A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner F on 13 April 2017 while in the custody of Cork Prison

***Please note that names have been removed to anonymise this Report**

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Office of the Inspector of Prisons

into the circumstances surrounding the death of Prisoner F

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Presented to the Minister for Justice and Equality pursuant to Part 5 of the Prisons Act 2007

The Investigation was conducted and this Report prepared by the undersigned.

Helen Casey
Deputy Inspector of Prisons

15 March 2018

Contents

Preface

The aim of this investigation is to:

- Establish the circumstances surrounding the death;
- Examine whether any changes in operational methods, policy and practice, or management arrangements would help to prevent recurrence of a similar death or serious event; and
- Address any concerns of the family.

The deceased was a 22-year-old man who died on 13 April 2017 while in the custody of Cork Prison.

I offer my sincere condolences to the family of the deceased.

I would like to point out that names have been removed to anonymise this Report.

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15 March 2018

Investigation Report

1.0 General Information

1.1 The deceased was a 22 year old man who came from the Munster region.

1.2 He is survived by his mother, brothers, sisters, partner and daughter.

1.3 The deceased was committed to Cork Prison on 12 January 2017. He had a release date, with remission, of 6 November 2017 on existing warrants.

1.4 While in custody the deceased appeared on other charges at various Courts. He appeared before the Central Criminal Court on 20 March 2017, where he was convicted on serious charges, and remanded for sentencing to 15 May 2017.

1.5 During his term of imprisonment, the deceased was transferred between the Midlands Prison and Cork Prison on a number of occasions to facilitate Court appearances. He was due to transfer back to the Midlands Prison on 14 April 2017.

1.6 The deceased was found unresponsive in his cell – Cell 4 on B1 landing on 13 April 2017 at 03:03:26. When found, the deceased had a ligature around his neck.

1.7 The deceased was removed by Ambulance to Cork University Hospital where he was pronounced dead at 04:35 on 13 April 2017.

1.8 When carrying out this investigation I had unrestricted access to staff, prisoners and relevant records, including CCTV footage.

2.0 Status of the deceased in prison

2.1 The deceased was on the 'Standard level' of the Incentivised Regime[1] accommodated in Cell 4 on B1 landing.

2.2 Due to the nature of the charges before the Central Criminal Court there was conflict between the deceased and other prisoners in Cork Prison. On 30 March 2017, the deceased was placed on a restricted regime under Rule 63[2] of the Prison Rules 2007.

3.0 Meeting with Next of Kin

3.1 I met the deceased's mother and partner on 22 May 2017 and they provided the following information:

3.2 The deceased was the second eldest in his family and was the father of a young daughter.

3.3 The deceased's partner informed us that she had visited her boyfriend in Cork Prison on 12 April 2017. She stated that he had given no indication of thoughts of self-harm during that visit.

3.4 The deceased's mother stated that her son had no history of self-harming and there was no history of depression or psychiatric illness. She said he "*smoked a little hash and some years ago he used to take some tablets, but not in recent years"*.

3.5 The deceased's Mother informed us that she had, since the death of her son, become aware that a serious charge was pending. His partner also stated that she was not aware of the pending charge.

[1] The Incentivised Regime has three levels of privilege – Basic, Standard and Enhanced. Basic level provides the least amount of privileges (number of phone calls permitted, amount daily gratuity paid etc) while the Enhanced level offers the best privileges. All committals are placed on the Standard level of the Incentivised Regime.

[2] Restricted Regime which is limited out of cell time to protect vulnerable prisoners.

3.6 The deceased's mother explained that on 13 April 2017 she missed a telephone call from the prison at 04:00. She received another call at approximately 04:15 which was Cork Prison informing her that her son had self-harmed and was in an ambulance on the way to hospital. The deceased's mother arrived at the hospital at approximately 04:40 but the ambulance had not arrived and did not do so for a further 20 minutes.

3.7 The family expressed certain concerns which they asked to have investigated, as follows:-

(i) Why was their son/partner on 23 hour lock up?
(ii) Was their son's/partner's checked regularly in his cell?
(iii) Why was there a delay in the Ambulance arriving at the hospital?
(iv) Was their son/partner shop order cancelled? Had he cigarettes?
(v) Where is the remainder of the deceased's property? - "*Runners not returned*".

