A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner B in the Midlands Prison on 12 February 2013

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

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

Judge Michael Reilly
Inspector of Prisons

15 June 2015

Preface

Prisoner B was a 61 year old man who died in Midlands Prison on 12 February 2013.

I offer my sincere condolences to the family of the deceased. As part of my investigation I met with the family and have responded, in this Report, to questions and issues raised by them.

My Report is divided into 18 sections as follows:-

- General Information.
- My *modus operandi*.
- Matters of immediate concern.
- Meeting with the family.
- Profile of the deceased.
- The Criminal Investigation.
- Status of the deceased and his accommodation in various parts of the prison.
- Period 26 January 2013 to morning of 12 February 2013.
- Assessments of prisoners sharing cell 30 on G1 Landing.
- Relevant sequence of events on 12 February 2013.
- Dispensing of medication.
- Officers' obligations to regularly check prisoners.
- Unusual articles in cell 30.
- Hooch.
- Addressing my initial concerns referred to in paragraph 15.
- Findings.
- Addressing the concerns of the family.
- Recommendations.

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

Judge Michael Reilly
Inspector of Prisons
15 June 2015

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 61 year old single man who came from the Munster area. He is survived by his three brothers, a sister and extended family.

2. The deceased was committed to Prison on 14 May 2012. He was due for release in October 2016. This was the first occasion that he had been in prison.

3. At the time of his death the deceased shared a double occupancy cell with another prisoner on G1 Landing in Midlands Prison.

4. The deceased died on 12 February 2013 following, what could be described as, a traumatic incident in his cell in which he received injuries.

5. A criminal investigation was immediately initiated by members of An Garda Síochána.

6. I met with members of the deceased's family at an early stage in my investigation in order to ascertain if they had any particular concerns. I met with them subsequently and corresponded with them. In this Report I endeavour to address their concerns.

7. Members of the deceased's family visited him on a regular basis and he was in constant telephone contact with them.

8. In carrying out my investigation I had unrestricted access to all parts of the prison, to all records, to all staff and to all prisoners. I also had access to CCTV footage.

My modus operandi

9. It is relevant that I set out briefly my *modus operandi* when investigating all deaths in custody.

10. As a first step:-

(a) On being informed of a death of a prisoner in custody, which in all cases happens within hours of a death, I immediately seek a preliminary report on the death from the prison.

(b) I ascertain whether or not a criminal investigation is taking place.

(c) I visit the scene.

(d) I secure CCTV footage.

11. I then meet with the family to hear of any concerns that they may have.

12. The next part of my investigation entails, *inter alia*, examining the deceased's medical files held by the prison, examining the CCTV, getting statements from prison personnel, interviewing prison personnel, prisoners and others who may be relevant, examining prison records etc. This is not an exhaustive list as each investigation carries its own dynamics.

13. I submit my report to the Minister but prior to the publication of same I again meet with the family to inform them of the contents of the report.

Matters of immediate concern

14. At 00.30 hours on 13 February 2013, I was informed that the deceased had been discovered at approximately 19.15 hours the night before, 12 February, in an unconscious state by prison staff, that efforts to revive him were unsuccessful and that he was pronounced dead by the prison doctor - Dr. A at 20.20 hours.

15. Very early in my investigation I identified a number of issues that caused me concern as follows:-

(a) Evidence of violence. The deceased had head injuries which appeared not to have been self inflicted.
(b) There was an unusual implement in the cell, namely, a stick.
(c) The disordered state of the deceased's clothing.
(d) The fact that the deceased was sharing the cell with a prisoner who, in the past, had exhibited volatile tendencies.
(e) The presence of 'hooch' and distilling paraphernalia in the cell.
(f) The scene might not have been adequately preserved as a crime scene.

Meeting with the family

16. On 5 March 2013, I had an initial meeting with the family in their home. Subsequent to that meeting I had correspondence with them and a further meeting.

17. In my meetings and correspondence with the family they expressed the following concerns which they wished me to address:-

(a) Why was the deceased moved from a single cell into a double cell?
(b) What was the deceased's cell mate in for?
(c) Was the prisoner sharing the cell a drug dealer?
(d) The prisoner sharing the cell with the deceased was an inveterate smoker. Why was the deceased placed in a cell with a smoker when he was a known asthmatic?
(e) The prisoner sharing the cell with the deceased was "brewing hooch" and a stick was discovered at the foot end in the upper bunk. How was this let happen?
(f) Was the deceased on a sex offender's wing with only other sex offenders there?
(g) Did the "agreed sentence management plan, as written in his PHMS record" suggest single cell?
(h) What criteria are used to determine (1) who, (2) when, and, (3) why an inmate should be moved from a single to a shared cell and from one wing to another?

