A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner M on 28 July 2015 while in the custody of 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 M on 28 July 2015 while in the custody of Portlaoise Prison.

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

Helen Casey
Office of the Inspector of Prisons

16 June 2017

Preface

The deceased was a 30 year old man who came from the Dublin area.

I offer my sincere condolences to the partner and family of the deceased.

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

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Investigation Report

General Information

1. The deceased was a 30 year old man who came from the Dublin area. He is survived by his Partner, two sons, his mother and siblings.

2. The deceased was committed to prison on 16 September 2014 with a remission date of the 16 March 2016.

3. The deceased did not have regular visits while in prison. However, he maintained telephone contact with his partner.

4. On 28 July 2015 at approximately 21:05 hours the deceased was discovered in an unresponsive state on the floor of his cell, Cell 6 on Unit 1, A Block in Portlaoise Prison.

5. We met with the deceased's partner at an early stage in our investigation to explain our role and to ascertain if she had any concerns. She expressed a number of concerns and as far as possible I respond to these in this Report.

6. When carrying out this investigation we had unrestricted access to all parts of the prison, to all staff, to all prisoners and to all records including CCTV footage.

Meeting with next of kin and concerns raised

7. As part of the investigation, we met with the deceased Partner who informed us that their 15 year relationship had recently broken up due to his drug addiction but they maintained regular contact. She stated that the deceased was not depressed or suicidal.

8. She also informed us that the deceased "*was so against suicide, he would never do it, it was against his religio*n". *Furthermore,* (deceased*) was going back to Wheatfield the next day like he wanted to"*.

9. She stated the deceased was sent from Wheatfield Place of Detention to "*Portlaoise on punishment*" as a result of a fight. She stated that he was accommodated on A Block segregation and he had told her, during a telephone conversation, he "*wanted out of Portlaoise prison".*

The deceased's partner raised the following concerns:

a) Why was it not noticed that the deceased had "*sudden weight loss" as he was* "*feeling sick with blood in his urine*".
b) The deceased "*didn't hit the officer intentionally*" and "*why was (deceased) sent to Portlaoise on punishment".*
c) Why was the Solicitor of the deceased "*refused entry to Portlaoise"* to see his client*?*
d) Please check CCTV from the time he got his tobacco at 17.44 until he was found.
e) How did deceased get a fresh mark on his chin?
f) Why wasn't the deceased checked and shoe laces removed if prison management thought deceased suffered from depression?
g) Why was the deceased in the 'pad' on 26 July?
h) Why were the deceased clothes washed and pressed?
i) Where was the deceased's holy bracelet, which he always wore?
j) Why was there a contribution towards funeral expenses and where did the loose change come from?
k) Why were attempts made to resuscitate the deceased, he was dead and what was the time of death?
l) Was the lace around the neck of the deceased when found?

Status of Prisoner

10. The deceased was an Ordinary Prisoner who was on the Basic Regime from 17 May 2015 to the time of his death.

11. Assistant Governor A confirmed that the deceased *"was on Special Obs"* at the time of his death.

Disciplinary Proceedings (P.19) and the transfer to Portlaoise Prison

12. The deceased was the subject of a Disciplinary Report (P.19) for an assault on staff on 19 June 2015 while in Wheatfield Place of Detention. According to the prison records an officer intervened in an altercation involving the deceased and he "*began throwing punches in the direction of Officer A*". The deceased "*took Officer A to the ground*"

13. The P.19 hearing took place on 21 June 2015 in Wheatfield Place of Detention. According to the records the deceased accepted the report but stated that "*I didn't intend to hurt the officer, I just snapped".*

14. The deceased was sanctioned as follows:-

    a. "Prohibition of Specific Activities/evening recreation

    b. Prohibition personal visits

    c. Prohibition on using money/credit

    d. Prohibition on using phone calls

    Loss of each for 42 days".

15. The deceased was transferred from Wheatfield Place of Detention to Portlaoise Prison on 25 June 2015 for the duration of his loss of privileges, on an arranged 'Chief Officer to Chief Officer Transfer'. That transfer was approved by Irish Prison Service Headquarters.