4.0 Contact with Medical Service

4.1 The deceased had been medically assessed by the Prison Doctors on committal to both Cork and Midlands Prisons. The medical records indicated that he was in good health, with no thoughts of self-harm or any psychotic issues and did not require any medical treatment while in custody.

4.2 The deceased did not have any contact with the Prison Psychology service.

5.0 Sequence of Events

5.1 The deceased received a visit from his partner and young daughter on 12 April 2017 at 15:15. The visit concluded at 15:45.

5.2 Following the visit, the deceased can be seen on CCTV footage waiting with other prisoners in the hallway for an officer to escort them back to the landing.

5.3 The deceased returned to his cell at 15:50 and soon after exited the cell with a plate of food and placed it into the bin on the landing. The deceased then returned to his cell and closed out the cell door.

5.4 An officer unlocked the deceased's cell at 17:45. The deceased exited the cell, collected a sweeping brush, mop and bucket and cleaned out his cell. At 17:53 the deceased walked down the landing, with the cleaning utensils, to the store.

5.5 At 18:01 the deceased returned to his cell and closed out the cell door.

5.6 An officer went to the deceased's cell at 18:46 and opened the door. The deceased exited the cell, walked down the landing and made a telephone call. Prison records verify that he made the telephone call to his partner. He returned to his cell at 18:53 and closed out the cell door.

5.7 The deceased's cell was master locked for the night by an officer at 19:15. The officer lifted the viewing flap and looked into the cell.

5.8 Between 19:15 and 03:02 the deceased was checked by officers on 15 occasions – approximately every 30 minutes. The checks consisted of an officer going to the cell door, lifting the viewing flap and looking into the cell.

5.9 Officer A stated, in his operational report, that when he lifted the viewing flap and looked into the cell with the aid of a torch he "*observed the deceased sitting on the floor by the TV counter.* He also reported that he *" was unable to see his head – he was unresponsive to my calls"*. Officer A can be seen on CCTV footage leaving the cell and running down the landing to the Class Office.

Officer A reported that he *"immediately called ACO A for keys. I also called Nurse Officer A to attend"*.

5.10 At 03:03:26, Officer A returned to the cell. Nurse Officer A, who carried the emergency response bag arrived moments later at the cell, followed by ACO A. All three entered the cell at 03:04:46.

5.11 The Officers, in their respective reports, described how they found the deceased unresponsive with a ligature around his neck, which was removed and CPR commenced.

5.12 Nurse Officer A, described the incident in her Operational Report as follows:-

> "*While on duty on 13 April 2017, I received a radio call from Officer A at 03:03am asking me to come to B1 landing as there was an unresponsive prisoner and my assistance was required……. When I looked through the hatch at the deceased's cell, only his legs and torso were visible to me. I could not see his head/face due to the way he was positioned. Officer A called out to the deceased and kicked the cell door, but did not receive a response. ACO A arrived with the master keys and we gained access to the cell.* …… Nurse Officer A reported that she removed the ligature with the assistance of Officer A. Nurse Officer A also reported that "*ACO A contacted the control room to ring an ambulance" Nurse* Officer A reported that the deceased "*was not breathing."* They *"commenced CPR"* Nurse Officer A stated that she *"placed electrodes from the defibrillator on the deceased's chest and then awaited instructions from same, following its assessment. It instructed me to continue with CPR which I continued to do so until the ambulance crew arrived on site"*.

5.13 Ambulance Paramedics arrived to the cell at 03:21 and took over CPR.

5.14 Ambulance Paramedics continued to apply CPR. The deceased was removed from the landing at 04:01.

5.15 Nurse Officer A stated that she then contacted the next of kin.

5.16 The Ambulance Service recorded arrival at Cork University Hospital Emergency Department at 04:34.

5.17 Death was pronounced at Cork University Hospital at 04:35

6.0 CCTV Footage

6.1	19:15:38	ACO checked cell – lifted viewing flap and looked in while master locked the cell for the night.
	19:34:52	Officer went to cell – lifted viewing flap and looked into cell.
	20:01:58	Officer checked cell – lifted flap and looked into cell.
	20:02:40	Lights were dimmed on the landing.
	20:32:07	Officer went to cell – lifted viewing flap and looked into the cell.
	21:01:24	Officer with torch checked cell next to the cell of the deceased but did not check the deceased. Officer returned at 21:06 did not check the deceased on either occasion
	21:30:15	Officer with torch lifted viewing flap looked into deceased's cell.
	21:59:05	Officer with torch lifted viewing flap and looked in deceased's cell.
	22:04:01	Officer checked cell –lifted viewing flap and looked into cell.
	22:30:38	Officer checked cell – lifted viewing flap and looked into cell.
	23:00:34	Officer with torch checked cell – lifted viewing flap and looked into the cell.
	23:32:28	Officer checked cell – lifted viewing flap and looked into the cell
	23:58:07	Officer checked cell – lifted viewing flap and looked into the cell