(i) When movement/change does occur what account is taken re: suitability and safety of those being moved?

(j) When and how exactly did the prison personnel become aware of the assault?

(k) Has it been ascertained as to where the actual assault occurred?

(l) What type of implement was used to inflict the lacerations to the deceased and how did such become available to inmates?

(m) At a meeting between the family and prison management on Wednesday 13 February the family was told that the deceased was found to be in poor health. They could not reconcile this with the fact that on the previous Friday - 8th February medical tests showed all results within "the normal range".

(n) The deceased was sentenced to serve a prison sentence for his crimes. He was committed to a single cell on A Landing of the Midlands Prison. He was inexplicably transferred from the above mentioned unit to the G Wing of Portlaoise Prison. There, quite vulnerable because of the nature of his crimes, he was put to share a cell - occupying the lower bunk. The assault and death occurred between 3.00 and 3.30 in the afternoon (a fact that was only made known to us at our meeting in September with the investigating Gardaí) his body was not discovered until hours later that evening. It was after 8.30pm when contact was made with a family member. Why?

(o) What medication was he supposed to get on 12 February 2013? What medication did he get and at what time is this recorded?

Profile of the deceased

18. Despite his 'relatively young age' the deceased's demeanour in the prison was that of a much older man. He was frail and seemed to shuffle around the prison. He did not engage in any physical exercise or in any social or therapeutic activities. He did not attend the workshops or the school. He was a loner who relied on others – fellow prisoners and officers to help him and these people were kind to him.

19. He could be described as an inoffensive country man whose main interest was in sport. His dress sense was poor. His appearance as seen on CCTV was dishevelled and his clothes were loose fitting.

20. He was a non smoker who suffered from asthma and breathing difficulties. He had a history of diabetes. He also had other complex medical issues which are not relevant to this investigation save that they contributed to his general state of debility in the prison. His speech was difficult to understand at times. Dr. A reported that – "*in spite of suffering from multiple medical problems he remained reasonably stable on the medications and his health was reviewed from time to time"*. He was last reviewed by the medical team on 8 February and his vital functions were reported as within normal range.

21. He maintained a daily diary. It is extremely difficult to decipher the contents of this diary. It seems to detail times he arose in the morning, the weather, matters of sporting interest and insignificant vignettes of life in prison. The family examined this diary and were satisfied that there was nothing of consequence in the diary which might assist with my investigation. An Garda Síochána also examined this diary and concluded that there was nothing of probative value in same which could assist them in their criminal investigation.

The Criminal Investigation

22. As I have already stated in paragraph 5 an immediate criminal investigation was commenced by An Garda Síochána. Members of An Garda Síochána arrived at the prison at 20.31 hours on 12 February 2013 and took charge of the scene.

23. I did not take any steps which might compromise the criminal investigation such as the interviewing of possible witnesses to a potential criminal act. On 14 February 2013, I wrote to Governor A of Midlands Prison specifically informing him that – *"at this stage I do not require you to take statements from either prisoners or officers"*. I refer to this later in this report at paragraph 93.

24. The State Pathologist concluded that the cause of death was:-

> *"Cardiomyopathy (cardiac arrest precipitated by blunt force trauma to the head and trunk".*

25. While it is a matter for the Coroner's Inquest to investigate all the circumstances surrounding this death I understand that the injuries were to the head, chest and arms of the deceased and that there was no associated internal trauma such as fractures, significant internal bleeding or damage to any vital organs.

26. By letter dated 27 May 2014, I was informed by the Chief Superintendent of An Garda Síochána leading the criminal investigation that – *"the law officer has directed no prosecution in this matter".*

27. Even though there has been no prosecution the Garda investigation remains open. Therefore, I have been mindful not to prejudice any further Garda investigation and in this connection I do not comment, in this report, on the names or activities of prisoners who may have been in or had contact with the deceased or the cell occupied by the deceased on 12 February 2013. However, this does not take from the thrust of my report.

Status of the Deceased and his accommodation in various parts of the prison

28. The deceased was classed as an ordinary prisoner who was free to mix with other prisoners.

29. When first imprisoned in Midlands Prison he was accommodated in a single cell on A Wing. He was then in a double cell on the same wing for a period. He shared with Prisoner 1. He then moved back to a single cell prior to being moved with others to G1 Landing on 26 January 2013. At no stage was he in Portlaoise Prison.

