A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner I on 25 November 2016 in the Midlands Prison
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Presented to the Tánaiste and Minister for Justice and Equality pursuant to Part 5 of the Prisons Act 2007

Helen Casey
Office of the Inspector of Prisons

7 June 2017
Preface

The deceased was a 73 year old man who died on 25 November 2016 while in custody of the Midlands 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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Inspector of Prisons Investigation Report

General Information
1. The deceased was a 73 year old man who came from the Dublin area. He is survived by his wife, sons and extended family.

2. The deceased was committed to Mountjoy prison on 7 March 2016 with a remission date of 3 December 2016. He was transferred from Mountjoy Prison to the Midlands Prison on 8 March 2016.

3. On the evening of 25 November 2016 the deceased was discovered by his cell mate in the toilet area of their shared cell (Cell 27 on G3 landing) in an unresponsive state. The deceased was pronounced dead in the prison at 21.10 hrs by Doctor A.

4. I did not meet with the family as part of this investigation but corresponded with them by letter.

5. When carrying out this investigation we had unrestricted access to all parts of the prison, to all staff, to all prisoners and to all records including CCTV footage.

Status of the deceased in Prison
6. The deceased was an ordinary prisoner who was on the standard level of the Incentivised Regime at the time of his death. He was a member of the Midlands Prisoners choir. He was very well behaved and did not have any disciplinary breaches recorded against him. He was always courteous and engaged with staff in a positive manner. He did not make any complaints during his imprisonment.

7. The deceased was accommodated in a double cell (cell 27 on G3 landing). He had a good relationship with his cellmate Prisoner A who was good to the deceased and treated him like a father figure.
8. The deceased received regular visits from family members and had daily phone contact with his family.

**Deceased’s contact with the Medical Services**

9. I received permission from the next of kin of the deceased to access the Medical Records held in the prison.

10. The deceased had regular contact with the Medical Services. He had no history of Psychiatric illness. He did have some underlying medical conditions.

11. He was seen in Mountjoy Prison on 8 March 2016 by Dr. B for a Committal Interview having been committed on 7 March 2016. The notes record that the deceased had recently attended the Mater Hospital Respiratory Clinic. However he was not prescribed any medication at that time.

12. On transfer to the Midlands Prison on 9 March 2016 he was seen by Dr. C who recorded in the medical notes the fact that the deceased had attended the Mater Hospital Respiratory Clinic and further recorded that the deceased had some difficulty with his hearing and also had cataracts in both eyes.

13. Dr. C outlined a care plan in the medical notes which included the deceased getting help to quit smoking and checking if an appointment had been made for the deceased to have the cataracts dealt with. Dr. C also mentioned a referral to Audiology ENT regarding hearing impairment, ordered an ECG and requested regular blood pressure checks.

14. The Nursing Notes of 10 Mach 2016 confirm ECG done and blood pressure monitored. The weight of the deceased was noted as 48.2kg.

15. Contact was made with the deceased GP in the community and details of medical history was obtained.

16. The deceased continued to be monitored by the Nursing staff including monthly appointments with the Prison GP.
17. The records show that the deceased was taken for a medical appointment to the Mater Hospital Respiratory Clinic on 29 August 2016. However, this appointment appears to have been cancelled.

18. The Nursing Notes dated 23 September 2016 made by Nurse Officer A records the deceased blood pressure as 150/60 and his weight as 9 stone 7lbs (60.32kg).

19. The deceased was again taken to the Mater Hospital Respiratory Clinic on 24 October 2016.

20. The Medical Notes of 10 November 2016 record that the deceased was offered the flu vaccination and advised of the benefits. However, the deceased is recorded as having declined the vaccine.

21. The deceased was monitored by healthcare staff with blood pressure taken regularly, Pharmaton Capsules being prescribed daily and an inhaler to help his breathing. There is nothing recorded in the Medical Records that would indicate any immediate risk to his health.

