

**A report by the Inspector of Prisons  
Judge Michael Reilly into the circumstances  
surrounding the death of Prisoner J  
on 13 June 2015 in Tallaght Hospital,  
following his release from Cloverhill Prison**

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

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**A report by the Inspector of Prisons Judge Michael Reilly  
into the circumstances surrounding the death of Prisoner J  
on 13 June 2015 in Tallaght Hospital, following his release  
from Cloverhill Prison**

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

Judge Michael Reilly  
Inspector of Prisons

1 April 2016

## **Preface**

The deceased was a 58 year old man from Slovakia.

He is survived by his wife and daughter.

I did not meet with members of the deceased's family but wish to offer them my condolences on their sad loss.

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

Judge Michael Reilly  
Inspector of Prisons

1 April 2016

# **Inspector of Prisons Investigation Report**

## **General Information**

1. The deceased was a 58 year old man who came from Slovakia. He is survived by his wife and daughter.
2. He was on remand in Cloverhill Prison since 30 May 2015 and was due to appear in Cloverhill Court on 2 June, 2015. A medical report, from the Prison Doctor, was sent to the presiding Judge on 2 June advising that he (the deceased) was “unfit to attend court”.
3. The charges against the deceased were ‘struck out’ by the Court on 5 June, 2015. Consequently the deceased was not in prison custody on the date of his death but as he was admitted to hospital while on remand I felt it important to examine the circumstances surrounding his death.
4. The wife and daughter of the deceased were not resident in Ireland. Management of the Irish Prison Service made contact with the family of the deceased on 11 June, 2015, through the Slovak Embassy, and advised them of his serious medical condition.

## **Status of the deceased while in Prison**

5. The deceased was on remand in Cloverhill prison and was on the standard regime level.
6. The committal interview was conducted by Nurse Officer A on 30 May, 2015, who noted in the medical records that the deceased had “*very little English*” and information was “*ascertained by sign language*”. It also stated that the “*committal interview was not completed*”.
7. The deceased was assessed by Dr. A on 31 May 2015.

8. The deceased was placed in a double cell on the A1 landing on 31 May, 2015 having spent one night in a committal cell on A2.

### **Sequence of events**

9. At approximately 08:15 hours on 2 June, 2015 Officer A, while unlocking prisoners for breakfast, noticed the deceased “*lying awkwardly*” in his bed. Officer A “*began to call (deceased) but he was not responding*”. Officer A notified the Nurse Officer on duty.
10. Nurse Officer B attended the cell at approx 08:20 hours where she found the deceased sweating and whom she states “*presented as confused*”. Nurse Officer B took the deceased’s vital signs and administered medication.
11. Nurse Officer B states that she was concerned about the deceased so returned to his cell, with a wheelchair, at approx 09:15 hours accompanied by Nurse Officer C.
12. At 09:20 hours the deceased was removed in a wheelchair and escorted to the medical unit “*to be reviewed as soon as the GP arrived*”.
13. At approximately 10:00 hours, while in the Medical Unit, the deceased had a seizure.
14. Dr. B examined the deceased and decided to refer him (deceased) to A&E and an ambulance was called.
15. At 10:14 hours Dublin Fire Brigade Ambulance crew arrived at the Medical Unit in Cloverhill prison and removed the deceased by ambulance to Tallaght Hospital.
16. Chief Nurse Officer A was informed that the deceased had suffered a cardiac arrest shortly after arriving at Tallaght Hospital on 2 June and was moved to the Intensive Care Unit. His health continued to deteriorate and he died on 13 June 2015.

## **Findings**

17. The Officer on duty in A1 landing took immediate and appropriate action when he found the deceased unwell on 2 June, 2015.
18. I am satisfied that the deceased was promptly and appropriately treated by the medical personnel in the prison.
19. The CCTV footage provided would appear to be from a camera at the opposite end of the landing to where the cell of the deceased was located and the quality was very poor.
20. While the cause of death is a matter for the Coroner I am informed that his death was due to natural causes.
21. I am satisfied that there are no further issues that I should investigate.

## **Recommendations**

1. Committal interviews should be fully completed for all prisoners on committal. If necessary the services of an interpreter should be engaged.
2. I recommend that CCTV quality and coverage be addressed.