A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner H on 26 August 2014 in Cloverhill Prison

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

Office of the Inspector of Prisons
24 Cecil Walk
Kenyon Street
Nenagh
Co. Tipperary

Tel: + 353 67 42210
Fax: + 353 67 42219
E-mail: info@inspectorofprisons.gov.ie
Web: www.inspectorofprisons.gov.ie
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A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner H on 26 August 2014 in Cloverhill Prison

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

Judge Michael Reilly
Inspector of Prisons

12 May 2015

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Preface

Prisoner H was a 37 year old widower who died in Cloverhill Prison on 26 August 2014.

I did not meet with the family of the deceased, but offer my sincere condolences to them.

My Report is divided into 11 sections as follows:-

- Introduction
- General Information on the deceased
- Deceased's contact with the medical services in Cloverhill Prison
- Deceased's hospitalisation in Our Lady of Lourdes Hospital, Drogheda
- Relevant sequence of events - 26 August 2014
- Relevant Prison Records
- Status of deceased on 26 August 2014
- Matters of Concern
- Findings
- Recommendations
- Inspector of Prisons Comments

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

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Inspector of Prisons

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Inspector of Prisons Investigation Report

Introduction

1. The deceased was a 37 year old Polish national who had been living in this country for a number of years. While in Ireland the deceased had married and had two children. He is survived by his mother, his siblings and two young children.

2. The deceased was remanded in custody to Cloverhill Prison on 7 September 2013 following his arrest on a serious charge which related to the death of his wife. He remained on remand until his death on 26 August 2014. He did not achieve bail.

3. On 27 January 2014 the deceased was sent forward for trial to the Central Criminal Court on the charge referred to in paragraph 2 and remanded in custody to Cloverhill Prison pending his trial.

4. On 18 August 2014 the deceased was brought, under prison escort, to Navan District Court to participate in family law proceedings. During a recess in the court proceedings the deceased, while in the custody of prison officers, suddenly ran across the courtroom and jumped through a window landing on the ground approximately 25 feet below. He was taken to Our Lady of Lourdes Hospital in Drogheda. He had suffered a fractured hip. He remained in hospital, under prison guard, until 26 August 2014 when he was discharged into the custody of prison officers and returned to Cloverhill Prison.

5. On his return to Cloverhill Prison on 26 August 2014 he was placed in a Close Supervision cell for observation and for review the following morning.

6. The deceased died in tragic circumstances on the night of 26 August 2014.

7. Prior to the deceased's remand to Cloverhill Prison on 7 September 2013 he had significant contact with the mental health and medical services in the community. Between the date of his committal and the date of his death he

also had considerable contact with the psychiatric, medical and psychology services in the prison. He spent approximately 6 weeks in the Central Mental Hospital in April/May 2014.

8. I had unrestricted access to all parts of Cloverhill 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.

9. I did not meet with any member of the deceased's family.

10. I offer my sincere condolences to the family of the deceased on their sad loss.

General information on the deceased

11. The deceased was born in Poland. He received a good education. When he left school he worked but studied at the same time qualifying with a degree at the age of 23.

12. He moved to Ireland in 2005. He worked in the retail trade and was promoted.

13. In 2008 he sustained a back injury which kept him out of work for a year. 3 months after he returned to work, due to physical and psychiatric difficulties, he was again certified as unfit for work and did not work thereafter.

14. The deceased disclosed to the medical personnel in Cloverhill Prison that he attended a psychiatrist in Poland in 2004. He stated that this was for depression and that he was suicidal.

15. From 2009 to September 2013 the deceased attended a psychiatrist in Ireland and was treated for depression, anxiety and panic attacks. He was prescribed medication. He also attended his family doctor.

16. For the purposes of this report it is not appropriate that I give further information regarding his medical history except to say that during the period

referred to in paragraph 15 he was in constant contact with the relevant services in the community and was being treated.

Deceased's contact with the medical services in Cloverhill Prison

17. For confidential and privacy reasons I do not intend giving exhaustive details regarding all the deceased's contacts with the medical services in Cloverhill Prison.

18. For the majority of his time in Cloverhill Prison the deceased was accommodated in a combination of a Safety Observation cell, a Close Supervision cell or a cell on D 2 Landing (at times in a single and at times in a double cell).