    Chief Officer A of Wheatfield Place of Detention stated the deceased "*was transferred to maintain security and good order in Wheatfield POD".*

    Chief Officer B of Portlaoise Prison stated in his report that he had been informed that the deceased "*had assaulted a staff member".* He had been asked to "*transfer (deceased) to Portlaoise on punishment for the duration of the sanctions imposed".*

16. Chief Officer C, Portlaoise, contacted Wheatfield Chief Officers by email on 27 July 2015 to arrange the transfer of the deceased back to Wheatfield. Wheatfield agreed to the return transfer of the deceased. Prison Administrative Support

Officer (PASO) A confirms that she was asked to arrange for the transport of the deceased back to Wheatfield Place of Detention. She sent an email to PSEC on 27 July 2015 and sent another email on 28 July 2015 seeking transport to transfer the deceased.

Deceased's contact with Operational staff in Portlaoise Prison

17. The deceased was placed on A Block in Portlaoise Prison. The A Block accommodates prisoners who are on Restricted Regimes including 'Protection Prisoners' and those who have been sanctioned by the Governor for breaching prison discipline.

18. The staff in Portlaoise Prison who had contact with the deceased stated in their reports that the deceased lacked motivation and did not interact well with staff or prisoners. They said he exercised very little and had little interest in keeping himself or his cell clean, they had noted he was not eating very well.

19. Chief Officer D in her report states that she met the deceased twice or three times a day when on duty and describes the deceased as *"very quiet and subdued*" and his "*usual request was to get tobacco from the shop*". She states the deceased "*remained in his cell most of the time*" despite being "*encouraged....to go to the yard but he rarely went outside*". T*he deceased's "personal hygiene" was "not good and his appetite was very poor*". She reports that she "*encouraged"* the deceased to *"wash himself and clean the cell*". She asked the deceased to clean/sweep the landing to get him out of his cell but she reports that "*he showed little interest in this work*".

Deceased's contact with the Medical Services while in prison

20. Committal interview notes of the 16 September 2014 at Wheatfield Place of Detention recorded that the deceased stated he *"smokes 6/7 bags of heroin daily. Looking for detox*". He committed to participating in a Methadone Detox Programme. According to the Prescriptions Chart he was placed on a Detox programme for 21 days from 17 September 2014. The medical notes go on to state that the deceased "*denies thoughts of self harm or suicide*".

21. The Portlaoise Prison, Doctor A, committal notes on the deceased dated 26 June 2015 records, "*Mood is ok, denies any self harm or suicidal ideas. Burning pain in tummy on off, no nausea or vomiting. Smokes 10 cigs per day. On maintenance methadone …. Alert & looks ok*".

22. The notes of Nurse Officer A dated 12 July 2015 record his conversation with the deceased at 06:50 hrs as having "*complained that he has not been eating in cell. Pacing in the cell. Stated to the ACO he does not feel safe in the cell. Reassured re same. Advised he is to see nurse or doctor later today".*

23. The notes of Nurse Officer B dated 12 July 2015 record; "*Seen in exercise yard. mood appears low ... not willing to engage in conversation ... not eating well". The deceased stated that "he wished to see Dr he is not eating well*" and was placed "*on special obs until seen by Dr*".

24. The medical records show the deceased listed for the Doctor's Clinic on the following morning but according to these notes was not seen by the Doctor on the 13 July citing "*out of time*" but the appointment was "*rescheduled as priority for tomorrow*".

25. Nursing notes confirm that the deceased was seen by Nurse Officer C on the evening of the 13 July he records that the deceased "*is feeling low but has no thoughts of self harm. Wishes to see dr in the morning*".

26. The deceased was seen by Prison Doctor B on 14 July 2015. The medical notes, *inter alia*, state that "*Pt stated he cannot hold food in the stomach, eating very little. Checked system and noticed that he did loose weight – 12kgs since last September. No vomits no diarrhoea. I have asked the patient if any bleeding. He stated that when he has his bm he bleeds via back passage. Bld noticed on the tissue. Not feeling depressed – subjectively – objectively apparently mood dysphoric. Denies DSH ideation/intent. Advised the PT for Ensure 1 can tid for 7/7, adv the Pt that Ensure will be only for one week as not an alternative option for food. He needs to start eating. Adv the Pt for Psych r/v pt refuses to see the Psych".*

27. The deceased was seen by the prison Nurses on 15 July. The medical record states that the deceased declined the offer of speaking to the Chaplin and was not leaving his cell for exercise. It is also noted that the deceased stated he was "*ok*" when asked by the nurse on 16 July.

