A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner A on 13 February 2016 in Mountjoy 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
E-mail: info@inspectorofprisons.gov.ie
Web: www.inspectorofprisons.gov.ie

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A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner A on 13 February 2016 in Mountjoy Prison

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

Helen Casey
Office of the Inspector of Prisons

21 February 2017

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Preface

The deceased was a 29 year old man from the Dublin area who died in Mountjoy Prison on 13 February 2016.

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

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

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Office of the Inspector of Prisons Investigation Report

General Information

1. The deceased was a 29 year old man who came from the Dublin area. He is survived by his father, sisters, brothers and extended family.

2. The deceased was committed to Mountjoy prison on 29 June 2015 with a remission date of 21 August 2017.

3. The deceased was discovered in an unresponsive state in his single cell (Cell 9 D3) in Mountjoy West on 13 February 2016 at 04:35:20. He was found with a ligature around his neck which was attached to the cell window.

4. The deceased was transferred by ambulance to the Mater Hospital where he was pronounced dead at 05:22:30 on 13 February 2016.

5. I met with the deceased's family at an early stage in my investigation in order to ascertain if they had any particular concerns. In this report I endeavour to address their concerns.

6. In carrying out my investigation I had unrestricted access to all parts of the prison, to all records held in the prison, to all medical records and relevant CCTV footage. I also had access to appropriate members of staff, others working in the prison and to prisoners.

Concerns of the family

7. On meeting with the deceased's family they informed me that the deceased was a "*quiet man who kept to himself but would listen to you*". He had a history of depression and had self-harmed in the past. They further informed me that a brother in law of the deceased committed suicide 2 months before. The deceased received his first sentence when he was 17 years of age and was "*in and out of prison*" since then. The deceased received regular visits from

his girlfriend and family while in prison. The deceased telephoned his girlfriend and family on a regular basis.

8. The family raised the following issues of concern that they wished to have investigated:-

   (a) Was the deceased checked as required by IPS Policy?
   (b) What time was the deceased last checked? Was it 2.30 am?
   (c) What time was the deceased found at?
   (d) If his phone calls were recorded why didn't they hear him say he was going to kill himself? He was making death threats.
   (e) Why did the prison not respond to his "cry for help" that night?
   (f) Was he being bullied on the landing?
   (g) Did he engage with Psychology or Probation?

Status of the deceased in Prison

9. The deceased was a protection prisoner and was located on a protection landing in the prison. He was on the basic level of the Incentivised Regime.

10. The deceased attended the gym and the school. No official complaints were made by him during his time in prison. On the week he died he was looking for a job on the landing as a cleaner.

11. The deceased had been placed on the Special Observation list by Nurse Officer A from 1 February 2016 following a phone call from a family member who raised concerns that he might deliberately self-harm.

12. On 10 February 2016 the deceased was reviewed at a weekly Special Observation Assessment meeting attended by staff from Prison Healthcare, Probation Service and a Chief Officer. At this Review it was agreed that the deceased should be removed from the Special Observation List which meant hourly checks during periods of lock up, rather than every 15 minutes when on the Special Observation List.

Breaches of Discipline and Protection

13. The deceased had been the subject of a number of breaches of discipline during his most recent period of imprisonment. The most serious occurring on 7 November 2015 when he was involved in an incident with another prisoner. This matter was the subject of a Garda investigation. The deceased was subject to a disciplinary report as a result of that incident and was placed on a 'restricted regime' from 11 November 2015 until 14 December 2015.

14. The deceased was placed on protection on the 14 December 2015 at his own request. He was allocated Cell 9 on D3 Landing which is a protection landing in Mountjoy West.

15. On the 21 January 2016 at a disciplinary hearing the deceased admitted that he had received contraband (illegal substances) during an open visit with a family member the previous day. The sanction imposed was loss of evening recreation for 40 days.

16. Staff and fellow prisoners confirmed that the deceased got on well with prisoners in his protection group and he interacted well with staff on the landing. According to other prisoners he had spoken of fears he had for his family outside of the prison. He did not give any indication that he was thinking of deliberately self - harming.

Visit and Phone Calls

17. I checked the logs held in the prison of all visits made to the deceased. He received weekly visits from his girlfriend and he also had visits from family members.

18. I also checked the log of phone calls made by the deceased. He telephoned his girlfriend every other day and also phoned his father and other members of his family.

