

**A report by the
Office of the Inspector of Prisons
into the circumstances surrounding the
death of Prisoner J on 17 September 2017
in Wheatfield Place of Detention**

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

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circumstances surrounding the death of Prisoner J
on 17 September 2017 in Wheatfield Place of Detention**

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

This Investigation was conducted and the Report prepared by
the undersigned

Helen Casey
Deputy Inspector of Prisons

28 September 2018

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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.

Prisoner J was a 23-year-old man who died on 17 September 2017 while in the custody of Wheatfield Place of Detention.

I offer my sincere condolences to the family of Prisoner J.

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

Helen Casey
Deputy Inspector of Prisons

28 September 2018

Investigation Report

1.0 General Information

- 1.1 Prisoner J was a 23 year old single man who came from the Eastern Region.
- 1.2 He is survived by his parents, brothers and sisters.
- 1.3 Prisoner J was committed, on remand, to Cloverhill Prison on 25 July 2016. He was subsequently convicted on 20 February 2017 and his sentence was dated from 25 July 2016. His release date with remission would have been 9 December 2019.
- 1.4 This was Prisoner J's first time in prison.
- 1.5 On 21 February 2017 Prisoner J was transferred from Cloverhill Prison to Wheatfield Place of Detention where he was accommodated in Cell 17 on East1 (E1) landing.
- 1.6 When unlocked for breakfast at 08:10 on 16 September 2017 Prisoner J was found unresponsive.
- 1.7 CPR was administered prior to Prisoner J's removal to the Accident and Emergency Department at Tallaght Hospital. His death was pronounced in Tallaght Hospital at 00:15 on 17 September 2017.
- 1.8 We met the family of Prisoner J at an early stage in the investigation to explain our role and to ascertain if they had any concerns.
- 1.9 During the course of our investigation we had unrestricted access to staff, prisoners, prison records including all relevant CCTV footage.

2.0 Status of Prisoner J

- 2.1 Prisoner J was on the 'Enhanced' level of the Incentivised Regime¹.
- 2.2 Our investigation established that Prisoner J was a good worker who got on well with officers and fellow prisoners. He had a good discipline record.

3.0 Meeting with next of kin

- 3.1 We met with Prisoner J's parents and two of his brothers early in our investigation. Prisoner J was the youngest of a large family. We were informed that their son/brother had no health issues of concern and they described him as a "*strong young man*".
- 3.2 The family were upset that they were not contacted by Prison Management when their son/brother became ill and was taken to hospital. They were notified by a prisoner (whose name was not disclosed). They said they went straight to the hospital when they received the telephone call and Prisoner J had just been admitted when they arrived.
- 3.3 Prisoner J's brother said they were told by another prisoner that his brother became unwell during the night and was calling for help "*from 5:30am*". He was told that two officers went to his cell but "*didn't do anything*" to help his brother.
- 3.4 His parents told us they had a visit with their son the day before his death and he was "*in fine form*". When in hospital they noticed a mark on his forehead and a "*fresh haircut*" which he didn't have the previous day.
- 3.5 The family raised the following concerns which they asked us to investigate:-

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

- (i) *“Why were we not contacted by the Irish Prison Service when our son/brother became ill and was removed to hospital?”*
- (ii) *Was our son/brother seeking help during the night/morning before he was unlocked?*
- (iii) *Did our son/brother activate his cell call alarm during the night? If so, did Prison Officers respond?*
- (iv) *Was our son/brother seen by the Medical Staff?*
- (v) *How did our son/brother get a mark on his forehead?*
- (vi) *Where did our son/brother get his hair cut?*

