A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner I in the Mater Hospital on 14th September 2013 while in the custody of 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 I in the Mater Hospital on 14th September 2013 while in the custody of 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 June 2014

Preface

Prisoner I was a 34 year old man who died in the Mater Hospital on 14th September 2013 having been moved there after a serious self inflicted incident in Mountjoy Prison on 8th September 2013.

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 Medical Services
- Sequence of events in Mountjoy Prison
- Status of deceased in prison and relevant Standard Operating Procedures
- Sequence of events on 8th September 2013
- Deceased's interaction with Services and fellow prisoners
- Findings
- Addressing 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
10th June 2014

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 34 year old unmarried man at the date of his date. He came from the Dublin area. He is survived by his two children, his parents and three siblings.

2. The deceased had many previous convictions and had served many prison sentences. The deceased was remanded in custody to Cloverhill Prison on 15th March 2013. He remained in custody until 17th April when he was sentenced. He began his sentence in Cloverhill Prison as he was also on remand for other crimes. He was convicted for these crimes on 18th July 2013 and began his sentence in Mountjoy Prison. His release date was to be 16th July 2017.

3. The deceased was well regarded by both prison officers and his fellow prisoners.

4. The deceased was found at approximately 4.48pm on 8th September 2013 in an unconscious state with a ligature around his neck in his cell – Cell 31 on C2 Landing in Mountjoy Prison. He was moved to the Mater Hospital where he died on 14th September 2013.

5. This Report does not disclose any significant incidents between 17th April 2013 (the date of his committal to prison) and 8th September 2013.

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. In this Report I endeavour to address such concerns.

7. 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 but unfortunately Cell 31 on C2 Landing is not covered by the CCTV installed in Mountjoy Prison.

8. From a very early age the deceased had a history of illicit drug use including the use of heroin. He and his family had taken steps over the years to endeavour to deal with his severe addiction. He had contact with the relevant services in the community and had spent time dealing with his addiction in institutions such as Coolmine.

Meeting with the Family

9. I met with the deceased's mother, father and one of his siblings.

10. The family stated that the deceased did not want to go to Mountjoy Prison because of the availability of drugs in the prison. This was not communicated to the authorities in Mountjoy Prison.

11. The family stated that, despite his earlier reservations, the deceased settled in well and was happy to be in a single cell on C2 Landing.

12. The family stated that a nephew of the deceased had got him to C2 Landing before he (the nephew) was transferred to Loughan House.

13. The family stated that the deceased had been on drugs for many years. They stated that when he was 19 he was sent to Mountjoy Prison and was drug free but came out of prison taking drugs. I have been unable to corroborate this statement.

14. The family informed me that the deceased had been on prescribed methadone in the prison but for a period of two weeks prior to 8th September he was off all methadone stating that - *"He had weaned himself off it"*. The family stated that when he came off methadone he asked to see a psychiatrist and was put on a waiting list. The family informed me that the reason for the deceased's self detoxification was that he wished to be moved to an Open Centre and he understood that this would not be possible if he was taking methadone. He was refused a transfer to Loughan House on 29th August.

15. The deceased had regular visits from his family including his children and he spoke to his mother, his siblings, his ex-partner and his children in addition to others on the telephone on a regular basis. Many of these calls were made on mobile telephones.

16. The deceased was visited on the Wednesday before 8th September by his family and they found him *"in great form"*. He told them that he wished to get to an open prison and was in high spirits.

17. On the Wednesday night referred to in paragraph 16 he telephoned his mother and her opinion was that he was in great form. His daughter was also speaking to him. He telephoned his mother on the Thursday and stated that he was in great form but was not going out to the yards as *"drugs are pushed in your face"*.

18. On Friday 6th September he spoke to his mother, his daughter and his ex-partner. His ex-partner was of the opinion that he was *"the best she ever heard"*. She stated that he arranged to telephone again on the Sunday (8th September) at approximately 6.30pm to speak to his son.

19. On Saturday 7th September the deceased telephoned his mother twice. She stated that he was very happy and positive about everything.

20. On Sunday 8th September the deceased telephoned his brother at approximately 2.00pm. His brother was of the opinion that he was in the best of form.

21. The family described him as being happy go lucky and street wise. They stated that he had never given any indication that he would do anything to himself. They stated that he loved his family and particularly his children.

