Office Ref: 2018/K

FINAL INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr K

AGED 31

AT MOUNTJOY PRISON

ON 25TH JUNE 2018

[Date finalised: 8th June 2020]

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GLOSSARY

AGS	An Garda Síochána
CCTV	Close Circuit Television
Code Red	Terminology used within the Prison system to identify an emergency situation
CPR	Cardiopulmonary Resuscitation
GP	General Practitioner
IoP	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of Inspector of the Prisons
OSG	The Operational Support Group (OSG) was established by the Irish Prison Service in 2008 to support prison Governors in preventing contraband entering prisons. The role of the OSG is to prevent the direction of crime from prisons and to detect prohibited articles within prisons
PIMS	Prisoner Information Management System

PREFACE

The Office of Inspector of Prisons (OIP) was established by the Department of Justice and Equality under the Prisons Act 2007 (the Act). Since 2012, the Minister has requested the Inspector of Prisons to investigate deaths in prison custody. In 2018, clarification was received that the Inspector is also requested to investigate the death of any person which occurs within one month of their temporary release from prison custody. The Office is completely independent of the Irish Prison Service (IPS). The Inspector and staff of the OIP are civil servants, however, they are independent of the Department of Justice and Equality in the performance of statutory functions.

We make recommendations for improvement where appropriate; and our investigation reports are published by the Minister for Justice and Equality, subject to the provisions of the Act, in order that investigation findings and recommendations are disseminated in the interest of transparency, and in order to promote best practice in the care of prisoners.

Objectives

The objectives for Inspector of Prisons investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the IPS;
- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- Assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. The Office of the Attorney General has informed the IPS and Inspector that the provisions of the Prisons Act 2007 in relation to the Inspector accessing healthcare /medical records of deceased prisoners in relation to investigations of deaths in custody cannot be relied upon. As an interim arrangement pending legislative amendment, the IPS has agreed to release such records with consent from Next of Kin (NoK). This inevitably leads in some instances to a failure to review healthcare/medical records where NoK is unknown, cannot be located, or refuses to provide consent. Mr K's NoK provided

consent to the Inspector to access his healthcare/medical records for the purposes of this investigation.

This report is structured to detail the events leading up to, and the response after Mr K passed.

Administration of the Investigation

There was a delay of five weeks in obtaining the documentary material required for this investigation - it should have been provided as per protocol within seven days of Mr K's passing.

A letter was sent to the then IPS Director General about this delay on 31st July 2018 and a response was received from the Director of Operations on 1st August 2018. As there was an ongoing delay in obtaining officers statements, the Inspector of Prisons (IoP) visited Mountjoy Prison by arrangement to interview relevant staff on 8th and 16th August 2018.

Recommendation
The IPS should prioritise Death in Custody investigations and adhere to the protocol that requires all relevant material to be provided to the Inspector of Prisons within seven days of the prisoner's death.

Following Mr K's death Chief Officer A was commissioned to conduct an internal review on behalf of the IPS. The material that I received in relation to Mr Ks death did not contain an internal review report. Rather there was a series of e-mails, which lacked specific findings or recommendations.

Recommendation
Internal IPS reviews into Deaths in Custody should have a clear format, structure and content.

The OIP is willing to work with the IPS to identify the best model for this purpose.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Inspector of Prisons role when investigating a death in custody.

A colleague and I met with Mr K's mother and two sisters in September 2018. Based on their understanding of the facts, they raised several questions. These questions and related findings are set out in more detail in the Summary of this report. In broad terms their questions related to alleged unfavourable treatment by some IPS staff, Mr K's access to drugs and tablets, his care in prison, the emergency response when he was found unresponsive and the manner of notification to them of the incident.

Although this report will inform several interested parties, it is written primarily with Mr K's family in mind. I offer my sincere condolences to them for their sad loss.

I am grateful to Mr K's family and the Irish Prison Service for their contributions to this investigation.

PATRICIA GILHEANEY
Inspector of Prisons
8th June 2020

SUMMARY

Mr K was aged 31 when he was found unresponsive in his cell at 08.05 on 15th June 2018. He was in a single cell on B3 Wing of Mountjoy Prison and was found by two staff when they unlocked his cell during the morning medications round.