28. The deceased was seen by Nurse Officer B on 24 July at his own request citing *"pain*". The record states that "*when seen, not interested in engaging .... offered to take vital signs but declined*". It is also recorded that the deceased showed *"no signs of perceptual abnormalities or thought disorder ... personal presentation and hygiene very poor*".

29. On 25 July the deceased was again seen by Nurse Officer B at his own request with "*chest tightness*" but the notes state there was "*no obvious symptoms*" and the deceased "*would only allow me take Pulse*". The Nurse goes on to state that the deceased "*Appears uneasy and preoccupied. Superficial cut marks on R wrist. Would not elaborate on same but said his head hurted. Denies any intent of self harm*". The Nurse placed the deceased on Special Obs until seen by the Doctor whom it is noted he refused to see. The deceased refusal to see the Doctor is corroborated by ACO A as follows: "*On Sunday 25th Doctor B attended A-Block to see (deceased) and he declined to see her*". ACO A goes on to say that he "*tried to talk him around but he refused to see her*".

30. On 26 July the Nurse was again called as the deceased stated he was "*feeling unwell..... was making veiled threats regarding self harm..... Such as he "might not be here in the morning to see the Dr*". The records state that the deceased was placed on "*Close supervision for his own safety*". This is corroborated by Officer B in his statement in stating "*Nurse Officer A turned to ACO B and informed him that (deceased) should go to the Close Supervision Cell*" as "*he indicated his intention to self harm*". Officer C, on taking up duty as Night Guard, on 26 July 2015 reports the deceased "*was pacing up and down his cell*" requested a medic as he couldn't sleep. At 21:44:05 Officer C accompanied by ACO B, Nurse Officer A and Officer B escorted the deceased to the search area and placed him in the Close Supervision Cell (CSC) on Unit 1 at 21:46:32. Officer C reports that the deceased "*continuously activated his cell call*" for the

following two hours requesting to be returned to his cell but eventually "*settled down*". CCTV footage shows an Officer carrying out seven checks on the CSC between 21:46:32 and midnight on 26 July 2015. A further 10 checks were conducted between midnight and 8 a.m. on 27 July 2015.

31. On 27 July the deceased according to the report made by ACO C *"the Doctor assessed (deceased) and cleared (deceased) to come out of CSC and return to cell 6 Unit 1".* According to the cell custody record, *"He returned to his cell at 2.30 p.m."* Prisoner had been seen by Dr.C in the CSC.

32. On 27 July at 16:58 hrs the deceased was once again seen by Nurse Officer D at his own request. It is recorded that deceased stated "*that his head is at him ... he was tormented about things but declined to say what*". The notes state that the deceased was asked "*if he had any thoughts to harm himself he stated that he told the doctor he was fine ... as he wanted to come out of the pad.....states that he is not eating and doesn't feel like eating*". The Nurse Officer records that the deceased "*declined any suicidal ideation or thoughts of self harm at this tim*e". The deceased remained on Special Obs. The nursing notes of 27 July have a record that the deceased was again checked by Nurse Officer E at 21:48 who recorded "*he feels better*". At 23:06 hrs on 27 July the deceased called for a medic as "h*e felt that he was dying when he lay down on the bed*". According to the records he was asked "if *he wanted to die or to harm himself in any way...he said "O God no*".

33. Officer D was in charge of Units 1 & 2 A Block on 27 July 2015. He asked Nurse Officer E to check on the deceased while she was in A Block as "*he was pacing up and down the cell".* He reports that ACO B and Nurse Officer E spoke to the deceased. Officer D reports that he was "*uneasy*" so later that night "*asked Nurse Officer E to speak to the deceased*" when she was in A Block, this was approx. 22.30.

34. ACO C together with Chief Officer C and Assistant Governor A spoke to (deceased) on the morning of 28 July 2015 and *"(deceased) requested tobacco*

from the governor's account" which was obtained "*from the Tuck Shop"* and given " *to the (deceased) immediately"* by the Class Officer.

