A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner S on 13 October 2015 in Midlands 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
E-mail: info@inspectorofprisons.gov.ie
Web: www.inspectorofprisons.gov.ie
Office Ref: 2015/S

A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner S on 13 October 2015 in 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

27 May 2016

Preface

The deceased was a 41 year old man who died in the Midlands Prison on 13 October 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

27 May 2016

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 41 year old man who came from the Mid-West Region. He is survived by his mother, father, brothers, sisters, children and extended family.

2. The deceased was a life sentence prisoner who was committed to Limerick Prison on 24 July 2013. He was transferred from Limerick Prison to Portlaoise Prison on 16 April 2015 and was transferred from Portlaoise Prison to the Midlands Prison on 10 September 2015.

3. On the evening of 13 October 2015 the deceased was discovered in his single cell (Cell 3 on D2 Landing) in an unresponsive state with a ligature around his neck which was attached to the back of the cell door. The deceased was pronounced dead in the prison at 20.15 hrs by Doctor A.

4. I met the deceased's family in their home town at an early stage of my investigation and have responded, where possible in this report, to the concerns that they wished me to investigate.

Concerns of the family

5. The family informed me that the deceased was very outgoing and had lots of friends. They further stated that "*he struggled with alcohol from a young age and took drugs*" and had attended an Addiction Treatment Centre on a number of occasions. I was also informed that he had "*served a lot of time in prison, that he had suffered depression but had attended counselling and the Psychology services while in prison"*.

6. The family informed me that the deceased had two voluntary short admissions to a hospital in his home town approximately 6 years ago for intoxication and suicidal thoughts. He self discharged each time.

7. I was informed that the deceased was a member of the Red Cross in prison and had received a number of certificates of achievement including one for First Aid. He attended the school on a regular basis and had passed a number of subjects in the Leaving Certificate. The deceased did not attend school on the day he died.

8. I was further informed that the deceased had received a visit from his sister on 9 October 2015 in the Midlands Prison. He received regular visits from his family while in Prison. He telephoned his family regularly. They also stated that he had not by his actions, words or otherwise intimated to them that he was contemplating attempting to take his own life. The deceased left a suicide note in his cell which had been passed to the family. While the contents of this note are not relevant to this investigation they helped provide some closure for the family on their sad loss.

9. The family told me that he had no access to his children and this was very difficult for him.

10. The family raised the following concerns:-

    (a) Why was he transferred out of Limerick Prison to Portlaoise Prison on 16 April 2015? Their understanding was that he had appealed against the decision to transfer him from Limerick Prison.
    (b) Why was he transferred from Portlaoise Prison to Midlands Prison on 10 September 2015?
    (c) What Counselling and Psychology care did he receive while in prison?

11. The family wished to state that the deceased was treated very well while in prison and they wanted this to be noted.

Status of the deceased in Prison

12. The deceased was an ordinary prisoner who was on the enhanced status level of the Incentivised Regime at the time of his death. He engaged well with the services and supports available to him. The deceased was not employed or held any other duties in the Midlands Prison.

Deceased's contact with medical and therapeutic services

13. I received permission from the deceased's next of kin to examine the deceased's medical records. I examined the medical records for the period 24 July 2013 (date of his last committal) to the date of his death. I also sought information on any contacts the deceased may have had with the Psychiatric, Psychology and Counselling Services while in prison.

14. The deceased had regular contact with the medical services in Prison from the period of his last committal to the date of his death. The deceased was not on the Special Observation list at the time of his death although he had been placed on the Special Observation list on a number of occasions in the past.

15. The deceased was seen on committal to Limerick Prison on 24 July 2013 by Doctor B . The medical notes stated:-

> "*new comm*
> *Well known to Limerick prison*
> *For Zimovane 7.5 and Librium 10mgs*"

16. On 30 July 2013 the deceased was seen by Psychiatrist A and declined an assessment. He was referred back to the Prison GP. He was again seen by the Psychiatric Team on 3 September 2013 and by Psychiatrist A on 16 December 2014 where his medication was adjusted.

17. On 14 April 2015 the deceased was referred to Psychiatrist B. The deceased was "*verbally loud, aggressive and intimidating*" and demanded medications from the Psychiatrist. The Psychiatrist stated that there was "*no active mental*

illness" and discharged him back to the Prison GP. The behaviour of the deceased was reported to the Governor and he was dealt with under the P19 disciplinary code and transferred to Portlaoise Prison on 16 April 2015. I refer to this aspect in Paragraphs 29 to 30.