30. It is obvious from the medical notes that the deceased knew in advance of his pending transfer to G Wing and to the fact that he would likely be sharing a cell as on 21 January 2013 he attended the prison doctor. Dr. A noted –

> *"Upset that he will be transferred to shared cell and not happy. Advised to speak to management. He should be in single cell considering his condition and vulnerability"*

There are no records to suggest that Dr. A contacted management on behalf of his patient.

31. When he was moved to G Wing on 26 January 2013 the deceased shared Cell 30 (a double cell) with Prisoner 2 on G1 Landing. The two prisoners shared this cell until the death of the deceased on 12 February 2013.

32. I should point out at this stage that the G Wing had just been opened. This was a newly constructed wing of the prison. The accommodation and other facilities in this wing were superior to that in the older prison. A decision was made by management in the prison to move a cohort of prisoners from the A Wing to the new G Wing and particularly to G1 Landing. There prisoners were, in the main, convicted of similar offences and a significant number were more elderly than the main population of a prison.

33. The regime on G1 Landing was more relaxed than on other landings having regard to those prisoners accommodated there. Some prisoners stayed most of the time on the landing. Some were unable to attend school, workshops, recreation or other activities. Many were in poor health. Many rested or slept in bed during parts of the day.

34. Officers working on the landing and younger prisoners, sympathetic to the needs of this cohort of prisoners who because of debility were unable to adequately care for certain of their personal needs, assisted them when and where necessary.

35. The prisoners that I interviewed as part of my investigation commented favourably on the kindness of the officers on the landing towards the older prisoners and in particular picked out Officer A who in their words – *"went the extra mile"*.

36. Prisoners 3, 4 and 5 assisted the deceased in many ways which ranged from getting him his meals, to ensuring that he had an adequate supply of relevant necessary provisions in his cell.

37. Prisoners from G2 Landing could access G1 Landing at certain times and were allowed to do so.

Period 26 January 2013 to morning of 12 February 2013

38. There were no incidents or issues between 26 January (the date the deceased was moved to cell 30 on G1 Landing) and the morning of 12 February (the day he died) concerning the deceased that gave cause for concern.

39. I stated in paragraph 7 that the deceased was in constant telephone contact with his family. The following information from telephone calls with his brothers is relevant:-

(a) 14 January 2013 – talked about moving to G Wing.
(b) 23 January 2013 – stated that he had requested a single cell on health grounds and thought he might get it.
(c) 29 January 2013 – stated that he was sharing a cell with a 30/31 year old who smoked a lot in the cell. Cell mate was making poitin in the cell. New cell is nice and bigger than last cell and was very warm.
(d) 31 January 2013 – cell mate very nice but a chain smoker.
(e) 6 February 2013 – no problem with new cell mate – *"so far so good"*.
(f) 12 February 3013 – talked of family matters and the fact that he was getting ready to watch a UEFA Cup soccer game on the television later in the day. Made no mention of his cell mate.

Assessments of prisoners sharing cell 30 on G1 Landing

40. Assessments were carried out on both the deceased and Prisoner 2 on their initial committals to prison.

41. I have been informed that an informal risk assessment of both prisoners took place to check the compatibility of both prisoners to share a cell. I was further informed that –

> "*Other available information would be taken into consideration such as previous history etc and that verbal agreement would usually be obtained by staff from both parties indicating prisoners' satisfaction to share with each other".*

Governor A set out the criteria for the allocation of cells on G Division in the following terms:-

> "A*s part of the preparations for the complete opening of the new 'G' Division in early 2013 it was decided by management that the 'A' division prisoners would be relocated to the new division. However all cells in the 'G' Division are fitted out as double occupancy cells and as a good number of prisoners on the 'A' Division had single cells, it was decided to provide the majority of these men with single occupancy in the 'G' Division notwithstanding the fit out of the cell. Priority was given on the basis of sentence length and the resulting cut-off to obtain a single cell at this time was a minimum of 14 years. The deceased was one of the men who did not obtain a single cell".*

However, Governor A confirmed that he was not in a position to provide me with documentation to suggest that any assessments had been carried out on either prisoner.

42. In order to place in context my findings in paragraphs 73, 74 and 75 it is necessary to refer to the different personas of the two prisoners as follows:-

(a) The deceased was 61 years of age. Prisoner 2 was 31 years old.

(b) The deceased was on the enhanced prisoner incentivised regime. Prisoner 2 was on the standard regime. In their Internal Investigation Report into the circumstances surrounding the death of the deceased the prison authorities in the Midlands Prison in describing Prisoner 2, stated – "*He was considered a volatile prisoner*".

(c) The deceased was a non smoker. Prisoner 2 was a heavy smoker.

(d) The deceased did not consume alcohol in prison. Prisoner 2 was a known '*brewer of hooch'*.