19. D 2 Landing is divided by a Class Office effectively creating two distinct areas which in the prison are referred to as – D2 'Security' and D2 'Vulnerable'. There are 2 Safety Observation Cells, 4 Close Supervision Cells and 12 Accommodation Cells in the area known as D2 'Security'. There are 10 Accommodation Cells in the area known as D2 'Vulnerable'. D2 'Vulnerable' and the 2 Safety Observation Cells in D2 'Security' comprise a specialist unit within the prison which is used to accommodate vulnerable prisoners. An In-Reach Forensic Mental Health Team from the Central Mental Hospital provides psychiatric services to those prisoners who need same in this unit. This is a multi-disciplinary team which is led by a Consultant Forensic Psychiatrist. It also comprises, *inter alia,* a Psychiatric Registrar and Registered Psychiatric Nurses. The level of healthcare and supervision in this unit is very high. All staff is appropriately trained. When the D2 'Vulnerable' area is fully occupied additional vulnerable prisoners are accommodated in the area known as D2 'Security'. The same level of care is provided for such prisoners as is provided in the area known as D2 'Vulnerable'. The medical personnel in the prison comprise doctors and registered nurses (general and psychiatric) who provide 24 hour cover in the prison.

20. For the majority of his time in Cloverhill Prison the deceased was under the constant care of the In-Reach Forensic Mental Health Team from the Central

Mental Hospital referred to in paragraph 19. Dr. A was the consultant psychiatrist leading the In-Reach Team during this period.

21. Between 7 September 2013 and 24 March 2014 the deceased's mental health deteriorated. On 24 March 2014 he was placed on a waiting list for the Central Mental Hospital.

22. On 3 April 2014 he was transferred to the Central Mental Hospital.

23. On 15 May 2014 the deceased was discharged from the Central Mental Hospital to Cloverhill Prison where he was assessed by Nurse Officer A who noted in the Medical Notes that – "*he feels much better but exhausted. Expressed positive ideation about future.... Denies thoughts of D.S.H or suicide*"

24. While the deceased's mental state undoubtedly improved while in the Central Mental Hospital he had continuing issues which were monitored by the medical personnel from the In Reach Team and the prison.

25. Dr. A referred him to the Counselling Psychologist. The Counselling Psychologist considered, in his professional opinion, that the deceased should be transferred to Wheatfield Prison where he would have access to on-going psychology counselling. Despite representations made in this regard such a transfer was not effected.

26. The deceased's contact with the psychology services continued in Cloverhill Prison but was restricted as the Psychologist found difficulty accessing the prison. On one occasion the Psychologist had to conduct a counselling session after waiting 35 minutes and then in a screened visiting box. This was impractical and unsatisfactory.

27. Despite the difficulties experienced by the Psychologist referred to in paragraph 26 the deceased continued to have weekly psychology counselling in Cloverhill Prison up to 18 August 2014.

28. The deceased was constantly monitored by members of the In-Reach Forensic Mental Health Team and the prison medical team up to 18 August 2014.

29. Throughout the period 15 May to 18 August 2014 the deceased's mental health could be described as being relatively stable. It is noted in the medical notes for 15 August 2014,when seen by Dr. A and the Psychiatric Nurse, that - *"He reported that he feels much more settled in mood and finds counselling sessions with the psychologist very helpful..... he denied thoughts or plans to harm or kill himself. He said he was looking forward to visit from his children next week."*

30. At this juncture I should point out that the In-Reach Forensic Mental Health Team from the Central Mental Hospital led by Dr. A operates in Cloverhill Prison. It is a specialist team which is in a position to monitor and treat certain prisoners with specific psychiatric needs in a regulated setting other than those who require inpatient treatment in the Central Mental Hospital. Wheatfield Prison does not have such a facility. On the other hand the psychology services in Wheatfield Prison could be said to operate in a more formalised setting. This paragraph is relevant when one reads my comments in paragraph 117.

Deceased's hospitalisation in Our Lady of Lourdes Hospital, Drogheda

31. On 18 August 2014 the deceased was brought, under prison escort, to Navan District Court to participate in family law proceedings. When the Court went into recess the deceased jumped though a window in the court room landing on the ground approximately 25 feet below. The deceased's restraints had been removed for the Court proceedings. This is normal practice in practically all circumstances but is particularly so in family law proceedings.

