Oifig An Chigire Príosún

Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. Q

Wheatfield Prison

23 October 2022

Submitted to Minister: 23 October 2024

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GLOSSARY

AED	Automated External Defibrillator
CCTV	Closed Circuit Television
CT	Computed Tomography
DiC	Death in Custody
GP	General Practitioner Doctor
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System

INTRODUCTION

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1. Preface

1.1 The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Chief Inspector of Prisons has been obliged to investigate all deaths in prison custody. This includes the death of any person which occurs within one month of their temporary release from prison custody. The OIP also carries out regular inspections of prisons. The Office is independent of the Irish Prison Service (IPS). The Chief Inspector of Prisons and the staff of the OIP are independent of the Department of Justice in the performance of their statutory functions.

1.2 The OIP can make recommendations for improvement where appropriate. Our investigation reports are published by the Minister for Justice, subject to the provisions of the Act, in order that investigation findings and recommendations can be disseminated in the interest of public transparency, to promote best practice in the care of prisoners.

2. Objectives

2.1 The objectives for investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the IPS;
- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in the future;
- Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- Assist the Coroner's investigation and help to fulfil the obligations of the State under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

3. Methodology

3.1 Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, next of kin (NoK); analysis of prison records in relation to the deceased's life while in custody; and examination of evidence, such as CCTV footage and phone calls.

3.2 This report is structured paying particular attention to the care that was afforded to Mr. Q during his time in prison.

4. Administration of Investigation

4.1 On 23 October 2022, the OIP was notified Mr. Q had passed away while in Wheatfield Prison. On 24 October 2022, the investigation team attended the prison.

4.2 Wheatfield Prison Management provided the OIP with all relevant information in accordance with the standardised checklist of required information.

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

5. Family Liaison

5.1 Liaison with the deceased's family is a very important aspect of the Inspectorate of Prisons' role when investigating a death in custody.

5.2 An Inspector spoke to Mr. Q's NoK, his parents, via telephone on 14 November 2022 and also on 5 December 2022. Inspectors met in person with Mr. Q's parents and extended family on 20 January 2022.

6. Wheatfield Prison

6.1 Wheatfield Prison is a closed, medium security prison for adult males, which primarily caters for prisoners from the counties of Louth, Meath, Monaghan, Wexford and Wicklow. It has an operational capacity of 610 beds.

6.2 Mr. Q was the first death of a prisoner from Wheatfield Prison in 2022 and the 17th death in IPS custody which met the criteria for investigation by the OIP in that year.

7. Family Liaison

7.1 Mr. Q's NoK were complementary of the level of care and support he had received while in IPS custody. The family recounted the difficulties Mr. Q had encountered in his personal life prior to prison. These included having survived cancer and suffering from cardiac problems and addiction issues. The NoK expressed profound sadness as they reflected on a visit with Mr. Q just prior to his passing. They considered that he was physically at the healthiest and most upbeat they had seen him when compared to how he presented prior to his committal. They believed that his time in prison had had a positive impact and this brought them comfort in their loss.

7.2 The NoK asked three questions relating to Mr. Q's medical/healthcare while in custody:

1. The OIP was asked to review Mr. Q's prison medical records to ascertain if he received adequate care.

   The health and medical care provided to Mr. Q is outlined in section 9

2. Was Mr. Q referred for a CT scan while in custody?

   Mr. Q did not have a CT scan while in custody. Mr. Q had an appointment at the Radiology department on 13 August 2022 which was cancelled. A new appointment was awaited at the time of Mr. Q's passing – paragraph 9.3 refers.

   An appointment was also awaited for the Neurology department – paragraph 9.5 also refers.

3. What medication was Mr. Q prescribed?

The medication that was prescribed for Mr Q at the time of his passing is outlined in section 9 (paragraph 9.2 and footnote 2).

8. Background

8.1 Mr. Q was 41 years old when he passed away in Wheatfield Prison.

8.2 Mr. Q was committed into Mountjoy Prison on 29 June 2022 and transferred to Wheatfield Prison on 10 July 2022. He was moved to Cell 4 on the 3 F landing on 11 July 2022. Mr. Q remained the sole occupant of this single cell until his passing on 23 October 2022.

