoner's medical history is explored.

On 17 May 2015, the morning after his committal to Portlaoise Prison, Mr G was seen by Doctor A who recorded Mr G's medical history and his prescribed medications on the Prisoner Health Management System (PHMS). His vital signs were checked and recorded. The doctor also noted that Mr G should continue on the medications he was prescribed prior to committal to prison. Mr G was provided with his medication on a weekly basis and was authorised to hold the supply provided in his possession.

Mr G had continuing routine interactions with the medical staff during his time in Portlaoise Prison.

On the 9 August 2016 Mr G attended at the outpatients department of PGH where he underwent a colonoscopy and a CT scan of his abdomen and pelvis. The notes record that he would need to have another colonoscopy within two to three years.

On 12 December 2016 Mr G was seen by the prison GP, Doctor B, as he was complaining of central chest pains the evening before when he was out walking in the yard. He recorded that Mr G was "Alert, no distress, no dyspnoea²." His vital signs were checked and he was referred to PGH. Doctor B recorded the episode on the PHMS and noted that he had a similar episode when out hill-walking four years previously. At that time he attended the Mater Private Hospital and nil was found. Although at the time he had been advised to have an angiogram he did not do so.

On 13 December 2016 Mr G was taken to PGH. He failed a 'stress test'³ and was admitted to the hospital overnight.

On 14 December 2016 Mr G was removed to the Mater Private Hospital (as a private patient with personal health insurance cover). PHMS records showed that he had two stents inserted and he was to undergo a repeat angiogram on Monday 19 December 2016 with a view to a further procedure. Mr G was prescribed medication and it was recommended that he return to PGH A&E.

² Dyspnoea: Shortness of breath.

³ Stress test: also known as a treadmill test. It is used by doctors to find out how well a patient's heart works during physical exercise.

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

On 15 December 2016 Mr G returned to Portlaoise Prison with further appointments scheduled in the Mater Private Hospital.

On 21 December 2016 Mr G attended at the Mater Private Hospital for further treatment – however the PHMS record showed there was a failed attempt at stenting his right coronary artery.

Two days later, on 23 December 2016, Mr G was returned to Portlaoise Prison with a plan to re-attempt stenting in 2-3 weeks. Mr G continued to receive nursing and medical care in prison.

On 21 January 2017 Mr G returned to the Mater Private Hospital and following treatment returned to Portlaoise Prison on 23 January 2017.

On 21 March 2017 Mr G returned to the Mater Private Hospital for “further *angiogram that also included a stent*” and he returned to Portlaoise Prison the following day.

On 23 March 2017 Doctor B recorded on PHMS that Mr G had returned from the Mater Private Hospital having had an angiogram and further stents. His recommended medication was prescribed by Doctor B.

Mr G continued to receive ongoing routine medical and nursing care in Portlaoise prison.

On 23 May 2017 Mr G complained of feeling unwell all day. He had several episodes of palpitations and associated dizziness. He complained of chest pain, scoring it as 4 out of 10. His vital signs were checked. In view of his cardiac history a transfer to PGH Emergency Department was recommended to rule out cardiac issues and the transfer was effected. The following day, 24 May 2017, Mr G was discharged back to Portlaoise Prison. An angiogram request was sent to Mater Private Hospital.

On 31 May 2017 Mr G attended the Mater Private Hospital for the angiogram and was discharged back to Portlaoise Prison on the same day.

On 8 June 2017 Doctor B reviewed Mr G and recorded on PHMS that Mr G’s stents were patent and the present treatment was to continue until March 2018.

Mr G continued to receive ongoing medical and nursing care at Portlaoise Prison and he also continued to have his medication in his possession.

Mr G had his last review with Doctor B on 16 May 2019.

CHAPTER 2: EVENTS RELATED TO MR G ON 25 MAY 2019

On 25 May 2019, Mr G had returned to his cell after spending some time in the garden area.

At approximately 11:45, the Cell Call Alarm activated at Cell 45 on E2 landing. Officer A, who was assistant to the Class Officer on the landing, responded by going immediately to Cell 45. On arrival Officer A found Mr G in a distressed state complaining of severe chest pains. Officer A immediately alerted Officer B, who was the Class Officer in charge of E2, and asked that the medics be contacted urgently as Mr G was ill. Officer A remained in the cell with Mr G and placed him in the recovery position on his bed and awaited the arrival of nursing staff.

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

Officer B stated that when alerted the surgery was contacted immediately and urgent attention was sought for Mr G. Officer B then went to Cell 45 and confirmed that Mr G was in distress and was complaining of severe chest pains.

Nurse Officer A confirmed receiving an emergency call to Mr G's cell at about 11:45. Nurse Officer A immediately responded and on arriving at Cell 45 observed Mr G lying on his bed in obvious distress, complaining of severe central chest pain radiating down his left arm. Nurse Officer A immediately checked his vital signs - pulse 73 bpm, blood pressure 160/80mmHg, and oxygen saturation 99%. Dispersible Aspirin 75mg was administered followed by two puffs GTN4 spray sublingually. Oxygen was administered via mask. Minimal relief noted. Mr G's vital signs were rechecked - pulse 63bpm, blood pressure 120/80 mmHg and oxygen saturation 99. Administration of GTN sublingually by 2 puffs was repeated. His pain score was 10. At this stage Mr G became unresponsive and CPR compressions were commenced and continued until the Ambulance paramedics arrived at about 12:05.

