A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner N on 27 December 2014 in Limerick Prison

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

Office of the Inspector of Prisons
24 Cecil Walk
Kenyon Street
Nenagh
Co. Tipperary

Tel: + 353 67 42210
Fax: + 353 67 42219
E-mail: info@inspectorofprisons.gov.ie
Web: www.inspectorofprisons.gov.ie

Office Ref: 2014/N

A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner N on 27 December 2014 in Limerick Prison

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

Judge Michael Reilly
Inspector of Prisons

27 July 2014

Preface

Prisoner N was a 25 year old unmarried man who died in Limerick Prison on 27 December 2014.

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

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

Judge Michael Reilly
Inspector of Prisons

27 July 2014

Inspector of Prisons Investigation Report

Introduction

1. The deceased was a 25 year old unmarried man who came from the Munster area.

2. He is survived by his parents, his siblings, partner and son.

3. The deceased was committed to prison on 21 February 2012. His release date was to be 19 December 2023.

4. The deceased had served a number of terms of imprisonment prior to his most recent committal.

5. The deceased was found in an unresponsive state in his cell in Limerick Prison in the early hours of 27 December 2014.

6. I met the deceased's parents at an early stage of my investigation and have responded in this report to concerns raised by them.

7. In carrying out my investigation I had unrestricted access to all parts of the prison, to all records held in the prison, to all medical records and relevant CCTV footage. I also had access to appropriate members of staff, others working in the prison and to prisoners.

Meeting the deceased's family

8. I met the deceased's mother and father at an early stage of my investigation.

9. They informed me that their son had left school after completing his Junior Certificate and had been in and out of prison for many years – mostly for public order offences.

10. I was informed that the deceased had a history of alcohol abuse from his early teenage years but that he never took drugs apart from some *'hash'*.

11. I was informed that the deceased *"got a bad beating"* numbers of years ago and that he was fortunate to survive. The family told me that the deceased was *"a different kind of chap after the beating"*. They told me that the deceased's doctor had to put him on medication to enable him sleep.

12. The family informed me that their son had been shot by a person or persons unknown about two years previously and that he had shot gun pellets in his body.

13. I was informed that the deceased had completed many courses while in prison including the Red Cross course, an anger management course to name but two and that he was a regular attendee in the prison workshops.

14. His parents and extended family visited him on a regular basis in prison and he was in almost constant telephone contact with his family. He was last visited in prison on the Saturday before Christmas – 20 December 2014.

15. The deceased worked out in the gym on a regular basis and was engaged in body building exercises.

16. I was informed that the deceased had told one of his sisters that he had a pain in his heart and thought there was something wrong with his heart. He also told his sister that *"his legs were killing him"* but the family attributed this to the amount of exercise he was taking.

17. The family raised the following concerns that they wished me to investigate:-

    (a) They wanted to know if their son had medical problems.

(b) They were aware that he worked out a lot in the gym and questioned if this could have been the cause of his death as he had told them his legs "*were killing him*".

(c) They wanted to know if he had heart medical problems as he had told his girlfriend that he had a pain in his heart.

(d) They asked why it took so long for the priest to be called. They asked if their son had been brought to the chapel in the prison.

(e) They asked if the deceased was in a cell on his own.

(f) They wished to know who had given the papers the information that was printed which upset them.

Deceased's status in prison

18. The deceased was an ordinary prisoner on the enhanced regime level at the date of his death. He attended workshops, the school and the gym.

19. He was well behaved and had no recent P.19's.

20. He was well respected by prison staff and his fellow prisoners.

21. He was accommodated in a single cell – cell 19 on C4 Landing.

Deceased's contact with medical services

22. In view of certain concerns raised by the deceased's family relating to his medical condition it is relevant that I disclose certain details of contacts that the deceased had with the medical services while in prison. For privacy reasons I confine myself to those medical details that are necessary to disclose in order to address the family's concerns.

23. I have confined my examination of the medical records maintained in the prison to the period of the deceased's last committal to prison – 21 February 2012.

