OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

# Investigation Report

## Into the Circumstances Surrounding the

## Death of

## Mr T

## AGED 74

## in Portlaoise General Hospital

## While in Custody of Midland's Prison.

**[Date finalised: 09 December 2021]**

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## GLOSSARY

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| **Act** | Prisons Act 2007 |
| **AGS** | An Garda Síochána |
| **ACO** | Assistance Chief Officer |
| **CCTV** | Close Circuit Television |
| **CNO** | Chief Nurse Officer |
| **TR** | Temporary Release |
| **HCA** | Health Care Assistant |
| HSE | Health Service Executive |
| **Inspector** | Inspector of Prisons |
| **IPS** | Irish Prison Service |
| **NO** | Nurse Officer |
| **NoK** | Next of Kin |
| **OIP** | Office of the Inspector of Prisons |
| **PIMS** | Prisoner Information Management System |
| **PGH** | Portlaoise General Hospital |

## PREFACE

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 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 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 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 T's NoK provided consent to the Inspector to access his medical records for the purposes of this investigation.

This report is structured to detail the events leading up to, and the response after Mr T passed.

### *Administration of the Investigation*

The OIP was notified of Mr T's passing on the morning of 27 December 2019. Prison management provided a briefing and all information requirements for the investigation were provided 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.

The OIP made contact with Mr T's NoK in writing and by telephone and provided a detailed overview of the OIP investigation process. The requirement to obtain NoK consent to view Mr T's medical records was explained. On the 23 March 2020 a signed consent for the release of healthcare records from the IPS was received from the NoK. The NoK did not wish to meet with the OIP and did not express any concerns.

Although this report is for the Minister for Justice it will also inform several interested parties. It is written primarily with Mr T's family in mind. My colleagues and I offer our sincere condolences to them for their sad loss.

### *Recommendation*

There was one recommendation in the draft report provided to the Irish Prison Service for review and comment. The IPS did not accept the recommendation as a Standard Operating Procedure is in place which allows for local management to decide on whether a two or three officer hospital escort is warranted, taking into account the risks involved in the specific escort. The discretion afforded to local management in the IPS policy is welcome and we will monitor its application in the course of our oversight statutory functions and report accordingly.

PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)
09 December 2021

## SUMMARY

Mr T was 74 years of age at the time of his death at Portlaoise General Hospital (PGH). The prison was aware Mr T was terminally ill for approximately eight months prior to his passing. Mr T had received medical treatment both in prison and at PGH leading up to his death.

A case conference was held at the Midlands Prison on the 19 December 2019 to discuss Mr T's declining health as his prognosis was not good. On review of the case conference minutes, it was evident that those in attendance wanted Mr T's final days of his life to be in a palliative care setting in the community and not the prison environment. Details of actions agreed at this case conference are set out in Chapter 1.

Mr T was taken to PGH by ambulance on 24 December 2019 with respiratory issues associated with his terminal illness. He remained in hospital until he died on the 27 December 2019.

The cause of death is a matter for the coroner.

## Recommendation

**It is recommended that a review of the current practice regarding a three person hospital escort be undertaken having particular regard to end of life hospital supervision. The review should consider the need for a risk assessment of the person to be hospitalised. (page 10)**

Not accepted by the IPS for the following reason: In accordance with the Irish Prison Service "Escorting of Prisoners Standard Operating Procedures" a hospital escort can consist of two or three officers. Decision making in respect of the appropriate staff complement is a matter for local management taking into account the risks involved in the specific escort. On this basis, the Irish Prison Service does not believe that there is a necessity to review the escort guidelines at this time.

## Midlands Prison

Midlands Prison is a closed, medium security prison for adult men. It is the committal prison for counties Carlow, Kildare, Kilkenny, Laois, Offaly and Westmeath. It had an occupancy capacity of 845 beds. On the 27 December 2019 the total number of persons in custody in the Midlands Prison was 835[1]

Mr T was the fourth death of a Midlands prisoner in 2019; and the 20th death in IPS custody in 2019 that met the criteria for investigation by the OIP.