Emergency medical attention including CPR, was applied. He was removed by ambulance to the Mater Misericordiae Hospital where he was placed on life support. However he did not regain consciousness and was pronounced dead ten days later, on 25th June 2018.

The cause of Mr K's death is a matter for the Coroner.

Mr K had been committed to Mountjoy Prison on 9th February 2018 for drugs related offence and he was due for release on 8th November 2018.

Following Mr K's removal to hospital on the morning of 15th June 2018, some 22 small wraps were found in his cell by An Garda Síochána. They contained a substance that appeared to be diamorphine (heroin) and this was subsequently confirmed.

Mr K was accommodated on B3 wing of Mountjoy Prison. B3 accommodated prisoners who required protection under Rule 63 of the Prison Rules. He was on the Standard Level of the Incentivised Regime. Mr K had been accommodated on B3 at his own request.

In relation to the queries raised by Mr K's family, findings in response to each query are below:

1. **Mr K had taken tablets which were poisoned and may have been provided by a prison officer?**

   The evidence available for this investigation does not support either aspect of this suggestion. The family may seek the answer to this particular question from the toxicology report which will be available at the Inquest

2. **The family queried whether relatives of another prisoner who were prison officers had arranged for him to be transferred to Castlerea Prison for two weeks; and if so, why?**

   The evidence available for this investigation does not support this suggestion.

3. **The family heard that Mr K was severely under the influence of drugs in the prison yard and in the gym the evening before he was found unresponsive. If this was true, then why was he not properly cared for, including with medical attention and hourly checks that night?**

   The evidence available to this investigation does not support this suggestion. There was no identified need for special observation during the night of 14th-15th June 2018. Oral and documentary evidence indicate that Mr K was reviewed regularly during the night. Investigators were unable to verify this by reviewing CCTV footage as such

footage was unavailable due to a technical fault. A review of CCTV footage in the gym area does not indicate that Mr K was severely under the influence of drugs.

4. **Was he being urine tested for drugs as the Court ordered?**
   The court order instructed that Mr K should remain drug free while in custody. A review of the Warrant from the Court does not indicate any direction from court that Mr K should be subject to urine testing.

5. **The family queried whether he was found sitting up on the bed with one leg on the bed and his eyes open. If he was sitting up like that all night why wasn't he checked if he had not moved position?**
   There were slight variations in the reports provided by first responders in relation to Mr Ks posture when he was found unresponsive, but nobody said he was sitting up. All first responders were consistent in reporting that he was in his bed; some said he was lying on the bed and one said he was semi-upright. All said that his eyes were open.

6. **On the morning he was found unresponsive the family learned from a friend rather than from the IPS that he had been taken to hospital.**
   In responding to this query Governor A informed the investigation that Chaplain A contacted Mr K's mother sometime between 10:00-11:00 hrs. Governor A visited Mr K in the Mater Hospital at 15:00 and met his mother. She informed him that she had heard her son had died on Facebook. Governor A reported that a number of prisoners may have put information on Facebook and may also have contacted family members prior to official notification by the prison Chaplain. The Governor further stated that he had no way of confirming this and unfortunately due to the prevalence of illicit mobile phones it is difficult to prevent reoccurrence.

7. **The family queried why the cameras on the landing were not working and how long they had been out of action?**
   The cameras had not been working on B3 landing for a month due to a fibre optic fault. The cameras in the boxed visits used by B3 prisoners, including Mr K, were not working for 11 days. While there is nothing to suggest that inoperable cameras contributed in any way to Mr Ks death, this is a very serious matter. It calls into question the IPS monitoring of its CCTV system in Mountjoy. I recommend accordingly.

8. **The family queried how he could have obtained drugs in the prison and suspected a particular visitor may have brought them in for him.**
   The investigation was unable to ascertain how drugs were in the possession of Mr K.

Several learning points arise from this investigation. Twelve recommendations for improvement are made.

All twelve recommendations in this report have been accepted by the IPS (recommendation 3 partially accepted) and an Action Plan setting out how the recommendations have/or will

be address was provided by the IPS. These will be monitored in future investigations into Deaths in IPS Custody.

