A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner G on 9 May 2015 in the Midlands 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 G on 9 May 2015 in the Midlands Prison

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

Judge Michael Reilly
Inspector of Prisons

31 March 2016

Preface

Prisoner G was a 36 year old man who died in the Midlands Prison on 9 May 2015.

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.

Judge Michael Reilly
Inspector of Prisons

31 March 2016

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 36 year old man who came from the Leinster area.

2. The deceased is survived by his parents, sisters, daughter and extended family.

3. The deceased was committed to prison on 8 October 2013. He was serving his sentence in the Midlands Prison. His remission date was to be 2 February 2016. The deceased had served previous sentences.

4. The deceased was found in an unresponsive state in the early hours of 9 May 2015 in cell 8 on A2 landing – a double cell that he was sharing with another prisoner.

5. I met the family of the deceased. I have responded, in this report to concerns raised by them.

6. In carrying out my investigation I had unrestricted access to all parts of the prison, to all records and CCTV. I received total co-operation from all persons while carrying out this investigation.

Status of the deceased in prison

7. The deceased was an ordinary prisoner on the enhanced regime.

8. He was well thought of by other prisoners and prison staff.

9. The deceased worked as a cleaner and at times as a painter in the prison.

10. He had no P19s during the currency of his latest imprisonment.

Meeting with the deceased's family

11. I met the deceased's family on 28 May 2015.

12. The family informed me that the deceased had served a number of previous sentences – mostly of short duration.

13. They informed me that he was a drug user from a very young age and had used many drugs including hash and heroin. They stated that latterly he had been endeavouring to address his drug habit and to this end was staying away from *"his former friends who only brought trouble"*. They *"felt he really was making an effort this time to get off the drugs and get life back on track"*.

14. He telephoned his mother every day and his sister at weekends. His family visited him every week.

15. The family informed me that the deceased was attending the gym each day .

16. The family had a number of concerns which they wished me to investigate as follows:

    (a) What medication was he on?

    (b) Were the telephones in the prison out of order on 8 May as he did not telephone on that day?

    (c) Did he go to the gym on 8 May?

    (d) The family wished me to ascertain the sequence of events on the night of 8/9 May in so far as same affected the deceased.

    (e) What happened?

    (f) Did they try to resuscitate him?

    (g) Was the cell call bell working?

(h) Who telephoned the deceased's mother at 8.30 am?

(i) Why was the family not contacted earlier than 8.30 am when the deceased was found at approximately 6.30 am?

(j) What time did the ambulance arrive?

Deceased's relevant medical history

17. I received permission from the deceased's next of kin to examine the deceased's medical records. These records were comprehensive. I examined such record from the date of the deceased's committal to prison on 8 October 2013.

18. On 8 October 2013 the deceased was seen on committal by Nurse Officer A who carried out an assessment. He was then seen by Dr. A on 9 October who took a full case history. This disclosed a history of depression and paranoia and that the deceased had attended a clinic previously for treatment for his condition. The deceased also disclosed a history of significant drug and alcohol use.

19. Between 9 October 2013 and the date of his death the deceased had constant contact with the medical personnel in the prison. Much of this contact was for 'every day' minor medical problems which are not relevant to this investigation.

20. However, he was also seen on a regular basis by consultant psychiatrists, prison doctors and psychiatric nurses who treated him not only for his depression and paranoia but also for his drug addiction. He was prescribed medication and was on a methadone programme. His medication was reviewed on a regular basis.

21. The deceased voluntarily submitted to regular drug screening. He tested negative for illicit substances apart from methadone. I should point out that he was on a methadone programme for many years.

22. For privacy reasons I have not, in this Report, detailed the substance of the consultations that the deceased had with the medical personnel while in prison which, in fact, do not add to this investigation.

Relevant events

23. Between 14 December 2013 and 8 May 2015 the deceased occupied cell 31 on A2 landing. This was a single cell with in cell sanitation.

24. The deceased worked as a cleaner and attended the gym every day. There were no management issues with the deceased.

25. On 5 May 2015 Prisoner A was committed to Midlands Prison. He was initially accommodated in cell 6 on C1 Right landing. On 6 May 2015 he was transferred to cell 30 on A2 landing. On 8 May 2015 he transferred to cell 8 on A2 landing. This was a double cell. The deceased moved to this cell at the same time.