[1] Irish Prison Service Daily Prisoner Population 27/12/19 https://www.irishprisons.ie/wp-content/uploads/documents_pdf/27-December-2019.pdf

## Chapter 1: Background

Mr T was a life sentenced prisoner who had completed 21 years in prison at the time of his death. He was described as a solitary figure while in prison. For a number of years prior to his passing Mr T received no visits, nor did he make any personal phone calls. Mr T was on the enhanced level of the IPS incentivised regime[2] and was accommodated on the G1 landing. Mr T was terminally ill for a period of eight months and had been receiving ongoing medical treatment from the healthcare staff attached to the Midlands Prison and at PGH. Mr T had 24 hour care assistant support in the prison during this time.

On 19 December 2019 a case conference was convened to discuss Mr T's health condition. Governor A, Chief Officer A, CNO A, Nurse Officer A, Nurse Officer B, ACO A, Doctor A, National Operational Nurse Manager A, Palliative Care Nurse A, Palliative Care Nurse B and Prison Chaplain B were in attendance. It was reported that Mr T's health was deteriorating and he had not long to live. There was consensus that if possible a suitable community facility should be secured so that Mr T would not die in a prison environment. The agreed actions were:

- arrange a hospital bed for Mr T's cell;
- a member of the Palliative Care Nursing team was tasked with sourcing a suitable facility in a community setting;
- a risk assessment to be conducted when an appropriate community facility had been secured;
- the Governor to submit an application to Operations Directorate, IPS HQ seeking approval for Temporary Release (TR) on compassionate grounds; and
- NoK to be informed of the situation.

Mr T was provided with a hospital bed in his cell.

An application for TR on compassionate grounds was not made between the 19 and the 27 of December 2019 as seeking approval for TR was contingent on a hospice place being identified in the community. It was confirmed by prison management that the Health Service Executive (HSE) were actively working to source a place for Mr T in a regional community hospice however Mr T passed before a place became available.

[2] 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.

## Chapter 2: Events of 24 December 2019 leading to the transfer of Mr T to Portlaoise General Hospital

ACO B was in charge of the G Wing on 24 December 2019. The ACO engaged with Mr T twice during the tour of duty and noted that he had no requests.

Officer A reported that Mr T declined his breakfast on 24 December 2019. Following breakfast a Health Care Assistant (HCA) checked in on Mr T and administered medication. Dinner was served at midday, again Mr T declined to eat. The Officer along with the HCA changed Mr T's clothing. Officer A continued to regularly check on Mr T throughout the afternoon. Officer A reported that Mr T also declined his tea time meal.

Nurse Officer B covered G1 landing on the 24 December 2019 between 08:00 and 19:00. The Nurse Officer stated that Mr T was reviewed regularly throughout the day. At approx. 14:40 Doctor B reviewed Mr T in his cell at the request of Nurse Officer B. Mr T was diagnosed with having cellulitis in his right foot and a respiratory tract infection. The Doctor recorded on the Prison Health Management System (PHMS) that Mr T did not appear distressed. The Doctor prescribed Mr T antibiotics and recommended that he should be monitored in relation to the progress regarding the cellulitis in his right foot.

HCA A and HCA B commenced duty at 07:00 on 24 December 2019. The HCA's assisted Mr T with personal care and movement to and from his bed to his chair. It was reported by HCA A that Mr T appeared weaker in the afternoon and was assisted by the HCA into his bed at 18:30. HCA C commenced duty at 19:00 that evening.

Night Guard Officer F was conducting observation checks and at approximately 21:00 observed Mr T sitting on the edge of his bed. Officer F reported that Mr T appeared to have difficulty breathing and contacted ACO C and HCA C. HCA C requested that Officer F call the nurse to review Mr T. The Officer reported that the healthcare team arrived and attended to Mr T shortly afterwards.

Nurse Officer C commenced duty at 21:00 and reported that during a handover with Nurse Officer D they received an emergency call to G1 landing. On arrival they were directed to Cell 3 where they reported observing Mr T sitting on his bed breathless. Due to Mr T's acute presentation Nurse Officers C and D recommended that he be transferred to hospital as a priority. Nurse Officer D stated that all necessary medical treatment was provided until the paramedic crew arrived and took over care.

