A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner C on 22nd April 2014 in Mountjoy Prison

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

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A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner C on 22nd April 2014 in Mountjoy Prison

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

Judge Michael Reilly
Inspector of Prisons

10th February 2015

Preface

Prisoner C was a 36 year old man who died in Mountjoy Prison on 22nd April 2014. He came from the Dublin area.

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

My report is divided into 10 sections as follows:-

- General Information
- Meeting with the family
- Deceased's contact with the medical services
- Status of deceased in prison and relevant Standard Operating Procedures
- Sequence of events on 22nd April 2014
- Duties of Relevant Officers on night of 21st / 22nd April 2014
- Relevant issues during night of 21st / 22nd April 2014
- Addressing the concerns of the family
- Findings
- Recommendations

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

Judge Michael Reilly
Inspector of Prisons
10th February 2015

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 36 year old unmarried man at the date of his death. He came from the Dublin area. He is survived by his parents, four brothers and two sisters.

2. The deceased was sentenced to Mountjoy Prison on 7th July 2010. His remission date was to be 8th January 2015.

3. The deceased died on 22nd April 2014 having been found in his cell – cell 2 on E5 Landing in Mountjoy Prison.

4. I met with members of the deceased's family as part of my investigation in order to ascertain if they had any particular concerns. In this Report I endeavour to address such concerns.

5. 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 received total co-operation from all persons while carrying out my investigation. I examined CCTV footage.

Meeting with the family

6. As part of my investigation I met with the parents of the deceased. They informed me that he had been a drug user from an early age – first of all taking cannabis and tablets and then progressing to heroin.

7. They informed me that he was first incarcerated in St. Patrick's Institution.

8. They informed me that in the recent past he had managed to give up his drug habit and was off heroin completely.

9. During his time in prison he used to telephone his girlfriend and his mother on a regular basis. This is borne out by his list of telephone calls.

10. His girlfriend visited him in prison on a regular basis. He did not want his mother visiting him in prison as opposed to not wanting to see her.

11. The family informed me that in March 2014 the deceased had been given day release to visit them in their home, that he had arrived with a prison officer who then left and that he returned to prison with the prison officer later in the evening. His parents explained that in similar circumstances in the past their son would have absconded. They relayed this to me in order that I would understand the change that had taken place in the attitude of their son.

12. They explained that their son was on protection in the prison, that he had had *"hassle"* with other prisoners, that one particular prisoner was *"harassing him and forcing him to do things for him*" and that in the words of their son *"he would be okay if he was on protection"*.

13. His parents told me that in April 2013 his mother heard that the deceased had been involved in an altercation with another/other prisoner/s in the prison and had been *"cut up and was covered in blood"*. His mother explained that she had telephoned the prison having received this information and was told by an officer that her son was "*ok*". She stated that she went to visit him but he would not show her his scars but informed her that he had been badly cut both on his back and on his face.

14. I reviewed all relevant documentation including the medical notes and am satisfied that this altercation happened on 12th May 2013. The deceased was appropriately attended to in the prison and was referred to A&E where he was sutured. On his return to the prison he received appropriate follow up treatment.

15. His parents informed me that their son had never self harmed in the past, that while on drugs he had not injected himself and that in their opinion if he had intended to do what he did he would have done it years before.

16. The last time that the family talked to their son was on Easter Sunday – 20th April 2014. He joked with his mother saying that he knew what she was

cooking for dinner. He also referred to getting out for a day the following Friday and asked his mother to be sure to have a special dinner ready for him. There is no record in the prison of such temporary release having been sanctioned.

17. The family informed me that he gave no indication directly or indirectly to them, his girlfriend or to his extended family that he intended to take his own life.

18. The family raised the following concerns with me:-

(a) Could I explain why it happened?

(b) Was someone with him in the cell? They felt that he must have had someone with him in the cell or that he had met someone or had spoken to someone on the telephone "*who had made him do it*".

(c) Was he checked every hour?

(d) What about his shoes? They understood that prisoners do not have laces.

(e) They were told he did it with a plastic bag. If this was true where did he get it?

(f) Why was the family not allowed go to the city morgue?

(g) The family understood that their son had left two letters but had not seen them. They wished to know if this was true.

(h) The family got some of his personal belongings. They stated that there were personal pictures on the wall etc. that they had not received. They asked that I would try to find out where they were.

(i) They were distressed that the circumstances of their son's death had been *"all over the papers"*. They wanted to know who had given out this information.

Deceased's contact with the Medical Services

19. The deceased engaged with addiction services throughout his time in custody in Mountjoy and other prisons. His engagement with the addiction services is well documented in the medical files. At the date of his death and for some time before he had been drug free. He was on the methadone maintenance programme and was seen regularly by the drug treatment services.

