A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner A on 3 January 2017 in Cork Prison

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

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A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner A on 3 January 2017, in Cork Prison

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

Helen Casey
Office of the Inspector of Prisons
30 November 2017

Preface

The deceased was a 52 year old man who died in Cork Prison on 3 January 2017.

He is survived by his wife and extended family.

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

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Inspector of Prisons Investigation Report

General Information

1. The deceased was a 52 year old man who resided in the Munster area. He is survived by his wife and extended family.

2. The deceased was committed to Cork Prison on 13 October 2016 with a remission date of 9 March 2017. Prior to this committal, the deceased had served a number of short terms of imprisonment.

3. The deceased was discovered in an unresponsive state in his cell, Cell 4 on B1 Landing, which is the designated Vulnerable Persons Unit, in Cork Prison on 2 January 2017 at 23:38.

4. The deceased was pronounced dead at 01:20 on 3 January 2017.

5. In carrying out my investigation, I visited Cork Prison on 3 January 2017, where I enquired into the circumstances surrounding the death of the deceased. I visited his cell and had access to all relevant prison records and to staff. I subsequently examined relevant CCTV footage.

6. I met with the family of the deceased at an early stage in my investigation.

Status of the deceased in Prison

7. The deceased was an Ordinary Prisoner who was on the Standard Level of the Incentivised Regime.

8. At the time of his death the deceased was on Special Observation, having been moved to the Vulnerable Persons Unit (VPU) on B1 Landing earlier that evening.

Meeting with the family

9. I met the deceased's wife and daughter on 9 January 2017 and explained the role of the Inspectorate and the procedures we follow in the course of our investigation. I enquired if they had any particular concerns relating to the deceased's death in custody.

10. I was informed that the deceased had medical issues. He had been hospitalised and was in intensive care at least three times in the last year and he had suffered a number of seizures over the past fifteen months. I was also informed that the deceased was arrested shortly after his discharge from hospital and, following a court appearance, was committed to Cork Prison. I was also told the deceased had a history of "*smoking a little weed*".

11. The family expressed a view that the prison contributed to the untimely death of the deceased and asked me to investigate the following:-

a) What medication was he put on in prison?
b) Did the prison thoroughly check his physical and mental health before medicating?
c) What medical checks were done?
d) Was he in intensive care before going to prison?
e) The family asked if the deceased had been diagnosed as mentally ill? They stated that Prison Management told them that the deceased was suffering from physical illness not mental illness but were informed by the Gardaí and GP that he had a mental illness.

Deceased's involvement with Prison Medical Services

12. On Committal the deceased was seen in the Reception area of Cork Prison on 13 October 2016 by Nurse Officer A for initial Committal Interview. The Medical records show that the Nurse Officer was concerned for the deceased's health and made the following notes;-

"Unkept appearance, blood on shirt, left thumb has dressing in place, breakthrough bleedings….Bizarre behaviour observed in holding cell, appears

to be interacting with unseen stimuli, encouraged to shower with little success. Due to his bizarre behaviour (the Nurse Officer) *recommended the deceased be placed in a Safety Observation Cell for review by the Prison Doctor the following morning and also for Psychiatric Review".*

13. The records show that the deceased was placed in the Safety Observation Cell (SOC) on 13 October 2016 and given food and drink, which he consumed.

14. Nurse Officer A recorded that the deceased removed a bandage from his left thumb. While the nurse tended to the wound, it is recorded that the deceased said "*my blood is pure, that is medicine, I want a bandage"*. Nurse Officer A then applied a fresh bandage to the wound.

15. On 14 October 2016 the deceased was reviewed by Doctor A in the SOC who noted that during the interview the deceased denied alcohol or drug use. However, medical records from previous terms of imprisonment show that the deceased had a history of substance misuse, including alcohol. The Medical Records received indicate that the deceased may have been suffering from a neurological disorder.