24. I should point out at this juncture that the deceased was, for operational and other reasons, transferred between various prisons during the currency of his last imprisonment.

25. The deceased had significant contact with the medical services while in prison. These contacts can be summarised as follows:-

(a) On his initial committal and on his subsequent transfers between prisons the deceased was assessed by both doctors and nurses and relevant entries generated on the PHMS computer system.

(b) The assessments referred to at (a) above were comprehensive. In all cases a case history was taken. The deceased was not diagnosed as suffering from any illness.

(c) From the date of his committal to prison on 21 February 2012 the deceased complained of periodic acute pain from gunshot wounds. The medical notes document significant scarring which resulted from such wounds. He was prescribed medication for this pain.

(d) The deceased was diagnosed with depression. He was referred to a consultant psychiatrist and was treated for this depression. In essence he had incidents of flash backs which were related to the offence on which he was committed to prison. He found it hard to sleep. He also visualised being beaten by men. This was attributed to the beating he was subjected to and referred to in paragraph 11. The last contact that the deceased had with the psychiatric services was on 21 January 2014.

(e) The deceased attended for one session with an addiction counsellor in March 2012 but did not attend thereafter.

(f) The deceased attended the prison dentist but this is not relevant to this investigation.

(g) The deceased's last contact with a doctor was on 11 November 2014. The deceased never complained to any doctor in any prison of a pain in his heart or any other heart related illness.

(h) The deceased's last contact with the nursing services in Limerick Prison, apart from contact when he was getting his daily medication,

was on 10 November 2014. The deceased never complained to any nurse officer of a pain in his heart or any other related heart problems.

(i) The deceased was in receipt of two types of medication each day – one to be taken in the morning and one in the evening. I have examined his medicines chart and can confirm that he attended regularly for his medication. I will inform the deceased's family of the nature of this medication prior to the publication of this report.

Events prior to 26 December 2014

26. The deceased's last visit from his family was on the Saturday before Christmas – 20 December 2014. Nothing untoward transpired at that visit.

27. There were no issues prior to 26 December 2014 that could have signalled, either directly or indirectly, the events that led to the death of the deceased on the night of 26/27 December 2014.

Telephone calls

28. The deceased telephoned his mother and other members of his family almost on a daily basis. On certain days he made more than one telephone call. These were calls on the prison telephone system. Such calls are recorded and can be monitored. This fact is known to all prisoners.

29. On 26 December 2014 the deceased made three telephone calls as follows:-

(a) At 18.31.55 he telephoned his mother. The call lasted 45 seconds. Nothing of relevance was discussed.

(b) At 18.46.08 he telephoned a friend. This call lasted for 7 minutes 20 seconds. The tenor of the call was that the deceased was lonely and urged his friend to arrange a prison visit for the following Monday for a number of people. There is no mention of any nefarious activity during this call. Matters of general family interest were discussed.

(c) At 19.00 hours he telephoned his mother. The tenor of the call was that he wanted his mother to ensure that those that he wished to visit

him on the following Monday would in fact visit him. His mother enquired – *"you sound, you sound very down in yourself today"*. The deceased replied – *"No I'm not down at all mother. Mother tell you the truth I was having a party last night and I'm just sick really"*.

Sequence of events on 26/27 December 2014

30. The events of 26/27 December can be divided into three separate segments, namely, the hospitalisation of a number of prisoners who had ingested hand sanitizer, suspected drug dealing in one of the prison yards and the events relevant to the deceased.

31. I have not been able to ascertain if the first of these events referred to in paragraph 30 was directly connected to the third event. However, it is relevant that I refer to all three.

Hospitalisation of a number of prisoners

32. At approximately 16.00 hours on 26 December Nurse Officer A reported that a prisoner in the kitchen was very ill and severely inebriated as he had consumed hand sanitizer. The Nurse Officer called an ambulance and the prisoner was taken to hospital.

33. At approximately 17.05 hours another prisoner became very ill and had to be taken by ambulance to hospital on the orders of Nurse Officer A. This prisoner was also severely inebriated as he had consumed hand sanitizer.