32. The deceased was taken to Our Lady of Lourdes Hospital in Drogheda. He had suffered a fractured hip.

33. On 19 August 2014 Chief Nurse Officer A was informed by personnel from the Orthopaedic Department of Our Lady of Lourdes Hospital, Drogheda that the deceased had a plate and pins inserted in his hip and should be an inpatient for approximately 5 days.

34. The deceased remained in hospital, under prison guard, until 26 August 2014.

35. The deceased was discharged from the hospital into the custody of prison officers and returned to Cloverhill Prison on 26 August 2014 where he was assessed by Nurse Officer B. He was placed in a Close Supervision cell for observation and for review by the prison doctor the following morning.

Relevant sequence of events – 26 August 2014

36. At approximately 18.15 on 26 August the deceased was in the Reception Area of Cloverhill Prison having been discharged from the hospital at approximately 17.10 that day. His presence can be seen on CCTV.

37. He walked with the aid of two crutches. His upper leg had been dressed by hospital staff prior to his discharge as a plate and pins had been inserted in his hip while in hospital.

38. The deceased was given a complete change of clothing by the officers in Reception. He was processed in Reception by Officers A and B. The deceased was also seen by Nurse Officer B who, following her review, directed that he be placed in a Close Supervision cell for observation and review by the doctor the following morning. Officers A and B asserted that they had searched the deceased in Reception. He was not placed on the BOSS chair as the officers were aware that he had metal objects in his hip. For reasons of privacy CCTV cameras do not cover the searching area.

39. The deceased was escorted to the Close Supervision cell on D2 by Officer C. This cell is in the area referred to as D2 ‘Security’ as described in paragraph 19.

40. The deceased asked that he might keep his crutches in his cell. This request was acceded to by ACO A. The deceased and his crutches were then searched. The crutches had to be taken apart to conduct this search.

41. The deceased's clothing was taken and he was given refractory clothing.

42. The times referred to in paragraphs 43 to 51 are actual times as recorded on CCTV.

43. At 18.38.00 the deceased was locked in his cell – Close Supervision Cell Number 3 on D2.

44. At 18.58.50 Nurse Officer C attended at the deceased's cell for the purpose of administering nightly medication. The Nurse Officer has stated that the deceased declined his medication stating that - "*he wished to stay awake to watch a match on TV*". From my perusal of the CCTV it appears that this was the last occasion that the deceased was visited by a member of the medical team prior to being discovered as described at paragraph 47 – 3 hours 33 minutes and 16 seconds later.

45. At 19.08.10 officers distributing late suppers called to the deceased's cell.

46. At 19.15.49, 19.31.50, 20.10.36, 20.55.47, 21.20.21 and 21.57.29 the deceased's cell was checked by Prison Officers. They performed this function by looking through the inspection hatch of the cell door.

47. At 22.32.06 Officer D, on checking the deceased's cell, noticed – *"the prisoner laid face down beside his bed with his mattress half off the bed. I observed what I thought was to be faeces spread all over the walls. I banged on the door and called out to the prisoner which yielded no response. I then proceeded to turn on the main light in the cell which was when I saw that the cell was covered in blood"*. The prison officer immediately called for medical attention.

48. At 22.33.46 ACOs B and C entered the cell followed Nurse Officers D and E who were carrying the emergency bag.

49. At 22.53.50 Dublin City Fire Brigade Ambulance Personnel entered the cell.

50. At 23.03.54 the deceased was removed to hospital.

51. At 23.45.40 Gardaí arrived at the scene.

52. The deceased was pronounced dead at Tallaght Hospital by Dr. B at 23.27.

53. While the cause of death is a matter for the Coroner it is understood that the deceased died from self inflicted wounds to both arms. A blood stained razor blade was found in his cell.

Relevant Prison Records

54. I had unfettered access to all records held in the prison which included all medical records.

55. The medical records are held in electronic form on the PHMS computer system.

56. The PHMS system includes details of medication prescribed for prisoners together with details of the dispensing of such medications.

57. I examined the records referred to at paragraph 54.

58. A daily journal is maintained for each Close Supervision Cell. I examined the journal for the deceased's cell for the 26 August 2014.

Status of deceased on 26 August 2014

59. On 26 August when the deceased was returned to Cloverhill Prison from Our Lady of Lourdes Hospital, Drogheda he was placed in a Close Supervision Cell.

60. As the deceased was in a Close Supervision Cell he was classed as a prisoner on "*special observation*". He was placed there by a member of the medical team. As such, prison officers were obliged to check him every 15/20 minutes in accordance with Standard Operating Procedures/Governor's/Chiefs' Orders.