20. He had reduced his methadone intake, under the supervision of the medical team. The deceased was reviewed, as necessary, throughout his incarceration and as required by the GP services. There are no documented concerns from the drug treatment services.

21. The deceased was reviewed once by the psychiatric services in 2010 and was found to have no mental illness and was discharged back to the prison doctor. There are no recorded incidents of self harm or documented concerns for his mental health by healthcare staff disclosed in the medical files.

22. The deceased was under the care of the Hepatology Department of St. James' Hospital for an unrelated illness.

23. There are documented episodes throughout the deceased's incarceration in Cloverhill and Mountjoy where he complained of shortness of breath, minor chest pain and feeling unwell.

24. In view of the suicide note left by the deceased I feel it relevant that I refer to each occasion that the deceased complained of his ailments referred to in paragraph 23.

25. The deceased complained of chest pains on 11th, 13th and 31st August and 29th September 2013. On all occasions he was assessed by a nurse officer and on occasions by a doctor. On all occasions his vital indicators were within normal range. The medical opinion was that he did not require referral to hospital for further examination on those occasions.

26. On 28th March 2014 the deceased stated that he was feeling dizzy and unwell. He is reported as stating that he felt he was *"gonna have a heart attack"* and

that he wanted to go to hospital. He was assessed by Nurse Officer A on two occasions, who confirmed that his vital indicators were within the normal range. The Nurse Officer noted that he continued smoking on both occasions while she was examining him. The Nurse Officer had no concerns for his wellbeing and assured him of this.

27. On 14th April 2014 the deceased complained of chest pain. He was assessed by Nurse Officer B who confirmed that his vital indicators were within the normal range and noted that he was – *"not breathless, or pale, not sweaty, no pins/needles along arm"*. The Nurse Officer noted that the deceased was *"only concerned about getting tobacco for the night, advised he will not be getting any, refused any other intervention and returned to his cell"*.

28. At 11.31 pm on 21st April 2014 Nurse Officer C called to the deceased in his cell in the Separation Unit. The deceased complained of *"back pain, chest pain and head hotness"*. The nurse confirmed that the deceased's vital indicators were within normal range. The nurse advised the deceased that he should see the GP if the symptoms persisted.

29. At 8.26 am on 22nd April 2014 Nurse Officer D responded to an emergency call to attend at the Separation Unit where she found the deceased lying on the ground with a ligature around his neck. I refer to this aspect more fully later in this report.

30. I noted in the medical file that on occasions the deceased either did not present for appointments in the prison or refused to meet medical personnel.

Status of deceased in prison and relevant Standard Operating Procedures.

31. The deceased was classed as a protection prisoner and was accommodated in the Separation Unit in Mountjoy Prison at the date of his death. He was placed on protection at his own request.

32. The status of the deceased at the date of his death was that of an ordinary prisoner.

33. Ordinary prisoners should be checked every hour during periods of lockdown.

Sequence of Events on evening of 21st April and morning of 22nd April 2014.

34. In setting out the sequence of events I had the advantage of viewing the CCTV footage which I had directed be harvested as soon as I was informed of the death. In the instant case the CCTV footage was clear and I was able to identify all happenings on E5 Landing of the Separation Unit as they related to cell 2 for the night in question.

35. The sequence of events as outlined in this paragraph is accurate in fact and in time.

7.02.56pm	Deceased locked in cell 2 on E5 landing (general fall in).
7.50.29pm	Officer A checks cell 2.
8.55.35pm	Officer A checks cell 2.
9.48.20pm	Officer B checks cell 2 (can be seen speaking to prisoner). Officer B reported that the deceased had his observation hatch covered. The deceased removed this at the request of the officer.
9.48.20pm	Officer B leaves cell 2.
9.59.16pm	Call light can be seen flashing at cell 2
10.32.42pm	Officer A checks on cell 2 – can be seen at cell door obviously speaking with the prisoner
10.33.18pm	Officer A walks away from cell 2
11.04.48pm	Officers B and A, accompanied by Nurse Officer C and Officer C, go into cell 2.
11.12.08pm	Officer A exits cell 2 and checks on other cells on landing and leaves landing.
11.13.32pm	Nurse Officer C, Officer C and Officer B exit Cell 2 and the cell is locked.
12.41.25am	Officer A checks cell 2.
1.32.01am	Officer A checks cell 2.
2.08.32am	Officer A checks cell 2.
2.51.52am	Officer A checks cell 2.