16. The deceased was also reviewed on 14 October 2016 by the Psychiatrist, Doctor B while in the SOC. He noted the following:-

> "*Patient lying on floor demanding cigarettes. Uncooperative, physical health gives rise to concern……. Orientated re date but not time – get background - concern re hydration."*

17. The deceased was taken to the A&E department of the Mercy Hospital on 14 October 2016 to have the wound on his left thumb sutured. He was returned from A&E that day with a discharge letter "*recommending GP follow up*".

18. On return from the A&E department, the deceased was placed in the Vulnerable Persons Unit, B1 Landing. His injured thumb was dressed regularly with fresh bandages by nursing staff.

19. On 15 October 2016 Nurse Officer B checked the deceased's blood pressure and recorded that he was suffering from hypertension. She also examined the deceased as he had complained of chest pain, advising her that he had hurt his ribs prior to his committal.

20. On 17 October 2016 the deceased was reviewed by Doctor C. The records confirm that he presented well and was cooperative. He continued to be seen each day by the medical staff. Records show that he was generally cooperative with them.

21. On 21 October 2016 the Psychiatrist, Doctor B, who noted that the deceased was "*uncooperative and evasive*" regarding his history with Psychiatric Services, reviewed the deceased but the deceased did acknowledge that he had seen a Psychiatrist once in Great Britain. It is also noted that the deceased presented well and was "*not hallucinating*".

22. On 2 November 2016 the deceased was seen by the Prison Doctor and was treated for minor ailments not relevant to this investigation.

23. On 4 November 2016 Doctor D reviewed the deceased as he was "*becoming paranoid*" and "*not interacting socially*". It is recorded that he was "*not responding appropriately to questioning*" and had "*mild aggression*". The doctor prescribed night medication and placed the deceased on the list for review by the Psychiatrist, Doctor B.

24. Records show that over the following days the deceased continued to be agitated. On 6 November 2016 he was again seen by medical staff. Nurse Officer A records that the deceased was "*pacing and making fists, staring at the prison radio*" and asking staff if they saw "*lights / orbs passing through his cell*".

25. It was also recorded that the deceased was not resting at night and was either walking in his cell or sitting on the bed, but getting very little sleep. When he

did sleep it was on the mattress placed on the floor of his cell, under the counter. He was seen by Doctor C on 10 November 2016, who increased his night medication.

26. On 11 November 2016 the deceased was seen by the Psychiatrist, Doctor B who noted that the deceased was "*stable but unpredictable*". Medical Staff noted the deceased as having "*visual hallucinations",* reporting that he was seeing "*orbs"* in his cell.

27. Between 11 and 29 November 2016 the deceased was seen daily by the nursing staff, he had eight consultations with the prison Doctor and two consultations with the Psychiatrist.

28. On 29 November 2016 Psychiatrist, Doctor B reviewed the deceased and noted that while the deceased continued to have behavioural issues, he could be accommodated within the general prison population on a trial basis.

29. The deceased was moved to general population on 2 December 2016 - from B1 Landing to A3 Landing. He continued to be offered daily medication from the nursing staff, although not always accepting it.

30. On 22 December 2016 Nurse Officer A who reviewed the deceased noted – "*attended for paracetamol, cold symptoms, doing well, clean and beard trimmed".*

31. On 29 December 2016 Doctor D reviewed the deceased who was complaining of flu like symptoms. On examination Doctor D noted "*chest good and clear"* and the deceased's temperature was normal.

Sequence of Events on 2 January 2017

32. On 2 January 2017 Medical Orderly A was alerted by Officer A that the deceased was *"acting very strangely"*. It is recorded that he was observed "*sitting cross legged in the middle of the cell floor, with a duvet wrapped around his wrist*".

33. The deceased had declined to go for his dinner and remained in his cell. At 14:15 he was unlocked for afternoon recreation however he remained in his cell.