8.3 Mr. Q was serving a three and a half year sentence and had a remission date of 11 February 2025.

8.4 Mr. Q was on the enhanced level of the Incentivised Regime[1]. He worked in the laundry in Wheatfield Prison, had attended training courses and completed a welding course.

9. Health and Medical Care

9.1 A doctor's committal interview was completed by Doctor A on 30 June 2022, following Mr. Q's committal to Mountjoy Prison. Nurse A completed a nurse's committal interview on 10 July 2022, when Mr. Q was transferred to Wheatfield Prison. Mr. Q was seen by Doctor B, who completed a doctor's committal interview at Wheatfield Prison on 11 July 2022. It was noted on the Prisoner Healthcare Management System (PHMS) that Mr. Q had informed the doctors and nurse that he had been treated for cancer 16 years prior to his committal, he had a heart condition and was attending the Heart Failure Unit at St Michael's Hospital Dublin. It was also recorded that Mr. Q indicated he had no addiction issues, but shortly before his committal had been prescribed anti depression medication by his doctor in the community.

9.2 The medical records showed that a nurse made contact with Mr. Q's doctor in the community to confirm the medication prescribed prior to committal. Mr. Q was prescribed a number of medications which the records confirmed were administered daily.[2]

9.3 On 11 August 2022, St. Vincent's Hospital Radiology department rang Wheatfield Prison Surgery notifying them of an appointment for Mr. Q on 13 August 2022. St. Vincent's informed the Medical Administrator A who received that call that Mr. Q's family had been informed about the appointment. Medical Administrator A recorded on the PHMS that St. Vincent's were informed that the appointment would have to be rescheduled and the hospital personnel undertook to contact Wheatfield surgery when a new appointment was scheduled.

9.4 The investigation team was informed by healthcare staff in Wheatfield Prison that "*As part of security directions, healthcare are asked not to schedule hospital appointments if the prisoner's family are aware of the appointment. If, however, there are particular concerns re healthcare needs of individual prisoners this is reviewed by healthcare and operational staff and decision made regarding the healthcare needs of the prisoner*".

[1] The Incentivised Regimes Programme provides for a differentiation of privileges between prisoners according to their level of engagement with services and behaviour. The objective is to provide tangible incentives to prisoners to participate in structured activities and to reinforce good behaviour, leading to a safer and more secure environment. There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level.

[2] At the time of Mr. Q's passing he had prescriptions for the same medication as he had been receiving in the outside community, namely: Lustral, Entresto, Eplerenon Bluefish, Bisoprolol and Burinex.

9.5 The investigation team reviewed a copy of a Referral Form dated 16 August 2022, referring Mr. Q to the Neurology Out Patients Department. The Neurology team was advised that Mr. Q had "*missed a recent follow up appointment with the Neurology OPD following first unprovoked seizure.*" It was stated that his follow up appointment was scheduled for 13 August 2022 and it was missed as the letter went to his home address. Mr. Q had not been facilitated with a new appointment prior to his passing.

9.6 Prior to entering prison, Mr. Q's previous appointment at St. Michael's Hospital Heart Failure Unit was on 20 June 2022. It was recorded that his new appointment was scheduled for 14 August 2023. IPS Healthcare personnel made a hard copy of this information so that in the event Mr. Q was transferred to a different prison the referral letter would transfer with him. A reminder was set for July 2023 to notify healthcare personnel of the need to make contact with St. Michael's six weeks in advance. The investigation team was provided with a copy of this referral letter dated 12 July 2022 addressed to Mr. Q's home address advising him that "A*n annual review appointment has been arranged for [name] to attend the Heart Failure Unit" on 14 August 2023 at 9 am*."

10. Events of 23 October 2022

10.1 Officer A reported that prisoners were unlocked at the later time of approximately 10:20 due to a shortage of staff on the landing. Officer A reported seeing Mr. Q engaging with other prisoners in a friendly manner and described him as being in good form. Mr. Q remained on the landing until he collected lunch from the servery at approximately 12:00 and returned to his cell.

10.2 Officer A locked prisoners back in their cells for lunch at approximately 12:10 and reported enquiring from Mr. Q if he needed anything more before locking the cell door.