RECOMMENDATIONS

Recommendation 1
For the purposes of Death in Custody investigations the IPS should provide the Inspector of Prisons with all documentation provided by AGS when a prisoner was transferred into IPS custody.

Recommendation 2
IPS records of requests for transfers between prisons should indicate in detail the reason for the request. When prisoners are being transferred in the interests of good order and discipline, targets should be set with them as an incentive towards improved conduct.

Recommendation 3
The IPS should set a target to reduce the numbers of prisoners held in protection in Mountjoy Prison. This should commence with an analysis of application of Rule 63 and other forms of protection.

Recommendation 4
The IPS should improve the regime for protection prisoners and make every effort to safeguard their mental health by maximising opportunities for social interaction with other prisoners, staff and visitors.

Recommendation 5
The IPS should conduct regular routine and unannounced cell searches for illicit material. The results should be made available to the Inspector of Prisons for the purposes of Death in Custody investigations.

Recommendations 6 and 7

In relation to CCTV

- ***The IPS should urgently review its quality control processes for CCTV monitoring in Mountjoy and throughout the prisons estate;***
- ***It should satisfy itself that staff who monitor CCTV footage are trained and competent to fulfil all their duties and take any action necessary to remedy deficient practice.***

Recommendation 8
The IPS should review its external contracts to ensure they are fit for purpose and delivering against all requirements. Those that impact upon safety and security should be prioritised.

Recommendation 9
A cold debrief should be conducted within 14 days of the incident to provide further opportunity for everyone involved, including prisoners where relevant. The purpose should be to identify learning, support everyone involved and assess progress in relation to actions that were identified at the hot debrief.

Recommendation 10
The IPS should ensure all staff are cared for after a critical incident, including those who are experienced and appear to cope well at the time.

Recommendation 11
The IPS should prioritise Death in Custody investigations and adhere to the protocol that requires all relevant material to be provided to the Inspector of Prisons within seven days of the prisoner's death.

Recommendation 12
Internal IPS reviews into Deaths in Custody should have a clear format, structure and content.

MOUNTJOY PRISON

Mountjoy Prison is a closed, medium security prison for adult men. It has an operational capacity of 554 and is the main committal prison for Dublin city and county.

Prison Rule 63 aims to ensure the safety of prisoners who might be under threat if they are held within the general population. Mr K was subject to that Rule throughout his period in Mountjoy in 2018. It is not known whether the same Rule was applied to him during a short period (10 days) that he spent in Castlerea Prison.

Primary Healthcare at Mountjoy Prison is delivered by the Irish Prison Service.

The Irish Prison Service has a Drugs Policy & Strategy which, inter alia aims to eliminate the supply of drugs into prisons and provide prisoners with opportunities to adopt a drug-free lifestyle. It offers drug rehabilitation programmes for prisoners including methadone substitution treatment and psychosocial services.

Mountjoy Prison had nine places specifically allocated for a drug free programme. There was also a national addiction counselling service for prisoners with drug problems and an addiction specialist GP service was provided in a number of prisons. However Mr K did not seek any treatment for drug problems during his time in custody in 2018; on committal he denied any history of illicit drug use and he was not identified as someone who required such intervention.

Mountjoy Prison has a Visiting Committee whose role is to satisfy themselves regarding the treatment of prisoners. Their 2017 Annual Report was published on 24th May 2018. It highlighted two issues that were relevant to Mr K:

- While screening for drugs and random testing had contributed to a reduction in drug availability, which was greatly welcomed by prisoners, the increasing number of prisoners serving a sentence for drug-related crime required urgent focus, research and planning (Paras 1.16-1.17).

- Serious concern was expressed about the high numbers of prisoners on a Restricted Regime. Ireland was unique among Council of Europe Member States in having such high numbers of prisoners in such a regime - the proportion in Mountjoy varied between 23% - 30% during April 2017. There is a well-recognised risk to the mental health of prisoners such as Mr K, who spend long periods in their cell, isolated from human contact (Paras 1.14 & 1.19).

