

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner J
on 7 November 2014 in Wheatfield Prison**

***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 J
on 7 November 2014 in Wheatfield Prison**

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

Judge Michael Reilly
Inspector of Prisons

1 July 2015

Preface

Prisoner J was a 32 year old Lithuanian man who died in Wheatfield Prison on 7 November 2014.

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

My report is divided into 12 sections.

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

Judge Michael Reilly
Inspector of Prisons

1 July 2015

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 32 year old Lithuanian National who lived in Ireland since 2006.
2. He is survived by his parents and extended family who live in Lithuania.
3. The deceased was sentenced to prison on 15 March 2011. His release date was to be 12 September 2015.
4. The deceased successfully participated in addiction detox programmes while in prison.
5. The deceased was in regular contact with his mother by telephone while in prison.
6. The deceased worked in the laundry in Wheatfield Prison.
7. On 7 November 2014 the deceased became ill in the laundry, was taken to his cell where his health deteriorated.
8. The deceased was taken to hospital and pronounced dead at 12.56 hours on 7 November 2014.
9. I had email contact with the deceased's family in Lithuania. I wish to express my sincere condolences to them on their sad loss.
10. I had unrestricted access to all parts of Wheatfield Prison, to all records held in the prison, to all medical records and relevant CCTV footage. I also had access to all appropriate members of staff, others working in the prison and prisoners.

Status of the deceased in Prison

11. The deceased was classed as an ordinary prisoner at the enhanced regime level.
12. The deceased worked in the laundry.
13. The deceased was considered a quiet man but well thought of by his fellow prisoners and staff.
14. The deceased was sharing a cell – cell 13 on Unit 10F with prisoner A at the time of his death.

Contact with the family

15. My contact with the deceased's family was by means of email.
16. The family expressed the following concerns:-
 - (a) Why was the deceased forced to work with a sick person and as a result was infected with "*open form tuberculosis*"?
 - (b) Why was he treated with potent antibiotics which "*are hardly suitable to him under his general health condition*"?
 - (c) Why was he kept in prison when he had a pre-existing mental illness and he was being given strong sedatives?
 - (d) Why did the prison officers not attend to give him medical care on time?
 - (e) Why was there no officer "*who would be able to provide him medical assistance*"?
 - (f) Why was there no officer to open the cell door?
 - (g) Why was he left alone in the work place when he felt bad?
17. The family also raised other issues as follows:-
 - (a) As he suffered "*huge moral damage*" his family should be "*rewarded after his death in accordance with Irish Law*".
 - (b) Did he receive a salary as he worked in the Laundry?

- (c) As the prison was his employer did he have social insurance?
- (d) Should the prison make amends for his funeral expenses?
- (e) His personal documents e.g. passport, driving licence were not returned to his family. Without the passport the family “*cannot finish his death registration procedures*”.

Contact with medical services

- 18. In view of the concerns raised by the family of the deceased it is relevant that I set out briefly the deceased’s contact with the medical services.
- 19. The deceased had contact with the psychiatric services during his last and previous terms of imprisonment.
- 20. The deceased had been admitted to the Central Mental Hospital on two occasions.
- 21. The deceased was receiving on going monitoring and medication for his ailments up to the date of his death.
- 22. For privacy reasons I do not intend giving further details of the deceased’s medical history. This does not take in any way from the thrust of this report.

Tuberculosis (TB) in Wheatfield Prison

- 23. In view of the concerns expressed by the family it is relevant that I refer briefly to an incident of TB in Wheatfield Prison in 2014.
- 24. In April 2014 a prisoner in Wheatfield Prison was diagnosed with TB.
- 25. The prisoner referred to in paragraph 24 worked with the deceased.
- 26. On 13 May 2014 a Public Health Specialist from the Health Service Executive visited the prison and completed a “Mantoux Test” on a number of prisoners including the deceased. The deceased’s test proved positive. A chest x-ray taken at that time was clear.

27. The deceased was described as “*asymptomatic*” which indicated that he had “*latent TB*”. However, the deceased was not infectious but required prophylactic medication to ensure his condition did not become active.
28. The deceased received ongoing treatment and medication for his latent TB condition up to the date of his death.
29. His treatment consisted of, *inter alia*, regular blood test and x-rays as requisitioned by medical personnel in addition to prescribed medication.
30. I asked one of my experts – a medical consultant - to review the medical files in Wheatfield Prison insofar as these related to the outbreak of TB in the prison. Her report concluded:-

“(The deceased) was in contact with a fellow prisoner who was diagnosed with TB. Following assessment by a public health specialist, (the deceased) was diagnosed with latent TB but remained asymptomatic; however, in line with best practice, he was commenced on anti TB medications as a prophylactic measure. He died almost 5 months into the treatment but his death appears to be unrelated to the TB”.

