A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner B in Limerick Prison on 21st January 2012

***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 B in Limerick Prison on 21st January 2012

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

Judge Michael Reilly
Inspector of Prisons
26th February 2014

Preface

Prisoner B was a 24 year old single man who died in Limerick Prison on 21st January 2012.

I offer my sincere condolences to the deceased's family. 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 9 sections as follows:-

- General information
- Interaction by the deceased with the Prison Medical Service for the 6 month period prior to the deceased's death
- Sequence of events on 21st January 2012
- Meeting with the family
- Relevant Interviews
- Status of the deceased in Limerick Prison
- Addressing the concerns of the family
- Findings
- Recommendations

Matters of concern are disclosed in this Report.

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

Judge Michael Reilly
Inspector of Prisons
26th February 2014

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 24 year old single man. He came from the Munster area.

2. The deceased had a number of previous convictions including a 10 year sentence for his part in a serious crime. He served this sentence and was released in 2010. He was recommitted to prison on 27th July 2011. The deceased was released from prison the following day and recommitted to Limerick Prison on 18th October 2011.

3. From the time that the deceased was imprisoned for 10 years, referred to in paragraph 2 above, and due to the nature of his crime, he was on protection in all prisons.

4. The deceased had a known alcohol and prescription drug problem. He was known to the prison psychiatric services and also to the community based psychiatric services.

5. At the time of his unfortunate death protection prisoners in Limerick Prison were, in the main, locked up for 23 hours per day. They were given one hours exercise. Access to therapeutic activities for such prisoners was limited to non-existent.

6. I had unrestricted access to all parts of the Prison, to all records held in the Prison, to prison staff and to prisoners. I also had access to relevant CCTV footage. I was afforded all facilities by prison management.

Interaction by the deceased with the Prison Medical Service for the 6 month period prior to the deceased's death

7. On 27th July 2011 Nurse A noted on the Prisoner Healthcare Management System (PHMS) that the deceased was a new committal. There was a copy of

the formal nursing committal interview on the PHMS. There was no prison doctor assessment recorded on committal.

8. Nurse A recorded that the deceased had self inflicted cuts on his arms and that he was addicted to Benzodiazepines. The notes also raised a concern that the deceased may have consumed what looked like tablets while in the holding cell at the main gate. He was therefore placed in isolation and placed on the Special Observation List.

9. The deceased was recommitted to Limerick Prison on 18th October 2011. A committal interview was conducted by Nurse B. Details of the interview are not recorded in the nursing notes for that day.

10. On 19th October 2011 it is recorded that the deceased saw the prison doctor.

11. On 25th October 2011 there is a note from the prison doctor stating – *"Prisoner requesting psychiatrist"*. On 26th October 2011 the doctor noted that the deceased had been seen by the psychiatrist the day before and that there was *"no mental illness"* diagnosed. He noted that the deceased was "*complaining about the Benzodiazepine taper from the psych service"*. There was no referral letter on the PHMS to the psychiatrist outlining what the concerns were at the time nor is there any detail of the psychiatric assessment on the PHMS.

12. On 26th October 2011 a nursing note created by Nurse C states that the deceased was referred to the psychologist and addiction services. There is no letter of referral for assessment to either the psychologist or the addiction services on the PHMS. I have being informed that the deceased was not seen by the psychologist or by the addiction services. I was also informed that his name was not placed in the psychology referral book.

13. On 31st October 2011 the deceased was transferred to Cloverhill Prison where Doctor A – the prison doctor, noted that he was on medication at the date of committal. He was continued on medication but the dosage was adjusted.

14. On 8th November 2011 the deceased was transferred back to Limerick Prison. Doctor B – the prison doctor noted *"Transfer back well"* with no other comments noted. There was no comprehensive committal interview and assessment documented on the PHMS by either a nurse or a doctor.