22. The family expressed the following concerns:-

(a) When the family went to the prison they were kept waiting for 20 minutes, they were searched and were subjected to the drug dog. They felt this was intrusive.
(b) The family wish to know why it happened.
(c) The family wish to know why the deceased did not see a psychiatrist.
(d) The family wish to know what the ligature was attached to.
(e) The family stated that it took approximately 12 minutes for the ambulance to arrive and wish to understand the delay.
(f) When the family received the deceased's belongings from the hospital such belongings were incomplete.
(g) When the family got the deceased's belongings from the prison everything had been washed. Among the belongings were items of clothing which they did not believe to be his. They did not accept being told by prison management that prisoners swap clothes as the deceased had plenty of his own.
(h) The family wish to know who had alerted the staff and how long did it take for help to arrive.
(i) The family wish to know who cut the deceased down.
(j) The family stated that they would like to see the cell and all relevant CCTV.

Deceased's contact with Medical Services

23. In view of the information provided to me by the family I considered it appropriate to examine the prison medical notes relating to the deceased to ascertain what contact he had with the medical services. I obtained the necessary consent from his next of kin.

24. I do not intend giving exhaustive details of all contacts the deceased had with the medical services. However, it is appropriate that the detail referred to in paragraphs 25 to 34 is included.

25. On 15th March 2013 when the deceased was remanded to Cloverhill Prison an appropriate committal assessment was carried out by both the nursing staff and by Doctor A. It is noted that the deceased had been a heroin user and was

then on methadone. The deceased was seen by the Psychiatrist Doctor B on 20th March and was reviewed.

26. On 18th April 2013 Doctor C noted that the deceased tested positive for opiates and that he wished to see an addiction specialist regarding methadone maintenance. However, he declined to be seen in the methadone clinic on 1st May 2013. On 13th May 2013 the deceased met with the addiction counsellor and it was arranged that he would be put on the next list for addiction counselling.

27. The deceased was seen by the psychiatrist on 16th May and on 17th May the Psychiatrist Doctor B started the deceased on a methadone maintenance programme.

28. The dosage of methadone was increased on 22nd May, 5th June, 3rd July and 10th July. Among the reasons for such increases were the *"craving"* and *"sweating"* of the deceased. It was noted that on 25th May when the deceased attended at the methadone clinic for methadone that *"he appeared stoned"*. Due to his condition he was not administered any methadone on that visit.

29. On 18th July the deceased was committed to Mountjoy Prison. He was assessed by Nurse Officer A in the Committal Unit. This was a thorough assessment and he was continued on methadone at the level prescribed in Cloverhill Prison. On 19th July he was seen by the prison doctor – Doctor D.

30. It is noted that the deceased began to self detox on 2nd August and that he increased his rate of detoxification on 7th August, 14th August and on 31st August his rate of detoxification was a matter of concern to the medical personnel in the prison. The Pharmacist noted – "(the deceased) *left approx 10mls of methadone in his cup today and refused to take the rest of the dose despite numerous attempts by myself to encourage him to do so. He is adamant that he wants to self detox as quickly as possible and this he believes is the way to do it as we will not facilitate larger, more rapid reductions for obvious reasons. I explained to him the risks of detoxing too quickly but he*

dismissed them saying "I know the story I have done it before". I will speak with him tomorrow to again try to encourage him to remain on his constant full dose until he can be reviewed by Doctor E *so that his detox can be achieved in a more stable controlled manner".*

31. On 1st September 2013 there is a further note from the Pharmacist as follows – "*Following on from yesterday* (the deceased) *again left approx 10mls of methadone in his cup after he was dispensed his full dose…….I made several attempts to offer to help him detox in a more controlled manner but he declined to do so maintaining the same reasons as yesterday".*

32. On 2nd September 2013 at 10.25am the deceased declined methadone when called by the officer. On 3rd September 2013 the deceased was called numerous times to attend for his methadone but declined to attend.

33. On 5th September 2013 the deceased was reviewed by the Psychiatrist – Doctor F. He carried out a comprehensive assessment. He found the deceased to be a person with moderate depressive symptoms who had attempted self harm in the past which required inpatient treatment. No psychotic features were elicited. He devised a care plan which involved certain medication.