4.0 Prisoner J’s interactions with Staff and Prisoners

- 4.1 Records show that Prisoner J worked in the prison kitchen. Staff and fellow prisoners informed us that he was a good worker who got on well with everyone.
- 4.2 Chief Officer A reported that Prisoner J never came to unfavourable notice of the Chief Officers.
- 4.3 Work Training Officer (WTO) A reported that Prisoner J had been working in the prison kitchen since July 2017, except for a short period when he injured his finger. WTO A found Prisoner J to be a good worker whom he reported *“always did what was asked of him”* and *“was never in any trouble”*.
- 4.4 Class Officer A who worked on E1 landing, where Prisoner J was accommodated, reported that Prisoner J *“went to work daily”* between 09:00 and 09:30. When he returned to the landing in the evenings around 18:00 he stated that Prisoner J regularly went to the gym and never caused problems.
- 4.5 The prisoners who worked with Prisoner J and those who associated with him on E1 landing reported that he had been in good form prior to his death.
- 4.6 Prisoner A and Prisoner B in their statements stated that they were *“working on the Wednesday 13 and Friday 15 September 2017 with [Prisoner J]”*. Neither noticed anything out of the ordinary. *Both reported “he seemed fine.”* Prisoner A stated he *“saw him on the landing Friday evening when we were getting water*

at about 6.45pm after I had done the gym and he was talking and joking with others on the landing and he seemed ok". Prisoner B reported that "He was full of energy on Friday and was laughing and talking with me as we usually did when working together".

- 4.7 Prisoner C who worked in the kitchen with Prisoner J and who was with him on Friday 15 September 2017 in his statement said that "[Prisoner J] *seem to be himself, happy out, laughing and joking with us all*". He reported that he "*didn't notice anything different with him*" and that he "*was talking to him back on the landing that evening and he seemed fine*".

5.0 Prisoner J's interaction with the Medical and Therapeutic Services

- 5.1 The prison medical records were examined from the date Prisoner J transferred from Cloverhill Prison to Wheatfield Place of Detention until his death.
- 5.2 Prisoner J was seen by Doctor A on 22 February 2017 who conducted a committal examination following his transfer from Cloverhill Prison. The Doctor made a note of his interview and examination. The note outlined Prisoner J's medical history and Doctor A stated "*.....no medical problems at present...*".
- 5.3 On 14 April 2017 Prisoner J was examined by the Optician who prescribed glasses which Prisoner J received on 5 May 2017.
- 5.4 On 18 April 2017, Prisoner J was complaining of a sore throat and headache and was seen by Nurse Officer A. He was given paracetamol.
- 5.5 On 24 May 2017, at approximately 16:00, Prisoner J reported to Nurse Officer B that he had chest pain. Nurse Officer B noted on record "*Checked his pulse*" and "*he did not appear to be in any distress. No cyanosis or breathlessness*". At 17:50 Nurse Officer B checked Prisoner J's vital signs again. Nurse Officer B recorded in the medical notes that she informed Prisoner J "*that he may be suffering from stress as his vital signs appeared within the normal range and he agreed*". The records showed that Nurse Officer B advised Prisoner J "*about*

practicing deep breathing exercises that he may find helpful". Prisoner J was also advised to contact the surgery if symptoms continued and he was placed on the Doctor's list for review.

- 5.6 Doctor A reviewed Prisoner J on 25 May 2017. He recorded that Prisoner J reported "*Left side chest sensation, palpitation, tachycardia episodes*". The Doctor checked Prisoner J's vital signs and diagnosed "*anxiety with tachycardia episodes*". The Doctor referred Prisoner J to the Radiology Department at Tallaght Hospital for a walk-in ECG. Prisoner J attended Tallaght Hospital for these tests on 29 May 2017. The records showed that the result of the ECG as normal with normal sinus rhythm.
- 5.7 The next interaction recorded in the medical records is dated 18 August 2017 when Prisoner J was seen by Doctor A who noted "*C/O deformity and pain in right 5th finger due to sport injury that he sustained yesterday – played soccer. R 5th Finger is bruised, very little ROM, cannot bend it. Dg: Fracture – refer to A/E*". Prisoner J was taken to Tallaght Hospital and Nurse Officer C recorded his return at 17.31 making the following entry "*returned from hospital with splint supporting finger.... Received Ortho appointment for Friday 8 Sept 17.*"
- 5.8 On 30 August 2017 Doctor A certified Prisoner J as fit to return to work.
- 5.9 It is recorded that Prisoner J engaged with the Addiction Counsellor and had, while in Cloverhill Prison, attended 12 counselling sessions from 9 September 2016 to 9 February 2017.
- 5.10 The Addiction Counsellor in Wheatfield reported that Prisoner J had attended an addiction counselling information group on 30 August 2017 and also attended an evening counselling session held by the Coolmine Group – an In-Reach Support Group. He also attended a group session facilitated by Addiction Counsellor A on 4 September 2017 and was to attend the next drugs '*Relapse Prevention Programme*' in Wheatfield.