34. Medical Orderly A, in his statement, said he was asked to attend to A3 landing as the deceased was "*sitting on the floor of cell and would not cooperate*" with the Class Officer. Medical Orderly A stated that he found the deceased "*in the middle of his cell*". He said the deceased looked at him "*but would not engage further*".

35. Medical Orderly A stated that he "*observed the behaviour as a deterioration in* (the deceased's) *mental health*" which required him to be placed in the VPU for observation. He informed Chief Officer A and ACO A of the situation. He also informed the deceased that he would be placed in the VPU, who replied "*ok*". CCTV footage viewed shows the deceased walking unaided as he was escorted to the B1 Landing where he was placed in cell 4.

36. Medical Orderly A informed Nurse Officer C that he had moved the deceased to the VPU, cell 4 because, in his view, there was a deterioration in the deceased's mental state and he required further observation. Medical Orderly A placed the deceased on the GP review list for the following morning.

37. Nurse Officer C states in his operational report that he attended at cell 4 on B1 Landing at 17:30 and "*administered medication"* to the deceased.

38. At 17:45 Chief Officer A visited the deceased in the VPU, accompanied by ACO B and Officer B. She reports that the deceased "*appeared to be having some sort of incident where he was shaking and looked like fitting".*

39. ACO B contacted the surgery and Nurse Officer C attended at the cell at 17:50.

40. Nurse Officer C in his operational report describes how he received a call to attend at the deceased cell in the VPU. He states that when he entered the cell,

the deceased was "*lying just inside the cell door on his left side with his head propped up with his left hand".* He said the deceased "*appeared preoccupied*" and was "*grabbing at the air with his right hand and would not communicate verbally*". He stated the deceased "*aggressively pulled his right hand away*" when he was asked if his vital signs could be taken.

41. Nurse Officer C states that in his considered view,

> "(the deceased) *was in a psychotic state of mind and was mentally deteriorating to the point of relapse"*.

42. At approximately 18:20 Nurse Officer C returned to the VPU to check on the deceased and reports that the deceased was "*over by the back wall of his cell and lying with his left ear up against the wall as if listening to something"*. The Nurse Officer again tried to engage in conversation with the deceased but he just replied "*shush*" and would not engage. Nurse Officer C states that the deceased "*appeared to be making writing gestures with his right hand on the cell wall*" and that he was in a *"psychotic state of mind and mentally deteriorating".* Nurse Officer C states he was "*unable to form a full view of the deceased's physical state as he would not let me take his vitals*". He listed the deceased for review by the Prison Doctor the following morning and placed him on the Special Observation List.

43. As part of the handover, Nurse Officer C informed Nurse Officer D of the situation with the deceased when she commenced her night duty.

44. Nurse Officer D states she went to cell 4 in VPU at approximately 19:20 where she observed the deceased "*sitting on the bed in his cell and he appeared to be rolling a cigarette*". She reports that he "*appeared to be calm and settled*". Nurse Officer D also states that the deceased had a "*history of bizarre behaviour and refusing to co-operate*".

45. Nurse Officer D further states in her operational report that the deceased "*had been assessed on 29 December 2016 by the GP"*. She states that it was of "*their view*" (Nurses on duty) that "*the deceased had not declined medically*"

– however, the assessment of the nurses on duty on 2 January 2017 was that he appeared to be "*having a possible breakdown in relation to his mental health*".

46. Officer C in his report states that he checked the deceased's cell at approximately 19:25 and the deceased was "*in his usual position at night time, lying on the cell floor with his duvet over him*" and that he was "*moving*".

47. Officer D was the Night Guard Officer in charge of the VPU and Committal Area and took up duty at 19:30. He states that he spoke with Nurse Officer D who informed him that she had checked on the deceased and that there was "*no cause of concern*".

48. Officer C states he again checked the deceased's cell at 21:10 and he was *"still lying on the floor with the duvet over him and he was moving"*.