26. Officer A was the Class Officer on A2 landing on Wednesday 6 May 2015. He described his dealings with the deceased in the following terms:

> *"I had a couple of dealings with* (the deceased) *on Wednesday* (6 May). *He asked me could his cousin, Prisoner A move into cell No. 30 which was next door to him. I told him that Prisoner A could move into cell 30. Prisoner A moved into cell 30.*
>
> *On two or three occasions during the day, I asked one or other of them to move from each others cell as they were just hanging around the landing"*.

27. Officer B was the Class Officer on A2 landing on Thursday 7 May 2015. He described authorising the transfer of both the deceased and Prisoner A to cell 8 in the following terms:

"When I came on duty on the Thursday 7 May 2015, I was Class Officer A2. (The deceased) *and Prisoner A approached me to see if they could double up together as they were cousins. I had no problem with this and as they were cousins and both had requested it".*

28. Officer C described his dealings with the deceased on 8 May in the following terms:

"*the first thing I noticed about* (the deceased) *was that he had moved cell. I asked* (the deceased) *why he had moved from a single cell to a double cell. He told me that everything was grand and that he had moved in with his cousin. There was no issues with him during the day but on a number of occasions I asked him was he still cleaning as he had not cleaned the landing and did not appear to be in his normal routine.*

There appeared to be a number of prisoners in and out of his cell during the morning. I was suspicious with the amount of movement in and out of the cell and I had a feeling that things were not right. I felt that this behaviour was out of character for (the deceased). *I felt there was a lot of drug use on the landing and I suspected that the drugs were being dealt with from* (the deceased's) *Cell. I asked* (the deceased) *on a number of occasions if everything was alright and he assured me that it was.*

During the Governors parade at about half ten I spoke to ACO A, I informed him of my feelings that there was a lot of drug use on the landing and asked if he could arrange to have Cell No. 8 searched as I felt that this was where the drugs were being supplied from.

During the afternoon or early evening ACO A informed me that he had informed the OSG about the drug use and had requested that they search Cell No. 8. He asked me to enter this into the Class Officers journal which I did".

29. ACO A corroborated the statement of Officer C that he had requested a cell search of cell 8. He stated that he dispatched an email at 11.04.00 hours on 8 May to two ACOs attached to the Operational Support Group (OSG) requesting such a search. I have seen this email. Unfortunately, this email was not opened by either ACO - the first being on a training course and the second being off duty on the day (8 May) with no recourse to their emails.

30. The deceased did not go to the gym on 8 May.

31. Numbers of prisoners made statements during the course of this investigation of which the following extracts are relevant, at this juncture, to 8 May:

Prisoner B stated:

"He was stoned out of his head on the Friday. I reckon it was gear he was on.... I told him on the Thursday not to double up, he was to stay on his own".

Prisoner C stated:

"I knew he was taking drugs but he didn't look like a lad that would overdose"

Prisoner D stated:

"I knew him very well..... We talked up and down. He was out of his head for a while before he died. He looked like he was on a constant buzz, on gear and tablets. I was talking to him at the server 4 pm on Friday and he asked me what day it was. He looked grand".

32. The deceased was locked in his cell for the night at 19.25.37 hours on 8 May 2015. CCTV cameras are installed in Midlands Prison. There is CCTV coverage of A2 landing. I examined the CCTV footage for the period 19.25.37 hours on 8 May to the time the deceased was taken from his cell to hospital at 06.55.30 on 9 May. I was able to identify all relevant movements on the landing which were relevant to the deceased's cell.

33. As an ordinary prisoner the deceased should have been checked by prison staff during periods of lock down approximately every hour. This checking in prisons takes the form of an officer looking through the observation hatch in the cell door.

34. The following are the relevant times that I observed activity at the deceased's cell during the night of 8/9 May 2015:

8 May 2015

19.25.37	Deceased and Prisoner A locked in cell for the night.
19.30.11	Officer checked cell – looked through the viewing hatch.
20.04.39	Officer checked cell – looked through viewing hatch.
21.00.25	Officer checked cell – looked through viewing hatch.
22.01.00	Officer walking the landing. Can be seen checking some cells **but not** cell 8.
22.59.05	Officer checked cell – looked through viewing hatch.