- 5.11 Prisoner J had a further assessment scheduled with Addiction Counsellor B on 13 September 2017. The Counsellor reported that *“at no time did he present with any imminent issues or cause of concerns. He was well presented at the three interactions I had with him”*.
- 5.12 On 8 September 2017 Prisoner J declined to attend scheduled appointments at both the Trauma Orthopaedics and Occupational Therapy Clinics at Tallaght Hospital which were follow up clinics for his injured finger.
- 5.13 There were no further medical interactions recorded on the Prison Health Management System (PHMS) until the emergency call on the morning of 16 September 2017.

6.0 Sequence of Events on 15 and 16 September 2017

- 6.1 On 15 September 2017 Prisoner J had a visit from his parents between 14:30 and 15:44 which can be seen on CCTV footage.
- 6.2 Following that visit, Prisoner J returned to work in the prison kitchen. At 17:32 he returned to E1 landing.
- 6.3 Prisoner J can be seen on CCTV footage freely associating with other prisoners on the landing until he returned to his single cell at 19:16 when he was locked back for the night.
- 6.4 From 19:19 on 15 September 2017 until 08:12:29 on the morning of 16 September 2017 officers walked E1 landing on an hourly basis. Due to the lack of lighting the actual actions of the officers in relation to the checking of the cells could not be seen, it was only possible to see a silhouette of a person on the landing, with a lighted torch. The figure can be seen stopping at intervals but we cannot state, due to the darkness lighting if s/he stopped outside the cell door of Prisoner J.
- 6.5 At 08:12:29 Class Officer A unlocked Prisoner J’s cell. He reported *“[Prisoner JJ] was unresponsive in bed to my verbal call so I entered the cell in an attempt*

to wake him. I placed my hand on his shoulder and shook him. I noticed he was warm to the touch. He was still unresponsive to my shaking. I exited the cell and shouted to Officer B I/C² East 2 for assistance. I asked Officer B to contact ACO A and ask him to report to me on East 1 immediately. Officer B and I entered the cell and Officer B told me he could feel a pulse in his [Prisoner J] wrist. ACO A entered the cell and I left to get medical assistance. I went towards the Class Office on East 1 and called to Officer C on East 2 to send the nurse officer that was on duty in the East 2 surgery to come immediately to East 1. I went back down the Landing to cell 17 and Nurse Officer D arrived. We lifted the prisoner to the floor on the instruction of Nurse Officer D, commenced CPR and Officer B called code red East 1 over his Tetra Radio”.

- 6.6 Officer B corroborated the report of Class Officer A.
- 6.7 The CCTV footage viewed showed that at 08:12:29 an officer unlocked cell 17, entered the cell for a short period and exited the cell at 08:13:48.
- 6.8 At 08:15:40 two officers entered the cell.
- 6.9 At 08:18:59 a Nurse Officer also entered the cell.
- 6.10 Nurse Officer D reported that while on East 2 (E2) landing issuing medications there was a request for medical assistance on E1 landing. The Nurse reported that on arrival the “[Prisoner J] was lying in right lateral position in bed. Was unresponsive. Pulse check. No carotid pulse. Requested attending officers to assist in moving [Prisoner J] onto floor. CPR commenced”. The Nurse further reported “that assistance was provided” by Nurse Officer E who “arrived with Defib,” Nurse Officer Conway further reported that “DFB³ arrived at approximately 08:40. Care handed over. Arrest managed by

² In Charge

³ Dublin Fire Brigade

Doctor B National Ambulance Service. Pulse return and spontaneous breathing following their interventions”.