15. On 2nd December 2011 at 1.44am the deceased was seen by Nurse D following a fall from his bed when he sustained a bang to the head. He was assessed and his observations were stable at the time. The deceased was seen by Doctor C – the prison doctor later that day and a laceration to his skull was noted. He was referred for x-ray of his skull and thoracic spine. However, there is no referral letter requesting these tests and there is no record of the deceased having had these tests. There is a note from Doctor C on 3rd December 2011 which says *"declined"* but it is not clear what this refers to.

16. The deceased was referred to the psychiatrist on 11th January 2012 - Doctor D – the prison doctor noting that this was at the patient's request as he was feeling *"low and his head was racing"*.

17. The assessment by the psychiatrist – Doctor E – referred to in paragraph 16 was conducted on 17th January 2012. He was initially triaged by the Community Mental Health Nurse followed by a full psychiatric assessment by the consultant psychiatrist Doctor E. It was noted that the deceased had numerous previous psychiatric contacts with the psychiatric services. It was noted that on that day he presented as being well kept, established good eye contact and good rapport. It was noted that his speech was a bit loud but coherent. He subjectively described himself feeling tense. Objectively his affect was congruent. Doctor E did not find any evidence of psychotic features, suicidal ideation, plans or intent. *"He had good insight. He requested 'sleepers'"*. The Doctor explained the risks and benefits of certain medication to the deceased and prescribed appropriately.

Sequence of events on 21st January 2012

18. On the day of his death and for some time prior to same the deceased had shared a cell with his brother. They were both on protection.

19. At 12.40pm the deceased and his brother were offered recreation for 1 hour. The deceased's brother opted to go to the yard for exercise but the deceased declined and was locked in his cell on his own.

20. Prison Officer A took the deceased's brother and another prisoner for exercise at 12.40pm. It is clear from CCTV footage that the deceased was left unattended in his locked cell from that time until 1.40pm as referred to as paragraph 21.

21. At 1.40pm Prison Officer B checked on the deceased's cell and found the deceased hanging by a ligature which had been attached to the rail of the top bunk.

22. A comprehensive rapid response was put in place immediately. The Prison Officers who were in attendance commenced immediate CPR. They were then assisted by Nurse Officers.

23. An emergency ambulance was called. Despite sustained efforts by the paramedical team the deceased remained unresponsive. Resuscitation ceased at 2.45pm and the deceased was transferred to Limerick Regional Hospital where he was pronounced dead.

24. A note written by the deceased was found in his cell.

Meeting with the family

25. I met with the deceased's mother and other family members on two occasions.

26. The deceased's mother explained that her son had major problems with prescribed medication. She explained that if he got a weeks or months supply

he could take them over a very short period of time. She explained that he was also a very heavy drinker.

27. The deceased's mother stated that she was satisfied that no one, including herself, knew that her son would take the action that he did.

28. The family's queries can be summarised as follows:-

1. What medication was the deceased on prior to his death and how often was he getting this medication?
2. What time of the day did it happen?
3. Was the deceased on protection?
4. Was he on suicide or other type of protective watch?
5. The deceased's bed was broken but was mended by a board. Would it have been possible for the deceased to hang himself if this board had not been placed on the top bunk?

29. The deceased's mother wished it to be placed on record that the prison personnel and in particular the Governor provided every assistance to her and her family after the death of her son.

Relevant Interviews

30. The deceased's brother was interviewed. He was his cell mate at the time. He indicated that his brother (the deceased) was in good form on the day of his death. His brother reported that there was nothing to indicate in advance that he would take his own life.

31. The deceased's solicitor was interviewed. He stated that be had been in telephone communication with the deceased on the day before his death and described him as being in good form, upbeat and positive. His solicitor was of the opinion that the deceased was more coherent than he had been for some time.

Status of the deceased in Limerick Prison

32. At the date of his death and for a considerable period prior to same the deceased was classed as a protection prisoner. In effect, this meant that he was on virtual 23 hour lock up.

33. The duty of officers is to check protection prisoners once every hour in the same manner as they would check any other prisoners other than those who are classed as Special Observation Prisoners. In this case the deceased was being checked every hour. If a prisoner is on a Special Observation List he/she must be checked every 15 minutes.