3.48.40am	Officer A checks cell 2.
4.31.50am	Officer A checks cell 2.
5.25.22am	Officer A checks cell 2.
6.36.38am	Officer B checks cell 2 and removes master locks.
8.15.47am	Officer D walks down the landing but does not check the cells.
8.16.25am	Officer D walks back up to the landing but does not check the cells
8.24.47am	Officers E and D walk onto the landing. Officer E unlocks cell 2 and enters the cell. Officer D walks passed cell 2 and on down the landing
8.24.52am	Officer D runs back to cell 2 and enters same.
8.24.59am	Officer F arrives, running and enters cell 2.
8.25.23am	Nurse Officer D enters cell 2.
8.25.27am	Nurse Officer D exits cell 2 apparently to get the emergency bag.
8.26.20am	Officer D removes bag of clothing from the cell apparently to make room in the cell.
8.26.32am	Nurse Officer D returns to cell with the emergency bag accompanied by Supervising Officer G.
8.30am	Dublin Fire Brigade Ambulance arrived and assisted prison medical personnel. Deceased was unresponsive.
8.54am	Dr. A arrived and pronounced the deceased dead.
9.20am	Gardai from Mountjoy and Scenes of Crime Unit arrived at the prison to examine the scene

Duties of Relevant Officers on night of 21st /22nd April 2014

36. The Separation Unit was a stand alone unit forming part of Mountjoy Prison. It had its own separate door and the Unit accommodated prisoners on a number of Landings. One officer was responsible for, *inter alia*, recording the names of all persons coming into and leaving the Separation Unit.

37. On the night of this incident Officer B was the officer in charge of the door as referred to in paragraph 36. Officer A was the Night Guard in charge of the relevant Landing – E5.

38. Officer B handed over his responsibilities to Officer H at 7.15am on 22nd April as evidenced by his signature on the official handover form for that morning. This officer was the "*Early Start Officer*" on that morning. He would ultimately hand over to the Day Guard who would have responsibility for the gate sometime after 8am.

39. Officer A handed over his duties to Officer F at 7.20am on 22nd April as evidenced by his signature on the official handover form for that morning. Officer F was now the *"Early Start Officer"* in charge of landings E4 and E5.

40. Officer D took over as Day Guard on E5 Landing sometime after 8am as he is seen on CCTV at 8.15.47am walking down E5 Landing.

41. Officer E is also on Day Duty on E5 Landing assisting Officer D as he is seen on CCTV at 8.24.47am on that morning.

42. Officer F already referred to continued after his duties as "*Early Start Officer*" to assist Officer E on the Landing for the breakfast unlock period.

Relevant Issues during night – 21st / 22nd April 2014

43. At 9.48.20pm Officer B while checking the cells on E5 Landing noted – "*Whilst carrying out my checks on E4/E5 at 9.45pm the deceased had his cell spy hole covered*". This was Cell 2 on E5 Landing. The Officer stated that he asked the prisoner to unblock the spy hole and he did so. This statement is corroborated by the CCTV footage which shows the Officer remaining at the door of the cell for approximately 9 seconds and obviously speaking to the prisoner in the cell.

44. At 10.32.42pm Officer A is seen on CCTV checking Cell 2 where he is obviously speaking to the prisoner for approximately 36 seconds. The officer in his statement has stated that the prisoner was looking for a medic at that time.

45. At 11.04.48pm Officers B and A accompanied by Nurse Officer C and Officer C can be seen on CCTV entering Cell 2 on E5 Landing.

46. At 11.12.08pm Officer A can be seen on CCTV exiting Cell 2 and continuing his checks on other cells on the Landing.

47. At 11.13.32pm Nurse Officer C, Officer C and Officer B exit Cell 2 and the cell door is locked.

48. Nurse Officer C in her statement to me stated that the deceased had complained of back pain, chest pain and head hotness. He is also alleged to have stated that the pain in his chest "*shoots to his toes and he felt his face drop earlier that evening*". The Nurse Officer assessed the deceased's vital signs which were satisfactory. His blood pressure was normal as was his pulse rate. Her assessment was that his presentation was not consistent with the symptoms that he alleged and informed him that he would not be going to hospital that night. Her recollection was that the deceased was placed on Special Obs by Officer C.

49. Officer C in her statement to me confirmed that she had attended at the cell of the deceased on the night of 21st April as already described in this Report. She confirmed the statement of Nurse Officer C insofar as same related to the demeanour of the deceased. However, she stated that the deceased was not placed on the Special Obs list as there was "*nothing unusual about his request or behaviour and he was calm and content when we left him*".

Addressing the concerns of the family

50. In paragraph 18, I set out the concerns of the family as raised with me at my meeting with them. In this paragraph I endeavour to answer such concerns. For ease I adopt the same numbering sequence as in paragraph 18. The following are my responses to such concerns:-

(a) I cannot explain why the deceased took his own life. There were no indications of his intentions either in the records maintained in the prison or elsewhere or in the statements given to me by prison officers or in my conversations with officers or others in the prison. The

deceased did not by words or actions indicate to any members of his family that he intended taking the action that he did. In fact, on the contrary, in his last conversation with his mother on 20th April 2014 he referred to getting out for a day the following Friday and asked his mother to be sure to have a special dinner ready for him. The deceased did leave suicide notes which I refer to at (g) below.