35. Between 11:52:18 and 11:52:50 on 28 July 2015 the deceased had a consultation with the prison doctor. Dr. C made the following entry in the medical Notes at 11:53 – "*Deceased wants Lyrica again, advised that this can't be given".*

36. The deceased was seen on the morning and afternoon of 28 July by nursing staff and again seen at 18:48 where it is recorded that he was not exercising and when asked stated that he was "*ok but felt stressed .... head is wrecked*". The medical notes state that the deceased denied any thoughts of suicide.

Contact with Psychiatric Service

37. The deceased was seen by a Forensic Psychiatrist from the Central Mental Hospital in February 2015 whose notes of the meeting recorded that the deceased previously self harmed but "*denied any current thought, plan nor intent to harm himself*". The Psychiatrist formed the view that there was "*no evidence of major affective or reactive illness at this time*" and discharged the deceased back to the care of the GP stating that "*we will be happy to see him again on request*".

38. The deceased was referred to the Psychiatric Service on Committal to Portlaoise Prison. On 14 July 2015 a response issued from Dr. D, Consultant Forensic Psychiatrist, Central Mental Hospital, to Dr. B, GP, Portlaoise Prison which, inter alia, states that in February 2015 the deceased was "*regarded as not suffering from a major mental illness and returned to the care of the prison GP".* Dr D stated that he would "*not schedule (the deceased) for a psychiatric evaluation until such time you evaluate him to determine whether or not there are new grounds for a psychiatric assessment*".

Dr. D goes on to state that "*it would seem to me that his primary problems are substance misuse related. I am taking him off our psychiatric clinic list unless you determine that there are other reasons why we need to review him*". There

is nothing in the medical records received to indicate if a reply issued to Dr. D, CMH.

39. I have been advised that the deceased was not a client of the Prisons Psychology Service.

40. The deceased continued on the Methadone Programme up until his death.

Sequence of events on 28 July 2015

41. At 08.00 Officers with the food trolley go to cell 6 and offer the deceased breakfast. However, he did not avail of anything from the food trolley. The officers locked the cell door and moved to other cells.

42. At 10:33 Nurse Officer D doing her medical rounds calls to cell 6. Nurse Officer D speaks with the deceased and then leaves the cell.

43. At 10.45 Assistant Governor A and Chief Officer C visit cell 6 as part of the Governor's Parade. After a short conversation, they leave and cell 6 is locked.

44. At 11.44 four officers with two food trollies call to cell 6. The deceased exits his cell and takes some items from the food trollies and re-enters his cell. Cell door closed and officers moved on.

45. At 11.51 an officer calls to cell 6 and opens same. The deceased exits the cell and walks with the officer off the landing to an outer landing where he enters a consultation room to meet Dr C. After the consultation the deceased returns to his cell and the door is again locked at 11:53:17.

46. At 15.46 three officers with the food trolley call to cell 6. The deceased exits his cell and takes some items from the food trolley, then returns to his cell and the door is locked/closed.

47. At 16.19 visited in cell by Nurse Officer D who had a conversation with the deceased about how he was feeling. He stated that he was tormented about things but declined to say what. Advised that he would see the doctor again in

the morning and encouraged him to discuss how he was feeling with the doctor. He was given Ensure and the deceased agreed to go to the yard later.

48. At 17.29 the deceased exits cell and goes across the corridor towards the telephone. The deceased speaks to the officers on the Landing and then returns to his cell and the door is closed.

49. At 17.56 two officers go to cell 6 and open the door and hand goods (shop order) over to the deceased. Cell door is closed.

50. At 18.43 three officers with a food trolley call to cell 6. The door is opened and the deceased exits and he takes items from the trolley and returns to cell. The cell door is closed and locked.

51. Officer E was Night Guard in charge of Unit 1 and commenced duty at 20.00 relieving the Evening Guard Officer F. Officer E states that he was busy dealing with another prisoner who was in the CSC. Officer E stated that the prisoner in the CSC was very agitated and was in a distressed state. He stated that he had to attend to this prisoner on a number of occasions as the prisoner was shouting and pressing the call bell.

52. At 21.00 Officer E explains that he was joined in A Block by Officer G who had been at the staff search area. At this stage Officer E stated that he started his watch tour.