34. I wished to investigate whether or not the deceased was classed as a Special Observation Prisoner at the time of his death as he had been on and off such a list on numerous occasions during his terms of imprisonment.

35. The prison authorities, subsequent to the death of the deceased in responding to questions from me, stated that the deceased was not, at the time of his death, on Special Observations.

36. The categorisation of prisoners as being Special Observation Prisoners is undertaken, in the main, by the medical personnel in prisons. Subsequent to such categorisation a record is generated on the PHMS.

37. The PHMS is, in effect, the medical file of the prisoner held in electronic form. This file is not available to prison management or prison officers for medical confidentiality reasons.

38. All information relating to a prisoner, other than medical information is kept on the Prisoner Information Management System (PIMS). This is the prisoner's file held in electronic form. This, *inter alia*, informs management on issues of special care which must be afforded to prisoners.

39. When a prisoner has been categorised as Special Observation this information should be entered on the PHMS and immediately transferred to the PIMS in

order that management and staff are aware of such categorisation and can take appropriate care of the prisoner.

40. There should be clear records on the PHMS and the PIMS as to which prisoners are on Special Observation at all times. These records should mirror each other.

41. Similarly, when prisoners are taken off the Special Observation List this information should be entered on the PHMS and immediately transferred to the PIMS. Proper records should be maintained.

42. Prison management have been unable to provide me with accurate records either in electronic form or otherwise to assist me in determining whether the deceased was or was not on Special Observation at the date of his death.

Addressing the concerns of the Family

43. I set out in paragraph 28 the concerns of the family. In paragraph 44, I endeavour to address these concerns.

44. (1) Prior to the publication of this Report I will inform the family of the medication that the deceased was taking prior to his death.
(2) The deceased died some time between 12.40pm and 1.40pm.
(3) The deceased was on protection.
(4) The deceased was not on suicide or other protective watch.
(5) There were many ligature points that the deceased could have utilised in his cell. In this case the ligature was attached to the bar of the top bunk.

Findings

45. The medical records were incomplete, inconsistent and demonstrate poor follow up on key aspects of healthcare.

46. The deceased was on protection. He was left unattended in his cell for approximately one hour. This complied with the procedures for prisoners on protection.

47. The records in the prison and the statements of management do not assist me in determining whether or not the deceased was a Special Observation Prisoner. As I cannot rely on records in the prison the views of the deceased's mother (paragraph 27), the statements of the deceased's brother (paragraph 30), his Solicitor (paragraph 31) and the findings of the psychiatrist (paragraph 17) all point to the fact that the deceased exhibited no signs of a psychotic nature or an indication that he intended self harm. Therefore, on the balance of probabilities, I conclude that the deceased was not on the Special Observation List on the date of his death.

48. Relevant records on the PHMS and the PIMS were not generated. Therefore, information from such systems could not be relied on.

49. From 1.40pm (the time the deceased was discovered in his cell) all relevant and appropriate procedures were put in place. There was no time delay.

Recommendations

1. A full audit of the healthcare provided in Limerick Prison should be undertaken immediately.

2. Recommendations from such an audit should be implemented.

3. A paper and/or electronic trail detailing all actions taken and decisions made by prison staff and/or outside professionals such as doctors relating to the care of prisoners must be available for inspection at all times.

4. The Irish Prison Service should undertake a review of its procedures for prisoners who are under Special Observation. When a decision is made to place a prisoner on Special Observation the reason for such decision should be recorded on the PHMS and the fact recorded on the PIMS. This decision

should be time limited and reviewed at specified times throughout its duration. All reviews of such decisions should be recorded on the PHMS and relevant records recorded on the PIMS. When a decision is made to remove a prisoner from the Special Observation List the reasons for such removal should be recorded on the PHMS and a relevant record recorded on the PIMS.

5. When a prisoner is on the Special Observation List management must ensure that this fact is known to all officers who may come in contact with the prisoner and must monitor the implementation of same.

6. Appropriate records should be kept on both the PHMS and the PIMS. If the deficiencies outlined in this Report are service wide immediate steps must be taken to remedy these deficiencies.