A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner D on 21 August 2016 in Portlaoise Prison

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

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A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner D on 21 August 2016 in Portlaoise Prison

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

Helen Casey
Office of the Inspector of Prisons

20 April 2017

Preface

The deceased was a 32 year old man who died in Portlaoise Prison on 21 August 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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Inspector of Prisons Investigation Report

General Information

1. The deceased was a 32 year old man who came from the Munster area. He is survived by his mother, father, brother, sisters, daughter and extended family.

2. The deceased was committed to Cork prison on 27 July 2015 and had a remission date of 24 January 2017. He transferred to Portlaoise Prison on 31 August 2015.

3. On 21 August 2016 the deceased was discovered in his single cell (Cell 16 on C3) in an unresponsive state with a ligature around his neck which was attached to the shower fixture. The deceased was pronounced dead in the prison at 04.40 hrs by Doctor A.

4. The family of the deceased were met at an early stage, they did not raise any concerns in relation to how the deceased was treated while in prison.

Meeting with the family

5. The family stated that the deceased was a "*kind person*" but he had addiction problems. They informed us that he was involved in a car accident about two years prior to his death and "*he was a different man after the accident*". He had attended the Psychiatric Service in the Community on a number of occasions. The deceased telephoned his mother twice a day to keep in contact with her and his young daughter.

6. I was informed that the deceased had received a number of certificates for courses which he completed in prison. The deceased worked in the prison kitchen and was reported by staff to be a hard worker.

7. The family stated that they were treated very well by staff when visiting Portlaoise Prison. They acknowledged the kindness shown to their family and in particular their grand-daughter while on visits. They reported that they were

given sufficient time for their visits but sadly their last visit with the deceased was "*cut short*" due to an incident in the prison visiting area.

8. The family discussed the tragic circumstances and loss of their son but did not raise any particular concern about his time in prison. They said the deceased was looking forward to his release and spending time with his young daughter.

Status of the deceased in prison

9. The deceased was an 'ordinary prisoner' who was on the enhanced level of the Incentivised Regime since 8 November 2015 until the time of his death. He worked in the prison kitchen. In the evenings he liked to spend time in his cell reading or watching television. The deceased was visited by his family on a regular basis. His most recent visit was on 10 August when his mother and friend visited him. He was in regular contact with his mother by telephone. The deceased did not make any official complaints while in prison.

Conduct of the deceased while in prison

10. The deceased was a very well behaved prisoner with no disciplinary breaches recorded against him. He was very well thought of by both staff and prisoners as is evidenced by the staff reports.

11. Officer D who worked in the kitchen with the deceased stated:-

"He started working in the kitchen on 4 September 2015 - he was hard working, reliable and good humoured".

12. Officer E stated in his report:-

"The deceased started working in the kitchen on 4 September 2015. He was very withdrawn at first and did not interact with staff or prisoners, always keeping to himself. I had occasion to speak to him and advised him to accept any help and gradually he integrated well with staff and prisoners alike.....I found him to be a diligent worker and a great timekeeper. He struck me as a happy go lucky type of person".

13. Officer F who worked in the kitchen stated:-

"I found him to be well behaved and a good worker..... I noticed that his spare time was on the landing spent in his cell and not out with others. On the day before his death the deceased was with me on the C3 servery, I did not notice anything out of the usual with him".

14. The deceased had also undertaken several courses in the prison to help him deal with issues in his life including Anger Management, Drug Relapse Prevention, Anxiety Awareness Causes. He worked closely with the Addiction Counsellor.

Contact with medical and therapeutic services

15. I received permission from the next of kin to examine the deceased's medical records. I examined the medical records for the period 27 July 2015 to the date of his death. I also sought information on any contact the deceased may have had with the Psychiatric, Psychology and Counselling Services.

16. The deceased had a history of poly substance abuse before admission to prison. The deceased was seen on committal (27 July 2015) by Medical Orderly A. The medical notes, *inter alia*, stated:-

"on committal (the deceased) *appears well. States to be on Abilify depot monthly. In Sarsfield Court two weeks ago for a few days. Went there voluntary. In Car crash 12mths ago approx. On Ixprim 37.5mg qid for pain relief. No thought of self harm, to see Dr. in the am".*

17. On 31 July 2015 Nurse Officer A states in the medical notes:-

"returned from court. Escorting officer informed staff that the (deceased's) Solicitor asked that he be 'watched' on his return to prison (5 year sentence – 3 years suspended received today). Placed on buddy system on his return to B3. Placed on special obs."

18. On 1 August 2015 the deceased was seen by Prison Doctor B who noted in the medical notes the deceased's medical history and medical issues.