19. The family stated the deceased had discussed being depressed and expressed thoughts of self-harm during phone calls. I received permission from his next of kin to listen to the recorded calls made from the official telephone.

20. Having listened to several calls most particularly the last 20 calls I did not detect any mention of self-harm. He did express wishes of being at home or out of prison, it was nothing more than one would expect from a person in prison.

Contact with Prison Healthcare

21. I received permission from the next of kin to examine the deceaseds' prison medical records. During the most recent committal the records showed the deceased had routine contact with the prison doctors and nurses for minor ailments. He received ongoing dental treatment. I noted that he did not have any engagement with the Psychology or Psychiatric Services. He was not linked in with the Addiction Counsellors or the Probation Service. I noted that the deceased was not on medication.

Sequence of events of 12/13 February 2016

22. At 19:18:00 the deceased was master locked in his cell - Cell 9 on D3 Landing. He was alone in his cell and he made no requests from the officers at this time.

23. During the course of the evening and night the deceased activated the cell call alert on nine occasions between 19:47:35 on the 12 February 2016 and 01:32:45 on the 13 February 2016. The Night Guard officers responded to all

these cell calls, taking varying lengths of time in which to attend at the cell as set out in the table below:-

Call Bell activated	Call bell answered	Time to respond
12/2/16 19:47:35	19:52:23	04:48 mins
12/2/16 19:52:32	19:53:45	48 secs
12/2/16 19:54:09	21:24:59	90:50 mins
12/2/16 21:25:14	22:10:04	44:50 mins
12/2/16 22:10:19	23:00:01	49:42 mins
12/2/16 23:30:10	23:54:25	24:15 mins
12/2/16 23:56:23	00:32:47	36:24 mins
13/2/16 01:31:22	01:32:18	56 secs
13/2/16 01:32:45	01:59:23	26:38 mins

24. From viewing CCTV of D3 Landing it can be seen that many prisoners were activating their cell call alerts throughout the evening and night.

25. Officers carried out ten checks on Cell 9 while either responding to the cell call alerts or just undertaking general checks on the landing between lock up at 19:18:00 and 04:35:20 when the deceased was discovered unresponsive in his cell.

26. At 22:56:28 Officer A, Nurse Officer B and ACO A attend on D3 Landing and checked on a number of cells. Officer A can be seen at Cell number 10 where he switches off the cell call light. He reaches down to the bottom of the cell door and picks something up. He then goes to Cell 9 where he pushes something under the door with his foot. He then looks through the viewing hatch and checks the cell before switching off the cell call light and moves on to check other cells.

27. Prisoners who were accommodated in nearby cells on the landing were interviewed and they stated that the deceased was annoyed as his television

wasn't working and he was looking for a replacement television from the officers.

28. Officer B states that when he checked on Cell 9 at about midnight that the deceased told him his TV wasn't working and he asked for a replacement. When asked what was wrong with the TV Officer B states the deceased replied that "*he had smashed it*".

29. Officer B goes on to state "*I could see the TV on the floor ….* (*deceased) was upset that he had no TV but was not aggressive or threatening*".

30. Officer B states that he spoke to ACO A on duty and he informed her of the deceased's request for a replacement TV. He states that at the time ACO A was busy dealing with another security matter but explained that she did not have access to a replacement TV at that time and that it would be dealt with the following day.

31. Officer B states that he again responded to a cell call at Cell 9 on D3 at about 00:30. He spoke with the deceased and explained to him that there was no replacement TV available, he would have to wait until morning.

32. Officer B states that at 01:30 he again checks on cell 9 and spoke with the deceased. He states that the deceased asked him to pass in some cigarette papers from a neighbouring cell which he did and that the deceased had thanked him. Officer B states that the deceased appeared fine at the time.

33. Officer B states he checked on cell 9 at 02:30 and he reports that he again explained to the deceased that there were no replacement TVs available and he would have to wait until morning. Officer B states that the deceased responded that "*he was ok and was going to bed*".

34. Having viewed CCTV, there were no checks carried out on the deceased in Cell 9 from 02:33.57 to 04:35:20 a period of 2 hours 1 minute 23 seconds.

The Irish Prison Service policy requires that ordinary prisoners be checked hourly during periods of lock-up.

Sequence of events

35. At 04:35:20 Officers C and D were carrying out a general check on all cells on D3 Landing. Officer C checked on cell 9. He saw the deceased was hanging from a ligature tied to the cell window bars.