53. On arriving at cell 6 Officer E describes the event as follows:

> *"I discovered prisoner (deceased) face down at the end of his bed on the ground. I called out to prisoner (deceased) several times but got no answer. I then removed my keys from my pocket and banged the door louder with my keys in an effort to get his attention. After getting no reaction I hurried off the Landing to contact ACO B from the Hub of Units 1 and 2 by radio. ACO B informed me that he was just entering A Block. I immediately informed Officer G that we had an unresponsive prisoner in cell 6 on Unit 1. I returned to cell 6 to check on the prisoner again and found him still unresponsive. On ACO B's arrival I informed*

him that deceased was unresponsive when I checked him and we immediately decided to open the cell door. Upon entering the cell we found deceased face down in the floor at the end of the bed. As I was first into the cell I rolled the prisoner onto his back and immediately I (saw) a ligature tied around his neck. I asked Officer G to go and get the Hoffman Knife to remove the ligature. I asked ACO B to get medic as quickly as possible. At the time I tried to break the ligature off his neck but found it impossible to break. I held it away from his neck until Officer G returned. We removed the ligature and commenced CPR until the Medic arrived. On the arrival of the Nurse Officer E informed her of the prisoners condition and for approximately 30 minutes both myself and Officer G assisted the Medic with CPR until the arrival of paramedics.

54. At 21.25 the ambulance paramedics enter cell 6.

55. Doctor E arrived at cell 6. ACO B in charge of Portlaoise Prison states Doctor E MIDOC pronounced the deceased dead at 21.58.

CCTV Recorded events of 28 July 2015

56. There are CCTV cameras located on Unit 1, A Block in Portlaoise prison. However, the practice is to turnoff the landing lights during lock-back. This made scrutiny of the CCTV footage difficult at times. However, I have scrutinised the footage and the following are the activities relating to the deceased and/or his cell:-

08:00:26 Seven Officers with breakfast food trolley on landing go to cell 6. One officer opens cell 6 and appears to converse with the deceased. The deceased did not take any food from the trolley at this time. Cell is closed and officers move to next cell.

09:24:39 Officers on landing – one officer opens cell 6 briefly speaks with deceased and closes cell door.

10:33:29 Nurse Officer D accompanied by three officers doing her medical rounds. Nurse Officer D calls to Cell 6, opens cell door and speaks with deceased.

10:45:58 Governor's Parade – Assistant Governor A accompanied by Chief Officer C on landing and visit cell 6. Door opened and they converse with deceased briefly before closing cell door and moving on.

11:44:54 Four Officers with two food trolleys on landing. They call to cell 6 and the cell door is opened. The deceased can be seen taking some items from the food trolley and going back into his cell. The door is closed and officers move away.

11:51:16 Officer calls to cell 6, opens door and speaks with the deceased. The deceased leaves the cell and walks with the officer off the landing to the outer landing where he enters a consultation room to meet with Dr C. He enters at 11:52:18 and exits at 11:52:50. The deceased is escorted back to his cell and is locked in at 11:53:17.

The deceased is checked five times between 13:14:12 and 15:34:07 (13:14:12, 13:50:46, 14:15:46, 14:31:30, 15:34:07).

15:41:43 The lighting is very poor on the landing.

15:46:33 Three officers call to cell with trolley. Deceased exits cell and takes items from the trolley. He walks out of camera shot then returns to the cell. The cell door is closed at 15:47:55 and the officers move on to the next cell.

16:09:36 Officer goes to the door of cell 6 and looks through the viewer for 8 seconds.

16:19:28 Six officers approach cell 6 and open the door. Four remain on the landing while one stands in the doorway and one enters the cell. The lighting is dimmed and it is difficult to see.

16:20:42 All six walk away from the cell after locking the door.

16:21:12 Four officers return to the landing outside cell 6. One officer opens the door, may have given something to the deceased and almost immediately closes the cell door and all four officers leave (Poor lighting).