34. At 17.30 hours approximately another prisoner became so unwell that he also had to be taken by ambulance to hospital. This prisoner left the prison under escort at approximately 18.00 hours. This prisoner was also severely inebriated as he had consumed hand sanitizer.

35. Chief Officer A was the Chief Officer in charge of Limerick Prison on 26 December. He organised the escorts for the three prisoners referred to in paragraphs 32, 33 and 34. He required nine staff for such escorts and had to –

"conscript staff" for the final escort *"as there was no one volunteering for this escort"*.

36. Subsequent to 18.00 hours a number of other prisoners had to be attended to by healthcare staff as they were also feeling unwell many of them having consumed hand sanitizer.

37. Chief Officer A instructed OSG officers to carry out a full search of the kitchen area for any further containers of sanitizer. A number of milk cartons containing hand sanitizer and orange juice were found. An empty five litre sanitizer container was also recovered.

38. On the instructions of Chief Officer A, a number of cells on the C Division were searched. A number of milk cartons containing the sanitizer/orange mix were found.

39. At approximately 19.20 hours Chief Officer A was informed by Nurse Officer A that a female prisoner was unwell and would have to go to hospital. He arranged an escort and this prisoner left the prison at 20.05 hours approximately.

40. When the escort referred to in paragraph 39 had left the prison eleven staff and four prisoners were at the hospital.

41. In his statement Chief Officer A described the atmosphere on the C Division as being tense with *"a lot of prisoners appearing to be under the influence"*.

42. In other searches that evening a quantity of tablets was recovered.

<u>Suspected drug dealing in prison yard</u>

43. A significant number of prisoners were taking exercise in the C Yard on the evening of 26 December. Among them was the deceased.

44. Officer A who was on duty in the Control Room of the prison and monitoring the CCTV described the scene as follows:-

> *"During the reserve period 5.30 pm – 7.30pm I observed a number of prisoners during the course of the evening entering the toilet area of C Yard. They appeared to be exchanging contraband. I informed the ACO / Supervising I/C C Wing of what I had observed. Prisoner* (deceased) *was one of the prisoners I observed entering the toilet area".*

45. CCTV footage corroborated the account given by Officer A referred to in paragraph 44. The following information gleaned from the CCTV footage is relevant to this investigation:-

18.50.00	A considerable number of prisoners were in the C Yard. They were walking around and congregating in groups. A number of prisoners appeared to be 'on edge'.
18.59.00	A number of prisoners went into the toilet cubicle. There is a half door on this cubicle. The top half of their upper bodies and the bottom half of their legs could be seen. The prisoners could be clearly seen as the CCTV was, at that time, being operated manually.
18.59.50	At this time there were six prisoners in the toilet cubicle. The prisoners could be seen standing in a circle and in animated conversation. During the next two minutes various prisoners looked in over the door of the toilet cubicle.
19.03.00	The deceased entered the toilet cubicle.
19.04.37	A prisoner appeared to have something in his hand. Some prisoners left the cubicle.
19.04.37	All the prisoners left the cubicle.

Between 19.04.37 and 19.08.19 it is obvious from the CCTV footage that many prisoners in the yard were in a state of high excitement. They gathered in groups. One or two prisoners went from group to group. There was much hand shaking.

19.08.19	Four prisoners including the deceased entered the toilet cubicle.
19.10.58	Four prisoners including the deceased appeared to be examining a small plastic bag containing a white substance.
19.11.26	Prisoners suddenly left the cubicle.

46. Chief Officer A stated that he was informed that prisoners were congregating in the C Yard and it was suspected that contraband was being distributed. This statement of the Chief Officer corroborated the statement of Officer A that he had relayed his observations of unusual activity in the C Yard.

47. The CCTV footage from the C Yard corroborated the statement of Chief Officer A in that it shows the Chief Officer entering the yard at 19.11.46.