18. No nursing committal interview was conducted in Portlaoise Prison on 16 April 2015. The deceased was considered a "*transfer committal*". Portlaoise Prison has a contingency plan for the management of "*transfer committals*". This policy is in place for times when staffing is low or when workload prevents full screening of "*transfer committals*". The Policy states:-

> *"Transfer committals will be seen for full screening if this is possible. However, it must be recognised that a full committal screen takes upwards of 15 minutes to complete (if/where) the prisoner does not have complex health needs and does not require the nurse to follow up with the enquiries to hospitals, clinics etc.*
>
> *Given that every effort will be made to see all committals, 'fresh' committals will be given priority and must under go committal health screening in accordance with Healthcare Standard 1. In the event that it is not possible to see all transfer committals, healthcare staff will review the already existing information on prisoners. Only those with extant health risks will be seen for screening. Of particular importance will be those with a history of self harm or suicide attempt, or with unstable chronic diseases. All will be scheduled and seen by the doctor the following day"*

19. However, the deceased was placed on special observation on 16 April 2015 on arrival at Portlaoise Prison as a new committal.

20. The deceased was seen in Portlaoise Prison on 17 April 2015 by Doctor C who noted in the medical notes:-

> "*Committed yesterday by transfer from Limerick prison*
> *Today general appearance ok*

No health concerns today
repx lyrica 50 mg tid
d/c zispin as the pt didn't take the same for a while and declines, to take it, agreed
denies self harm/suicidal ideation/plan
denies taking illicit substances"

21. He was removed from the special observation list in Portlaoise Prison by Chief Nurse Officer A on 17 April 2015 subsequent to the Doctor's assessment referred to in Paragraph 20.

22. The deceased was transferred to Midlands Prison on 11 September 2015 and was seen by Doctor D who noted in the medical notes:-

"Committed yesterday by transfer from Portlaoise Prison
No health concerns today replx lyrica 50 mg twice daily
Dc zispin as the pt didn't take same for a while and declines to take it,
Agreed denies self harm/suicidal ideation/plan
Denies taking illicit substances, good health and eating and drinking normal"

23. The deceased was on medication at the time of his death and was relatively compliant in taking his medication. The deceased did not have regular contact with the Doctors in Portlaoise Prison and Midlands Prison.

24. The deceased was seen by medical staff in Limerick Prison, Portlaoise Prison and Midlands Prison for minor conditions not relevant to this investigation.

25. On 5 November 2014 in Limerick Prison, the deceased was referred to the IPS Psychology Service. He was seen on 6 November 2014 for an "*initial session*" with Psychologist A.

26. Psychologist A stated that he met the deceased while on a previous sentence who was complaining of having sleep difficulties. Psychologist A noted that

the deceased "*was under the care of forensic psychiatry and had previous hospitalisations for depression but noted no suicidal episodes or history of self harm"*. The deceased was compliant with medication. He was "*reticent throughout this contact with Psychology (on remand) and unwilling to go into detail in sessions*". The deceased engaged in a total of 3 sessions with the Psychology Service. The deceased was discharged from Psychology Services because he was seeking "*psychotropic intervention rather than psychotherapy to address sleep difficulties and anxiety*". The Psychology Service referred the deceased back to Psychiatry.

27. The deceased had no contact with the Psychology Service in either Portlaoise Prison or Midlands Prison.

28. The deceased was also referred to the Addiction Counsellor and had attended approximately 17 counselling sessions in Limerick Prison from 30 September 2013 to 10 April 2015 His case was closed on 5 May 2015 as he was no longer a prisoner in Limerick Prison.

Significant events prior to 13 October 2015

29. The deceased was transferred from Limerick Prison to Portlaoise Prison on 16 April 2015. I was informed that the transfer was arranged on a "*Chief to Chief basis*". This transfer took place following the deceased's P19 disciplinary hearing for "*threatening abusive and insulting behaviour*" towards the Psychiatrist in Limerick Prison on 15 April 2015.

30. The record of the hearing attributes the following to the deceased:-

> *"I was called to the medical floor to see the psychiatric team. I told them I did not want any medication. I did not take the medication. The medication was changed three times in six months. I did not agree with what he said. I may have got up and held the door before he went out*"

Governor A recorded his findings in the following terms:-

"This medical professional is very experienced and he was concerned for his safety. Your actions of going to the door and holding it was deemed threatening..... You cannot self-prescribe and or take medication one minute and not take it the next"

Governor A imposed the following sanction on the deceased:-

"Prohibition on Specific Activities/Evening Recreation – 14 days
Prohibition on using money/credit - 14 days"

The deceased was transferred to Portlaoise Prison as referred to above.