**Sequence of events of 25 November 2016**

22. The deceased cell mate Prisoner A described the events of the evening as follows:-

   “I returned to the cell after finishing work in the Mess and I changed and went to the gym. I returned to the cell about 18.30 and I spoke with the deceased. I told him I was going to collect my shop order and I would collect his. I returned to the cell about 19.00 and I gave the deceased his shop order tobacco and mints. Another Prisoner B called in to the cell for a chat. We were all in good form. Prisoner B left and the cell was locked for the night at about 19.25. The deceased and I watched darts on TV. I had my dinner and I gave the deceased some desert. At this time the deceased was sitting smoking. He didn’t eat anything. At about 20.20 he got up, he went over to the loo, and he pulled the modesty curtain across. I could hear him using the cigarette..."
lighter but then as I watched T.V. after about 5 minutes I thought everything was very quiet. I could see his feet under the curtain but I felt something was wrong. I shouted are you alright but after not getting an answer after calling a few times I looked in. I saw the deceased was slumped against the wall and was not responding. I immediately rang the emergency call bell. Officer A responded by coming to the hatch within seconds. I explained there was something wrong with the deceased and he needed help. The officer then got his radio and called for help. ACO A and two or three other officers and the medic responded within two minutes. They opened the cell door and having put on gloves they entered. I took down the modesty curtain. ACO A asked me to step outside. They took the duvet off the bed and placed it on the floor. The officers placed him on the duvet on the floor. Made him decent and checked his vital signs. I saw them commence CPR”.

23. Report from Officer A describes the events of the evening of 25 November 2016 as follows:

“I reported and took charge of G3 Landing at 7.40pm. I checked all prisoners finding all correct. At 8.36pm by my own watch I responded to an emergency cell call from G3 #27. Prisoner A informed me that his cell mate the deceased was unconscious on the toilet. I raised the alarm and entered the cell at 8.40pm. Present were ACO A, Officer B, Officer C, myself and Nurse Officer B. ACO A, Officer C and myself moved the deceased from the toilet area to the cell floor. Nurse Officer B, ACO A and Officer C started CPR on the deceased at 8.41pm. They were still doing CPR when the ambulance crew arrived at 8.55pm and assisted. Dr. A arrived at 9.00pm and the prisoner was pronounced dead by the Doctor at 9.10pm”.
24. Nurse Officer B reported the events as follows:

“At approx. 20.40 hrs I arrived on to G3 Landing with the emergency equipment. ACO A was in the process of unlocking the cell door. ACO A entered the cell and lowered the deceased from the toilet, where he was slumped, to the floor. ACO A and myself then did a pulse check. No pulse was found and the prisoner was not breathing so we immediately commenced CPR. At approx. 20.55 hrs the ambulance crew arrived. We continued CPR until the crew had their mechanical chest compression machine and AED in position on the prisoners. I continued to bag the prisoner until Dr. A took over approx. 21.00hrs”.

CCTV Record of Events
25. I viewed the CCTV footage for G3 Landing. The times recorded are in accordance with the settings on the recording equipment at that time.

19.25.10 Two officers masterlocked cells in G3 Landing for the night.
19.56.20 Officer A checks all cells – check Cell 27 lifts flap and looks in.
20.32.28 Officer A leaves the Class Office on G3 Landing and walks down the Landing to cell no 27. Within moments of checking the cell he can be seen using his Tetra Radio.
20.33.55 Two Officers a male and female can be seen arriving on the Landing and going to speak with Officer A.
20.35.47 ACO A joins the officers and enters cell no 27.
20.36.57 Nurse Officer B arrives at cell 27 carrying the Emergency Bag and she enters the cell.
20.55.10 Paramedics arrive and enter cell 27.
21.00.10 Dr A enters cell 27.
Findings

26. Prisoner A took appropriate actions and alerted the prison staff as soon as he became aware that the deceased needed medical assistance.

27. As soon as the alarm was raised there was an immediate response from the prison officers and medical personnel.

28. The deceased was pronounced dead in the Prison by Doctor A at 21.10 hrs.

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