

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner N
in Mountjoy Prison
on 2nd December 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 N
in Mountjoy Prison on 2nd December 2012**

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

Judge Michael Reilly
Inspector of Prisons

7th November 2013

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Preface

Prisoner N was 26 years old when he died while in custody in Mountjoy Prison on the 2nd December 2012.

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

My Report is divided into 8 sections as follows:-

- General information.
- Sequence of events.
- Deceased's demeanour while in prison.
- Meeting with the family.
- Standard Operating Procedures.
- Findings.
- Addressing the concerns of the family.
- Recommendations.

Matters of concern are disclosed in this Report.

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

Finally, I would like to thank all those who assisted with this investigation.

Judge Michael Reilly

Inspector of Prisons

7th November 2013

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 26 year old man. He is survived by his mother, his partner and two young children. He came from the Dublin area. He was committed to prison on the 4th May 2012. His release date was to be the 23rd June 2015.
2. I had unfettered 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.

Sequence of events

3. On the 4th May 2012 the deceased was committed to Mountjoy Prison.
4. On the 5th May 2012 a full committal assessment was carried out on the deceased. As part of this assessment Doctor A recorded – *“No medical, psychiatric or drug history and no thoughts of self harm”*.
5. On the 6th May 2012 the deceased was placed in cell 29 on A2 landing where he remained until the 23rd August 2012.
6. On the 14th May 2012 the deceased told Governor A that he had ‘taken’ a package of heroin prior to his committal and he was concerned that it might rupture inside him. Doctor B and Officer A – a Nurse Officer - discussed the situation and the deceased was sent to the A/E at the Mater Hospital where he was treated. He was returned to the prison later that day with a prescription and no further concerns were raised by the medical staff in the prison or by the deceased.
7. On the 23rd August 2012 the deceased was transferred to cell 19 on A2 landing. This was a single cell.

8. On the 6th October 2012 Officer B discovered a mobile phone and a sim card in the deceased's cell. He issued a P.19 disciplinary form to the deceased.
9. On the 8th October 2012 Governor B dealt with the P.19 referred to at paragraph 8. He imposed sanctions of loss of evening recreation, a prohibition on personal visits and a prohibition on phone calls from the 8th October to the 19th November 2012.
10. The deceased was prescribed nicotine patches intermittently throughout his time in prison as he was trying to give up smoking.
11. A2 landing is well covered by CCTV cameras. The landing and particularly the door to the deceased's cell (cell 19) can be clearly seen on the cameras. The times referred to in paragraphs 12 to 25 have been verified by reference to the CCTV footage.
12. At 7.30pm on the 1st December 2012 the deceased was master locked into his cell by Officers C and D. Both officers reported that the deceased appeared in good form and nothing appeared amiss or out of the ordinary in his mood.
13. Officer E was detailed as the Night Guard for landings A1 and A2. He reported in the Night Guard Journal that all was correct for his tour of duty.
14. Officer E carried out regular checks of cell 19 and in particular at the following times – 11.33pm, 12.09am and 12.28am.
15. At 1.27am the deceased's cell was checked by Officer F.
16. At 2.24.36am Officer G checked the cell. He observed the deceased hanging by a bed sheet from the bars of the cell window.
17. Officer G immediately contacted Officer H - his ACO – saying: “get the master key for A2 as there was a hanging”.

18. The ACO referred to in paragraph 17 has stated that as he made his way to the keys office he called Control on his radio and requested an ambulance. Officer I was the Control Officer on that night. The ACO also called the surgery and requested a medic.
19. At 2.26.19am the ACO, Officer G, Officer J and Officer E unlocked and entered cell 19. The deceased was hanging with his feet off the ground. A bed sheet was knotted around his neck and the other end was tied to the bars of the cell window. The officers lifted the deceased and untied the ligature. They then placed the deceased on the bed. He was unresponsive and appeared to the officers to be dead.
20. At 2.30am Officer K – a Nurse Officer - arrived at the cell and immediately checked for signs of life. There were no signs of breathing or of a pulse. Officer K – Nurse Officer - reported that the deceased's pupils were fixed and dilated. Officer K decided not to commence CPR as the prisoner was dead. Officer L - Nurse Officer - who arrived at the cell at 2.40am concurred with this decision.
21. The ACO already referred to contacted Officer M – a Chief Officer - by telephone and briefed him on the situation. The Chief Officer briefed the Governor by telephone. The Chief Officer contacted the prison chaplain and An Garda Síochána.
22. At 3.25am the Chief Officer, already referred to, met members of An Garda Síochána at the prison and brought them to cell 19. At that time he also requested the Gardaí to make contact with Dublin City Fire Brigade as the ambulance, requested by the ACO (see paragraph 18) had not arrived.
23. At 3.40am three members of Dublin City Fire Brigade attended at the scene in the prison and on being briefed they requested an ambulance.
24. At 3.55am the ambulance arrived and two paramedics visited the scene and carried out their assessment which was that the prisoner was dead.

25. At 5.19am Doctor C, who was the Garda Doctor on call, pronounced the prisoner dead.
26. It is clear from the CCTV footage that a large number of people – prison officers, nurse officers, the chaplain, the external emergency services, and senior management – attended at the scene and entered the scene. This action could contaminate a potential crime scene. In this connection note my observations in Recommendation 2.