9 May 2015

00.01.37	Officer checked cell – looked through viewing hatch.
00.59.42	Officer checked cell – looked through viewing hatch.
01.59.47	Officer checked cell – looked through viewing hatch.
03.02.26	Officer checked cell – looked through viewing hatch.
04.00.38	Officer checked cell – looked through viewing hatch.
05.00.31	Officer checked cell – looked through viewing hatch.
06.01.41	Officer checked cell – looked through viewing hatch
06.16.50	Officer goes directly to cell 8 – remains at the door for 18 seconds.
06.19.24	Two officers arrive at the door and joined by the officer just referred to and enter the cell at 06.19.31.

06.20. 06	Two further officers enter the cell. Prisoner A is taken from the cell and placed in a cell on the opposite side of the landing.
06.21.08	Nurse Officer A enters the cell carrying emergency equipment.
06.44.29	Two Ambulance Crew Paramedics enter the cell.
06.55.30	The ambulance crew remove the deceased from the cell and take him to hospital.

35. The deceased's cell – cell 8 was equipped with a cell call bell. I examined the call bell records for the Midlands Prison for the period 19.25.37 (the time the deceased was locked in his cell for the night) until the cell was entered by officers at 06.19.31. According to the prison records the call bell was activated on the following occasions:

	<u>8 May 2015</u>		
Activated at	19.54.25	Reset at	20.08.15
	<u>9 May 2015</u>		
Activated at	06.17.34	Reset at	06.20.42

36. I should point out at this juncture that the times recorded on the CCTV or on the call bell electronic records may not correspond with actual time or indeed with one another as they are not necessarily synchronised with one another.

37. Officer D was the officer in charge of A1 and A2 landings on the night of 8/9 May. He detailed his performance of his duties as follows:

> *"I did my checks as required and my clocks every hour. At my last check at 6.06 am I observed everything to be ok. At approx 6.30 am I heard banging on A2 and I went to A2 Cell 8 and Prisoner A informed me that* (the deceased) *was not breathing and he was purple in the face.*

I contacted ACO B who came to the landing with Nurse Officer A and performed CPR".

According to the CCTV Officer D went directly to the cell at 06.16.50.

38. ACO B responded to Officer D's call and can be seen on CCTV entering cell 8 at 06.19.31. He detailed his involvement as follows:

> *"At approximately 06.30 hrs on the 09/05/2015 I received a radio call from Night Guard I/c A1/A2 Officer D who informed me that one of the occupants of double occupancy cell no 8 A2 class was unresponsive in his cell. I contacted N.O. A and instructed her to attend the cell and to bring resuscitation equipment.....*
>
> *On entering the cell I observed Prisoner A standing up in the cell and also* (the deceased) *lying in the bed with the duvet pulled up to his chest. I immediately removed Prisoner A from the cell and had him placed in an empty cell across the landing and I asked him if they had taken anything and he replied that they had taken heroin and tablets. I called Prisoner* (the deceased's) *name and checked for a pulse but he was unresponsive. N.O. A attended and I gave her my observations.*
>
> *I assisted N.O. A to give CPR to the prisoner and ordered that an ambulance be called immediately. Officer E also gave assistance with CPR until the paramedics arrived".*

39. Nurse Officer A immediately responded to ACO B's instruction and can be seen on CCTV entering the cell at 06.21.08. She described the scene in the medical notes in the following terms:

> *"Received call to A2 at 06.20. Prisoner was lying in the bed unresponsive, no pulse, not breathing, cold, extremities cold and blue, pupils fully dilated and unresponsive. Chest compressions commenced immediately and emergency call made for ambulance. Helped by*

officers to put (deceased) *on floor. Defib attached and CPR commenced. There was no indication from defib to shock* (the deceased) *throughout CPR. Informed by ACO B that his cell mate stated that* (the deceased) *had taken tramadol and smoked heroin last night. Helped by ACO B and Officer E with CPR..... Ambulance arrived at 06.50 approx. Handover given and CPR and care taken over".*

40. I was informed that the deceased was pronounced dead in Midlands Regional Hospital, Portlaoise at 07.38 hours on 9 May 2015.

41. I was informed by Governor A that immediately on hearing that the deceased had been pronounced dead he telephoned the deceased's mother to inform her of her son's death and to express his sympathies to her.