16:54:16	Officer checks cell 6.
17:23:15	Officer walks down the landing but does not check the cells.
17:29:21	Officer unlocks cell 6 – second Officer on landing.
17:29:42	Deceased exits cell – walks across corridor towards telephone – does not go to the phone. Speaks with the officers and returns to his cell.
17:31:12	Deceased is locked in cell and officers walk off the landing.
17:56:15	Two officers go to cell 6 – one seems to be carrying 'goods'. Cell door is opened and 'goods' given to the deceased. Cell door is closed and locked.
18:43:02	Three officers with trolley go to cell 6. Door is opened and deceased takes items from the trolley.
18:43:25	Cell door is locked.
21:01:08	Lights on landing turned off – very poor visibility.
21:01:57	Officer checks cells on landing and goes to cell 6 looks in the viewer. He leaves the cell door and leaves the landing at 21:02:43.
21:03:33	Different officer to the door of Cell 6 (Very dark and difficult to see what is happening at the cell door).
21:03:49	Second Officer to the door of cell 6.
21:04:12	Second Officer leaves the landing, running.
21:05:21	Two officers arrive and unlock the cell. ACO B, Officer G, Officer E all enter the cell. Two officers run from the cell almost immediately.
21:06:21	Third Officer runs from the cell.
21:06:39	Three Officers return, running to the cell.
21:07:12	Female Nurse Officer, carrying a bag arrives to the cell.
21:28:01	Ambulance crew arrive at cell 6.
21:34:50	Lighting improves slightly – body of the deceased lying on the landing outside the cell and covered with a blanket.
21:46:20	Ambulance crew leave.
21:57:20	Ambulance crew return, accompanied by the doctor. [1]
22:28:12	Deceased's body is removed by Ambulance crew. The cell is closed and locked.

[1] ACO B in charge of Portlaoise Prison states Doctor E MIDOC pronounced the deceased dead at 21.58

Response to concerns raised by the partner of deceased

57. The partner of deceased raised a number of concerns/queries. As far as possible I respond hereunder to these queries in the same sequence as set out in paragraph 9:-

a) This has been addressed in paragraph 26. The adequacy or otherwise of the medical treatment will be a matter for the Coroners Inquest.

b) I have viewed the CCTV footage of the incident in Wheatfield Place of Detention which is addressed in paragraphs 12 to 15 inclusive.

c) The prison record has the visits recorded as 'cancelled'. I wrote to the Solicitor in relation to this matter on 12 October 2015, sent a reminder on 21 January 2016 and a further reminder by registered post on 14 July 2016 and also contacted the Solicitor's office by telephone. I have not received a response.

d) The CCTV recorded activity of 25 July 2015 is as set out in Paragraph 56

e) There is nothing on the medical records, provided to me, regarding a 'fresh mark' on the chin of the deceased. The Coroner's Inquest would be the appropriate forum to explore the origins of the mark.

f) The medical records disclose that the deceased regularly denied any thoughts of self harm as shown in paragraph 20, 21, 25, 26 and 29. However, on 26 July 2015 when the deceased did make *"veiled threats to self harm"* a decision was made to place the deceased in a Close Supervision Cell. When placed in the Close Supervision Cell the deceased's shoes were removed.

g) The deceased was placed in the Close Supervision Cell on 26 July 2015 as the Nurse Officer had concerns about his well being. The deceased informed Nurse Officer A that "*he might not be here in the morning to see the Dr"* – and that *"he refused to guarantee his own safety".* The deceased was removed from the Close Supervision Cell on 27 July 2015 following medical examination by a Doctor, referred to in paragraph 31.

h) Prison management advised that they felt "*it was the right thing to do*" in returning the clothes to the next of kin to have them laundered and pressed.

i) Portlaoise prison management were unable to confirm whether or not the deceased wore a holy bracelet and advised they could find no mention of same in their records.

j) The Irish Prison Service can make a contribution towards funeral expenses of persons who die in custody, this is normal practice. The loose change was the balance of his gratuity account.

k) It is normal practice to attempt to resuscitate someone found unresponsive. The actual time of death will be a matter for the Coroners Inquest to determine. However Dr E pronounced the deceased dead at 21.58.

l) This is addressed in paragraph 53.

Findings

58. The deceased was an Ordinary Prisoner on the Basic Level of the Incentivised Regime at the time of his death.

59. He was accommodated in a single cell.

60. The deceased had a history of alcohol misuse and had been addicted to illegal substances.

61. The deceased was on a Methadone maintenance programme and was being prescribed methadone up to the date of his death.