Deceased's demeanour while in prison

27. The deceased, apart from those contacts already referred to in this Report, had little contact with the medical staff of Mountjoy Prison. He was not being treated for any medical condition prior to his death. The medical staff did not have any concerns for his health, either physical or mental.
28. The deceased was deemed to be a well behaved prisoner who had only two P19 prison discipline breach reports recorded against him.
29. Between the 4th May 2012 and the 2nd December 2012 the deceased presented as a normal prisoner.
30. The prison staff had not noted any change in the demeanour of the deceased in the days prior to his death. Officer N stated that he had spoken to the deceased on a number of occasions in the days prior to his death and he appeared to be in good form. In one of the conversations the deceased was asking about the reopening of the refurbished B Division and expressed the hope that he might be moved there when it was opened.
31. Prisoners who had contact with the deceased immediately prior to his death expressed surprise that he had taken his own life as he appeared to be in his 'usual form' and they did not notice anything unusual about him.

Meeting with the family

32. I met with the deceased's mother and his partner. The deceased had a close relationship with his mother, his partner and his two young children. He telephoned his partner every day and spoke to her and to his daughter.
33. The deceased was upset that he was not at the birth of his son. He was in prison at the time.
34. The deceased had regular visits from his partner. She visited him on the Wednesday before he died and he appeared fine. He was looking forward to seeing her and his children on the following Wednesday. In their last telephone conversation at 2.45pm he stated that he would telephone her the following day but unfortunately he took his life that night.
35. Both his mother and his partner stated that there was nothing worrying the deceased and that he did not have any reason to be worried.
36. The family had questions that they wanted answered. They can be summarised as follows:-
 - (a) How the deceased could hang himself in his cell as they were of opinion that this should have been impossible.
 - (b) The family raised serious issues concerning publicity following the death of the deceased.
 - (c) How it was that people in their locality knew of the death of the deceased prior to the family being informed.

Relevant Standard Operating Procedures

37. I have been informed by the Prison that the relevant Standard Operating Procedure is a Governor's Order dated 29th July 1987 which provided, *inter alia*, that:-

“Officers on night duty shall patrol all the landings, etc. constantly during the night and check prisoners according to instructions, i.e., those on special observations at least every 15/20 minutes, all others at irregular intervals at least hourly...”

Findings

38. (a) The deceased was not on the special observation list at the date of his death or at any time while in prison.
- (b) The Governor’s Order referred to in paragraph 37 was complied with in that irregular checks of the prisoner at least hourly were carried out during the night of the 1st/2nd December 2012.
- (c) The deceased did not display any symptoms or emotions prior to his death which could have alerted his family or the prison authorities that he might take his own life.
- (d) The deceased was in a single cell on the night that he took his own life.
- (e) The ligature used was a bed sheet which was tied to the bars of the cell window.
- (f) The response to the emergency by prison officers and the prison medical personnel was immediate.
- (g) The Nurse Officers referred to in paragraph 20 did not commence CPR as in their medical opinion the prisoner was already dead.
- (h) Officer I did not call for an ambulance as he took the view that the ACO had called the ambulance himself.
- (i) The delay in calling an ambulance had no bearing on the outcome of this case.

Addressing the concerns of the family

39. In paragraph 36, I set out questions that the family wanted answers to. In paragraph 40, I endeavour to provide such answers.
40. (a) A proper and adequate assessment was carried out on the deceased when he was committed to Mountjoy Prison. The deceased was in a single cell. This is considered best practice. Cell 19 was part of Mountjoy Prison that had not been refurbished for many years. Prisoners had access to windows which had bars on them.
- (b) I do not propose dealing with the particulars of the publicity in this report. I will address this issue with the family when I brief them on the contents of this Report prior to same being published by the Minister. The media must be sensitive to the distress that can be caused to a family who have been bereaved, such as in this case, by ‘sensational reporting’ of the circumstances surrounding the life, conviction and subsequent death of a prisoner.
- (c) Despite exhaustive enquiries I have been unable to ascertain how others in the locality knew of the death of the deceased prior to the family being informed.

Recommendations

1. **The Irish Prison Service should, as a matter of urgency, examine its current practices for alerting the emergency services with a view to ensuring that, in an emergency, such services are alerted as soon as is practicable.** All radio and telephone traffic relevant to the emergency should be recorded, logged and preserved.
2. In investigating this particularly sad death I can confirm that in excess of eight officers, an ACO, two nurse officers, the Chaplain, the external emergency services i.e. medical, fire brigade and Gardaí in addition to a Chief Officer and members of senior management entered the scene. In addition officers, surplus to requirements, can be seen on CCTV standing around outside the

cell. This is a cause of concern. One of the officers standing outside the cell can be clearly seen smoking a cigarette in the vicinity of the cell door and indeed flicking the butt of the cigarette down onto the landing below. The number of people entering the scene and the number remaining in the vicinity had the potential to contaminate the scene. This would be especially true if the scene were to be considered a crime scene by An Garda Síochána. Obviously incidents differ and one cannot set limits on the number of people entering a scene in advance. **The Irish Prison Service should, as a matter of urgency, examine its procedures with a view to defining a streamlined response to ensure compliance with best practice in scene preservation bearing in mind the necessity to preserve life.**

3. Mountjoy Prison and all prisons should ensure, as far as is practicable, that there are no obvious points that ligatures could be attached to.
4. Standard Operating Procedures and Protocols should be updated. I have noted in paragraph 37 that the relevant Standard Operating Procedure dates from 1987.