

**A report by the Office of the
Inspector of Prisons
into circumstances
surrounding the death of
Mr. A
on 10 January 2018
in
Mountjoy Prison**

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Foreword

Enclosed is a report of an investigation conducted by the Office of the Inspector of Prisons into the death of Mr A 2018 who died in custody in Mountjoy Prison on 10 January 2018.

The Inspector of Prisons has been investigating deaths in custody since 2012. Over the past seven years reports on deaths in custody have identified incidences of failure to complete 'checks' on prisoners during periods of lock-back. In accordance with the Irish Prison Service (IPS) policies and procedures in place at the time of Mr A's death, prisoners should have been checked every hour during the course of the night, unless they were deemed to require 'special observation' which was at more frequent intervals. The investigation into the death of Mr A identified that his hourly checks were not completed on the night he died. It is also observed from CCTV footage that the officer with responsibility for the landing on which Mr. A died did not remain on their post for the duration of their tour of duty.

Prisons are required to provide safe and secure custody and it is critically important that staff carry out their duties diligently and in accordance with IPS policies and procedure. Mr. A died during the night and his death was not observed by the night guard, or the officers who unlocked and locked his cell for breakfast, or the officer who unlocked his cell following breakfast to facilitate his attendance at morning activities. At a minimum, four opportunities were missed that morning to identify a serious situation. An officer unlocking a cell following periods of lock-back and particularly when unlocking for breakfast should ensure that they seek and receive a verbal response from each prisoner in the cell thereby ensuring s/he is alive.

There should be zero tolerance in instances where there is failure to carry out required observations and appropriate disciplinary action taken.

One of the objectives of an investigation into a death in custody is to examine whether any changes in operational methods, policy and practice, or management arrangements would help to prevent recurrence of a similar death or serious event. I wish to acknowledge and welcome the introduction of new policies and procedures governing the monitoring of prisoners during periods of 'lock up' by the Director General of the Irish Prison Service. Standard Operating Procedure 11/22, relates specifically to the monitoring of prisoners during night guard duty and it came into effect on 26 April 2019.

The Draft report of this investigation was provided to the Director General of the Irish Prison Service (IPS) on 21 May 2019 for review and comments. The draft report was accepted and no change requests were received.

The Director General of the IPS accepted 4 of 4 of the recommendations in this report. An Action Plan addressing the corrective and preventative actions that will be taken by the IPS to implement the recommendations has been received and with the consent of the Director General of the IPS is being made available to you and your officials.

The Director General in her response to the draft report highlighted progress in relation to the processes and procedures within the Irish Prison Service which will address issues highlighted in this report, and previous reports by this Office into Deaths in Custody as follows:

- *“As a service we have reviewed the policy and procedures in relation to the monitoring of prisoners. This review has allowed for the introduction of a new policy for the Monitoring of Prisoners during lock-up with a range of standard operating procedures which deal comprehensively with the responsibility of prison staff to monitor and check on all persons in custody. This policy and the related standard operating procedures were implemented with effect from 26 April 2019, and they highlight that the monitoring of prisoners is a core responsibility for frontline prison staff.*
- *All prison staff have been made aware that their compliance with the policy and procedures for the monitoring of prisoners is mandatory, and failure to comply fully will be considered to be serious misconduct warranting disciplinary action which may result in sanction up to, and including dismissal, where appropriate. In addition to this, the Irish Prison Service has also made changes to its policy of CCTV usage to allow for improved monitoring of compliance by its staff.*
- *All prison staff are required to familiarise themselves with the updated Special Observations/Monitoring lists at the start of each period on duty, and are required to fully record the monitoring of prisoners while on duty.*
- *In addition On Friday 5th of July I issued correspondence to all staff outlining that as a service, “the need for the highest standards of performance, attendance and behaviour from employees is essential for any service which strives to be a modern, competent, professional world class organisation”. In the same correspondence, I also issued the guidelines for the Imposition of Disciplinary Actions in which I outlined the categories of misconduct and the sanctions that can be applied to each.”*

My colleagues and I extend our sympathies to the family and friends of Mr A on their sad loss.

Patricia Gilheaney
Inspector of Prisons

3 September 2019

**A report by the Office of the Inspector of Prisons into circumstances
surrounding the death of Mr. A
on 10 January 2018 in Mountjoy Prison**

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

The Investigation was conducted and this Report prepared by the undersigned.

Helen Casey
Office of the Inspector of Prisons

3 September 2019

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Preface

The aims of this investigation are to:-

- Establish the circumstances surrounding the death;
- Examine whether any changes in operational methods, policy and practice, or management arrangements would help to prevent recurrence of a similar death or serious event; and
- Address any concerns of the family.

Mr. A was a 41-year-old man who died on 10 January 2018 while in the custody of Mountjoy Prison.