Relevant events prior to 7 November 2014

31. On 1 July 2014 Dr A wrote to kitchen staff in Wheatfield Prison stating that the deceased was to receive light food during his “*special treatment*”.
32. On two occasions in July 2014 the deceased complained of feeling tired and drowsy and could not eat.
33. On one occasion the deceased was unable to work in the laundry and was given a medical certificate to explain his absence.
34. On 15 September 2014 Nurse Officer A stated that the deceased continued to have anxiety symptoms with reports of paranoia.

35. At times the deceased complained of having a poor appetite with persistent stomach pains.

Sequence of events on 7 November 2014

36. In this part of my Report I refer to time lines. Where I refer to actual times these times are those taken from the CCTV footage.
37. Prisoner A stated that on the morning of 7 November the deceased was in good form, that he made himself a cup of coffee prior to breakfast unlock and got his tray of breakfast when the cell was opened. Prisoner A did not see the deceased after this as he was not on Unit 10F when the deceased returned as referred to later in this report.
38. At 08.13.00 the deceased left Unit 10F to go to work in the laundry.
39. Nurse Officer B stated that she met the deceased at approximately 08.15 hours as she was doing her nursing rounds. She said the deceased “*appeared in good spirits*” when she dispensed him his medicine.
40. Prison Officer A the Work Training Officer in the laundry confirmed that the deceased had attended at the laundry and appeared as normal.
41. Prisoner B who worked in the laundry with the deceased stated that he, the deceased, was in good form and was laughing and joking.
42. Prisoner C and Prison Officer A were talking at approximately 11.00 hours when the deceased went into the toilet area. Prisoner C went into the toilet and enquired of the deceased as to his health. The deceased told him – “*he was not feeling right, felt sick and was sweating*”. Prison Officer A and Prisoner B went into the toilet and found the deceased – “*on his hunkers and looking into the toilet*”.

43. Prison Officer A was concerned for the deceased's well being and brought him back to his accommodation on Unit 10F arriving at 11.07.57. He stated that he spoke to the officer in charge of the landing – Prison Officer B and explained to him that the deceased needed medical attention and asked the officer to contact the surgery.
44. At 11.08.21 the deceased entered his cell and closed the door. The door was locked.
45. Prison Officer B stated that he returned the deceased to his cell, contacted the surgery and told a nurse officer that the deceased was unwell.
46. Nurse Officer B stated that at approximately 11.10 hours on 7 November she received a telephone call from Officer B who stated that the deceased had returned from the laundry as his TB medication was making him feel sick. She stated that she advised Officer B that she could not review the prisoner straight away to which he replied – “*grand I'm just passing it on*”. The nurse officer explained that “*the information given did not alert me to be immediately concerned*” and that “*my intention was to have the prisoner reviewed if his nausea persisted*”. She further stated that she met Officer B at approximately 11.20 hours near the staff corridor and he, the officer, did not express any further concerns in relation to the deceased.
47. Prison Officer B stated that after he had contacted the surgery he secured the unit at approximately 11.15 hours and went to the Administration Area where he was to “*lodge paperwork and check out inmate requests*”.
48. Prison Officer B is last seen on CCTV at the class office of Unit 10F at 11.11.08.
49. Prisoner D was on Unit 10F but not locked in his cell as he was a cleaner on the unit.

50. At 11.24.35 the cell call bell light outside cell 13, the deceased's cell, can be seen on CCTV turning red.
51. I enquired of the management of Wheatfield Prison as to who or what part of the prison would be alerted in the event of a call for assistance from any particular cell. Governor A informed me that when a cell call is activated:-
- *“A red light is activated on the outside of the cell door and the Unit entry door on the spinal corridor.*
 - *A light is activated in the Unit Hub.*
 - *A light and audio is activated in the Console.”*
52. The Units such as Unit 10F are stand alone accommodation units which open onto the ‘spinal corridor’ referred to in paragraph 51. The Unit Hub referred to in paragraph 51 is the Class Office in the Unit. Each Unit has its own Unit Hub. The console referred to in paragraph 51 is the control centre for the prison.
53. Governor A explained the *modus operandi* of the Console Officer in dealing with calls, such as in the instant case, in the following terms:-
- “The Console Officer can communicate directly to the cell (regardless of whether the Unit Officer is on site). The Console Officer has direct contact with the prisoner and can contact by radio the Unit Officer/ACO if necessary to attend the prisoner in cell”.*
54. Prisoner D who was the cleaner in the Unit and who was not locked into his cell can be seen on CCTV exiting his cell at 11.36.36.
55. Prisoner D can be seen at the door of cell 13 at 11.36.40.
56. At 11.36.50 Prisoner D can be seen running to the door from Unit 10F which leads to the spinal corridor. This door was locked. This door must always be

kept locked except in certain defined circumstances. He can be seen at the door appearing to be calling for help.