(e) The deceased was a frail, vulnerable man. Prisoner 2 was a fit man.

(f) The deceased was in prison for the first time. Prisoner 2 had previous experience of imprisonment.

(g) The deceased was serving a number of concurrent sentences for indecent and sexual assault, theft, larceny and false accounting. Prisoner 2 was serving concurrent sentences for false imprisonment, assault causing harm and related counts of making a threat to kill and the production of a weapon were taken into consideration.

(h) The deceased was not subject to any disciplinary reports while in prison. Prisoner 2 was subject to many disciplinary reports for infractions of prison discipline, including, *inter* alia, one for threatening behaviour, two for fighting and six for 'hooch' related incidents.

Relevant sequence of events on 12 February 2013

43. I have had the benefit of clear CCTV footage which has enabled me give precise timelines for relevant events on G1 Landing on 12 February 2013. It is clear from the CCTV footage that throughout the day there was considerable movement of officers and prisoners around the landing. It is also clear that a more relaxed atmosphere prevailed on the landing than on other landings. Older prisoners can be seen walking or standing about. Some are talking to other prisoners or to the officers.

44. I am conscious that the criminal investigation is still live and despite no prosecution having been brought to date I should do nothing which might

jeopardise any future prosecution. For this reason I give a general description of the activities on the landing and only refer in detail to those times that are relevant to the movements of the deceased, the activities of officers and the sequence of events after the deceased is discovered in an unresponsive condition at 19.18 hours on 12 February 2013.

45. **I wish to make it abundantly clear that any reference either directly or by implication to any prisoner or other person is not to be taken as a suggestion that they or any of them were in any way implicated in the assault on the deceased on 12 February 2013.**

46. The following are the relevant sequence of events:-

11.03.50	Deceased leaves his cell with Prisoner 2. Goes to the telephone. Prisoner 2 appears to dial a number and hands the telephone to the deceased.
11.10.35	Deceased hangs up telephone.
11.10.55	Deceased enters cell 30.
11.11.30	Deceased exits cell and crosses the landing.
11.11.49	Deceased returns and enters his cell. Door is left open
11.12.57	Deceased can be seen standing in cell doorway.
11.13.04	Deceased walks across landing and then towards the Class Office.
11.14.30	Deceased walks back up landing and speaks to a prisoner in a wheelchair.
11.15.18	Deceased walks back to his cell and enters same.
11.15.36	The door of cell 30 can be seen closing. Cannot see who closed the door. However this closing action must have been performed by an individual as prison doors are steel doors and do not move involuntarily.
11.32.25	Deceased appears at the door for a few seconds and then re-enters the cell.
11.33.50	Deceased talking to another prisoner at the cell door.

11.34.50	Deceased walks down the landing and stands talking to another prisoner.
11.37.26	Deceased returns and enters his cell. The door is left open.
11.37.54	Deceased exits the cell and walks up the landing.
11.42.15	Deceased enters the cell and the door is closed.
11.53.15	Deceased comes to the door of the cell and looks out and re-enters the cell.
11.54.33	Deceased exits the cell carrying a tray and walks towards servery.
11.56.44	Deceased walks back to his cell carrying his tray but there is nothing on the tray. He enters the cell.
11.57.40	Prisoner 2 exits the cell followed by the deceased who is carrying a tray. He walks with him to the servery and appears to be encouraging him (the deceased) to get his food.
12.03.50	Deceased returns to his cell carrying his tray with food on it.
12.13.22	Officer B checks cell 30 by looking through the viewing hatch.
12.15.02	Officer C checks cell 30 by looking through the viewing hatch.
12.24.27	Officer C checks cell 30 by looking through the viewing hatch.
12.37.05	Officer A checks cell 30 by looking through the viewing hatch.
13.27.40	Officer A checks cell 30 by looking through the viewing hatch.
14.15.49	Officer A unlocks cell 30. He pushes the door open and does not look in. He is seen talking to a prisoner on the landing.
14.19.08	Deceased looks out the doorway of his cell and stays there for a number of seconds.
14.19.31	Deceased moves back into his cell.
16.00.25	Deceased is in the cell on his own. I have ascertained this by closely scrutinising the CCTV footage. The cell door can be seen closing slightly. As I have already stated prison doors cannot move of their own accord. Therefore, the movement of the door was a conscious action by some person inside the cell and that could only have been the deceased.
16.20.24	Officer A checked the cell and locked same.