48. I should point out at this juncture that the manual operation of the CCTV had the effect of focusing in on the activities in the toilet cubicle and on groups in the yard on that evening. By slowing down the playing of the CCTV footage it was possible to get clear pictures of all those involved in the activity described in paragraph 45.

49. **It does not fall within my remit to investigate the activities of prisoners or their unorthodox behaviour which could be related to the distribution of contraband as outlined in paragraphs 43 to 48. I refer to this aspect in my recommendations in paragraphs 1 and 2.**

<u>Events relevant to the deceased</u>

50. Numbers of prisoners and prison staff provided statements in connection with this investigation.

51. Prisoner A stated:-

> *"I'm not a fool. He was under the influence. He was down over Christmas. He would be singing alone after lock-up but not this night".*

52. Prisoner B stated:-

> *"He told me he had D/10s (internet tablets) crushed and he felt he had too many and he had also taken methadone. The reason they were crushed is that (name of another prisoner) was making a 'rip'".*

53. It is not possible to give a timeline for the events described by prisoners referred to in paragraphs 51 and 52, as the prisoners were unclear as to times.

54. Officer B observed the deceased at times during the day as he was class officer on C4 Landing. He stated that he did not notice anything *"unusual about his behaviour, demeanour, appearance etc. He was his usual self".*

55. Officer C stated that – *"at tea time I did my regular checks to find* (deceased) *dancing to music in his cell".*

56. Officer D stated that on the night of 26 December he was assisting the master locking of the C Division. He stated that he checked the deceased and that *"he appeared fine".*

57. Nurse Officer B stated that while issuing night medication at approximately 20.15 hours in the C Wing he met and spoke to the deceased and issued him with his night medication. Referring to the deceased he stated – *"he appeared alert, in good form, orientated and his health did not seem in anyway compromised".*

58. There are CCTV cameras located in the C Division and in particular on C4 Landing. However, it is the practice in Limerick Prison to turn off the landing lights during periods of night lock down. This made scrutiny of the CCTV extremely difficult from 21.05.27 on the night of 26 December until 04.05.02 on the morning of 27 December 2014. However, I have scrutinised the CCTV footage and the following appear to be activities on C4 Landing as they relate to the deceased and/or his cell:-

21.05.27	Lights out – Officer starts his checks on the landing.
21.07.30	Officer checks cell 19.
22.21.40	A faint light appears. An officer seems to be checking cells as a silhouette of a man is seen moving from cell to cell.
22.33.25	Officer appears to be checking cell 19.
22.58.32	An officer is seen walking down the landing on the opposite side of the landing to the deceased's cell.
00.03.21	Officer is seen on the landing checking cells – Cannot see what he does but he walks off the landing at 00.04.15.
01.01.25	The landing is in darkness. An officer appears to be checking the cells.
02.06.48	An officer is seen and appears to be checking the cells. The officer appears to be on the landing on the same side as cell 19 and goes up and down the landing a couple of times but it is not clear what he is doing or if he is at any particular cell. He walks off the landing at 02.11.32.
02.21.14	Officer walks down landing on the same side as cell 19. As the landing is in darkness, it cannot be confirmed if he checks the cells. He leaves the landing at 02.22.35.
02.59.10	Officer checks cell 19 by shining a torch into the cell.
03.53.04	The landing is in darkness. An officer is seen on the landing checking cells with a torch. He checks cell 19.
04.04.26	There is movement on the landing – It is not clear due to the darkness what is happening but some officer / officers are on the landing in the vicinity of cell 19.

04.05.02	Lights are turned on, on the landing.
04.05.37	Two officers arrive outside cell 19.
04.05.48	One officer looks into cell 19 through the viewing hatch.
04.05.53	One officer walks off the landing and the other officer remains outside cell 19.
04.07.35	Two officers arrive and unlock cell 19 and then all three officers enter cell 19.
04.08.49	3 officers exit the cell – one officer leaves the landing and the other 2 immediately re-enter cell 19.
04.11.03	An office arrives and enters cell 19.
04.11.40	3 officers can be seen exiting cell 19 as a 4th officer approaches on the landing. One officer leaves (ACO in shirt) two re-enter and the officer seen approaching stays outside door of the cell.
04.21.33	Ambulance personnel are seen approaching and entering cell 19. A group of officers are at door on the landing.
04.27.25	Focus of the camera changes and it zooms in onto door of cell 19. ACO and 3 officers on the landing are speaking with one of the paramedics. There are others in cell 19. (1 officer in t-shirt – appears to be a medic).
04.34.09	Paramedics leave the Landing with their equipment.