57. I interviewed Prisoner D. He stated that while in his cell – cell 12 – he heard the deceased banging on his cell door. He confirmed that the call bell light was on.
58. Prisoner D described what he did in the following terms:-

“I looked in. He was holding his left arm and he said to me – get the officers – as he was having a heart attack. I went and got the officer. I went up to the door and I saw a couple of the lads out on the drag and told them to get an officer. I couldn’t get out as I was locked in from the drag part”.

The prisoner explained that by the drag he meant the spinal corridor.

59. Prisoner E was on the spinal corridor. At interview he stated that he was walking along the spinal corridor on his way back from the gym when he heard someone knocking on the locked door from Unit 10F. He stated that the person was calling out to get help because he thought another prisoner was having a heart attack. The prisoner that was calling was Prisoner D.
60. Prisoner E immediately went to Unit 9F and alerted Officer C who was on duty in the Unit Hub of 9F as to the situation.
61. Officer C stated that a prisoner knocked on the door of the class office of Unit 9F and informed him that a prisoner on 10F was having chest pains and needed assistance. He stated that he contacted the surgery and informed Nurse Officer C of the situation and requested medical assistance.
62. Officer C stated that he proceeded towards Unit 10F and on the way met Officer B. They both went to Unit 10F.

63. At 11.39.22 Officer C went into the Unit Hub to activate the electronic cell locking system.
64. At 11.39.28 Officer B can be seen entering Unit 10F.
65. At 11.39.45 Officer B entered the deceased's cell – cell 13 – followed 10 seconds later by Prisoner D. They were followed by Officer C and Prisoner E. An immediate emergency call for medical assistance was made by Officer B.
66. Prisoner D stated that the deceased was on the floor partly under the bed at the ladder end. He described what he did when he went into the deceased's cell in the following terms:-
- “(The deceased) looked as if he was having a seizure. He looked like he was biting his tongue. I grabbed a teaspoon and I put it in his mouth and took his tongue back out and I told him to keep the spoon on his tongue so it wouldn't go back down his throat. He was breathing”.*
67. Prisoner D explained that he had done First Aid courses in Youth Reach and therefore knew what to do in an emergency.
68. The account given by Prisoner D is corroborated by Prisoner E. He stated that the deceased stopped breathing, that he put the deceased's head on his lap and tried to *“bring him around”*.
69. At 11.40.32 ACO A entered the cell. He stated that Officers C and B and Prisoners D and E were kneeling by the deceased and were talking to him. He stated that the deceased began to turn grey and that he was not breathing. He requested help from the two prisoners and began CPR on the deceased. This account was corroborated by the two prisoners.
70. At 11.44.35 Nurse Officer D and Dr. A arrived at the cell.

71. The medical notes entered by Nurse Officer D read as follows:-

“I attended the cell with the emergency bag at approx 11.40 hrs accompanied by Dr. A. On arrival (deceased) was lying on the floor of the cell in recovery position. His face was mottled and blue and did not appear to be breathing spontaneously. At that time I was unable to ascertain vital signs. Nurse Officer C then attended the cell. We immediately commenced CPR. Nurse Officer E then entered the cell when I was applying the AED. As advised shock given and CPR continued with all CPR team rotating. No further shocks advised during the remainder of CPR. During CPR (deceased) was suctioned. CPR continued until arrival of the ambulance crew. I then assisted CPR whilst transferring to trolley”.

72. At 12.15.03 ambulance personnel arrived at the cell.

73. At 12.25.03 the ambulance personnel left the cell with the deceased.

Duties of officers assigned to Units

74. I wished to ascertain if a Unit could be left unattended for any period of time while prisoners were in such Unit.

75. Governor A responded to me in the following terms:-

“It would be normal practice for an Officer to leave the Landing while there are prisoners locked back in their cells e.g. to attend to prisoners’ requests involving Reception, General Office, Censors etc”.