Nurse Officer B reported hearing the emergency call to cell 45 and immediately responded. On arrival at the cell, Nurse Officer A was already there. Nurse Officer B confirmed an ambulance had been called, they assisted with the taking of vital signs and CPR commenced with Mr. G became unresponsive. Nurse Officer B stated that after two cycles of CPR Mr G responded "*eyes opening, coughing, Pulse checked 53, ROSC⁵....*" At that stage Nurse Officer B stated that the ambulance service paramedics arrived and care was handed over to them.

Acting Chief Officer A in charge of A and E blocks stated that on hearing the emergency call for medical assistance a direction was given to the Control staff to call an ambulance immediately. Acting Chief Officer A went to Cell 45 and confirmed that Mr G was in distress and was being attended to by two Nurse Officers. Acting Chief Officer A then alerted Chief Officer A to the situation and the necessity to make security arrangements for the transfer of Mr G to hospital by ambulance. Acting Chief Officer A contacted Assistant Chief Officer A to liaise with security at the main gate to ensure speedy access of the ambulance to the prison. Acting Chief Officer A confirmed the arrival of the ambulance at 12:00 and its departure from the prison with Mr G at 12:37. At about 12:40 Acting Chief Officer A reported telephoning Mr G's wife to inform her that her husband had been removed to PGH and to make contact with the hospital.

At about 13:00 Acting Chief Officer A received a call from Assistant Chief Officer B who was in charge of the hospital escort who informed Acting Chief Officer A that Mr G had been pronounced dead at PGH at 12:54 by the duty Doctor in the Emergency Department.

On learning of the death of Mr G, Assistant Chief Officer C master locked Cell 45 and held it secure until it was examined by An Garda Síochána.

Acting Chief Officer A and Chief Officer A went to the E2 landing and informed the other prisoners of the death of Mr. G at PGH.

⁴ GTN Spray : Glyceryl Trinitrate Spray is administered for the relief of angina pain.

⁵ ROSC: Return of Spontaneous Circulation

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

Notification of Next of Kin.

At 12:40 Acting Chief Officer A telephoned Mr G's wife, his NoK, to inform her of the emergency removal by ambulance of her husband to PGH and advised her to contact the hospital to get information on his medical condition as he was seriously ill.

Chief Officer A on hearing that Mr G had been pronounced dead contacted Prison Chaplain A and informed him of the death. The Chaplain undertook to go to the hospital and also to liaise with Mr G's wife.

Authorisation for Emergency Removal to Hospital.

Chief Officer A on becoming aware of the medical emergency with Mr G immediately put in train the necessary emergency application for approval to remove Mr G to hospital.

Chief Officer A made contact with the Military on duty and alerted them to the imminent arrival of an ambulance and requested the necessary escort detail.

At 12:01 Chief Officer A sent an email to Official A at IPS HQ seeking emergency approval for the removal of Mr G to hospital under escort.

Chief Officer A also alerted Governor A of the medical emergency.

At 12.08 Official A gave verbal approval by phone to Chief Officer A for the emergency removal to hospital of Mr G. Written confirmation of the approval from Official A was subsequently received two minutes later at 12.10 by Chief Officer A.

Assistant Chief Officer B was detailed to take charge of the escort of Mr G to hospital and was assisted by Officers C and D.

At 12:37 the Ambulance conveying Mr G left the prison under Garda and Military escort and went directly to PGH.

CHAPTER 3: CRITICAL INCIDENT REVIEW

A Critical Incident review meeting was convened the following day, Sunday 26 May 2019 by Assistant Governor A at Portlaoise Prison and attended by Chief Officers A, B, and C, acting Chief Officer A and two ACOs B and D, Nurse Officer B, SSO Officer A, Chaplain A and Officers B, C and D.

Assistant Governor A recorded the condolences of all with the family of Mr G.

Acting Chief Officer A outlined the events of the previous day and fully described how events unfolded, how individual staff responded promptly to the emergency and how the ambulance paramedics were speedily escorted to the scene without compromising security. Acting Chief Officer A also acknowledged the swift receipt of the emergency approval from IPS HQ for the transfer to hospital and noted that the security detail, AGS, Army and Prison Officer Escort was assembled and ready to escort the ambulance to hospital.

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR G 2019

Acting Chief Officer A reported contacting Mr G's wife initially to alert her to the emergency transfer of her husband to PGH. On learning of the death of Mr G, Acting Chief Officer A informed Governor A and Chief Officer B and confirmed that Chaplain A was asked to liaise with the family. Acting Chief Officer A also reported accompanying Chief Officer A to E2 landing to tell the prisoners that Mr G had died at PGH.

Chief Officer A confirmed that CCTV was saved.

Assistant Governor A confirmed that the following had been notified of Mr G's death: Director General of IPS, Director of Operation IPS HQ, Inspector of Prisons, Chairperson of the Visiting Committee and the Coroner for County Laois.

It was noted that the Chaplain was organising a prayer service on E2 landing for the prisoners who wished to attend.

Assistant Governor A and Chief Officer B were due to meet with the family of Mr G later that day at PGH. The Chaplain was also to make contact with the family

It was noted that Assistant Governor A would implement the Critical Incident Stress Management (CISM) protocol for staff.

There is 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. G and prior to the completion of this investigation 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.