34. The deceased did not have further contact with the medical services in connection with his addiction problems.

Sequence of events in Mountjoy Prison

35. On 18th July 2013 the deceased was committed to Mountjoy Prison. He was initially accommodated in the Committal Unit of C Basement.

36. On 19th July 2013 the deceased was moved to a cell on D2 Landing where he remained until 24th July 2013.

37. On 24th July 2013 the deceased was moved to Cell 31 on C2 Landing. This was a newly refurbished single cell with in-cell sanitation and a wash basin. The deceased remained in this cell until 8th September 2013.

Status of deceased in prison and relevant Standard Operating Procedures

38. The deceased was classed as an ordinary prisoner in the prison.

39. The obligation to check ordinary prisoners during periods of lock down provides that such prisoners should be checked once every hour.

Sequence of events on 8th September 2013

40. At approximately 4.15pm on 8th September 2013 the deceased collected his tea and was then locked in his cell – Cell 31 on C2 Landing. He was on his own.

41. I have already stated in paragraph 7 that Cell 31 on C2 Landing is not covered by the CCTV installed in Mountjoy Prison. However, all areas adjacent to the cell are covered by CCTV and it is possible to state with accuracy the arrival times of various relevant personnel to Cell 31.

42. At 4.48pm Prisoner 1 who was working as a cleaner was on the stairs between C1 and C2 Landings heard a CD player skipping and went to Cell 31 on C2 Landing as this was where the sound was coming from. He lifted the viewing flap and looked into the cell. He saw the deceased was hanging from a cord with his back to the cell door. Prisoner 1 immediately called out for help, banged on the cell door but got no response and then ran for help.

43. Officer A who was the Tea Guard on C Division immediately went to Cell 31 on C2 Landing. Officer B and Officer C also responded.

44. Officer D who had heard Prisoner 1 call for help went directly to the keys office where he met the ACO and informed him of what had happened and sought the master keys.

45. The ACO and Officer D went to the cell. The ACO unlocked the cell door.

46. Officers A, B and D and the ACO lifted the deceased and removed the ligature from his neck and placed him on the floor of the cell. The ligature had been attached to a conduit pipe attached to the ceiling of the cell.

47. At 4.50pm Nurse Officers B, C and D responded to the call and entered the cell.

48. Nurse Officer C in his statement stated that when he arrived at the cell he found the deceased *"lying on the floor of the cell, unresponsive, no breath sounds and absent pulse, ligature mark evident around neck"*. He also stated that the Ambulance had been summoned. Nurse Officer C stated that chest compressions were commenced by Nurse Officer D while he Nurse Officer C administrated O2 therapy. He stated that the defibrillator was applied and Nurse Officer D was relieved by Nurse Officer B on chest compressions. Nurse Officer C stated-: *"The defibrillator not activated as could not identify rhythm - instructed to continue CPR. Continued CPR and O2 therapy – during compressions the deceased began to vomit slightly – rolled on side – airway cleared – pulse found on reinsertion of airway"*.

49. The account given by Nurse Officer C was corroborated in statements by Nurse Officers B and D**.**

50. At 4.58pm the Dublin Fire Brigade Ambulance passed through the Main Gate of the prison. I verified this time from CCTV footage taken of activity at the Main Gate.

51. At 5.01pm the Ambulance Crew arrived at the deceased's cell. The Ambulance Crew took over from the medical staff.

52. At 5.06pm the deceased was removed by Ambulance to the Mater Hospital where he was placed on life support.

53. The deceased died in the Mater Hospital on 14th September 2013 at 5.10pm approximately.

Deceased's interaction with Services and fellow prisoners

54. The deceased did not avail of the school or other educational or therapeutic regimes in the prison.

55. The deceased had a job as a cleaner for a short time but this employment ceased numbers of days prior to 8th September 2013.

56. The deceased appeared at different periods during his time in prison to be on drugs.

57. During the course of my investigation I spoke to many prisoners and in particular to Prisoners 1, 2, 3, 4, 5, 6, 7 and 8.