Mr K's was the 3rd death of a Mountjoy prisoner in 2018; and the 11th death in IPS custody that year.

CHAPTER 1 BACKGROUND

1.1 Mr K commenced a one year sentence on 9th February 2018 and was due for release on 8th November 2018.

1.2 He had been in continuous custody for just over four months at the time of his death.

1.3 He had been committed to custody on at least four previous occasions: March 2006, November 2007, September 2008 and February 2013.

1.4 Mr K was accommodated on Mountjoy's B3 Wing when he was found unresponsive on 15th June 2018. B3 held 33 prisoners and he was allocated to the Green Group, which was one of two subgroups for IPS management purposes. He lived there because he had requested to be kept apart from the general population for his own safety.

1.5 Mr K was transferred from Mountjoy to Castlerea Prison on 29th March 2018; and he was transferred back to Mountjoy on 8th April 2018.

1.6 On the night of 14th-15th June 2018 Mountjoy Prison held a total of 716 prisoners.

1.7 Shortly after Mr K was found unresponsive another Code Red alarm was sounded in a different area of the prison.

CHAPTER 2 COMMITTAL

2.1 No documentation relating to Mr K's handover from An Garda Síochána to the IPS was provided to this investigation. Such documentation can be useful to provide an understanding of the prisoner's demeanour and any immediate issues such as being under the influence of substances, suicidal ideation or other reactions to detention.

Recommendation 1
For the purposes of Death in Custody investigations the IPS should provide the Inspector of Prisons with all documentation provided by AGS when a prisoner was transferred into IPS custody

Medical History

2.2 Mr K's medical history in custody appeared unremarkable. He had an initial screening upon committal on 9th February 2018. He denied any substance misuse and said he did not have psychiatric problems, thoughts of self- harm or suicidal ideation. Lower back pain due to a road traffic accident was his only declared medical problem.

2.3 When transferred to Castlerea Prison on 30th March 2018 his mood was described as "variable" at medical assessment because he was concerned about missing his children, who were aged 1 and 5. It is not known if they visited him at Mountjoy Prison. Nor is it known if anyone else visited while he was in Castlerea.

2.4 Mr K saw a doctor in Mountjoy on 1st June for a small contusion to his forehead. He said he banged it off the door during a seizure in his cell. However he was not known to have epilepsy. Indeed Dr A noted on 11th April 2018 that he did not have epilepsy.

2.5 Mr K was reviewed periodically in relation to his back pain. On 20th April 2018 he was reviewed by Dr B who prescribed medication for anxiety along with the medication for back pain.

2.6 Mr K's medication records indicated a variety of prescriptions. They included analgesia, anti-inflammatories, vitamin supplements and antidepressant.

2.7 Medical records indicate that his prescribed medications were administered three times daily. He was permitted 'in-possession medication'. Governor A informed the OIP that at the time a formal risk assessment was not in place and such a decision was taken by the doctor in conjunction with the Chief Nurse Officer. However, he advised that new risk assessment procedures for 'in possession medication' are now in place.

2.8 The only interaction that Mr K had with the IPS Psychology Service was one meeting on 17th February 2018 when he was referred by a governor in respect of "Coping with Imprisonment." He was discharged after one meeting as "Intervention complete."

Transfers between Mountjoy and Castlerea Prisons

2.9 On 28th March 2018 Chief Officer B made an application to Irish Prison Service Headquarters recommending that Mr K be transferred to Castlerea Prison. Chief Officer C of Castlerea Prison agreed to the transfer and this was approved by a third party in IPS HQ Operations Directorate who noted the transfer was at *"Prisoner's own request."* Mr K was transferred to Castlerea Prison the next day, 29th March 2018.

2.10 On 8th April 2018 Chief Officer C applied to IPS Headquarters to have Mr K returned back to Mountjoy Prison on the basis that he *"…. had been moved to Castlerea to give Mountjoy a break on request. He was indirectly responsible for 3 different issues that required staff intervention here yesterday. Transfer requested to facilitate the security and smooth running of Castlerea prison."* There is no further detail in support of this application. The request was granted by IPS HQ and he was transferred back to Mountjoy Prison on 10th April 2018.