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

INVESTIGATION REPORT

1.0 General Information

- 1.1 Mr. A was a 41 year old single man who came from the Leinster Region.
- 1.2 Mr. A was committed to Mountjoy Prison on 21 December 2015 following a sentence to life imprisonment, which dated from the 15 August 2015. Prior to his conviction Mr. A was on remand in Cloverhill Prison.
- 1.3 On 29 October 2017 Mr. A was placed in a single cell, Cell 30 on C2 Landing in Mountjoy West (now Progression Unit) where he remained until his death.
- 1.4 At 09:57 on 10 January 2018 Mr. A was found unresponsive in his bed by two prisoners who called to his cell on their way to attend classes in the prison school. These prisoners alerted staff. Attempts to resuscitate Mr. A were not successful. The Prison Doctor pronounced death at 10:15 on 10 January 2018.
- 1.5 As part of our investigation we usually meet with the next of kin. However, having received our letter Mr. A's sister rang the office on behalf of her mother stating that they did not wish to meet with us or raise any concerns regarding her brother's death in custody.

2.0 Status of Mr. A in Prison

- 2.1 According to the Prison records Mr. A complied with prison discipline and engaged with support services available in the prison.
- 2.2 Mr. A. attended school which the Psychologist described "*as his lifeline*" where he achieved excellent academic results in the 2016 leaving certificate exams undertaken. Mr. A was registered for an Open University course at the time of his death.
- 2.3 Mr. A was on the Enhanced Level of the Incentivised Regime. The Incentivised Regime has three levels of privilege – Basic, Standard and Enhanced. The basic level provides the least amount of privileges (number of phone calls permitted, amount of daily gratuity paid etc.) while the Enhanced level offers the best privileges.

3.0 Interaction with the Prison Medical Services

- 3.1 Doctor A completed a committal medical review of Mr. A in Mountjoy prison on 22 December 2015. Doctor A recorded "*No medical problems at present.*"
- 3.2 On 23 December 2015 Mr. A was transferred to Wheatfield Place of Detention and was reviewed by Doctor B on 24 December 2015 who noted on record that Mr. A had a medical condition for which he required the support of a "*stick since January 2015.*"
- 3.3 According to the prison medical records Mr. A attended hospital appointments for his medical condition. Prescription records examined showed that medication prescribed by the Prison Doctor was administered daily by the Nursing Staff.

4.0 Sequence of Events

- 4.1 Mr. A attended the prison school on the morning and afternoon of 9 January 2018. At about 15:30 he had a meeting with Forensic Psychologist A who recorded that Mr. A *“presented in good form”*. Following that meeting, he can be seen on CCTV footage returning to his cell on C2 landing at 15:50.
- 4.2 At 16:02:17 a Nurse Officer called to Mr. A’s cell to dispense his daily medication. At 16:15 two prisoners arrived to his cell with food from the Servery. At 16:24 Mr. A’s cell was checked and locked. Following unlock at 17:25:23 Mr. A left his cell to make a telephone call and following that call he can be seen on CCTV footage interacting with other prisoners before returning to his cell for the night.
- 4.3 At 19:26:24 Officer A checked the cell of Mr. A and then master locked the cell for the night.
- 4.4 Officer B took up duty as Night Guard on C Division West at 19.30 on Tuesday 9 January 2018 and according to their report *“took charge of a total of 77 prisoners”*. Officer B reported that checks were carried out on each cell during the course of the night until the master lock was removed at about 06:30. Officer B reported noticing *“nothing unusual”*. Officer C took charge of the landing during Officer B’s meal break.
- 4.5 Officer C was posted Night Guard on D Division West on 9 January 2018. Officer C confirmed in their report that they assisted with checks on C Landing during the night of 9 January 2018. Officer C reported that Mr. A was *“observed... in his bed under the duvet cover”* during the course of these checks.
- 4.6 Officer D who was an Early Start at 07:45 reported taking over from Officer B on C Division on 10 January 2018 at 07:25 and commenced checks at approximately 08:00. Officer D reported that Mr. A was *“in bed like every other inmate”* when checked.
- 4.7 Officer E reported taking up duty on 10 January 2018 at 08:00 and was *“posted i/c (in charge of) C2 West landing” ... and that at 08:10 began to unlock with the assistance of Officer K. Officer E reported that Mr. A’s cell was opened and “asked if he wanted*

breakfast? Officer E's recollection is that "[Mr A] was lying fully covered in this bed". Officer E was "full sure" that Mr A responded "but it wasn't a yes which is not unusual with [Mr. A] as he rarely got up for breakfast. Officer E also reported that he was "happy with the interaction" and "moved on to the next cell and continued unlock."