31. The deceased remained in Portlaoise Prison until the he was transferred for operational reasons on a "*Chief to Chief transfer*" to the Midlands Prison on 10 September 2015. He had requested protection but would not disclose his reasons.

32. The deceased had not met with the Integrated Sentence Management (ISM) team in the Midlands Prison. He had not been interviewed by ISM and there was no plan in place for him at the time of his death. I have been informed that "*there was no hand over from Portlaoise apparent*".

Sequence of events of 13 October 2015

33. On the 13 October 2015 prison officers and prisoners reported that the deceased appeared in good spirits. Officer A states:-

"My dealing with the deceased that day were the usual i.e. nothing out of the ordinary. What I remember of that day was him coming to the office to get a paper. While patrolling the landing I saw him in his cell or out on the landing talking to other prisoners. I did not notice anything in his demeanour to indicate he was depressed or anything was wrong"

34. The deceased had concerns regarding his children as referred to by his family in Paragraph 9. Prisoner A stated that:-

> *"I met him a few times on the day that he died. He told me when I was speaking to him that he had not seen his son in thirteen years. ... I collected my tea and he went back to his cell"*

35. Officer B stated the following:-

> *"On the day in question, I was Class Officer on D1. At some point during feeding at dinner time, I observed the deceased talking to other prisoners on D1. The deceased was very consistent in form but on this occasion seemed much more lively he was laughing and joking. He appeared to be in much better form than I had seen him in before. I found this somewhat unusual so I observed him for a while longer to try to ascertain whether or not he was under the influence of anything. After observing him for a short period, I drew the conclusion that he was not.*
>
> *I was tea guard on D Division later that evening. As I patrolled the landing I observed the deceased writing at his desk. His form seemed fine and there was nothing unusual to report. I finished my tea guard duty and handed over charge to Officer D".*

36. The deceased was last seen entering his cell after collecting his tea from the servery at 16.16.51 hrs. Officer C stated:-

> *"I remarked that it was early for him to be banging out his door. I asked him if he was okay and he gave me a thumbs up gesture and said that he had everything. He was lying on the bed at this point and appeared to be relaxed and in good form".*

37. The deceased's cell door was closed by an officer at 16.19.27 hrs. He did not subsequently leave his cell that evening.

38. I viewed CCTV footage from 08.00 hrs to 20.15 hrs 13 October 2015. All activities relevant to the deceased and/or his cell are set out in chronological order in Appendix A. However, the following activities as observed on CCTV are relevant to this investigation:-

16.16.51	Deceased walks back into his cell alone
16.19.27	Officer goes to cell – seems to spend 20 seconds conversing with the deceased who is in the cell. Officer closed the cell door and walks down landing
16.26.03	Officer returns up the landing and checks cells – looks in viewing panel and moves to neighbouring cells
16.38.53	Officer (Tea Guard) checks all cells and checks on the deceased
17.34.12	A prisoner walks up landing and looks in the viewing panel of deceased's cell and leaves after few seconds
17.43.45	Officer checks cell of deceased through viewing panel and walks down landing
19.01.44	A prisoner walks landing and looks in viewing panel of deceased's cell
19.04.06	A prisoner walk up landing and looks in viewing panel of deceased's cell and leaves
19.16.34	A prisoner walks up landing and looks in viewing panel of deceased's cell and leaves
19.21.37	Officer walks up landing, checks door of cell. Does not look in door.
19.23.26	Officer walking up landing, tries to open door of cell but door does not open. Officer continues up landing and does not look into cell
19.23.42	Officer goes to door of cell and tries to open door and looks in viewing panel. Officer pushes the door open and enters the cell. Officer can be seen calling another officer to come to the cell
19.23.59	Officer goes to the cell door and immediately runs to the Class Office

19.25.08 Nurse Officer arrives at cell followed immediately by another Officer and second Nurse Officer

39. Prisoner A a prisoner referred to in Paragraph 38 explained his actions in the following terms.

"I collected my tea and he went back to his cell. I didn't see him that evening so I called up to his cell. The door was open about an inch, I looked in through the spy hole and it was dark, I assumed that he wasn't there and I went away"