10.3 At approximately 14:10, Officer A unlocked Mr. Q's cell and enquired if he wished to go to the prison exercise yard. Officer A reported that Mr. Q grunted a response and Officer A stated that he *"interpreted this grunt as a negative response which isn't unusual as he is a worker. Workers often stay back on a Sunday as many of them relax on their day off".* Officer A remained on the landing until 15:45, at which time he departed to take an order to the tuck shop.

10.4 At approximately 15:50, Officer B walked the landing informing prisoners that their tea time meal was ready. Officer B reported that "*As I approached [Mr. Q's] cell I saw he was lying in his bed. I told him to go get his food to which he did not respond, so I walked into his cell to check if he was ok. After attempting to get a response from him several times to no avail, without delay I alerted Nurse B*." Nurse B was on the landing and standing near the 3F Class Office at the time. Officer B stated that he immediately began to lock back prisoners in their cell.

10.5 Nurse B reported that, at approximately 16:00 while doing medication rounds, she was asked to attend Mr. Q's cell by Officer B. On arrival to the cell, Nurse B found Mr. Q lying in bed on his left side facing the wall. Nurse B pulled back the bed covers and attempted to get a response, Mr. Q did not respond. Nurse B immediately called a Code Red[3] requesting nurses to respond. Nurse B reported that she *"checked for a carotid pulse for 15 seconds, none*

[3] Prison alert for an urgent medical situation – requiring medical staff and equipment

present. No signs of breathing, blood pooling present on lower left thoracic area of his body." Nurse B then checked Mr. Q's pupils and described them as fixed and dilated.

10.6 Chief Officer A was present when Nurse B called a Code Red emergency. Chief Officer A radioed ACO A in the prison Control room and requested an ambulance to be called immediately for Mr. Q.

10.7 Upon arrival at Mr. Q's cell, Nurse C found Mr. Q lying on his bed and reported that he had *"no obvious signs of life, pupils fixed and dilated, no rise or fall of chest, no pulse".*

10.8 Nurse E also responded and reported that, at approximately 16:00 following a Code Red call, she collected the medical emergency bag and the Automated External Defibrillator (AED) and made her way to 3F landing. On arrival she met Nurse B and Nurse C followed shortly afterwards by Nurse E. Nurse D reported that lividity was obvious on Mr. Q's chest and abdomen, which are indicators that Mr. Q had passed. Nurses discussed the assessment and presentation of Mr. Q and decided not to commence CPR.

10.9 Nurse D reported that, at approximately 16:15, she made a phone call to Locumlink and requested a general practice doctor to attend Wheatfield Prison to pronounce Mr. Q deceased.

10.10 At approximately 16:20, members from Dublin Fire Brigade arrived, assessed Mr. Q and reported that his presentation was not compatible with life.

10.11 At 16:45, Nurse E was informed by Locumlink that no GPs were available and it would possibly be the following day before a doctor could attend the prison.

10.12 Two members of An Garda Síochána attended the prison. Assistant Governor A informed Garda A and Garda B that they were encountering difficulties in locating a doctor to pronounce death. The Gardaí arranged for their station on-call doctor to attend the prison. At 17:41 Doctor C attended Wheatfield Prison and pronounced the death of Mr. Q.

11. Prisoner Reports

11.1 Prisoner 1 informed the investigation team that Mr. Q was "*in great form"* on 23 October 2022. Prisoner 1 reported that he wanted to ask Mr. Q if he would accompany him to the exercise yard at 14:00, but was informed by another prisoner that Mr. Q was asleep in his cell so he left him be. At approximately 16:00, on return from the exercise yard, Prisoner 1 stated that Officer A appeared concerned about Mr. Q and asked other prisoners if Mr. Q was joking. Prisoner 1 entered Cell 4 and described seeing Mr. Q and described his complexion as grey with purple lips, he then left the cell to allow officers and Nurse B to enter the cell.