4.8 Officer E returned to C 2 landing at 09:20 "to unlock the cells" following breakfast. Officer E reported that no other officer assisted with the unlock but stated that Mr. A "was lying in bed presumed asleep so I left him to have a bit of a lie in as this was not unusual". Officer E reported that while unlocking the cell Nurse Officer A was also making enquiries about cell numbers. Officer E reported that he then went to the circle to speak to the ACO and while there "an inmate" unknown to Officer E called him to "come quick as [Mr. A] was not well in his cell". Officer E stated that there was an immediate response and accompanied by "Officer F went to the cell where they found [Mr. A] unresponsive lying in bed. Officer F called for the medics who arrived along with ACO A" and "commenced CPR".

4.9 Officer F's account of events concurred with that of Officer E. Officer F reported that an "inmate who I believe to be Prisoner 1 came to the front area of C2 landing and shouted down that there was an inmate dead in a cell on C2 West", they immediately ran to cell 30. Officer E further recounted calling "the inmates name several times but got no response. I pulled back the duvet cover and I saw that the inmates face was covered in what appeared to be vomit. I immediately called for the medic and ACO A to attend C2 West urgently."

4.10 Nurse Officer A reported "that at approximately 10am on 10 January 2018" there was a code red alert on the radio. The Nurse reported leaving "the surgery with our emergency bag.." and Officer G assisted in "carrying medical bags to C2 Cell 30". The Nurse Officer further reported that Officer F and ACO A removed Mr. A from the bed, placed him "on a flat surface", where they commenced CPR and applied the defibrillator but "no shock advised. Rigor Mortis had set in". The "Ambulance attended and did ECG tracing which confirmed that (Mr. A) had passed away". Doctor

C attended the cell and advised that CPR should stop. The Doctor pronounced death at approximately 10:15 on 10 January 2018.

4.11 The two prisoners who found Mr. A unresponsive in his cell were friends. Mr. A had difficulty with his balance and these two prisoners regularly assisted Mr. A in carrying food to his cell and accompanied him to the prison school. They both had been in the company of Mr. A on 9 January 2018 and both stated that Mr. A was in his usual good form.

4.12 Prisoner 1 in his statement reported *"talking to [Mr. A] at the railings on the night before for ten minutes. He was grand. This was around 4:10pm as my friend (Prisoner 2) was collecting (Mr. A) food"*. Prisoner 1 did not see Mr. A after that as he was on a different landing. Prisoner 1 reported that on the morning of 10 January 2018 he *"looked into his cell"* and thought Mr. A was sleeping but Prisoner 2 stated *"he would never be usually asleep at this time. We went in to wake him up"*. Prisoner 1 reported that *"Prisoner 2 started to shake him to wake him up... he "grabbed his arm and his arm was frozen stiff"*. Prisoner 1 stated that he *"knew he was dead"* and he *"ran to the circle and called for staff"*.

4.13 Prisoner 2 made a statement in which he recalled that Prisoner 1 and Mr. A had tea the previous evening and was *"..his cheerful self when I left him."* He stated that Mr. A *"never gets up for breakfast"* so he went to call him for school at 09:50. He reported that his *"mate Prisoner 1 said he was still in bed and I knew straight away that something was up. So I went into the cell and started shaking him to wake him up, because I got no response, I pulled back his duvet to give him a proper shake so that he would feel it. I opened his eye lids to see if I could get a response"*. Prisoner 1 recounted that Mr. A had been ill during the night as the sheets were soiled.

5.0 CCTV Footage

5.1 As part of the investigation we viewed CCTV footage covering the movement of Mr. A from 09:23 on 9 January 2018 up until he was pronounced dead on 10 January 2018 at approximately 10:15 (Appendix A).

5.2 In line with the Irish Prison Service Standard Operating Procedures at that time, Mr. A should have been checked hourly while locked back in his cell. There were two occasions during lock back when the period between checks on Mr. A's cell exceeded two hours, these were from:-

01:57:14 to 04:04:30 = 2 hours 30 minutes

04:04:30 to 06:36:33 = 2 hours 30 minutes

During these time intervals Officer C can be seen on CCTV footage walking the landing at 03:01 and at 04:59 but did not stop outside the door of any of the cells to check the prisoners.

It is recorded in the Night Guard Report for C West signed by Officer B that Officer C carried out supervision of C West during the period 04:00 to 05:00 whilst Officer B availed of a meal break.

5.3 Officer C was responsible for D West on the 9 January 2018. Officer C can be seen on CCTV footage on C West (which was not their area of responsibility on that night) checking cells on their own and also in the company of Officer B. Officer C can also be seen walking through C 2 landing and not checking cells as they proceed through the landing. In written response to queries from this office Officer C replied that they "*...assisted with checks on the C Division as is usual practice in Mountjoy West.*"

6.0 Visit

6.1 Mr A's brother had a visit booked at 11am on the morning of 10 January 2018. On his arrival to the prison he was met by a member of staff and escorted to meet Governor A and Chaplain A who informed him of the death of his brother.