2.11 Given the indications from Chief Officer C, it was surprising that the Deputy Governor subsequently (at the debrief after he passed) said Mr K *"never came to our attention in a problematic way"*. This may have simply been an act of kindness after he was deceased, but it raises a question about why was he transferred between Mountjoy and Castlerea Prisons.

2.12 It was the same Chief Officer in Castlerea who had agreed to accept him 10 days earlier, that applied for Mr K to be returned to Mountjoy. It is not clear which Mountjoy Chief Officer, if any was involved in the return application. Approval for his return was granted by a different official in IPS Operations Directorate.

2.13 This means there were at least four, and possibly five people involved in Mr K's transfers between Mountjoy and Castlerea. Final approvals rested with IPS HQ, rather than local staff. This appears to discount any hint of conspiracy in the transfer process as feared by Mr K's family.

Recommendation 2
IPS records of requests for transfers between prisons should indicate in detail the reason for the request. When prisoners are being transferred in the interests of good order and discipline, targets should be set with them as an incentive towards improved conduct.

CHAPTER 3 SOCIAL INTERACTION

3.1 Mr K enjoyed good family support during his time in custody in 2018. His mother and other family members visited regularly. He also had phone calls, usually on a daily basis and of short duration, with family and friends.

3.2 He did not send or receive any letters. The only written correspondence received were two postal orders which were left for him to spend in the Tuck Shop.

Protection under Prison Rule 63

3.3 On Saturday 10th February 2018, the day after Mr K arrived in Mountjoy, his sister sent an urgent e-mail at 21:32 to info@irishprisons.ie asking that an urgent message be relayed to Governor B in Mountjoy requesting that he continue to be held on protection as he was at serious risk of harm from other prisoners. On the next working day Monday 12th February 2018 at 09:02, the email was forwarded internally within the IPS to the 'queries email address in the operations directorate'. At 14:20 in the afternoon the original email from Mr K's sister was sent to all Governors and Chief Officers in Mountjoy. A handwritten note dated 27th February 2018 was on a print of the email received by the OIP and stated that "*[Mr K] kept under review since his committal on 9/12/2018. He remains on Protection on B2 Cell 3*" [signature illegible].

3.4 As required by IPS policy, Mr K subsequently submitted his own written application for protection. Three Protection Interview Forms are included in his file. The reason for seeking protection on each occasion was "Fighting with Others." He named one specific prisoner and declined to name others. They were located in different areas of Mountjoy. In two of the applications he indicated that he did not want to move to another prison, while on 29th April he indicated that he wanted to move to Mountjoy West.

3.5 The copy of the application form reviewed by the OIP notes that protection status would remain until a governor had investigated the threat and established it was removed and it would be safe to move the applicant to another location. During that time the prisoner would have one hours exercise each day. There may be unavoidable delays to their visits; and they may not be eligible for employment, education or gymnasium. Mr K signed each application in the knowledge that he would be living in these circumstances.

3.6 Mr Ks PIMS profile noted that he and Prisoner X should be kept apart. There is no indication of the reason for this. Indeed Chief Officer D told the Inspector of Prisons on 12th February 2019 *"I am not aware of any evidence of [Mr K] being bullied or threatened by anyone in the prison during his time here."*

3.7 His first Rule 63 application was processed by ACO A on 11th February 2018, two days after he was sentenced.

3.8 On 25th February 2018 he made a verbal request to be moved out of protection as he was frustrated by the regime. There was no obvious outcome and it is presumed the application was not pursued formally in writing, as he remained on B3.

3.9 There is no record available to the investigation indicating whether Mr K applied for, or was granted, protection status during his 10 days in Castlerea Prison.

3.10 Subsequent to his return to Mountjoy, Mr Ks protection status was reviewed on three further occasions (10th April 2018, 29th April 2018 and 5th June 2018). Each review was conducted by a different person and each confirmed that he should remain on protection.

Recommendation 3
The IPS should set a target to reduce the numbers of prisoners held in protection in Mountjoy Prison. This should commence with an analysis of application of Rule 63 and other forms of protection.