61. The Close Supervision Cell Journal for the 26 August 2014 for the deceased's cell shows that the deceased entered the cell at 18.45.00 and was removed from the cell 23.00.00 on the same night. The actual times retrieved from the CCTV were 18.38.00 and 23.03.54 respectively.

62. The Journal entries also certify that the deceased was checked every 15 minutes from 18.45.00 to 22.00.00.

Matters of Concern

63. At an early stage of my investigation it became apparent that I would have to address certain serious concerns disclosed in records, documentation and in my investigation.

64. These concerns can be summarised as follows:-
    a) The provision of psychology services to the deceased.
    b) The incident in the Courthouse in Navan.
    c) Issues disclosed in medications dispensing records.
    d) The provenance of the razor blade.
    e) Adherence to procedures for checking the prisoner in Close Supervision cell.

<u>The Provision of Psychology services to the deceased</u>

65. Despite representations having been made to transfer the deceased to Wheatfield Prison in order that he would have ready access to the psychology services this transfer was not effected by prison management. I refer to this issue in greater detail in paragraphs 87, 89, 114 and 117,

66. However, the deceased was seen on a weekly basis by the Psychologist in Cloverhill Prison but the conditions under which such professional consultations took place were, at times, far from satisfactory.

The Incident in the Courthouse in Navan

67. The deceased was taken, under prison escort, to Navan Courthouse on 18 August 2014 to participate in family law proceedings relating to the custody of his two young children.

68. As described in paragraph 4 the deceased escaped from the custody of prison officers, jumped through a window in the Courtroom and suffered the injuries already described in this report.

69. I examined the Courtroom at Navan Courthouse. With the benefit of hindsight it is questionable if the physical security arrangements in the Courtroom were adequate as no barrier existed, on the date of my examination, to prevent an incident such as in the instant case.

70. The adequacies of the prison escort and the security of the prisoner were and are a matter for the Irish Prison Service. It does not fall within my mandate to enquire further into this matter.

Issues disclosed in medications administering records

71. The medicines chart discloses all medications that the deceased was to receive while in prison. It details the times of the day that he was to receive such medications and the quantities of such medications.

72. Comprehensive records are also maintained showing the times that the medications referred to at paragraph 71 were either administered or not administered.

73. I noted from the records referred to at paragraph 72 that on two dates, namely, 20 August and 25 August prescribed medication was documented as having been administered by Nurse Officer C to the deceased. On the first occasion

two medications are documented as being administered at 16.39.00 and on the second occasion three medications at 19.25.00. **On these two dates the deceased was in Our Lady of Lourdes Hospital, Drogheda.**

74. I sought clarification from the Irish Prison Service as to the procedure to be followed when prescribed medication is to be administered to a prisoner. The following is the response of the Irish Prison Service:-

> "*All medication administered must be recorded on PHMS and as you are aware, the system defaults to "taken" i.e. when the nurse who administered the medication opens the "Drug Admin" round, each entry is presented with a tick, to indicate administration. The system was developed in this manner to facilitate efficient and timely recording of medication administration by the nursing staff. In the event that a medication is not administered, then the nurse clicks on the "tick" which is then unticked, to indicate that the drug was not taken, and the nurse also is required to record the reason for non-administration of that drug. The nurse then saves the drug administration record*".

75. I interviewed Nurse Officer C. She explained that it was a genuine mistake on her part that she did not correct the default position in the records.

76. I have stated in paragraph 72 that records show when medications are not administered.

77. I sought clarification from the Irish Prison Service as to the procedure in operation for the holding of prisoners' prescribed medication in the prison, for the return policy of un-administered medications in the prison and for the return policy of un-administered medications by the prison to the suppliers – a contractual external community pharmacy.