59. It was not possible to identify any individual officer or officers during the period that the lights had been turned off. Neither was it possible to be certain that other relevant activity had not occurred on the landing in the relevant period.

60. Officer D stated that the deceased *"was fine"* when the C Division was master locked on 26 December.

61. Officer E stated –

> *"While relieving on C Division I checked* (deceased) *Cell 19 C4 at approx 3.50 am. I looked through the observation slot.* (Deceased) *seemed to be asleep on his bed but did not look quite right. I contacted ACO A to come to C4 with the master key to enter the cell and check more closely. Officer F came to C4 and waited on the landing for ACO A and I went to D Division".*

It would appear from the timelines set out in paragraph 58 that the time Officer E checked the deceased was at 03.53.04.

62. Officer F stated:-

> *"At 04.00, I entered cell 19 C4 along with ACO A and Nurse Officer B. This was* (deceased's) *cell. The prisoner was non-responsive, appeared not to be breathing so we began first aid. Nurse Officer B asked me to go to the surgery for the difibulator. Paramedics arrived to the cell at 04.20.".*

It would appear from the timelines set out in paragraph 58 that Officer F entered the cell at 04.07.35.

63. ACO A stated:-

> *"At approx 3.55 am I was called to C4 Landing Cell 19 as Officer E was concerned about* (deceased). *While on my way I called Nurse Officer B to meet me on C4. On arriving N/Officer B and I went to Cell 19 accompanied by Officer F. On opening the cell I observed* (deceased) *lying prone on his bed. Nurse Officer B started CPR and I contacted radio base and instructed the officer i/c to call the ambulance service".*

It would appear from the timelines set out in paragraph 58 that ACO A entered the cell at 04.07.35.

64. The statement by ACO A that he received a call to go to C4 Landing at 03.55.00 approximately corroborates, to a degree, my statement in paragraph 61 that it was likely that Officer E's check on the deceased was at 03.53.04.

65. Nurse Officer B confirmed that he was a nurse officer on duty on the night of 26/27 December 2014. He confirmed that he was contacted at approximately 04.00 hours on 27 December and instructed to go to C4 Landing immediately. He entered cell 19 and described the situation as follows:-

> *"Observed* (deceased) *lying prone on bed, nil signs of respiration and foamy mucus around the mouth. O/e warm to touch, nil carotid pulse present and nil pin point pupils. Commenced chest compressions immediately, cleared airway and requested Officer F to go to the surgery and collect defibrillator. Continued with chest compressions. Defibrillator applied, nil cardiac rhythm detected and nil shock applied. Continued with chest compressions, defibrillator continued to register nil cardiac rhythm and nil shock applied. Continued with chest compressions. No signs of respiration, nil carotid pulse present and nil cardiac rhythm detected. Paramedics arrived. Gave a clinical handover and handed over charge. Paramedics unable to revive* (deceased) *and discontinued CPR".*

66. I was informed that drug paraphernalia was found in the deceased's cell.

67. The deceased was pronounced dead in the prison at 05.21 hours on 27 December 2014 by Dr. A.

68. The prison chaplain was contacted and he attended at the prison at 06.45 hours on 27 December in his pastoral capacity.

Other relevant information

69. The deceased was not on a methadone programme in the prison.

70. I was informed that there was a rumour in the prison that the deceased had consumed another prisoner's methadone at some time during 26 December. I could not verify the accuracy of this rumour.