Recommendation 4
The IPS should improve the regime for protection prisoners and make every effort to safeguard their mental health by maximising opportunities for social interaction with other prisoners, staff and visitors

Complaints
3.11 Mr K did not make any formal complaints during his time in Mountjoy Prison.

Spending
3.12 He spent €516 on Tuck Shop items during his time in Mountjoy. There is no record of expenditure for his time in Castlerea. There was nothing unusual in his purchase patterns or history, though it was not itemised. He appears to have received €11.90 per week from Gratuity Runs and this was supplemented with lodgements by visitors.

Adjudications
3.13 IPS records show Mr K had three adjudications during this period in custody:

- On 28th March 2018 he was found in possession of a syringe in his cell;
- On 6th April 2018 in Castlerea, he had an improvised phone charger and sim card;
- On 31st May 2018 he was charged with Threatening Behaviour towards an officer (because he felt he was unlocked late).

3.14 Only one of these adjudications appeared to have an outcome – on 9th April 2018 he was awarded a Suspended Loss of Association.

3.15 One month's records (16th May-14th June 2018) of Mr K's time out of cell shows he had just under three hours per day out of his cell, mainly for exercise, cleaning and showers. This usually was on three separate occasions during the day. He accepted almost all opportunities to leave his cell, and only declined one during the sample period.

CHAPTER 4: EVENTS PRIOR TO MR K BEING FOUND UNRESPONSIVE

4.1 Fifteen staff who might have had contact with Mr K during 12th–15th June 2018 were interviewed. None of them reported anything unusual in his demeanour or relationships.

4.2 While no prisoners were interviewed about Mr K during this time, it is reported by the family that at least one contacted them and provided their perspective. These led to concerns for Mr Ks family that he was under the influence of drugs on the day before he was found unresponsive; and his condition was not managed or treated.

4.3 Mr K had approached ACO B on the morning of 13th June 2018 to request another prisoner's visiting slot for that afternoon. His request was refused because such exchanges could lead to bullying. ACO B said Mr K appeared to accept the response.

4.4 Work Training Officer A said he saw Mr K in the gym on 13th and 14th June 2018. He did not recall Mr K acting any differently from normal. Work Training Officer A said Mr K *"…. was a fit fellow and a well-behaved prisoner in the gym."*

14th June 2018 Evening

4.5 Prison Officer A was on B3 on 14th June when Mr K went to the gym. He described his recollection of that evening: *"On return to the landing he showered and saw the medic when the medic was doing their rounds and went to his cell. No instances to report on that evening. He looked for a rubbish bag, all prisoners were locked up secured and the bag as requested was passed under the door to him."*

4.6 Mr K was allowed go to the gym with other prisoners in his group. CCTV footage shows him entering the gym at 17.44. There is clear footage which shows him freely associating with other prisoners in the gym. He worked out on a number of different machines.

4.7 After 16 minutes exercise Mr K went to make a phone call at 18.00. Prison records show this call was made to a friend. The call lasted until 18.07. The subject matter and tone of their discussion appeared normal, mostly involving television and sport.

4.8 Neither CCTV footage from the gym nor the phone call suggest that he was under the influence of drugs at this time, as was alleged to his family by others.

4.9 Mr K returned to the gym after this call. He continued to work out and chat with other prisoners until leaving the gym at 18:17, when he returned to his landing.

4.10 Records show that the Green Group, to which Mr K was assigned, remained out of their cells until 19.00, at which stage they were locked for the night.

4.11 The only account from a prisoner of this period is a brief statement from a prisoner accommodated in the cell next door to Mr K. He simply informed the IPS that that during the course of the evening/night he did not speak to Mr K at all, nor did he hear anything unusual.

4.12 An e-mail on 31 July 2018 from Chief A to 'Chief' and sent to WFLD Chief 1; WFLD Chief 2; MJOY Chief 1 and two assistant governors, requested a statement be sought from the prisoner in the cell on the other side of Mr K's. It was stated that such a statement must be given voluntarily and if refused, confirmation by email is required. There was no statement on the file received by the OIP from the IPS. It is unclear if a statement was requested and or refused.

