

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner N
in Wheatfield Prison
on 29th December 2013**

***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 N
in Wheatfield Prison on 29th December 2013**

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

Judge Michael Reilly
Inspector of Prisons

26th August 2014

Preface

The deceased was a 50 year old man who died on 29th December 2013 in Wheatfield Prison. He came from the Dublin area.

I offer my sincere condolences to the deceased's family.

Matters of concern are disclosed in this Report.

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

Finally, I would like to thank all those who assisted with this investigation.

Judge Michael Reilly

Inspector of Prisons

26th August 2014

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 50 year old married man who came from the Dublin area. He is survived by his wife and children.
2. The deceased was committed to Prison on 21st July 2010. His release date was to be 19th October 2018.
3. The deceased spent time in Cloverhill and Mountjoy Prisons before his transfer to Wheatfield Prison on 5th June 2011.
4. The deceased suffered from serious medical conditions.
5. The deceased was categorised as a Special Observation Prisoner – medical.
6. The deceased died in Wheatfield Prison on 29th December 2013.
7. I made contact with the family of the deceased but they did not take up my offer to meet with me. I fully understand and appreciate their position.
8. Where deaths in custody occur which fall to be investigated by my office I have agreed a protocol with the Irish Prison Service under which I must be provided with relevant documentation in accordance with an agreed checklist within certain time limits by a relevant prison. I am sorry to report that, in the instant case, the prison did not adhere to the agreed protocol. This meant that my investigation was prolonged and made more difficult as I had to request individual pieces of information, in some instances many times.

Deceased's contact with Prison Medical Services

9. The deceased had ongoing and significant contact with the prison healthcare services, with relevant doctors and when necessary was transferred to relevant hospitals.

10. Between mid June 2011 and the date of his death the deceased attended hospital on 20 different occasions for specialist medical intervention or investigation.
11. From my perusal of the medical notes it is clear that the deceased's health needs were being adequately addressed in prison.

Deceased's status in Prison

12. The deceased was categorised as a Special Observation Prisoner – medical.
13. Special Observation Prisoners must be checked every 15/20 minutes in accordance with recognised Standard Operating Procedures which operate in all Irish Prisons.
14. The deceased was accommodated in an ordinary cell in Wheatfield Prison where his medical needs were managed by the relevant health professionals.
15. From 3rd February 2013 to the date of his death – 29th December 2013 the deceased was accommodated in Cell 16 on 9G. This was a single cell with in-cell sanitation.

Investigation

16. From my thorough investigation of the deceased's time in Wheatfield Prison - from 5th June 2011 to 28th December 2013 (the day before his death) I am satisfied that no incidents of significance manifested themselves which would require investigation.
17. Therefore, my investigation is into the events in Wheatfield Prison from the evening of 28th December 2013 as these pertained to the deceased.
18. I had unrestricted access to relevant CCTV footage, official journals and reports, statements from all relevant parties and the medical records.

19. The CCTV footage of 9G and particularly the door to Cell 16 was of a high quality.
20. As the time of death was not apparent from the documentation or statements I decided, in the interest of compiling a comprehensive, fair, transparent and robust report, that I should view all CCTV footage for the period commencing with the lockdown of the deceased for the night of 28th/29th December at 7.30pm. When viewing this CCTV I paid particular attention to Cell 16. The sequence of events set out hereunder are those that are relevant to this investigation and must not be construed as referring to every movement on the landing during the relevant period.

Breakdown of CCTV footage

28/12/2013

- 7.30.00pm CCTV commences – deceased already locked in his cell.
- 9.03.51pm Officer checks Cell 16 – looks through viewing hatch.
- 10.02.04pm Officer checks Cell 16 – looks through viewing hatch.
- 11.01.54pm Officer checks Cell 16 – looks through viewing hatch.

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- 12.12.33am Officer checks Cell 16 – looks through viewing hatch.
- 01.16.40am Officer checks Cell 16 – looks through viewing hatch.
- 02.05.44am Officer checks Cell 16 – looks through viewing hatch.
- 03.10.01am Officer checks Cell 16 – looks through viewing hatch.
- 04.05.28am Officer checks Cell 16 – looks through viewing hatch.
- 04.56.23am Officer checks Cell 16 – looks through viewing hatch.
- 06.11.34am Officer checks Cell 16 – looks through viewing hatch.
- 07.02.49am Officer checks Cell 16 – looks through viewing hatch.