Call bell activation in Console

76. I have already stated in paragraph 51 that when a call bell is activated in a cell - *“A light and audio is activated in the Console”.*

77. I endeavoured to ascertain if, in the instant case, there were records to show that such a call from cell 13 on 10F Unit was noted or logged in the Console at 11.24.35 or at any time.

78. I ascertained that ACO B was one of the officers in charge of the Console on the morning of 7 November 2014. ACO C stated that at approximately 11.00 hours on 7 November 2014 he handed over charge to ACO B.

79. ACO B stated as follows:-

“I wrote a time stamped report in the control room journal detailing my actions between 11 am and 12.30 pm. I have nothing further to add to that report”.

80. The relevant detail from the journal that was provided to me reads:-

11.41 Officer B called for medical assistance to come to Unit F10. Officer B made several calls for assistance.

11.47 ACO A contacted console to ring for an ambulance ASAP and gave me as much information as possible at the time. Rang for an ambulance and then contacted Main Gate.

81. ACO B also stated:-

“As for the cell call system there was no report of any prisoners in distress or requesting assistance through that system during my shift that day”.

82. I have been informed that the usual practice is that if a call from a cell, as in the instant case, activates the system in the console the officer working in the console will contact the Unit officer if the activation remains active for a period of time.

83. However, I have been unable to verify whether or not the call made at 11.24.35 by the deceased in cell 13 on Unit F10 did, in fact, activate the system in the console.

Findings

84. The deceased was an ordinary prisoner at the enhanced regime level in Wheatfield Prison when he died on 7 November 2014.
85. The deceased worked in the laundry.
86. The deceased had considerable contact with the psychiatric and medical services while in prison.
87. A number of prisoners, including the deceased, were tested for TB in Wheatfield Prison in April 2014.
88. The deceased tested positive and was described as being 'asymptomatic' which indicated he had 'latent TB'.
89. The deceased received ongoing treatment and medication for his latent TB in prison.
90. The deceased became unwell in the laundry area of Wheatfield Prison at approximately 11.00 hours on 7 November 2014.
91. The deceased was brought back to his accommodation in Unit 10F at 11.07.57 and locked in his cell.
92. The prison officer in charge of Unit 10F alerted the surgery to the effect that the deceased was unwell.
93. There was no prison officer in Unit 10F between approximately 11.12 hours and 11.39.22 on 7 November 2014.

94. The call bell for cell 13 on Unit 10F was activated by the deceased at 11.24.35.
95. The call bell alert referred to in paragraph 94 was not responded to by prison staff.
96. A prisoner on Unit 10F responded to banging on the door of cell 13 by the deceased. He immediately alerted another prisoner who alerted the prison officers.
97. After the prison officers were alerted there was an immediate and appropriate response from both medical and disciplined staff.
98. The cause of death is a matter for the Coroner and the Inquest. However, issues have been raised by the family of the deceased and are referred to in paragraph 16 (a) to (d). I will inform the deceased's family that these are matters more appropriate to be raised at the Inquest.

Addressing the concerns of the family

99. In paragraph 16, I set out the concerns of the family that they wished investigated. In this paragraph I endeavour to address their concerns as follows:-
 - (a) This is a matter more appropriate to the Inquest.
 - (b) This is a matter more appropriate to the Inquest.
 - (c) This is a matter more appropriate to the Inquest.
 - (d) This is a matter more appropriate to the Inquest.
 - (e) Wheatfield Prison had a doctor and nurses on duty on 7 November who were in a position to provide and did provide medical assistance as evidenced by this report.
 - (f) There was no officer on Unit 10F to open the door to the deceased's cell. However, in this report I set out the relevant sequence of events as they are relevant to this concern.

(g) It is clear from this report that the deceased was not left alone in the work place when he became unwell.

100. In paragraph 17, I set out other issues raised by the family which they, the family, wished me to address. In this paragraph I endeavour to address such issues as follows:-

- (a) This is a matter on which the family must take their own counsel. I am precluded from giving advice on matters such as this.
- (b) He did not receive a salary.
- (c) He did not have social insurance.
- (d) The prison paid the funeral expenses in so far as they related to that part of the funeral that took place in this country.
- (e) I understand that the deceased's personal belongings were brought to his home country by the funeral undertakers who arranged the repatriation of the deceased to his own people. I have been informed that among the personal items returned was a European ID Card.

Recommendations

101. Appropriate and robust procedures must be introduced as a matter of great urgency in all prisons to ensure that prisoner call bells are responded to as soon as is humanly possible.

102. Appropriate counselling, similar to that provided to prison staff, must be provided for all prisoners who have been witness to or affected by the sudden death of a fellow prisoner.