78. The following is the response of the Irish Prison Service:-

> *"The monitored dose packing system that is in use in all prisons facilitates and supports easy review of compliance with medication, as it is easy for the healthcare staff to see if a particular patient is taking his/her prescribed medication. In the event that a patient is non-compliant with prescribed medication, the nurse will engage with the patient to determine the reason for such non-compliance, and will bring this to the attention of the doctor for review.*
>
> *All blister packs that are no longer required are placed in a dedicated returns tote in the prison pharmacy and are returned to the* (community) *pharmacy at least weekly. All empty packs are also returned. As part of the contract with the community pharmacy, all unused medication remaining in blister packs is considered as "waste medication" and disposed of by the pharmacy in an appropriate manner. As is normal pharmacy practice, as such medication is for disposal, there is no requirement on the pharmacy to record or account for such medication. It is practice in* **(named)** *Pharmacy to dispose of such medication within 2 or 3 days of collection of same from the prisons.*
>
> *In this particular case, it is not possible for me to state definitively that the unused medication was returned to the pharmacy, but the agreed practice, as underpinned by relevant SOPs, is that this procedure was followed by the nursing staff and this is what I would expect to have happened. The returned waste medication was not, nor is it required to be, accounted for by the pharmacy".*

79. I would like to point out, at this stage, that the concerns expressed in this section of my report, are concerns that are applicable to the entire prison system but, unless found otherwise by the coroner, are not matters which contributed to the death of the deceased.

The provenance of the razor blade

80. The blade referred to in paragraph 53 was a disposable razor blade. An Garda Síochána has investigated the provenance of this blade and is satisfied that the blade is of a make and kind used in Our Lady of Lourdes Hospital, Drogheda. This make of blade was neither sold, distributed nor in use in Cloverhill Prison at the time of the deceased's death.

81. I have been informed that the deceased was searched by prison officers on three different occasions, namely, when he was discharged from Our Lady of Lourdes Hospital, Drogheda, in Reception in Cloverhill Prison and when placed in his cell and that on all occasions his clothing was searched. This cannot be independently confirmed by CCTV evidence because of privacy issues which is best practice.

82. The deceased was not placed on the BOSS chair for the reason set out in paragraph 38.

83. The dressing on the deceased's upper leg was not removed for any of the searches referred to in paragraph 81.

Adherence to procedures for checking the prisoner in Close Supervision Cell

84. I have already stated that the deceased, as a prisoner in a Close Supervision cell, was a "*special observation prisoner*" and should have been checked every 15/20 minutes in accordance with Standard Operating Procedures.

85. In paragraph 62, I have referred to the official records for the deceased's cell, being the Official Journal for that cell, which showed that he had been checked every 15 minutes between 18.45.00 and 22.00.00.

86. My perusal of CCTV referred to in paragraph 46 sets out the actual times at which the deceased was checked during the times referred to in paragraph 85.

Findings

87. The deceased had significant psychiatric, psychological and medical problems. He received treatment for these both in the community and in prison.

88. Appropriate psychiatric and medical services were available in Cloverhill Prison.

89. The level of the psychology services available to the deceased in Cloverhill Prison was not comparable to what was available in Wheatfield Prison.

    Please note when considering my findings at paragraphs 88 and 89 my comments at paragraph 117.

90. For much of his time in prison the deceased was classed as a "special obs" prisoner.

91. At various times while in the community and in prison the deceased expressed ideas of self harming.

92. The deceased spent approximately 6 weeks in the Central Mental Hospital in 2014.

93. The deceased was taken under prison escort to Navan District Court on 18 August 2014. He escaped from the custody of the prison officers during a Court recess.

94. The injuries sustained by the deceased at the Courthouse in Navan on 18 August resulted from his own actions where, for whatever motivation, he appears to have exhibited total disregard for his own safety.

95. The deceased was treated for his injuries in Our Lady of Lourdes Hospital, Drogheda.

96. I accept that the deceased was searched on three occasions as described in this report.

97. The decision not to place the deceased on the BOSS chair was a correct decision as any reading would have been misleading as the deceased had a plate and metal pins in his hip.

98. The accommodation of the deceased in a Close Supervision Cell at 18.38.00 on 26 August was a correct procedure. Therefore, he was a '*special observation*' prisoner from that time forward.

99. While it is a matter for the Coroner it appears that the deceased died from self inflicted wounds to both arms caused by a razor blade.

100. The make of razor blade was neither sold, distributed nor in use in Cloverhill Prison at the time of the deceased's death. It was of a make and kind used in Our Lady of Lourdes Hospital, Drogheda during the period that the deceased was hospitalised there.

101. Having regard to my findings referred to in paragraph 100, I must assume that the deceased brought the razor blade from the hospital to the prison. I have not been able to ascertain whether he had the blade secreted on or in his person.

102. The deceased was found, as described in paragraph 47, at 22.32.06. He was covered in blood.

103. All appropriate action was taken by the medical and prison personnel as soon as the deceased was found as referred to in paragraph 102.