49. Officer D states he checked on the deceased at approximately 22:45 and he observed the deceased lying on the floor of the cell with the duvet over him and that "*this was the deceased normal sleeping position*". He stated that the deceased "*looked up when* (he) *lifted cell door flap"* and that the deceased had *"No request*."

50. ACO C states in his operational report that he was in charge of the prison for the night and he had taken over from ACO D, who had reported nothing unusual to him at the handover. ACO C further states in his report that while doing his rounds he looked into the cell at 23:38 and observed the deceased lying on the floor with the quilt covering him. He states "*I tried to get the deceased's attention but he didn't respond".* ACO C went to get the master key, returned to the cell and entered the cell accompanied by Officers E and D where they found the deceased unresponsive.

51. ACO C then called the surgery where Nurse Officer D responded immediately, rendered emergency first aid and commenced CPR with the assistance of Officer E.

52. Paramedics from the Ambulance Service arrived at the cell at midnight and took over CPR.

53. The deceased was pronounced dead by Doctor B at 01:20 on 3 January 2017.

CCTV Footage

54. CCTV footage corroborates the account given by Officers referred to in paragraphs 32 to 53.

55. The following information gleaned from the CCTV footage is relevant to this investigation:-

16:20:00	The deceased enters cell 4 – walking unaided down hallway and into cell. Cell door is locked.
16:21:47	Cell checked by Officer – lifts flap, looks in.
16:54:30	Cell checked by Officer – lifts flap, looks in.
17:30:40	Officer accompanied by Nurse Officer to cell – Nurse enters cell.
17:31:20	Nurse Officer exits cell – door locked.
17:33:57	Officer checks cell – lift flap, looks in.
17:48:10	Chief Officer, ACO and an Officer to cell. Door opened, brief conversation would appear to take place – cell door closed and locked.
17:48:33	ACO uses his Tetra Radio – all leave the area.
17:49:45	Nurse Officer to cell. Lifts flap and looks in.
17:50:30	ACO and Chief Officer return to cell and speak with Nurse Officer. Cell door opened, Nurse and ACO enter and Chief Officer remains at door looking in.
17:51:40	ACO and Nurse Officer exit - cell door closed and locked. Chief Officer, ACO and Nurse Officer have discussion. Nurse Officer looked through viewer into cell.
17:52:28	All leave the area.
17:53:20	Nurse Officer returns to cell - lifts flap and looks in briefly.

17:54:07	Officer returns to cell - lifts flap and looks in.
18:18:13	Officer goes to cell - lifts flap and looks in.
18:18:39	Nurse Officer arrives at cell. Officer unlocks cell and Nurse Officer enters.
18:20:29	Officer removes black plastic rubbish bin from cell and leaves it on the Landing.
18:23:10	Nurse Officer exits cell and cell is locked by Officer.
18:35:20	Officer checks cell - lifts flap and looks in.
18:44:48	ACO master locks cell - lifts flap and looks in.
19:19:15	Nurse Officer goes to cell - lifts the flap and looks in.
19:23:15	Lights dimmed on Landing.
19:25:10	Officer to cell – lifts flap and looks in.
19:26:19	Officer with torch goes to cell - lifts flap and looks in.
21:08:59	Officer checks cell – lifts flap and looks in.
22:46:50	Officer checks cell – lifts flap and looks in
23:38:26	ACO to cell – lifts flap and looks in.
23:38:48	ACO walks back down Landing.
23:39:38	ACO and two Officers go to cell, unlock the cell and enter.
23:40:39	Nurse Officer arrives running to cell. She looks in and immediately runs back down the Landing.
23:41:25	Nurse Officer runs back to cell 4 carrying the emergency bag and enters the cell.
00:00:20	Two paramedics to cell followed three minutes later by two more.
00:33:34	Paramedics exit cell and cell is closed.