19. On 5 August 2015 the deceased was assessed by Psychiatric Nurse A who noted the deceased engagement with the Psychiatric Services. She recorded the following:-

"The deceased presented with mild agitation..... He denies thoughts/plan/intent of dsh or suicide. He denies persistent low mood or feelings of anhedonia. He attended psychiatric services at 16 years. Attended as an inpatient in Sarsfield Court. Reported history from 16 years with police involvement for public order and drugs. Plan to re-commencement of depot…….. Clarify oral medications as the deceased reports that he was non compliant with same. For referral to addiction services....."

20. On 31 August 2015 the deceased was transferred from Cork Prison to Portlaoise Prison. On 1 September 2015 the deceased was seen by the Doctor C on committal and later by Prison Psychiatrist A. It is reported that the deceased was unable to relax and suffered anxiety.

21. The deceased was placed on the Special Observation list on 19 September 2015 as he "*was unable to relax with associated racing thoughts. Also c/o hearing voices and feeling paranoid*". When on special obs, a prisoner is checked every 15 minutes. The deceased was seen again by Psychiatrist A on 29 September 2015. On 1 October 2015 he was administered a prescribed 'depot' injection.

22. On 1 November 2015 the deceased refused his medication and was placed on the list for the Psychiatrist. On 13 November 2015 the deceased declined to attend the Psychiatrist for an appointment. He was seen again by Psychiatrist A on 17 November 2015, who recorded the following:-

> "*Unwilling to continue Antipsychotic medication – Denies any symptoms. Attributes his previous problems to drug misuse. Denies any thoughts of self harm or violence"*.

The deceased was seen again by the Psychiatrist on 12 January 2016 and 24 May 2016 where no immediate concerns were noted. The deceased was off all

sedative medication at this stage and was to be seen again by Psychiatrist A at the end of August 2016.

23. The deceased attended the Addiction Counsellor in the Prison on a number of dates between 14 March 2016 and 18 August 2016. During these sessions the understanding of anxiety to prevent relapse was addressed.

24. The deceased had no contact with the Psychology Service while in Prison.

25. The deceased was discussed at the Integrated Sentence Management (ISM) meeting on 24 May 2016 where it was stated that he had been assessed from a mental health perspective and was doing well. It was reported that the deceased was symptom free and managing well and could now be managed through the GP system. The group assessed his suitability for the Community Return Scheme and the Probation Service was looking into accommodation for him. His family had stated that they were happy to support him in accommodation near to their home. On release, he would have been subject to monitoring by the Probation Service for a three year period as his sentence included a Post Sentence Supervision Order.

Sequence of events on evening of 20 August 2016

26. The deceased was accommodated in Cell 16 (single cell) on C3 landing from the time of his arrival in Portlaoise Prison. The deceased returned to C3 landing from the kitchen at approx. 16.00 hrs where he met Officer A who unlocked his cell. He entered the cell and remained inside with the cell door open. Officer A returned to the deceased's cell at approx. 16.03 hrs and his door was closed shut. Officer B unlocks the cell for his tea at approx. 16.18 hrs. The deceased exits the cell approx. 1 minute later at 16.19 hrs. He enters his cell with his tea at approx. 16.21 hrs and leaves the cell door opened. Officer B closed the cell door shut at 16.23 hrs.

27. On the reserve period the deceased's cell is unlocked by Officer C at approx. 17.32 hrs. At this point the deceased does not leave his cell. During the reserve two prisoners, Prisoner A and Prison B entered his cell at different times.

28. Prisoner A entered the deceased's cell at 17.40.05 hrs and leaves the cell at 17.43.36. hrs. He stated at interview:-

"On that Saturday evening when I spoke to him in his cell he seemed to be in his usual form. He was my friend and he often spoke with me about his daughter and how his mother was taking care of her and how he couldn't wait to get out of Prison so he could be with them".

29. Prisoner B entered the deceased's cell at 18.31.16 hrs and leaves the cell at 18.31.53 hrs. He stated at interview:-

"I knew the deceased only since I came into prison. He was a nice friendly lad and I got on well with him. He was a good worker and he went off to the Kitchen every day to work. I used to see him mainly in the evening time when he would come back up on the landing after work. .... I recall last Saturday evening between 6 pm and 7 pm. I called in to his cell which was down at the end of the landing. I asked him for a rolly i.e. a cigarette and he gave me one. I went back to my cell. Then we were locked back for the night....."

30. The last time the deceased can be seen on the landing was 18.20.25 hrs when he walked down the landing. He returned to his cell at 18.20.50 hrs. At 19.31.51 hrs masterlocks are applied to cell 16 on C3 for the night. The cell is checked by an officer.