According to the records supplied to me the Night Guard responsible for 9G was Officer A. The checks carried out by the Night Guard were hourly checks. The deceased and two other prisoners on 9G were classed as Special Observation Prisoners who should have been checked every 15/20 minutes. I refer to this aspect later in this Report.

- 08.11.50am Officer B appears on landing 9G.
- 08.11.57 – 08.13.48am Officer B can be observed unlocking cells 1-15.
- 08.13.55am Officer B opens door of Cell 16 and looks in. In his statement the officer stated:- *“To the best of my recollection when I checked cell 16 (the deceased) I was met with a verbal response”*.
- 08.13.59am Officer B closes door of Cell 16.
- 08.15.53am Officer B enters Cell 16 (carrying something in his left hand). At interview the Officer stated that he dropped breakfast into the deceased’s cell as the deceased was not in great health and often didn’t get up in the morning. He stated that he thought the deceased was asleep and did not talk to him at that stage.
- 08.16.01am Officer B exits Cell 16 (still carrying something in his left hand).
- 08.16.39am Officer B walks out of camera shot.
- 08.33.58am Officer C – the breakfast guard - checks Cell 16 – looks in viewing hatch.

At 09.15am Officer C handed over duty to Officer B – the day guard.

- 09.57.37 to 09.57.41am Officer D goes to Cell 16 – opens door and is at doorway for 4 seconds and then enters.
- 09.58.25am Officer D exits cell 16 – Gestures towards the hub - stands waiting outside cell door.
- 09.58.41am Officer E enters Cell 16 with Officer D.
- 09.59.00am Both Officers exit cell and close cell door.
- 10.01.00 to 10.01.15am Officer B enters Cell 16 followed by several other officers including Nurse Officer’s A and B.
- 10.02.11am All Officers exit Cell 16 and door is closed.

Nurse Officer A recorded in the medical notes that:-

“On examination I found (the deceased) lying on his left side with his L hand up near his face. Unresponsive to verbal and physical stimuli. I removed the quilt, no carotid, radial or brachial pulse. No signs of respirations, attempted to open air way, unable due to rigor mortis. I then noticed patient to be cool to touch and mottled and pooling of blood L side. Following this assessment I found his condition to be incompatible with life.”

Nurse Officer B was present during this assessment and concurred with the findings of Nurse Officer A.

10.37.40am The Ambulance Service personnel enter Cell 16.

Between 10.37.40am and 11.10.28am there is general coming and going of staff on the landing.

11.10.28am Doctor A enters cell accompanied by medical staff.

11.12.41am Doctor A exits cell and speaks with Chief Officer A. According to the records the Doctor pronounced the deceased dead at 11.14am.

11.14.59am The deceased is removed from Cell 16. Chief Officer A in his statement stated that he instructed that the deceased was to be brought to the Prison Church.

12.14.56pm Members of An Garda Síochána enter Cell 16. The Gardaí examined the scene.

21. In examining the times in the preceding paragraph it is clear that between 7.30pm on 28th December and 08.13.55am on 29th December the deceased was checked 12 times whereas he should have been checked at least 38 times as a special observations prisoner in accordance with the Standard Operating Procedures set out in paragraph 13. Between 08.33.58am on 29th December and 09.57.37am – a period of 1 hour 24 minutes the deceased was not checked by any officer.

22. An understanding of the change of duties of officers from approximately 7.30am onwards can be confusing to anyone not associated with prison life. In order to address this confusion I set out in this paragraph the times of changeover of duties for the morning on 29th December for landing 9G:-
- 7.30am Officer A – night guard – handed over responsibility for the landing to Officer F – the ‘early start’ officer.
 - 8.05am Officer F – ‘early start’ officer – handed over responsibility to Officer B – the day guard.
 - Shortly before 8.30am Officer B – the day guard – handed over responsibility to Officer C – the breakfast guard.
 - 9.15am Officer C – the breakfast guard – handed back responsibility to Officer B – the day guard.
23. From a perusal of the CCTV it is clear that the ‘early start’ officer – Officer F did not check any cells on 9G landing during his period on duty as set out in paragraph 22.
24. When viewing the CCTV it became apparent to me that Prisoner 1 on 9G Landing entered the deceased’s cell at 08.12.29am carrying a carton of milk. At this time Officer B can be clearly seen on landing 9G adjacent to Cell 5 which is a matter of metres from Cell 16. This fact was not made known to me by the prison authorities or in statements or reports by the prison officers. At interview Officer B acknowledged, having been shown the CCTV footage, that Prisoner 1 did enter Cell 16 while he, Officer B, was on the landing within metres of Cell 16. I did not interview this prisoner as he had been released from prison when my investigation had reached the point when I was ready to interview him. However, I did not consider it necessary to locate this prisoner as his evidence could only be relevant as to whether the deceased was alive at the time that he was in the cell and as the time of death is a matter which falls to be investigated by the Coroner at the Inquest such evidence is more appropriate to that forum.