16.44.35	Officer D checked cell 30 by looking through the viewing hatch.
17.23.52	Officer A unlocked the cell and pushed the door open but did not go in.
18.08.34	Officer A looked into the cell through the open door to check the numbers in the cell.
19.17.29	Officer C pushed the cell door open to speak to the occupants.
19.18.10	Officer A went to cell 30.
19.19.00	Officer E entered the cell behind Officer A.
19.23.36	Nurse Officer A can be seen on CCTV running through the landings and entering the cell at the same time as Chief Officer A at 19.23.36.
19.37.00	Ambulance personnel arrived at cell 30.
20.31.00	Members of An Garda Síochána arrive at the prison.

47. During all periods of unlock on 12 February 2013 and especially after midday unlock at 14.15.49, numerous prisoners including Prisoner 2 can clearly be seen entering and leaving cell 30 on multiple occasions. At times one or a number are in the cell for seconds or minutes These prisoners appeared to be younger and fitter than many of the older and/or infirm prisoners accommodated on G1 Landing. It would appear that the reason for this activity was that Prisoner 2 was distilling 'hooch' in the cell and that other prisoners were calling to the cell either to drink 'hooch' or collect same for consumption elsewhere. I refer to the discovery of 'hooch' making equipment in paragraph 67.

48. It is noticeable when viewing CCTV footage of G1 Landing for 12 February that where elderly and/or infirm men were accommodated either in single or double cells with similarly old or infirm men rarely did other prisoners enter their cells.

49. Subsequent to 19.19.00 hours many members of the prison staff entered the cell. Other medical personnel also entered the cell. As part of my

investigation many officers, nurses and prisoners were interviewed. I was also supplied with statements from others. In paragraphs 50 to 61, I refer to the recollections of officers and nurses and to the actions they took. I refer to these in sequence in order that the reader will have an accurate understanding of the events as they unfolded on the evening of 12 February 2013.

50. At approximately 18.40 hours Officer A detected a smell of 'hooch' on G1 Landing. He was proceeding down the landing to investigate the source of the smell. When he approached cell 30 the smell of 'hooch' was strongest. He was satisfied that it was coming from cell 30.

51. Between 19.00 hours and 19.10 hours Officer A was approached by two prisoners who expressed concern that they had not seen the deceased for some time.

52. Officer A went to ACO A and told him that they should search cell 30.

53. At approximately 19.10 hours a 'lock up' was called. The purpose was to facilitate a search of cell 30.

54. Officer A went to cell 30 at 19.18.10. He shouted to the deceased asking – *"was he alright"*. He got no response and called to Officer E and they both went into the cell.

55. The deceased was lying on the bottom bunk with a blanket covering him. Officer A described the scene in the following terms:-

> *"I went into the cell and pulled the blanket down.* (The deceased) *was on his right hand side facing in towards the wall. I noticed that his pants were down below his waist.* (The deceased) *would think nothing of hopping into bed with his clothes on. I pulled him away from the wall and he was warm. At this stage I thought that he may have been given 'hooch' or had a seizure of some description. I noticed that there was blood on the blanket where he had been facing towards and*

I noticed blood coming from his mouth. He appeared to have some kind of a mark on the left hand side of his face. I literally got on the radio and called for a medic. (Officer E) *checked for a pulse and I remember him saying "he's gone". The medics arrived then very quickly, 2 female nurses. The nurses started performing CPR....."*

56. Officer E corroborated the statement given by Officer A.

57. Nurse Officer A answered the call for a medic. She ran from the nurses' station in the surgery, calling to the pharmacy on the way to get the resuscitation bag and proceeded running to cell 30 on G1 Landing. This can be seen on CCTV.

58. Nurse Officer A was assisted in rolling the deceased into the supine position. She stated that he was unresponsive, cyanosed and no pulse was present. She noted that he was cold to touch. She called for a cardiac ambulance and commenced CPR. The nurse officer described the deceased in the following terms:-

"I noticed bleeding from (the deceased's) *nasal area with a small amount of blood on the bed sheet as I applied the face mask. I also noticed a deep laceration approx 1" in length over his eyebrow. When the ambulance crew arrived they moved him onto the floor in the cell. I noticed that his genital area was exposed. I placed a peach towel that was in the cell over his lower body to maintain his dignity. When all treatment was administered I then noticed a laceration approx 1" in length in the back of his head.* (The deceased) *was wearing a trousers but it was down his legs exposing his genitals...."*

59. Nurse Officers B, C and D also attended the scene at cell 30. They corroborated much of the evidence of Nurse Officer A.

60. Nurse Officer A, assisted at various times by the other nurse officers and prison officers, worked on the deceased until the arrival of the ambulance

personnel at 19.37.00. During this time the defibrillator was applied. No shock was instructed.