Sequence of events of 21 August 2016

31. At 03.07 hrs on 21 August 2016 the deceased was discovered in his single cell (Cell 16 on C3) in an unresponsive state with a ligature around his neck which was attached to the shower fixture.

32. Officer G being the officer who discovered the deceased in an unresponsive state described the sequence of events in the following terms:-

"On my earlier watch tour I observed the deceased watching television in his cell. When I got to cell 16 I looked in. I didn't see the deceased but I saw steam

in the cell and I assumed that he was in the shower. In my experience I have seen prisoners taking showers at unusual times of the night. I proceeded to the watch tower button and pressed it. I looked back into the cell and I still saw steam. I continued with my guard tour and checked other prisoners on the landing and went back to the class office. Shortly afterwards I decided to go back and check on the deceased again. I was not completely satisfied so I decided to call ACO A to have the door opened so that I could satisfy myself. ACO A came to the landing shortly after I had called him and we were also joined by Officer H . ACO A gave me the cell key and I opened the door. We entered the cell and the deceased was in the shower area in a kneeling position. He had a white bed sheet attached to his neck and tied to the shower head. I immediately went to the class office to get the Hoffman knife. I returned to the cell and ACO A cut the ligature and I held the deceased to prevent him from falling over. We placed him on his back on the cell floor. ACO A had contacted Nurse Officer B who arrived shortly".

33. Nurse Officer B responded to the alert referred to above. Nurse Officer B describes her actions in the following terms:-

"I wish to report that I received an emergency call to C3 at approx 03:05 hrs. I immediately went to C3 and saw the (deceased) hanging from shower with ligature around his neck. Prisoner was cut down by staff. Colour pale, lips purple, cold to touch, not breathing and no pulse evident. Hands and feet nettled with pooling evident in feet. No sign of life, rigor mortis evident. Ambulance called and scene preserved, ambulance arrived at approx 03.30 hrs. No CPR commanded, doctor called by ambulance crew. Doctor A examined patient and pronounced dead at 04.40 hrs".

34. I viewed CCTV footage relevant to the deceased and/or his cell. The following activities as observed on CCTV which are set out in chronological order are relevant to this investigation:-

19.31.51	Officer master-locks Cell 16 and also lifts flap and looks into cell
20.18.21	Officer checks cells – checks Cell 16

21.03.32	Officer checks cells – checks Cell 16
22.08.23	Officer checks cells - checks Cell 16
23.10.16	Officer checks cells - checks Cell 16
00.02.48	Officer checks cells - checks Cell 16
01.03.47	Officer checks cells - checks Cell 16
02.03.08	Officer checks cells - checks Cell 16
02.56.38	Officer check cells - check Cell 16 with aid of a torch. Leaves after 30 seconds
03.00.04	Officer goes to cell 16. Looks in viewer with torch
03.02.37	Officer heads downstairs - leaves landing
03.05.51	Officer returns up the stairs accompanied by another Officer. They go directly to Cell 16 at 03.06.33. They lift flap of cell door and look in
03.07.40	ACO arrives at Cell 16. Cell door opened at 03.07.44. All three officers enter the cell
03.09.48	Nurse Officer climbs stairs with emergency bag
03.10.47	Nurse Officer enters Cell 16
03.41.50	Ambulance paramedics arrive and enter Cell 16
04.19.46	Members of An Garda Síochána at Cell 16
04.36.47	Doctor A enters Cell 16 and following examination, pronounces the prisoner dead.

Findings

35. The deceased was an ordinary prisoner on the enhanced level of the incentivised regime at the time of his death.

36. He was accommodated in a single cell at the time of his death.

37. The deceased did not leave a suicide note.

38. The deceased had considerable contact with the Psychiatric Service and Addiction Service while in Portlaoise Prison.

39. The CCTV footage was clear and showed the activities on the landing.

40. Between 19.31.51 on 20 August and 03.07.44 on 21 August 2016 the deceased was checked 11 times by Officers.

41. The deceased was discussed at the Integrated Sentence Management (ISM) meeting on 24 May 2016 where it was stated that he had been assessed from a mental health perspective and was doing well. The group assessed his suitability for the Community Return Scheme and the Probation Service was looking into accommodation for him.

42. The deceased did not have any dealings with the Psychology Service.

43. The deceased had not by his actions, words or otherwise intimated to his family, his fellow prisoners or the prison officers, Psychiatric or Healthcare Staff, his intention to take his own life.

44. As soon as the alarm was raised there was immediate response from the prison officers and the medical personnel.

45. The deceased was pronounced dead at 04.40 hrs on 21 August 2016.

46. While the cause of death is a matter for the Coroner I understand that the deceased died as a result of hanging.