ACO C reported attending Mr T's cell with two Nurse Officers; Nurse Officers C and D. Both Nurse Officers assessed Mr T and informed the ACO that Mr T required hospital care. The ACO arranged for an ambulance to be called and organised three Prison Officers; Officers B, C and D to escort Mr T to PGH.

**Recommendation 1**

**It is recommended that a review of the current practice regarding a three person hospital escort be undertaken having particular regard to end of life hospital supervision. The review should consider the need for a risk assessment of the person to be hospitalised.**

Nurse Officer D reported that Mr T was transferred to hospital at 22:15 on 24 December 2019. This account of events was supported by fellow Nurse Officer C who also responded to the emergency call.

## Chapter 3: Events surrounding the death of Mr T

On the 25 December 2019 Chaplain A visited Mr T in PGH. The Chaplain reported that Mr T was alert and shared a few words.

On the 26 December 2019 Chaplain B received a phone call from the Midlands Prison Control Room officer stating that they had received information that Mr T's condition had further deteriorated. Chaplain B immediately made his way to PGH, and arrived at approximately 12:00. Chaplain B was informed by PGH nursing staff that they had attempted to contact Mr T's NoK but were unsuccessful. On return to Midlands Prison Chaplain B informed the Governor that the NoK had not been contacted. Chaplain B discussed his concern with ACO D and ACO E who then located contact details for the NoK from the Prisoner Information Management System (PIMS). Chaplain B rang the phone number for Mr T's NoK, his sister. Mr T's brother in law answered the phone and informed the Chaplain that Mr T's sister had herself passed away in recent months. Chaplain B was aware that Mr T had a friendship with prisoner 1. The Chaplain approached this prisoner who informed him that Mr T had a son but they had not been in contact with one another for a considerable length of time. Chaplain B returned to PGH, spending time with Mr T and said prayers for the sick.

At approximately 03:30 on the 27 December 2019 Chaplain B received a phone call from ACO D informing him that Mr T had passed away at 03:20. Chaplain B arrived at PGH at approximately 04:10 and said prayers. Chaplain B noted that Doctor C arrived and pronounced the death of Mr T at 04:20. When members of An Garda Síochána (AGS) arrived at PGH the Chaplain left the hospital, reporting that this was approximately 04:45.

The following morning Chaplain B contacted Mr T's brother in law and informed him of Mr T's passing. On the 2 January 2020 Chaplain B received a voicemail message from Mr T's son. Chaplain B returned a call to Mr T's son and remained in contact with him regarding funeral arrangements.

ACO D reported that while on escort duty at PHG on 27 December 2019 along with Officer E they noticed a change in Mr T's condition. They immediately alerted the nurse's station. The nurses called the Doctor to pronounce his death.

At approximately 03:30 ACO D informed ACO F, Governor B, Chaplain B and AGS of the death. Garda 1, Garda 2 arrived at PGH at 04:00 and Chaplain B arrived at 04:15. ACO D noted that Doctor C officially confirmed the death of Mr T at 04:20. Garda 3 and Garda 4 arrived at 04:25 taking charge of Mr T's remains.

## Chapter 4: Post Event

### *Critical Incident Review*

A critical incident meeting was held on 31 December 2019. The purpose of a critical incident meeting is to establish the facts and provide an opportunity to share views in relation to how the situation was managed, and identify any additional support or learning. A total of eight members of staff attended, which was chaired by Assistant Governor A.

It was noted that:

- IPS HQ were aware that Mr T was terminally ill;
- he had been due to attend hospital to commence palliative care treatment;
- he was provided with 24 hour care assistance and also received additional medical supervision;
- he was facilitated with a hospital bed in his cell; and
- his cell was not master locked to allow ease of medical access.

It was also noted that Mr T was conveyed to PGH via ambulance at 22:15 on the 24 December 2019 and ACO D contacted the prison at approximately 03:30 on the 27 December 2019 to inform prison personnel that Mr T had passed away.

At the close of the meeting the healthcare staff and care assistants were thanked for their excellent care of Mr T.