61. Chief Officer A arrived at cell 30 at 19.23.36 – the same time as Nurse Officer A. He confirmed the sequence of events as described in paragraphs 58 to 60. He made calls to the relevant services including the ambulance. His recollection was that the deceased's trousers slipped down during the lifting of the deceased from his bunk to the floor. He also recalled that the pulling up of the trousers of the deceased was in the interests of modesty.

Dispensing of medication

62. I inspected the medications chart on the PHMS computer system. This showed the deceased having been administered certain medication at 16.00 hours and 19.00 hours on 12 February. This medication was dispensed on a weekly basis and kept by the deceased in his cell for self administration at defined times during the day. The deceased did not attend to collect other medications at 16.00 hours. This was an anti-inflammatory treatment. The records show the reason for non administration as being "*did not attend"*.

Officers' obligations to regularly check prisoners

63. During periods of lockdown prisoners must be checked every hour. This is provided for in Standard Operating Procedures.

64. At various times of the day and night officers are obliged to account for the number of prisoners in their custody. This is a physical head count of all prisoners in the prison at a given time.

65. Class Officers on G1 Landing do not have any specific instructions that prisoners who remain in bed be roused and spoken to. The instructions are that the Class Officer must satisfy himself/herself that such prisoners are "ok".

66. In the instant case cell 30 was locked between approximately 12.10 and 14.15 and again between 16.20 and 17.23.

Unusual articles in cell 30

67. The following unusual items were in the cell when searched:-

- A makeshift still.
- A bucket with liquid on the counter top.
- 2 sticks.
- A number of plastic bottles.

All the above were clearly visible in the cell

Hooch

68. 'Hooch' is an illicit alcohol distilled from a variety of ingredients. It is distilled by prisoners for their own consumption. The distilling of 'hooch' is considered a serious breach of prison rules and prisoners are disciplined for this activity.

69. Random and targeted searches are carried out by prison officers for evidence of the distilling of 'hooch'.

70. Paraphernalia for the distilling of 'hooch' including makeshift stills are difficult to conceal.

71. 'Hooch', when being distilled, emits a distinctive odour.

Addressing my initial concerns referred to in paragraph 15

72. In paragraph 15, I set out initial concerns that I had soon after I commenced my investigation. I adopt the same lettering sequence in addressing these concerns in this paragraph as I did in paragraph 15.

(a) The deceased did have injuries. These were not self inflicted. An Garda Síochána carried out a criminal investigation. However, to date, no prosecution has been initiated.

(b) Two sticks were retrieved from the cell. I do not know the provenance of such sticks. They remain exhibits in the ongoing Garda investigation.

(c) The disordered state of the deceased's clothing suggested to me that he may have been sexually assaulted. While this is a matter that may be explored at the Coroner's Inquest it seems, from the pathologist's report, that this was not the case.

(d) I have dealt with the issue of the sharing of the cell in paragraphs 41 and 42 and in my findings at paragraphs 73, 74 and 75.

(e) I have dealt with this issue earlier in this report and in my findings.

(f) The scene may have been contaminated. This could have arisen in a number of ways. Numbers of prisoners had access to the cell throughout the day. Governors, Chief Officers, Prison Officers, medical personnel and others entered the cell between the time the deceased was discovered in an unresponsive state and the time of the arrival of members of An Garda Síochána. While the admissibility of evidence is a matter for the Courts, An Garda Síochána and the Law Officers, having responsibility for the criminal investigation, must make an initial judgment as to whether or not evidence is contaminated. I raised the issue of the preservation of the scene with Governor A. His response was:-

> *"There are no prison officers in the Midlands Prison trained in scenes of serious incident preservation. However, I am aware that some members of the Operational Support Group are trained in this regard"*

Members of the Operational Support Group referred to are prison officers attached to Midlands Prison and were on duty in the Midlands Prison on 12 February but were not tasked with preserving the scene despite being available to do so.

Findings

73. Prison management did not exercise the duty of care that would be expected, in that:-

(a) No appropriate assessment was carried out on Prisoner 2 to ascertain his suitability to share a cell with any prisoner.
(b) No appropriate assessment was carried out on Prisoner 2 to ascertain his suitability to share a cell with the deceased particularly having regard to their respective profiles.
(c) No appropriate assessment was carried out on the deceased to ascertain his suitability to share a cell with another prisoner and in the particular case with Prisoner 2.
(d) It was totally inappropriate that the deceased, a non smoker who suffered from multiple medical problems including asthma and breathing problems, was accommodated with a prisoner who smoked.
(e) It was inappropriate that the deceased, a non drinker in prison, was accommodated with a prisoner who was a known 'hooch' distiller.