71. However, methadone was detected following an analysis of the deceased's blood.

Post Mortem

72. A Post Mortem was carried out on the body of the deceased on 27 December 2014.

73. I understand that evidence of polydrug use was detected with heroin, diazepam, alprazolam and methadone being the drugs involved.

Obligation to check prisoners during periods of lock down

74. The deceased was classed as an ordinary prisoner. As such the prison authorities were under an obligation to check on him every hour during periods of lock down.

Addressing the concerns of the family

75. In paragraph 17, I set out certain concerns that the family wished me to address. In this paragraph I endeavour to address such concerns. I adopt the same numbering sequence as in paragraph 17 as follows:-

(a) I have addressed this issue in paragraph 25.

(b) While the cause of death is a matter to be determined by the Coroner at his Inquest the deceased's activity in the gym was not a contributing factor in his death.

(c) The deceased did not complain of any related heart problems to any member of the medical team in any of the prisons where he was accommodated.

(d) The priest was called immediately following the death of the deceased and he arrived at the prison shortly thereafter. The deceased was not brought to a chapel in the prison.

(e) The deceased was in a cell on his own.

(f) I have been unable to identify the source of the information that appeared in the papers subsequent to the death of the deceased. I acknowledge that the information did cause great distress to the family of the deceased.

Findings

76. The deceased was a well behaved, well thought of prisoner who attended the prison workshops, attended the school and worked out in the gym. He secured many complimentary certificates on his completion of therapeutic and other courses.

77. The deceased was accommodated in a single cell at the date of his death.

78. The deceased had significant contact with the medical services while in prison. He was medically treated. However, his prior medical problems and his treatment were not relevant to his death.

79. Many prisoners on the C Division were intoxicated on 26 December having ingested hand sanitizer mixed with orange juice.

80. The prison was under-staffed on the night of 26/27 December due to the unexpected transfer of four prisoners to hospital which necessitated the deployment of eleven prison officers as escorts for such prisoners.

81. There was irregular activity in the C Yard on the evening of 26 December which appeared to be the possible distribution of contraband, namely, drugs. The deceased was part of that cohort of prisoners who were engaged in such activity.

82. The Chief Officer in charge of the prison on 26 December took all appropriate action to deal with the many unexpected situations that arose in the prison on that date.

83. From the time that the deceased was locked into his cell for the night on 26 December to the time that he was found in an unresponsive state, it is reasonable to assume that the deceased was checked in accordance with the checking procedures, having regard to activity on C Landing, referred to in paragraph 58.

84. When the deceased was observed at 03.53.04 he seemed, to the prison officer, to be asleep. However the officer had some concern and wished to have the cell opened. This was a correct decision.

85. After officers entered the deceased's cell at 04.07.35 and found the deceased in an unresponsive state there was an immediate and appropriate response from both the medical personnel and the operational staff.

86. CPR was commenced immediately, the defibrillator was applied and CPR continued until 04.34.09.

87. The deceased was pronounced dead at 05.21 hours on 27 December 2014.

88. Drug paraphernalia was found in the deceased's cell.

89. While the cause of death is a matter for the Coroner at his Inquest I understand that the deceased died as a result of the ingestion of vomit following polydrug use as described in paragraph 73.

90. I am not aware of the provenance of the drugs ingested by the deceased. I refer to this in more detail in my recommendations in paragraphs 1 and 2.

91. The turning off of the lights on C4 Landing made the identification of officers and the observation of their activities extremely difficult.

Recommendations

1. Prison management in Limerick Prison must carry out a thorough investigation into all the circumstances of the unusual activity in the C Yard on the evening of 26 December referred to in paragraph 45.

2. The contents of this report, in so far as they relate to the events in the C Yard referred to in paragraph 45, should be brought to the attention of An Garda Síochána. However, this should not delay the publication of this report.

3. The practice of turning off all landing lights during periods of lock-down should be reversed forthwith. It may not be necessary to have a full compliment of landing light during such periods. 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. This recommendation should be observed by any other prisons that, at present, adopt the practice of turning off lights during periods of lock-down.