- 6.11 Prisoner J was removed by ambulance to Tallaght Hospital at approximately 09:15.
- 6.12 Prisoner J was treated in the Emergency Department of Tallaght Hospital. He was pronounced dead at approximately 00:15 on 17 September 2017.

7.0 CCTV Footage

- 7.1 CCTV footage was viewed from the time Prisoner J received a visit from his parents on the afternoon of 15 September 2017 up until the morning of 16 September 2017 when he was removed by ambulance to Tallaght Hospital.
- 7.2 There is clear footage up until 20:03 on 15 September 2017 at which time cells on E1 were master locked for the night. At that time the lights were turned off and the landing was in darkness.
- 7.3 The Irish Prison Service Standard Operating Procedures provides for hourly checks of cells throughout the night and it would appear, from footage viewed, that hourly checks were carried out. However, due to the poor visibility, it was not possible to see the extent of these checks.
- 7.4 Footage viewed showed that from 19:19:54 to 19:57:51, Prisoner J was checked three times. Footage is clear and the officer can be seen at the cell checking Prisoner J through the viewing flap on the cell door. At 20:03:04 the lights are turned off and the landing is in darkness.
- 7.5 Between the hours 20:03:04 on 15 September 2017 to 08:10 on 16 September 2017 the landing remained in darkness. A silhouette of an officer was seen on the landing at hourly intervals (12 occasions) and appeared to be checking the cells with the aid of a torch. At 08:10 the lights on the landing were turned back on and visibility was once again clear. At 08:12:29 an officer was seen entering Prisoner J's cell but exited the cell almost immediately. At 08:13:50

two officers entered the cell, followed by medical staff. They remained in the cell until paramedics from Dublin Fire Brigade arrived at 08:41:22. Prisoner J was removed to hospital at 09:15. (Appendix A provides full details of CCTV footage viewed).

8.0 Cell Call System

8.1 When a prisoner wishes to contact staff, while locked back in their cell, they activate the cell call alarm from inside their cell. A red light situated outside and above the cell door switches on when activated and a buzzer also activates in the Class Office on the landing. As part of our investigation we checked the Cell Call System. This was working when checked in that the red call light outside the door was operating. The light and buzzer alert was also working in the Class Office.

8.2 In addition to checking the system in the cell and Class Office, we also sought a printout of the activations from the recording system. An Engineer's Report on the cell call system was requested from Company A which was received on 28 February 2018. The Report confirmed that Company A *"were called out to Wheatfield Prison on 22 September 2017 to download the cell call log of data for Cell 17 East 1"*. The Engineer's Report confirmed that the cell call alert in cell 17 was checked and *"the visual over door indicator flashed red and the display panel in the local Class Office on East 1 was audible and visually showing the call correctly"*. However, the Engineer found that *"the call logging facility for East 1 was not logging the call information."* Consequently there was no printout available. Our enquiries found that the last recording of activations for cells on E1 landing was on 20 May 2017.

8.3 As part of our investigation and in order to establish if the cell call light can be seen on CCTV footage if activated during darkness, we arranged for the cell call to be activated during the night when it was dark. It was found that a flashing red light could be seen on CCTV footage.

9.0 Addressing the concerns of the family

9.1 In paragraph 3.5, I set out a number of matters the family wished to have addressed. In this paragraph, I endeavour to address these issues hereunder.

(i) ***“Why were we not contacted by the Irish Prison Service when our son/brother became ill and was removed to hospital?”***

We were informed by Prison Management that the Prison Chaplain telephoned the contact number of the next of kin when Prisoner J was removed to hospital. The Chaplain spoke to Prisoner J’s sister in law. However, the family had already been notified that Prisoner J was removed to hospital by an unofficial source before Prison Management had an opportunity to telephone.