11.2 Prisoner 2 stated that he was a friend of Mr. Q and on 23 October 2022 "*he was his usual self, laughing and joking*" before they collected their lunch together at the servery. During the afternoon, Prisoner 2 went to Mr. Q's cell to ask for milk but noticed he was asleep so did not wake him. A few minutes later, he heard fellow prisoners calling Mr. Q's name. He reported that he *"knew there was something wrong, I went in, I tried to check his pulse, there was none."*

11.3 Prisoner 3 described Mr. Q as a "*lovely fella".* He reported going to the yard and, as Mr. Q was not there, he presumed he had stayed back in his cell to sleep. At approximately. 16:00 he heard

an Officer calling Mr. Q's name, he made his way down to Cell 4 along with Prisoner 4. He reported shaking Mr. Q then filled his hand with water from the sink and splashing it onto Mr. Q in a bid to wake him. There was no response from Mr. Q. Prisoner 3 then reported screaming for medical assistance.

11.4 Prisoner 5 reported speaking to Mr. Q after breakfast on the morning of 23 October 2022, describing him as being in great form. This was the last interaction they had together. Prisoner 5 reported witnessing the response to Mr. Q's cell and commotion in the afternoon. He stated that he felt very frightened as he knew something was seriously wrong with Mr. Q.

11.5 Prisoner 6 described having a close friendship with Mr. Q and sharing a number of similar interests. At approximately 16:00, Prisoner 6 reported hearing Officer B attempting to get a response from Mr. Q. Prisoner 6 stated that he entered Cell 4 and tried to get a response form Mr. Q, before checking for a pulse, he could not find a pulse and left so that a nurse could enter. Later on that evening, he reported being informed of Mr. Q passing, however, he stated that he was already aware of this having entered the cell.

11.6 Prisoner 7 described Mr. Q as a "*true gent*". He reported witnessing Officer B attempt to wake Mr. Q and that in his view Mr. Q "*didn't look right*". Prisoner 7 ended his account by stating "*No one on the landing would have expected what happened next, if so we would have helped in any way we could, a true gent. God bless him and his family, thoughts and prayers are with them*".

12. CCTV

12.1 As part of the investigation process, Inspectors from the OIP reviewed CCTV footage covering 23 October 2022. The CCTV corroborated the accounts of officers, nurses and prisoners. At 14:13, an officer was seen at Mr. Q's cell door, he opened the door and briefly looked in before departing. A prisoner entered Mr. Q's cell briefly at 14:14. Two prisoners, separately looked into Mr. Q's cell at 15:46 and 15:54 and departed almost immediately. The officer and prisoners were seen gesturing for assistance for Mr. Q at 15:58 and the officer was using his Tetra radio. The first nurse arrived to the cell at 15:59.

13. Critical Incident Review Meeting

13.1 On 26 October 2022, a Critical Incident Review meeting[4] was held at Wheatfield Prison to review and establish the facts regarding Mr. Q's passing. Fifteen staff were in attendance, Governor A chaired the meeting.

13.2 It was recorded that Mr. Q appeared in good form at lunch time and made no complaints to either officers or fellow prisoners. Nurse E said that the absence of Mr. Q's vital signs indicated that resuscitation efforts would not have assisted.

[4] This meeting is between prison management and all prison staff who were involved in the incident of who may have relevant information. These are conducted to identify good practice, potential shortcomings and to address any welfare needs. In this case no issues of concern were raised or identified.

13.3 Chaplain A reported informing Mr. Q's NoK in person and that they were grateful to the IPS for how Mr. Q had been treated while in prison. It was recorded that the NoK wanted Mr. Q's personal belongings to be re distributed to other prisoners who may not have the same family support as him.

13.4 The meeting agreed that Governor A was to discuss the lack of an on-site doctor with the Director of Care and Rehabilitation IPS HQ.

13.5 The OIP is pleased to note that a full-time doctor has since been assigned to Wheatfield Prison.

14. Recommendation

14.1 The Office of the Inspector of Prisons made one recommendation:

1. The OIP invites the IPS to review its policy of the automatic cancellation of hospital appointments of which family members have become aware. It recommends that any decision to cancel an appointment for this reason should be based on an individualised written risk assessment and formally approved by the Governor of the prison concerned.

15. Support Organisations

15.1 Those who are affected by a death in custody can obtain assistance or advice from a number of charities and support groups. The Office of the Inspector of Prisons has an information pamphlet for relatives and friends of someone who dies in the custody of a prison. Further information can be found on the OIP website at www.oip.ie