56. In examining the CCTV footage, it is clear that the deceased was not checked in accordance with the Standard Operating Procedure (SOP). The Standard

Operating Procedure for Special Observation Prisoners, in Cork Prison, states that "*Special Observation Prisoners must be checked every 15 minutes*".

57. The SOP for the Vulnerable Persons Unit at Cork Prison states that:-
"*this standard procedure applies to all staff, including healthcare. All prisoners in the Vulnerable Persons Unit are considered Special Observation Prisoners. These prisoners must be observed in accordance with the Standard Operating Procedures regarding Special Observation Prisoners".*

58. The following are intervals between checks which are in breach of the above SOP's:-

- 32 minutes and 43 seconds between 16:21:47 and 16:54:30
- 36 minutes and 10 seconds between 16:54:30 and 17:30:40
- 34 minutes and 27 seconds between 18:44:48 and 19:19:15
- 1 hour and 42 minutes and 40 seconds between 19:26:19 and 21:08:59
- 1 hour and 37 minutes and 51 seconds between 21:08:59 and 22:46:50
- 51 minutes and 36 seconds between 22:46:50 and 23:38:26

Relevant Journal Entries

59. 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.

60. I examined the 'Medical Observation Cell Book, V.P.U.' for 2 January 2017 in relation to the accommodation of the deceased in the V.P.U. This record certifies that 15 minute checks were carried out from 16:30 to 19:15 and from 20:00 to 23:15. It is obvious from viewing the CCTV footage that these entries are incorrect and misleading.

61. The times referred to in paragraph 55 in relation to checks on the deceased are actual times, as recorded on the CCTV. These checks do not correspond with the written records.

Addressing the concerns of the family

62. In paragraph 11, I outlined the concerns that the family wished to have addressed. In this paragraph, I endeavour to provide answers for the family.

a) For privacy reasons I do not intend disclosing the medication that the deceased was taking. However, I will inform the family of the medication prior to the publication of this Report.

b) I address this in paragraphs 12 to 31.

c) The Prison Doctors and the Psychiatrist regularly reviewed the deceased and the Nursing Staff had daily contact with him – this is also addressed in paragraphs 12 to 31.

d) I do not have information on any medical treatment provided to the deceased prior to his Committal to prison on 13 October 2016 as this is outside the remit of my investigation. However, the deceased was treated in the A&E Department at the Mercy Hospital, Cork on 14 October 2016 for a cut to his thumb which he suffered prior to his committal on 13 October 2016.

e) The prison medical records indicate that the deceased had "*hypertension*" and "*suffered psychotic episodes*" and may have been suffering from a neurological disorder.

Findings

63. The deceased was alone in a single cell on B1 Landing at the time of his death.

64. The deceased suffered psychotic episodes.

65. The deceased received ongoing medical and psychiatric attention during his period of imprisonment.

66. Staff acted promptly when the deceased was found to be unresponsive.

67. The deceased was not checked in accordance with Standard Operating Procedures relating to Special Observation Prisoners.

68. The entries referring to checks on the deceased in the 'Medical Observation Cell Book, V.P.U.', which is an official prison record, referred to in paragraph 60 are misleading in content and but for the CCTV footage viewed, I would have accepted the written record as representing compliance with the relevant SOP, referred to in paragraphs 56 and 57.

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

Recommendations

1. When the status of a prisoner is documented as 'special obs' this must be taken seriously as it suggests an element of vulnerability. Prison personnel, of all grades, must be aware that the management of 'special obs' prisoners carries a high degree of responsibility and must ensure that the Standard Operating Procedures are complied with.

2. All prison personnel must appreciate that official documents must reflect the truth of actions taken by officers.

3. Prison staff must understand that it is a serious matter to generate official documents that are misleading and/or inaccurate.

4. Irish Prison Service Management should address poor record keeping. Governors should ensure that regular audits of all records are carried out to ensure compliance. Incomplete and inaccurate record keeping regularly feature as a finding in reports from this office as does this recommendation.