(ii) ***“Was our son/brother seeking help during the night/morning before he was unlocked?”***

We could find no evidence that Prisoner J was seeking medical assistance during the night of 15/16 September 2017. A statement from Prisoner D who occupied the cell next to the deceased informed us that he *“did not hear anything unusual come from [Prisoner J]’s cell. [Prisoner J] was a quiet fella who kept to himself and I never heard any noises from his cell. The first I knew that anything had happened was the next morning when I was not allowed out for breakfast.”*

(iii) ***“Did our son/brother activate his cell call alarm during the night? If so, did Prison Officers respond?”***

In order to establish if the cell call light could be seen on CCTV footage if activated during darkness, a test was conducted. It was found that the red light over the cell door could be seen flashing on the CCTV footage when activated. Our review of the CCTV footage during the night of 15/16 September 2017 did not show any flashing light outside Prisoner J’s cell. However, as there was no recordings of activations of cells on E1 landing available since 20 May 2017 we were unable to confirm this finding. Details of the cell call system are provided in paragraphs 8.1, 8.2 and 8.3.

(iv) ***“Was our son/brother seen by the Medical Staff?”***

In paragraphs 5.2 to 5.12 I detailed the interactions the deceased had with Medical Staff.

(v) ***“How did our son/brother get a mark on his forehead?”***

We could find nothing in the records examined or from the statements obtained to indicate how Prisoner J came to have a mark on his forehead.

This is a matter which can be raised at the inquest.

(iv) ***“Where did our son/brother get his hair cut?”***

There is a barber service on E landing.

10.0 Findings

10.1 Prisoner J was a well behaved prisoner with a good discipline record who got on well with staff and fellow prisoners.

10.2 Prisoner J was attending addiction counselling while in prison and was participating in group work as part of a ‘*Relapse Prevention Programme*’.

10.3 Prisoner J worked in the kitchen of the prison.

10.4 Staff and prisoners reported that Prisoner J was in good form before he retired for the night on 15 September 2017.

10.5 Prisoner J was found unresponsive in his cell at 08:12:29 on 16 September 2017.

10.6 The prison staff responded quickly and commenced CPR while waiting for the ambulance and paramedics.

10.7 Prisoner J was resuscitated before he was removed by ambulance to Tallaght Hospital at 09:15 on 16 September 2016.

- 10.8 Prisoner J subsequently died in Tallaght Hospital at approximately 00:15 on 17 September 2017.
- 10.9 Lighting on the landing was turned off at 20:03 on 15 September 2017, consequently it was not possible to clearly see the extent of the checks carried out on the cell of Prisoner J during the course of the night.
- 10.10 The recording feature of the ‘Cell Call Alert System’ was not working and therefore it was not possible to definitively ascertain if Prisoner J activated his ‘Cell Call’ alert on the night of 15/16 September 2017.
- 10.11 The cause of death is a matter for the Coroner.

11.0 Recommendations

- 11.1 The lighting on landings should not be switched off or lowered to the extent that the staff conducting checks on cells cannot be seen clearly as they carry out their duties.
- 11.2 The Cell Call Alert Recording system should be regularly checked to ensure it is working properly and a record of checks maintained by a designated officer. Any faults coming to light should be reported immediately and rectified. Records of activations, checks and any fault(s) should be available for perusal by Senior Management and Oversight Bodies.

Appendix A

19:19:54 An Officer locked the cell door – lifted the flap and looked into the cell

19:22:23 An Officer checked all the cells – checked cell 17 – lifted the flap and looked in.

19:24:50 Landing lights were turned off – visibility on landing was limited.

19:57:51 An Officer checked the cells – appeared to check cell 17.

20:03:04 Landing was in darkness as all lights were off.

20:58 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

22:00 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

23:01 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

23:54 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

01:05 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

02:03 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

03:04 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

03:59 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

05:07 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

06:02 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

06:59 Silhouette of an Officer checked the cell with a torch – Landing was in darkness

07:30 Some lighting on the landing but visibility was still poor

07:49 Officer checked the cells

08:10 Lights turned on and landing was visible

08:12:29 Officer to cell 17 – unlocks – after a few moments he entered the cell

08:13:50 Officer exited the cell

08:15:40 Two officers entered the cell

08:18:59 Nurse Officer entered the cell

08:20:55 Officer carrying emergency entered the cell – followed by more medical staff

08:41:22 Paramedics from DFB arrived at the cell.