25. It is relevant that I should point out that despite specifically requesting of management the names of prisoners **who had contact with the deceased** I was not supplied with any such prisoner names.

Relevant journal entries

26. Official reports are generated by designated officers in the course of their respective tours of duty. These official records record relevant activities and are available for inspection by senior officers, management and relevant inspection agencies.
27. I perused the Night Guard Report generated by Officer A for the night of 28th December. Officer A recorded that:-

“Patrolled units throughout the night checking all prisoners paying particular attention to those on ‘spl obs’.”

The deceased was a Special Observation Prisoner. However, there were two other prisoners categorised as special observation prisoners accommodated on 9G during the night of 28th December. It is clear from the CCTV footage that neither the deceased nor the other two Special Observation Prisoners were checked every 15/20 minutes in accordance with the relevant Standard Operating Procedures.

28. I perused the Breakfast Guard Report generated by Officer C for the morning of 29th December. Officer C recorded that:-

“Patrolled the landings throughout the break, paying particular attention to the ‘sp ob’s’ list.”

Findings

29. The deceased suffered from significant medical problems.
30. The deceased’s medical condition was being adequately addressed by the medical staff in Wheatfield Prison.

31. The deceased was a special observation prisoner at the date of his death and for a considerable time prior to that. This was well documented and known to relevant prison personnel.
32. The deceased was accommodated in Cell 16 on 9G (a single cell with in-cell sanitation) at the date of his death and for a considerable period prior to that.
33. The deceased was not checked every 15/20 minutes in accordance with Standard Operating Procedures referred to in paragraph 13 during the periods outlined in paragraph 20.
34. The entries referring to Special Observation Prisoners in the journals referred to in paragraphs 27 and 28, being official prison records, were certainly misleading in their content and but for the CCTV viewed by me would have been accepted by me as representing compliance with the relevant Standard Operating Procedures referred to in paragraph 13.
35. While the time of death is a matter for the Coroner's Inquest it is obvious from the medical notes referred to in paragraph 20 that the deceased was dead for some time and that CPR was not an option that could be considered by the Nurse Officers at approximately 10.00am on 29th December.
36. The body of the deceased was removed from the cell prior to the arrival of members of An Garda Síochána. As this was a death in custody this did not accord with best practice for the preservation of the scene. The removal of the body prior to the arrival of An Garda Síochána did not, in this case, compromise my investigation but could have had very serious repercussions had this been a crime scene in a criminal investigation.
37. It is clear from my findings referred to in paragraphs 33 and 34 that the line management structure in the prison was deficient in that the implementation of relevant Standard Operating Procedures relating to the checking of Special Observation Prisoners and the checking of official prison journals was

inadequate. I wish to point out at this juncture that the failure to adhere to Standard Operating Procedures or the failure to record accurately in official prison records cannot be explained away by lack of training on the part of those primarily responsible or a lack of knowledge that this was happening by those in managerial positions.

38. The prison management did not fulfil its obligation to provide me with all relevant documentation in accordance with the protocol agreed between the Irish Prison Service and my office.
39. Statements and reports generated by prison personnel and submitted to me were in certain instances incomplete and at times inaccurate.

Recommendations

1. The deficiencies in the line management structure referred to in paragraph 37 must be addressed by the Irish Prison Service.
2. Scenes where deaths in custody occur must be preserved in accordance with best practice in all cases.
3. Governors must ensure that the protocols that have been agreed between the Irish Prison Service and my office relating to deaths of prisoners either in custody or on temporary release are adhered to.
4. Comprehensive and true records must be kept. Accurate and comprehensive statements and operational reports must be generated when required.