42. Dr. B (the prison doctor) noted in the medical notes on 9 May at 08.17 hours that he spoke to Prisoner A who was very upset and tearful and told the doctor that:

> "(the deceased) *has been smoking heroin last night and had few bags of heroin. He was noticed to be "snoring more than usual, and early hours he was noticed to have stopped snoring". He* (Prisoner A) *noticed that* (the deceased's) *lips were blue and no response.* (Prisoner A) *pressed the panic emergency call button and started banging at the door and shouted for help".*

43. During the course of my investigation Prisoner A made two statements. In his first statement he stated:

> *"I only came up to A2 on Wed 6 May and I went into the cell next door to* (the deceased). *I was on my own it was a single. I stayed there for 2 nights and we both agreed we'd go into a double cell together. We moved into cell 8 on Friday. It was ok with the class officer that we move in together.*

He was grand all day Friday and evening. That night after lock up, he was after taking some tablets and some gear he got on the landing. He took a good few tablets, he didn't take much gear, maybe just a few lines of heroin, smoking it. He would have taken it on the outside. I was smoking it also. I put him into the bed as he was out of it. After taking the gear, I went to bed myself and I woke up with him snoring at around 3.10 am. I saw the time on the TV. I got down to try to stop him snoring, but I couldn't stop him snoring, he just stopped then himself. I got back into bed and fell asleep and woke up again and made a cup of coffee. It was about 4 or 5 am, it was bright out. It was then that I noticed his lips were black. He was lying on his back. I tried to move him, due to his size but couldn't. There was froth at his mouth. I checked his pulse and got a faint pulse but he wasn't breathing, there was bubbles in his mouth. It was then I put on the red light, kicking the door. I tried CPR him, clearing his mouth with my top. The officers took me out and put me in the cell across the landing.

He only had a few lines. He wouldn't have taken much of it. He never took much on the outside. He only took the maintenance as he said it would make the day fly by. He was popping the tablets in between the heroin. He didn't know where he was as he asked me "who's gaff are we in"? He was taking more in here that night compared to what he'd have gotten in prison previously. I had my own supply of heroin/tablets. I brought them with me. I only brought in a few tablets and a small bit of gear. I shared that with him. He got other tablets on the landing..... I was smoking in my cell in the days after I came in. (The deceased) *smoked a few lines in the days before he died. I got caught with it in my pillow on C1".*

44. Prisoner A made a subsequent statement. Initially he outlined where he came from and his relationship with the deceased. He also outlined how they had got permission to share a cell. He stated that after they had been locked down for the night they watched television. When asked if they had taken drugs he answered – *He didn't take anything in front of me, but definitely I didn't see*

him taking anything and I didn't take anything". He went on to describe the events of the following morning in the following terms:

> *"So about half past 5 or it could have been half past 6 I got up and went to the toilet in the cell. I walked back over to go up on the ladder and I saw* (the deceased) *was lying up kinda again the corner. He wasn't lying flat and he had no bed clothes on him. He just had a pair of boxers or shorts on. He had no top on. I noticed a couple of bubbles on his mouth. I tried to wake him. I was shaking him and roaring at him, then I pressed the call light – the red light that goes on over the door and it goes up to the staff office. I was banging on the door for ages – well over half an hour. I also tried to pull him down on the bed to get him flat to give him CPR. I had felt his arm and it was warm and I thought I felt a faint pulse. He was cold on the core of his body. I kept beating the door for maybe ¾ of an hour. I woke the whole landing. Then an officer came. I was taken out of the cell and put into a different cell"*.

45. Numbers of prisoners who were on A2 landing on the night of 8/9 May made statements in which they referred to their recollections of the events of the morning of 9 May 2015. The following are relevant:

Prisoner E stated:

> *"I heard his cellmate calling on the door sometime after 5 am on Friday. He was just shouting for an officer"*.

Prisoner B stated:

> *"I heard the banging, it was really loud. I heard Prisoner A saying he's not breathing. We all started banging the doors but I reckon it took about 20 minutes before someone came"*.

Prisoner F stated:

> *I woke up banging which went on for a while. I heard his cell mate say he's not breathing, he's freezing cold"*.

Prisoner G stated:

> *"I didn't hear anything only except banging on the door, about ¼ to 6 very early anyway".*

Prisoner H stated:

> *"I got woken up by his cell mate banging on the door. My own cell mate woke up. We heard* (the deceased's) *cell mate shouting to the officers he's not breathing. As time went on, the banging went on to get the attention of the officer of the landing. It did take a long time for an officer to reach the cell, around 30-35 minutes to the time he received attention".*

46. I examined the call bell activity records for the A2 landing for the morning of 9 May 2015 for the purpose of ascertaining if call bells from cells other that cell 8 had been activated. There were activations from three cells on the landing at 06.25.39, 06.45.28 and 06.48.48.