58. The contributions of the prisoners referred to in paragraph 57 can be summarised as follows:-

- The deceased did not indicate by word, action or otherwise that he would attempt to take his own life.
- The deceased had a significant drug problem for many years.
- The deceased's appearance at times in prison suggested that he had taken drugs.
- The deceased had detoxed from methadone over a very short period of time which they considered extremely dangerous but despite this he presented as a lucid individual who interacted normally with his fellow prisoners.
- On 8th September the deceased met and conversed with a number of prisoners. He presented as normal and in good form.

Findings

59. The deceased had a history of illicit drug use including the use of heroin from an early age.

60. The deceased had significant contact with his family while in prison.

61. The deceased had never given any indication to his family that he would take any actions to harm himself.

62. While in Cloverhill Prison the deceased has significant contact with the medical and therapeutic services including contact with the psychiatric services.

63. While in Cloverhill Prison the deceased commenced methadone treatment which was increased on a number of occasions. On one occasion the deceased presented at the methadone clinic under the influence of an illicit substance.

64. On his committal to Mountjoy Prison the deceased was appropriately assessed by the medical service.

65. The deceased self detoxed during the month of August against professional advice in the prison.

66. The last psychiatric review of the deceased by the Psychiatrist was on 5th September 2013. This was a comprehensive review as outlined in paragraph 33.

67. The deceased occupied a single cell – Cell 31 on C2 Landing between 19th July and 8th September 2013. This was a newly refurbished single cell with in-cell sanitation and a wash basin.

68. The deceased ingested drugs or other prohibited substances between his committal to Mountjoy Prison on 18th July and 8th September 2013.

69. Prior to and on 8th September 2013 the deceased had significant contact with his fellow prisoners. He did not give any indication by word, action or otherwise to his fellow prisoner that he would attempt to take his own life.

70. At 4.15pm on 8th September 2013 the deceased was locked in his cell. He was on his own.

71. At 4.48pm on 8th September the deceased was discovered as detailed in paragraph 42. He was hanging from a cord with his back to the cell door. The ligature used had been attached to a conduit pipe attached to the ceiling of the cell.

72. There was an immediate response from prison personnel.

73. Within 2 minutes of the alarm being raised prison medical personnel were with the deceased.

74. The prison medical personnel and the prison officers acted promptly and in accordance with acknowledged best practice.

75. Within 10 minutes of the alarm being raised the Fire Brigade Ambulance had entered the prison. This could only be described as an immediate response from the Fire Brigade Service.

76. The cause of death is a matter for the Coroner's Inquest.

77. Contraband such as drugs and mobile telephones are available in Mountjoy Prison.

78. CCTV does not cover all relevant areas of Mountjoy Prison.

Addressing the concerns of the family

79. In paragraph 22, I set out the concerns of the family. In this paragraph I endeavour to address such concerns. In this connection I follow the same numbering sequence as in paragraph 22.

(a) I am satisfied that at this time of great trauma the family felt further traumatised by having to wait as described. However, it must be

acknowledged that Mountjoy Prison is a working prison where security must be paramount. Therefore, while it was undoubtedly distressing the time waiting could not be considered excessive and the searching procedure applies to all persons entering this or any other prison in the State.

(b) I cannot say why it happened. The deceased gave no indication to his family, to his fellow prisoners or to the prison staff that he intended to attempt to take his own life.

(c) The deceased did see a psychiatrist on 5th September 2013 having finalised his own self detoxification on 1st September.

(d) The ligature was attached to a conduit pipe attached to the ceiling of the cell.

(e) It took 10 minutes from the time the alarm was raised until the Ambulance entered the prison. This could only be described as an immediate response.

(f) This is a matter outside my remit. This should be taken up with the hospital.

(g) It would seem a reasonable step for the prison authorities to have washed the deceased's clothes prior to handing them over to the family. It is common practice in all prisons for prisoners to swap clothes.

(h) Prisoner 1 alerted the staff. As detailed in paragraphs 43 to 47 the prison officers and the prison medical staff acted immediately. I will inform the family of the identity of Prisoner 1 prior to the publication of this Report as I have obtained the permission of the prisoner to disclose his name to the family.

(i) I have addressed this in paragraph 46.

(j) This is not a matter that falls within my remit.

Recommendations

1. Further efforts must be made to reduce the instances of drugs, mobile telephones and other contraband in Mountjoy Prison.

2. An audit of the CCTV should be undertaken to ensure that all relevant areas of the prison are covered.