7.0 Findings

- 7.1 Mr. A was on medication for a debilitating health condition.
- 7.2 Mr. A engaged with support services, attended school and got on well with fellow prisoners and staff. He was on the Enhanced level of the Incentivised Regime.
- 7.3 Mr. A had not complained of being unwell to prisoners or staff.
- 7.4 Mr. A was locked back for the night at 19:25:24 on 9 January 2018. He was alone in his cell until he was found by fellow prisoners at 09:56:41 on 10 January 2018.
- 7.5 In line with the Irish Prison Service Standard Operating Procedures at the time, Mr. A should have been checked hourly while locked back in his cell. An officer can be seen on CCTV footage walking the landing at hourly intervals but Mr. A's cell was not checked on an hourly basis which is in breach of the Irish Prison Service Standard Operating Procedure.
- 7.6 Officer B was detailed for night guard duty on C West but did not remain on that post for the duration of the tour of duty as Officer C, who was night guard D West, can be seen on CCTV footage on C2 landing, for a period which exceeded time allowed for meal break(s) which is max of one hour duration as per Governors Order 2/2017.
- 7.7 The cause of death is a matter for the Coroner.

8.0 Recommendations

- 8.1 Officers when unlocking prisoners after periods of lock-back should verbally communicate with the prisoner and ensure they receive a verbal response to verify that s/he is well and not in need of medical attention.
- 8.2 The checking of prisoners in their cells should be conducted in accordance with the Irish Prison Service Standard Operating Procedure by the Officer assigned to the division/landing or by their approved relief officer. If an officer is required to respond to an emergency and in so doing is unable to complete required checks, an entry should be made in the appropriate Journal(s) (Night Guard Journal, Dinner Guard Journal etc.) by the officer concerned and countersigned by the supervising officer.
- 8.3 Where there is evidence to suggest that an officer(s) has/have failed to carry out his/her duties in relation to checking of prisoners in their cells appropriate disciplinary action should be taken.
- 8.4 All hand-over of duties should be recorded in the Night Journal by the Night Guard and signed off at the end of the tour of duty by the Supervising Officer / Officer-in-charge.

CCTV Footage

Details from 19:30 on 9 January 2018 to 10:15 on 10 January 2018

9 January 2018

19:23:22 Officer H checked cell – lifted viewing flap and looked in.
19:26:24 Officer I master locked cell – lifted viewing flap and looked in.
20:05:10 Officer C checked cell – lifted viewing flap and looked in.
21:05:06 Officer C checked cell – lifted viewing flap and looked in
22:09:27 Officer C checked cell – lifted viewing flap and looked in.
23:07:50 Officer B checked cell – lifted viewing flap and looked in.
23:51:23 Officer C checked cell – lifted viewing flap and looked in.

10 January 2018

01:08:00 Officer B checked cell – lifted viewing flap and looked in.
01:57:14 Officer B checked cell – lifted viewing flap and looked in.
03:01:30 Officer C walked down landing – did not check cells.
04:04:30 Officer C checked cells – lifted viewing flap and looked in.
04:59:23 Officer C walked landing – did not checks cell.
06:36:33 Officer B removed the master locks – lifted viewing flap and looked in.
08:01:36 Officer D checked cells – lifted viewing flap and looked in (Officer
checked cells on the other side).
08:11:51 Officer E checked cell - Lifted viewing flap and looked in.
08:14:57 Officer E unlocked cell – did not enter but looked in to cell and then
moved on.
09:23:59 Officer E accompanied by Nurse Officer unlocked cell – did not look in.
09:36:46 Officer J called to cell 30 – Lifted viewing flap and looked in. Appeared
to push open the door and then moved on.
09:55:56 Prisoner 2 and Prisoner 1 arrived on landing and rested against railing
outside deceased's cell.

09:56:22 Prisoner 1 went to door of cell and looked in – he turned back to Prisoner 2.

09:56:41 Both prisoners then enter the cell.

09:57:30 Prisoner 1 exited the cell and went towards the circle. Prisoner 2 existed behind him and he stood at the railing on the landing.

09:57:52 Prisoner 2 re-entered the cell as Prisoner 1 returned.

09:58:01 Prisoner 1 re-entered the cell.

09:58:01 Prisoner 1 exited cell and walked towards the circle end of the landing again. Prisoner 2 exited the cell and stood at the railings.

009:58:32 Prisoner 1 returned to the cell door followed by Officer F and Officer E.

09:58:36 Both officers entered the cell while the two prisoners remained on the landing at the railing. ACO A and three more officers arrived to the cell. Prisoners started to congregate in numbers on the landing. Officers moved the prisoners back to their cells.

09:59:46 Nurse Officer A entered cell carrying the emergency response bag. Three more Nurse Officers attended.

10:09:52 Dr. C entered the cell.