Findings

47. The deceased had a long history of illicit drug dependency and displayed psychotic symptoms.

48. He was treated by the medical personnel and by the psychiatric services while in prison and was on medication.

49. He was on a methadone programme in prison.

50. The deceased voluntarily submitted to regular drug screening while in prison. He tested negative for illicit substances apart from methadone.

51. The deceased was on the incentivised regime and was well thought of by the prison officers and his fellow prisoners.

52. The deceased occupied a single cell up to the morning of 8 May 2015.

53. He maintained constant contact with his family. He telephoned his mother every day.

54. On 8 May the deceased moved into a double cell with Prisoner A.

55. Prisoner A had been committed to Midland Prison on 5 May and had occupied a cell next door to the deceased since 6 May 2015.

56. The deceased appeared to have taken drugs on 8 May.

57. There is no evidence to suggest that the deceased had taken drugs in the prison prior to 6 May 2015.

58. Prisoner A brought drugs including heroin and tablets into the prison on his committal on 5 May 2015.

59. The deceased and Prisoner A were 'hanging around' the A2 landing on 8 May 2015. The deceased did not attend the Gym and did not attend to his duties as a cleaner on that date.

60. Officer C was concerned that drug activity was taking place in cell 8 and on A2 landing and reported this to his senior officer who in turn relayed the information by email to the OSG requesting that cell 8 be searched.

61. The OSG officers to whom the request to search was addressed did not open their emails on 8 May as they were not on duty. This is a reasonable explanation.

62. On the night of 8/9 May 2015 the deceased and Prisoner A took a cocktail of illicit drugs in cell 8.

63. Prisoner A admitted sharing his drugs with the deceased. It is relevant that according to his statement he still had drugs in his possession in prison days after the 9 May 2015.

64. The deceased was checked at regular intervals after midnight on the night of 8/9 May 2015 in accordance with procedures.

65. The deceased was last checked at 06.01.41.

66. Prisoner A discovered the deceased shortly before 06.17.34 in the state as described by him in his statement referred to in paragraph 44.

67. Prisoner A activated the cell call bell at 06.17.34 which was shortly after he discovered the deceased in an unresponsive state referred to in paragraph 66 and commenced banging on the cell door and shouting for the officer.

68. Officer D, as seen on CCTV, arrived at the door of cell 8 at 06.16.50 and the cell door was opened at 06.19.31.

69. The call bell activation system and the CCTV were not synchronised – hence the discrepancy in the times referred to in paragraphs 67 and 68.

70. The assertions by Prisoner A and the other prisoners referred to in paragraph 45 that there was a delay in the officers answering the call for assistance or the banging on cell doors for an extended period of time does not accord with the evidence.

71. There was an immediate response from the prison staff as soon as the alarm was raised.

72. When the officers entered the cell at 06.19.31 the deceased was in his bed covered by his duvet.

73. There was an immediate response from Nurse Officer A who was the only nurse on duty on the night.

74. The prison staff both uniformed and medical discharged their duty of care to the deceased.

75. While the cause of death is a matter for the coroner I understand that the toxicology report disclosed evidence of the ingestion of heroin and a range of other drugs.

Addressing the issues raised by the family

76. In paragraph 16, I set out a number of issues that the family wished me to investigate. In this paragraph I endeavour to address such issues. For ease of reading I have adopted the same numbering sequence as in paragraph 16.

(a) For privacy considerations I will inform the family of this medication prior to the publication of this report.
(b) The telephones were not out of order on 8 May 2015.
(c) No.
(d) These are comprehensively set out in the body of this Report.
(e) The full details of all events are set out comprehensively in this Report.
(f) Yes – the efforts are explained fully in this Report in paragraphs 38 and 39.
(g) Yes.
(h) This is addressed in the Report in paragraph 41.
(i) The deceased was not pronounced dead until 07.38.00 hours on 9 May 2015 at Midlands Regional Hospital, Portlaoise.
(j) The ambulance paramedics entered the deceased's cell at 06.44.29 hours on 9 May 2015.

Recommendation

The Governor of the OSG should put in place a robust system to ensure that adequate responses to communications of an urgent nature, such as referred to in paragraph 29, are not dependent on the availability of or the working schedule of any particular officer.