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

"A*t 7.20 pm, I called fall in and proceeded to lock up the landing, I approached cell 3 and found some resistance at the door and assumed he was on the toilet. I continued to lock up the landing until I returned to cell 3, again there was resistance at the door so I looked in through the spy glass and could not see anybody in the cell. I then pushed the door further and found the deceased hanging from a ligature on the back of the cell door.*

I lifted the prisoner to release the pressure on his neck. I then yanked the ligature from the back of the door and loosened it from his neck. I then brought the prisoner to the floor and called on staff to get medical staff and Hoffman knife. I then cut the ligature from his neck. Medical staff then arrived and took over and began CPR"

41. Officer D explained, in the following terms, that he assumed the deceased was using the toilet when he found some resistance at the cell door:-

"it would be the norm for a prisoner to put his foot at the door so that the door could not open when he is on the toilet, in the interest of his own decency"

42. An immediate alert was issued for personnel including the medical personnel.

43. Nurse Officer A accompanied by Nurse Officer B responded to the alert referred to in Paragraph 42. Nurse Officer A described her actions in the following terms:-

> *"Emergency call on D2 landing via radio and phone at 19.20 hrs approx. I Nurse A and Nurse B immediately went to D2 landing. On arriving at cell the deceased was lying face down on the floor with a white neck ligature around his neck. Head was facing towards the door. He was non responsive. Ligature removed by prison staff and the deceased was positioned on D2 landing floor in order to allow Nurse B to immediately commence chest compressions. I in turn contacted the surgery for immediate assistance and emergency equipment and for cardiac ambulance to be contacted.*
>
> *Nurse staff (Nurse C, D, E and F) immediately arrived with same. Defibrillator pads applied. The deceased still unresponsive. Defibrillator stated to continue CPR. Oxygen therapy and CPR continued. At 19.45 hrs approx. Nurse C contacted Doctor A .....*

44. The ambulance personnel arrived at approximately 19.37 hrs and CPR continued while the ambulance crew assessed the situation. Medical intervention ceased at approximately 19.50 hrs and the deceased was removed from D2 Landing on a stretcher by the ambulance crew at 19.57 hrs.

45. The deceased was pronounced dead in the Prison by Doctor A at 20.15 hrs.

Matters of concern

46. In Paragraph 10 the family of the deceased raised the question of his transfer from Limerick Prison to Portlaoise Prison on 16 April 2015.

47. The investigation of this aspect proved difficult in that the records initially made available to me were silent on this issue. While carrying out an

extensive trawl on records one of my officials became aware of an entry in the Portlaoise Prison Governors Parade Record of 19 May 2015 of the following:-

> *"Wants result of an appeal to a P19 he received in Limerick in April. I e-mailed Governor A. "*

48. I followed up on this aspect of the appeal and was provided with written confirmation that the deceased had on 15 April 2015 appealed in writing the result of the P19 adjudication. In his letter of appeal he set out clearly and in detail his grounds of appeal. It is obvious that this matter was of concern to the deceased as evidenced by his query to the Prison Governor in Portlaoise Prison referred to in Paragraph 47.

49. Under the present Prisoner Complaints Procedure prisoners are entitled to appeal against decisions made affecting them by prisons or Irish Prison Service Headquarters. Time-limits and procedures for processing such appeals are clearly outlined in the Complaints Procedure.

50. In the instant case no action was taken on foot of the appeal lodged by the deceased on 15 April 2015 or on any subsequent date.

Findings

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

52. He was accommodated in a single cell.

53. The deceased had a history of alcohol misuse and had suffered from depression. He was on prescribed medication at the time of his death.

54. The deceased left a comprehensive note for his family.

55. Between 17.43.45 and 19.23.26 the deceased was not checked by prison officers. However, Prisoner A went to the deceased's cell and looked through the viewing panel. His recollection is referred to in Paragraph 39.

56. Limerick Prison failed in its obligations to process the appeal by the deceased referred to in Paragraphs 46 to 50.

57. The deceased was not linked in with ISM when transferred to the Midlands Prison or thereafter.

58. The deceased had considerable contact with the Psychology Service, Psychiatry and Addiction Services in Limerick Prison but these ceased on his transfer from Limerick Prison to Portlaoise Prison on 16 April 2015.