36. Officer C immediately alerted Officer D who also looked into cell 9 and then used his radio to alert ACO A and seek the master key to open the cell. Officer D then went to the keys office to obtain a Hoffman knife which is used to safely remove a ligature. Officer C remained on the landing.

37. At 04:37:36 ACO A arrived at cell 9 with the master key. She unlocked the cell and entered followed by Officers A and D who had arrived on the landing.

38. Officers A and D cut the ligature from the deceased's neck and laid him on the bed.

39. At 04:39:44 Nurse Officer B arrived at the cell carrying the emergency equipment. She carried out an assessment which she recorded as follows: "*on assessment he was unresponsive, no pulse was found and he was not breathing. His right leg was still warm at this stage*". Nurse Officer B immediately commenced CPR.

40. At 04:59:10 Dublin Fire Brigade Paramedics arrived at the cell and they took over charge and continued CPR.

41. At 05:06:10 Dublin Fire Brigade Paramedics removed the deceased from his cell and took him by ambulance to the Mater Hospital.

42. At 05:22 the deceased was pronounced dead at the emergency department of the Mater Hospital.

43. At 05:25 Gardaí from Mountjoy Station visited cell 9 on D3 to carry out their investigations. Following a search of the cell by the Scenes of Crime Unit it was established that there was no note left by the deceased.

Addressing the concerns of the family

44. In Paragraph 8 I set out the concerns which the family wished to have investigated. In this Report I endeavour to address such concerns. For ease of reading I adopt the same numbering sequence as in Paragraph 8 and I point out the section of the Report which addresses each particular concern as follows:-

(a) I addressed this in Paragraphs - 23 to 35.
(b) I addressed this in Paragraphs - 33 and 34.
(c) I addressed this in Paragraph - 35.
(d) I addressed this in Paragraph - 20.
(e) I addressed this in Paragraphs - 25 to 34. The Officers on duty on D Landing on 12/13 February 2016 do not accept that the deceased was indicating that he would self-harm or that he had requested help other than to seek a replacement television.
(f) I addressed this in Paragraph - 16.
(g) I addressed this in Paragraph - 21.

Findings

45. The deceased was a protection prisoner, at his own request, who could associate with prisoners in his protection grouping. He was on the standard level of Incentivised Regime.

46. The deceased was accommodated in a single cell on D3 Landing in Mountjoy West.

47. The deceased was not prescribed any medication at the time of his death.

48. The deceased was not linked in with the Addiction Counsellor or the Psychology Services during his latest period of imprisonment and was not receiving any Psychiatric treatment.

49. I have not been provided with any record of the deceased having had any intervention by the medical team subsequent to him being placed on the Special Observation List on the 1 February 2016 and his removal from this list on 10 February 2016 or subsequently.

50. The deceased had regular contact by telephone with his girlfriend and his family and received weekly visits from them.

51. The deceased was not checked between 02:33:57 and 04:35:20 which is in breach of the Irish Prison Service Standard Operating Procedures.

52. As soon as the deceased was discovered at 04:35:20 all appropriate steps were taken by the prison staff, medical staff and subsequently by Dublin Fire Brigade paramedics.

53. The deceased used a ligature made from strips of torn bed sheet, tied to the window bars of his cell to take his own life.

54. The deceased did not leave a note.

55. The deceased was pronounced dead in the Emergency Department of the Mater Hospital at 05:22 on 13 February 2016.

56. The deceased had been actively seeking the attention of staff by repeatedly activating the cell call alarm subsequent to being locked up for the night in his cell.

57. Staff responded to the cell call alarm by visiting the cell on 9 occasions during the course of the evening and early morning taking varying lengths of time to do so.

58. The Night Guard records created during the course of the night are wholly incomplete and are in breach of Standard Operating Procedures. The hand over of charge between officers at meal breaks or for any other reason were not recorded in the Night Guard Book.

Recommendations

1. The Governor should take appropriate action to deal with the non-compliance by staff with Irish Prison Service Policy and Standard Operating Procedures.

2. A full review of how officers are briefed and detailed for duty should be under taken and deficiencies in the present system should be addressed.

3. The poor level of record keeping should be addressed by the Irish Prison Service. This may require some In-Service training or some other on the job training as poor record keeping has been raised as a concern in a number of previous Death In Custody Reports.

4. The supervision by Line Managers is a vital part of implementing policy. The Irish Prison Service should review the level and quality of training to satisfy itself that it is sufficient to equip supervisory grades with the necessary skills to carry out their functions.