74. In view of my findings at paragraph 73 and the facts disclosed in paragraphs 41 and 42, I do not accept that any meaningful informal assessment was carried out to ascertain if the deceased and Prisoner 2 should be accommodated in the same cell. The decision to accommodate the deceased and Prisoner 2 together was not made by the Class Officer of the landing or his officers.

75. In view of my findings referred to in paragraphs 73 and 74 the deceased should not have been sharing a cell with Prisoner 2.

76. It is clear from this report that Prisoner 2 carried out acts of kindness to the deceased on 12 February in that he assisted him with a telephone call and encouraged him to get his dinner. The deceased also spoke about his 'cell mate' in conversations with his brother as documented in paragraph 39.

77. Prisoner 2 was distilling 'hooch' in cell 30 on 12 February 2013. He was also distilling 'hooch' prior to that date. I base this finding on the contemporaneous telephone calls made by the deceased to his brother, the statements of prison officers and his disciplinary record in the prison.

78. ‘Hooch’ and a distilling still were found in cell 30 on 12 February. These were clearly to be seen by anyone entering the cell.

79. There was considerable activity in and around cell 30 all day on 12 February and especially after lunch-time unlock with numbers of prisoners entering and exiting the cell.

80. There was a smell of ‘hooch’ on G1 Landing especially after 18.30 hours on 12 February.

81. It is reasonable to conclude that the distilling operation being carried on in cell 30 was the catalyst for the numbers of prisoners visiting cell 30 during the 12 February and especially after unlock at 14.15.49.

82. The considerable activity referred to in paragraphs 79 and 81 did not excite the curiosity of prison officers working on the landing.

83. The deceased was a man ‘older than his years’. He had a multitude of medical problems for which he was being treated. He relied on prison staff and fellow prisoners to assist him with many of his basic needs.

84. The deceased was apprehensive of the suggestion that he would be moved to a double cell and sought assistance from Dr A. The doctor advised him that he should approach management but could not produce evidence to confirm that he had taken steps to relay the deceased’s concerns to management.

85. On 12 February 2013 the deceased was last seen at 14.19.08.

86. It is fair to assume that the deceased was alive at 16.00.25 as the door of cell 30 moved and at that time the deceased was in the cell on his own.

87. The deceased suffered the injuries referred to in paragraph 25.

88. The deceased was checked in accordance with Standard Operating Procedures every hour during periods of lockdown. He was not checked when his cell was opened after periods of lockdown. However, this finding must be tempered by the fact that the regime on G1 Landing was more relaxed than on other landings. This was appropriate having regard to the fact that the majority of prisoners, including the deceased, were elderly and it was not uncommon for them to rest or sleep for periods of the day.

89. Many officers and in particular Officer A were kind to the prisoners and were conscientious in their work. They endeavoured to make life as bearable for prisoners under their control as possible. This finding must be read in conjunction with my finding at paragraph 88.

90. The deceased was in a state of partial undress as disclosed in this report. Witnesses give different timelines and locations for their observations of this fact. I must point out that this was a fraught situation and events happened fast. The timelines covered seconds or at most minutes. It must be borne in mind that, while in prison, the deceased always wore loose clothing. On the balance of probabilities I am satisfied that the deceased's trousers slipped down while he was being moved in the bunk and/or from there to the floor. While this is a matter that may be explored at the Coroner's Inquest no adverse conclusion should be drawn, at this stage, as the post mortem report does not disclose any evidence of interference with that part of the deceased's body.

91. I cannot ascertain the provenance of the two sticks found in the cell. However, neither seems to have been used as a weapon as the State Pathologist in her post-mortem report states – "*there were no injuries which showed any pattern or distinctive outline to suggest the use of an object*".

92. Once the deceased was found at 19.18.10 there was an immediate and appropriate response by prison personnel and medical personnel. In particular

Nurse Officer A proceeded to cell 30 as quickly as possible. She can be seen, on CCTV, running on the landings.

93. The prison did not carry out an immediate internal investigation and review of its procedures subsequent to the death of the deceased. This review was only undertaken many months after the event. It was an incorrect interpretation on the part of the Governor to interpret my letter of 14 February 2013, referred to in paragraph 23, as a suggestion that he should not proceed with an internal inquiry and review and gather operational reports from his own staff. In all cases of serious incidents occurring in prisons, whether they result in a fatality or not, prison management must conduct an **internal** review. Such a review would inform management of any inadequacies in their procedures which might directly or indirectly have contributed to such serious incidents such as in the instant case. It is obvious that this review must commence immediately and should not depend on the outcome of a criminal investigation or on the progress of an external independent investigation such as that of the Inspector of Prisons in this case.