62. The deceased did not engage with the Addiction Services in Wheatfield Place of Detention.

63. The deceased was not linked in with the Psychology Services.

64. As soon as the alarm was raised there was an immediate response form the Prison Officers and Medical Staff.

65. From my examination of CCTV footage from 08.00 to 21.00 on 28 July 2015 there are several periods throughout the day when the deceased, who was locked in cell 6 was not checked in accordance with the Standard Operating Procedure relating to these cells.

66. On examination of the Close Supervision Cell records for 26 July 2015 and 27 July 2015 I note that the document is not fully completed. It is inaccurate in that;
(a) it states the placement in the cell was at the deceased own request when in fact the deceased was placed in the CSC by Nurse Officer A and ACO B;
(b) Records show that the deceased was checked in the cell every 15 minutes from 21.00 on 26 July 2015 to 14.15 on 27 July 2015 when this was not the case. While the cell was checked on 29 occasions during that period there were several periods of up to or in excess of one hour between checks contrary to the Standard Operating Procedures.

67. The entries on the prison computer system (PIMS) differ depending on what field is checked. Not all dates correspond between the 'Cell Movement History' and 'Completed Movements' record. The Records show the deceased as placed in a Close Supervision Cell on 27 July and removed on 28 July 2015. The deceased was in fact placed in the Close Supervision Cell on 26 July and removed on 27 July 2015.

68. On checking the CCTV footage, I found no evidence that the officers finishing Day Duty or commencing Night Guard Duty in A Block Portlaoise Prison, carried out checks on cell 6 between 18:43:25 and 21:01:57 on 28 July 2015.

69. The deceased was subject to a disciplinary hearing (P.19) and awarded sanctions for 42 days as set out in paragraph 14. In addition to the sanctions imposed at the hearing it would appear a further sanction was imposed in that the deceased was transferred to Portlaoise High Security prison for 42 days, on agreement between the Chief Officer in Wheatfield and the Chief Officer in Portlaoise and approved by Irish Prison Service, HQ. While in Portlaoise Prison he was placed on a restricted regime referred to in a number of statements as a "Punishment Transfer".

70. Lighting on the landing was poor, at times almost dark, so it was very difficult to identify personnel or see what activity was taking place.

71. The deceased did not leave a note.

72. The cause of death is a matter for the Coroner.

Recommendations

1. Irish Prison Service Management should ensure that they implement their own written policies and where these policies are breached, as in this instance, that appropriate disciplinary investigation be conducted and those who failed to carry out their duties be held to account.

2. Irish Prison Service Management should address the poor record keeping. Governors should ensure that regular audits of all records are carried out to ensure compliance. Incomplete and inaccurate record keeping regularly feature as a finding in our reports as does a recommendation to have this addressed.[2]

3. Movements of prisoners between prisons or between cells in a particular prison should be properly recorded in the relevant Journals and on PIMS in order that any authorised person can track such movements for a particular prisoner for a particular period of time. Immediate steps should be taken to remedy deficiencies in this area.

4. Local Management in requesting approval for a prisoner transfer should ensure these transfers are not used as a means of further punishment. If, on occasion, incomplete information on the circumstances surrounding the request for transfer is provided to Operations Directorate (the authorising authority), the Governor of the Prison should be held to account.

5. The practice of turning off all landing lights during periods of lock-back should be discontinued forthwith. It may not be necessary to have a full compliment of landing lighting during lock-back however, there should be sufficient light to enable the identification, by means of CCTV, of personnel and relevant activity in any part of the prison. The recommendation should be implemented across

[2] E.g. Report Ref No. 2014/M – Prison Personnel must appreciate official documents must reflect the truth of action taken by officers.
2015/C – Proper, adequate & appropriate records must be maintained.
2015/P – Prison Staff must understand that it a serious matter to generate official documents that are misleading and/inaccurate.
2016/A – The poor level of record keeping should be addressed by the Irish Prisons Service. This may require some In-service training or some other on the job training as poor record keeping has been raised as a concern in a number of previous Death in Custody Reports.

all prisons in the event that the practice as outlined above is operating in any other prison it should be stopped forthwith. If energy conservation is the basis for switching off landing lighting during periods of lock-back consideration should be given to the installation of a motion detection lighting system in all prisons.

6. On any occasion where a medical consultation is of a very short duration and for the purpose of clarification it would be desirable that the Clinician put a note on the Medical file(s) to set out the circumstances in that particular case.