104. While the checks of the deceased up to 21.57.29 were frequent they did not accord with Standard Operating Procedures which dictate that a prisoner, such as the deceased, should be checked every 15/20 minutes.

105. The deceased was not checked for a period of 25 minutes and 37 seconds prior to his discovery referred to in paragraph 102. This did not accord with Standard Operating Procedures. It appears that the deceased was last visited

by a member of the medical team 3 hours 33 minutes and 16 seconds prior to being discovered as described at paragraph 47.

106. The official prison record, being the Close Supervision Cell Journal, detailing the times that the deceased was checked does not accord with the facts, namely, the times disclosed on the CCTV.

107. The official medical records on the PHMS computer system disclose that on two dates medication was administered to the deceased when this could not have happened as the deceased was in hospital on such dates.

108. The explanation by the nurse officer for the incorrect record referred to in paragraph 107 is reasonable having regard to the default mechanism referred to in paragraph 74.

109. The procedure for the recording of the return of non administered medication to the prison and then to the external supplier is neither robust nor transparent. There are no records to demonstrate that prescribed medications that have not been administered (for whatever reason), apart from controlled drugs, are accounted for and ultimately returned to the external supplier.

Recommendations

110. In the event of a review of searching procedures for prisoners who have been discharged from hospital with hospital medical dressings, as in the instant case, the clinical requirements of the prisoner must be considered and the professional advice of the medical personnel must be respected and acted on.

111. A proper line management structure must be put in place to ensure compliance with Standard Operating Procedures, Governor's and Chiefs' Orders.

112. Public officials must realise that it is a serious matter to create inaccurate public records.

113. The Courts Service should consider carrying out an audit of Courthouses to ensure that they comply with Health and Safety standards in light of the events disclosed in this report.

114. Psychology services relevant to a prisoners' needs must be provided. This recommendation must be read in conjunction with my comments in paragraph 117.

115. A robust policy should be introduced in order to account for all prescribed medication delivered to prisons by external providers. Not alone should robust records be maintained for all prescribed medication administered but a robust, transparent returns policy for all declined/not administered (for whatever reason) medication should be introduced in order to account for such declined or not administered medication. In other words an audit trail of all prescribed drugs should be maintained. A clinical review should also be undertaken to ascertain whether or not a default position of "taken" (see explanation of Irish Prison Service at paragraph 73) is best practice in order that questions, as in the instant case, cannot arise in the future. At present there is a robust audit trail which accounts for all controlled drugs delivered to prisons.

Inspector of Prisons Comments

116. Persons or bodies having oversight of prisons, prison systems or prison records must have confidence that they can rely on the accuracy of official records.

117. In paragraphs 88 and 89, I refer to the psychiatric and psychology services in Cloverhill and Wheatfield Prisons. In the instant case it is clear that the deceased required considerable intervention from both disciplines. I have pointed out in this report that the level of service provided by the two disciplines differed between the two prisons. It would be simplistic to state that the deceased should have been transferred to Wheatfield Prison in order that he could avail of the enhanced psychology service in that prison. If such a transfer had been sanctioned an argument could have been advanced that by

doing so the level of psychiatric intervention would have been less than that available in Cloverhill Prison. Any balancing of these competing interests would always invite adverse comment. In cases such as the instant case a multi disciplinary team comprising all players in the "medical family" and the "psychology family" should prepare a care plan to provide appropriate intervention from both services. The care plan should specify the particular prison most appropriate for the accommodation of the prisoner. The Irish Prison Service and relevant prisons must facilitate the practical implementation of such a care plan. The implementation of this plan should not involve the transfer of a prisoner between prisons to enable delivery of service unless such transfer is certified by both the medical (psychiatric) and psychology personnel as appropriate in all the circumstances. In other words the services must go to the prisoner not *vice versa*.

118. My findings in paragraph 109 and my recommendations in paragraph 115 should be taken seriously by the Irish Prison Service. During the course of my exhaustive investigation I uncovered no suggestion of any malpractice by any members of the medical team. I am also satisfied as to the *bona fides* of all medical staff in Cloverhill Prison. However, in order to protect staff in all prisons in the future against any suspicion a robust audit trail for all prescribed medication, not only controlled drugs, must be in place because certain prescribed medications can have a currency in prison settings which mirrors anecdotal evidence of same in the wider community.