13 April 2017

00:40:47	Officer checked cell – lifted viewing flap and looked into the cell
01:14:20	Officer checked cell – lifted viewing flap, looked into the cell.
02:02:20	Officer checked cell – lifted viewing flap and looked into cell.
02:30:20	Officer checked cell – lifted viewing flap, looked into cell using a torch.
03:02:37	Officer checked cell – lifted viewing flap, looked into cell using torch. Officer then ran from the cell down landing towards the Class Office.
03:03:26	Officer went to cell – lifted flap and looked into cell with a torch and waited.
03:04:14	Nurse Officer arrived to the cell carrying an Emergency bag. Lights on landing were turned on.
03:04:40	ACO arrived to cell running and unlocked the cell.
03:04:46	ACO entered the cell followed by an Officer and Nurse Officer, with an Emergency bag.
03:05:46	ACO observed on a Tetra Radio at the cell door – other officers arrived to the landing.
03:07:58	ACO left the landing – two officers can be seen outside the door on landing.
03:08:49	ACO returned and entered the cell.
03:21:29	Two ambulance paramedics arrived and entered the cell.
03:43:29	Two more Paramedics arrived to the cell with a gurney.
03:52:30	The deceased was placed on the gurney while CPR continued to be administered.
04:01:01	The deceased was removed from the landing on the gurney by four paramedics, CPR continued to be administered.

7.0 Addressing the concerns of the next of kin

7.1 In paragraph 17, I set out the matters of concern raised by the next of kin. I address their concerns hereunder.

(i) ***Why was the deceased on 23 hour lock up*****?**

Due to the nature of the charges pending before the Central Criminal Court, the deceased was placed on protection and on a restricted regime for his own protection. This is referred to in paragraph 10.

(ii) ***Was the deceased checked regularly in his cell?***

Yes. Details are provided in paragraphs 5.8 and 6.1.

(iii) ***Why was there a delay in the Ambulance arriving at the hospital*****?**

Our investigation found no evidence of delay in transferring the deceased to hospital. This is addressed in paragraphs 5.13 to 5.16.

(iv) ***Was the deceased's shop order cancelled? Had he cigarettes?***

We examined the records in relation to the Prison Tuck Shop. The deceased was entitled to one Tuck Shop order per week as per the level of regime he was on (Standard). The records show that the deceased made his final purchase from the Tuck Shop on Friday 7 April 2017. There is no record of any subsequent shop items being ordered or cancelled. I was unable to establish if in fact the deceased had cigarettes when found unresponsive in his cell.

(v) ***Where is the remainder of the deceased's property? – "runners not returned".***

When a prisoner is transferred between prisons, as in the instant case, normally their personal property is transported separately and at a later date. Prison records provided to me did not indicate the whereabouts of the deceased's runners which had not been returned to the family. We made enquiries with prison management who advised that the property could not be located.

8.0 Findings

8.1 The deceased was accommodated in a single cell at the time of his death.

8.3 The deceased was checked regularly when locked in his cell on B1 Landing in Cork Prison.

8.4 The deceased was placed on Protection on 30 March 2017.

8.5 The deceased was in good health and did not give any indication that he would self-harm.

8.6 The staff responded promptly when the alarm was raised.

8.7 Item(s) of the deceased personal property were mislaid during his transfers between prisons.

8.8 The cause of death is a matter for the Coroner.

9.0 Recommendations

9.1 This Report highlights the lack of robust records on prisoner property. The safe custody of a prisoners' personal property is a matter that must be addressed by Management of the Irish Prison Service. A robust tracking system should be introduced to account accurately for any property prisoners are not allowed to take with them when transferring to another prison. This tracking system should be linked to the prisoner's custody file so that – upon release or in the sad event of a death in custody- all property is returned safely and in a timely fashion to the prisoner or his /her next of kin.