(b) The deceased was alone in his cell. I have examined the telephone activity of the deceased and can confirm that apart from calls to family members and his girlfriend the deceased did not speak on the prison telephone to any others in the days or weeks leading up to his unfortunate death. His last telephone conversation was with his mother on 20th April 2014.

(c) The deceased was checked approximately every hour up to 6.36.38am on 22nd April 2014. He was not checked between 6.36.38am and 8.24.47am on the morning of 22nd April 2014 when he was discovered by prison officers in an unresponsive state.

(d) Prisoners wear their ordinary clothes which includes their shoes. Laces are only taken if prisoners are in Safety Observation or Close Supervision Cells.

(e) The deceased did use a plastic bag as a ligature. I could not discover where the deceased had got the plastic bag. Plastic bags would be common place in prisons as being receptacles for a variety of uses. This mirrors what happens in the community.

(f) The issue that the family had when they were unable to go to the City Morgue falls outside my remit. This is a matter that they might take up with the relevant authorities - not the Prison Authorities.

(g) Two letters and a poem were left by the deceased for members of his family. I will give copies of these to the family prior to the publication

of this Report. I refer to this upsetting aspect in my findings and my recommendations.

(h) I understand that the issue of the deceased's personal belongings has been attended to.

(i) I have been unable to ascertain how the information had been "*all over the papers*". I refer to this matter in my recommendations.

Findings

51. The deceased was an ordinary prisoner who was on protection at his own request in the Separation Unit. Ordinary prisoners should be checked every hour during periods of lockdown.

52. The deceased was accommodated in a single cell in Cell 2 on E5 Landing at the time of this death.

53. The deceased had a history of drug abuse and was on a methadone maintenance programme. He had reduced his methadone intake under medical supervision.

54. The deceased had contact with the medical services in the prison as outlined in paragraphs 19 to 30.

55. In August and September 2013 the deceased complained of chest pains and other symptoms. However, on all occasions he was assessed by a nurse officer and on occasions by a doctor. I am satisfied that the medical opinion that he did not require referral to hospital for further examination was in accordance with the medical assessment of the deceased.

56. On 28th March 2014 the deceased complained that he felt he was going to have a heart attack and that he wanted to go to hospital. He was assessed by a Nurse Officer who confirmed that his vital indicators were within normal range and this combined with his demeanour did not warrant his referral to

hospital for further assessment. I am satisfied that the Nurse Officer's assessment was appropriate and correct.

57. On the evening before his death the deceased also complained of back pain, chest pain and head hotness. The assessment by the Nurse Officer was that the deceased did not require referral to hospital as his vital indicators were within normal range. This was a reasonable assessment having regard to her medical assessment and the demeanour of the deceased.

58. The report of the State Pathologist confirms that the coronary arteries of the deceased were "*widely patent and that his myocardium and cardiac valves were healthy as were his aorta and other major vessels*".

59. The deceased was not placed on Special Obs on the night of 21st April 2014.

60. The deceased was not checked between 6.36.38am and 8.24.47am on the morning of 22nd April 2014 in accordance with the Standard Operating Procedures referred to in paragraph 33.

61. As soon as the deceased was discovered at 8.24.47am all appropriate steps were taken by the prison staff, the medical staff and subsequently by the Dublin City Fire Brigade Ambulance personnel.

62. There is no record of any briefings by the Night Guards of the Early Start Officers or Day Guards when responsibility changed hands on the morning of 22nd April 2014.

63. There is no evidence that the Early Start Officer with responsibility for E5 landing completed his head count of prisoners in accordance with his duties. This is confirmed by reference to the CCTV footage.

64. The deceased had not, either directly or indirectly suggested to any person either his family or otherwise that he intended taking the action that led to his unfortunate death.

65. While the cause of death is a matter for the Coroner, his death seems to have been as a result of a premeditated decision having regard to the letters referred to in paragraph 50(g).

Recommendations

1. All Standard Operating Procedures and Local Procedures must be observed to the letter. **This is particularly important where officers are obliged to check prisoners during periods of lockdown and prior to certifying numbers under their care.**

2. The system for the handover of responsibilities from one officer to another should be examined in order that the deficiencies, such as disclosed in this Report, are not repeated.

3. The Irish Prison Service should ensure that personal information regarding any prisoner is not disclosed to any third parties. Any person breaching this should be subject to disciplinary sanction.

4. Copies of suicide notes or any documentation obviously left for a deceased's next of kin should be handed to the next of kin as soon as is reasonably practicable after a death unless the handing over of such documentation could prejudice a criminal investigation or a coroner's inquest.