59. The CCTV footage was clear and showed the movements of the deceased in the hours before he died.

60. The deceased did not attend School on the day he died. He can be seen on the landing going in and out of his cell during the day. He had interactions with officers and other prisoners. The officers and prisoner on the landing reported that the deceased seemed to be in good spirits.

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

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

63. The deceased was pronounced dead at 20.15 hrs on 13 October 2015.

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

Addressing the concerns of the family

65. In Paragraph 10, I set out the concerns the family wished me to address. In this paragraph I endeavour to address such concerns. For ease of reading I adopt the same numbering sequence as in Paragraph 10 as follows:-

(a) On 16 April 2015 the deceased was transferred to Portlaoise Prison for 'operational (accommodation)' reasons. In Paragraphs 29 to 30 I have set out in detail the events leading to this transfer.

(b) On 10 September 2015 the deceased was transferred from Portlaoise Prison to the Midlands Prison for operational reasons. He had requested protection but would not disclose the reason that he wanted protection.

(c) The information is set out in Paragraphs 25 to 28 of this report.

Recommendations

1. Prison Governors must ensure that they comply with their obligations under the Irish Prison Service Prisoner Complaints Procedure.

2. The Irish Prison Service must ensure that when prisoners, who are actively engaging with relevant therapeutic and other services in a prison, are transferred to another prison they are linked with such services in the transfer prison.

3. Appropriate assessments must be carried out on all prisoners entering prison whether on remand, committal or transfer.

4. The transfer of prisoners between prisons must, except in exceptional circumstances where the good order of a prison dictates, form part of a sentence management plan for such prisoners.

Appendix A

Activities as observed on CCTV on D2 Landing - 13 October 2015

8.17.16	Deceased exits cell carrying tray
8.23.39	Deceased returns to cell carrying tray and breakfast
8.25.27	Officer goes to deceased's cell – opens door, checks on deceased and closes door
8.37.38	Officer checking cells – lifts flaps and looks into cell
9.32.01	Officer unlocks cells
9.32.16	Deceased exits cell and immediately returns to cell
9.38.07	Deceased exits cell and walks down landing
9.46.45	Deceased returns to cell alone
9.47.53	Deceased exits cells and walks up landing
9.50.35	Deceased returns with a mop and bucket and proceeds to clean his cell
9.54.50	Deceased leaves cell with mop and bucket and walks down landing
10.10.53	Deceased returns to cell alone
10.13.22	Deceased exits cell carrying towel
10.24.59	Deceased return to cell
10.35.11	Deceased exits cell

The deceased can be seen on the landing for the remainder of the morning.

12.26.10	Deceased return to cell alone
12.27.19	Officer closes cell door
12.27.36	Officer checks cell through viewing panel
12.29.41	Officer checks cell through viewing panel
12.53.05	Officer checks cell through viewing panel
14.18.00	Officer unlocks cell

The deceased can be seen on the landing for the remainder of the evening.

16.06.41	Deceased exits cell and walks down landing
16.10.44	Deceased returns to cell with tray of food
16.16.38	Deceased exits from his cell and stand at railing on landing
16.16.51	Deceased walks back into his cell alone
16.19.27	Officer goes to cell – seems to spend 20 seconds conversing with the deceased who is in the cell. Officer closed the cell door and walks down landing
16.26.03	Officer returns up the landing and checks cells – looks in viewing panel and moves to neighbouring cells
16.38.53	Officer (Tea Guard) checks all cells and check on the deceased
17.34.12	A prisoner walks up landing and looks in the viewing panel of deceased's cell and leaves after few seconds
17.43.45	Officer checks cell of deceased through viewing panel and walks down landing
19.01.44	A prisoner walks landing and looks in viewing panel of deceased's cell
19.04.06	A prisoner walk up landing and looks in viewing panel of deceased's cell and leaves
19.16.34	A prisoner walks up landing and looks in viewing panel of deceased's cell and leaves
19.21.37	Officer walks up landing, checks door of cell. Does not look in door.
19.23.26	Officer walking up landing, tries to open door of cell but door does not open. Officer continues up landing and does not look into cell
19.23.42	Officer goes to door of cell and tries to open door and looks in viewing panel. Officer pushes the door open and enters the cell. Officer can be seen calling another officer to come to the cell
19.23.59	Officer goes to the cell door and immediately runs to the Class Office
19.25.08	Nurse Officer arrives at cell followed immediately by another Officer and second Nurse Officer

19.25.30 Deceased is taken to the floor of the landing and the Nurse Officers perform CPR on the deceased