94. I make no finding as to whether or not the scene was or was not adequately preserved as a crime scene as this is a criminal investigation that is still open. However, during the day of 12 February many people including a large number of prisoners had access to cell 30 and after the deceased was discovered at 19.18.10 numbers of prison personnel, medical personnel and others were in the cell. All other issues relating to the harvesting of evidence are matters for An Garda Síochána.

95. While it is a matter for the Coroner the cause of death appears to be - *cardiomyopathy (cardiac arrest precipitated by blunt force trauma to the head and trunk).*

Addressing the concerns of the family

96. In paragraph 17, I set out concerns that the family wished me to address. In this paragraph I endeavour to answer such concerns. I adopt the same numbering sequence as in paragraph 17, as follows:-

(a) I deal with this in paragraphs 42 and 43 and in my findings at paragraphs 73, 74 and 75.

(b) This information is detailed in paragraph 42(g).

(c) No. The prisoner sharing the cell was not a convicted drug dealer.

(d) No explanation has been given for this decision. The deceased made his concerns known to the doctor but these concerns were not brought to the attention of management by the doctor or any other person. The deceased had requested a single cell on Governor's Parade on 9 July 2012 but no reason for such request is recorded.

(e) No explanation has been given. There were two sticks and one was obviously visible on 12 February after the deceased was discovered at 19.18.10.

(f) There was a mix of sex offenders and others. The majority were sex offenders.

(g) The documentation supplied to me is silent on this issue.

(h) I have addressed this issue in paragraphs 41 and 42 and in my findings at paragraphs 73, 74 and 75.

(i) I have addressed this issue in paragraphs 40, 41 and 42 and in my findings at paragraphs 73, 74 and 75.

(j) At 19.18.10 Officers A and E entered the cell as Officer A had been informed by prisoners that they had not seen the deceased for some time that day and especially at tea time.

(k) All evidence points to the fact that the assault took place in cell 30.

(l) While this is a matter for the Coroner's Inquest it appears that an implement was not used.

(m) While it is true that medical results of 8 February 2013 showed results as being within "the normal range" the fact is that the deceased was in poor health as referred to in this report.

(n) I have outlined the sequence of events on 12 February in this report. I have also detailed all information that has come into my possession. The reading of the whole report in its entirety should address this issue. At 20.20 hours the deceased was pronounced dead by the prison doctor. The family were informed at 20.56 hours. At no time was the deceased in Portlaoise Prison.

(o) For privacy reasons I do not intend detailing the medication prescribed for the deceased. However, I will inform the family of this information prior to the publication of this report. The record on the PHMS relating to the self administration of certain medications was generated in the reasonable belief that the deceased would have taken this medication, as he had control of same. As the medication that the deceased was to collect at 16.00 hours was an anti-inflammatory treatment, his non attendance did not excite concerns in the minds of the medical personnel at that time. This explanation would seem reasonable in the circumstances.

Recommendations

97. The result of all committal assessments should be recorded and these records should clearly specify the appropriate accommodation and regimes for each prisoner.

98. When prisoners are being moved from one accommodation to another or from one prison to another the reasons for such movements should be clearly recorded.

99. Prisoners should not share cells unless a comprehensive assessment (both management and medical) is carried out on each prisoner to ensure that there are no issues which **could** militate against such sharing of a cell. The results of such assessments and the decisions of management must be clearly documented. This recommendation places a significant responsibility on the prison governor of all prisons and must not be taken lightly. **This recommendation must be followed across the entire prison estate.**

100. The Irish Prison Service and Governors of **all** Prisons **must be aware of their legal obligations to protect the health of prisoners** and must be vigilant to ensure that these rights are vindicated when decisions for the accommodation of prisoners in two or multiple cells are contemplated. **A prisoner who objects to sharing a cell with a prisoner who smokes should never have to share a cell with such a prisoner**. Governors must be proactive in this regard and the assessments referred to in paragraph 99 must specifically address this issue.

101. Elderly prisoners, such as in the instant case, should be accommodated in single cells.

102. Long term prisoners should have single cells.

103. **All** scenes which could be **potential** crime scenes must be properly and legally preserved. Such scenes are not confined to those where a fatality has occurred or where a person, prisoner or staff, has been brought to hospital but shall include all instances where criminality is suspected.

104. The Irish Prison Service should, **as a matter of urgency**, examine its procedures with a view to defining a streamlined response to ensure compliance with best practice in scene preservation bearing in mind the necessity to preserve life.

105. In all cases of serious incidents occurring in prisons prison management must commence an immediate internal investigation and review to establish, *inter alia,* if inadequacies in their procedures could have contributed either directly or indirectly to such serious incidents.