Night of 14th-15th June

4.13 Mr K's cell bell was activated twice on 12th June 2018. It was not activated on 13th June; and it was activated five times on 14th June:

- Activated 10.15 - Reset 10.17
- Activated 14.04 - Reset 14.12
- Activated 14.12 - Reset 14.20
- Activated 16.05 - Reset 16.11
- Activated 19.19 - Reset 19.22

4.14 The significance or otherwise of these activations is unclear. All were of short duration before being reset. Only one was after he was locked for the night at 7pm.

4.15 Officer B was in charge of all of the B landings between 21:00 and 22:00 on the evening of 14th June 2018. He recalled checking Mr K at 21.00 and seeing him walking around his cell. When he checked again at 22:00 Mr K was lying down on top of the bed covers and nothing unusual was observed. There is no specific written record of these checks – none was required as Mr K was not on any form of special observation.

4.16 Officer C stated that he was on Night Guard duty on A3 and B3 landings during 14th-15th June 2018. Between 21.00 and 23.00 he was fully redeployed to A Division. However from 23:00 until 07:30 he was Night Guard on A3 and B3 landings, except for two half-hour meal breaks when he was relieved.

4.17 Officer C reported that he checked Mr K's cell at regular intervals throughout the night. The frequency of his checks is unclear as there was no CCTV footage available for this investigation. Officer C's written record in the Night Guard Book stated *"…Patrolled the landings throughout the night finding all correct, reported same to ACO C on each of his many visits to this post."*

4.18 Officer C recalled that Mr K was lying on his bed throughout the night. He commented that prisoners regularly lay on their beds uncovered, as the weather was very warm at that time. His overall recollection was of a quiet night with nothing unusual to report.

4.19 Officer C was relieved from duty by the Day Guard on the morning of 15th June 2018. At that stage he was unaware of Mr K's condition and only heard that he had been taken to hospital upon returning to work that night.

CHAPTER 5: EVENTS AFTER MR K WAS FOUND

5.1 Recruit Prison Officer A came on duty at 08.00 on 15th June 2018 and was assigned as Class Officer to B3 landing. He went to the landing and on arrival saw Nurse Officer A was already there to dispense medication.

5.2 Recruit Prison Officer A accompanied Nurse Officer A to a number of cells. On arrival at Mr K's cell he looked through the viewing panel before opening the door. He could not recall whether the light was already on inside or if he switched it on. He opened the door and called Mr K to let him know the nurse was present.

5.3 When he did not receive any response he walked into the cell and called Mr K again. There was still no response so he moved closer and called a third time. He kicked the bed and there was still no response. He noted that Mr K's eyes were open.

5.4 Recruit Prison Officer A went out and told Nurse Officer A, who looked in. Recruit Prison Officer A then called a Code Red at 08:05.

5.5 There was an immediate response from other prison officers and healthcare staff. Two Chief Officers B and D arrived. Governor A informed the OIP that the nursing staff arrived on the scene within minutes (08:10). They went into the cell, at which stage Recruit Prison Officer A left and handed over the keys to ACO A.

5.6 Chief Officer D contacted the Control Room and directed that an ambulance be called. Upon learning that the nurses could not get a pulse at that time and were applying CPR, he also contacted Mountjoy Garda Station in order to report an apparent Death in Custody.

5.7 In his statement of 29th July 2018 Recruit Prison Officer A said Mr K *"was in a semi-reclined position, his eyes were open and fixed."* Recruit Officer B said Mr K was *"lying flat on his back."* Nurse Officer B (who attended the emergency, checked for a pulse and undertook chest compressions, alternating with another nurse) and said Mr K was *"lying on his bed."* While several first responders concurred that Mr K's eyes were open when he was found, nobody suggested that he was found sitting up on the bed as his family had understood.

5.8 Nurse Officer A corroborated the evidence of Recruit Prison Officer A. She also said Mr K showed no response to tactile stimuli and no pulse was detected. His eyes were open and fixed. An ambulance was requested and CPR commenced with Nurse Officer B. A defibrillator was attached and oxygen administered. Two Nurse Officers alternated chest compressions until ambulance staff and an Advance Paramedic arrived to the cell at 08.23. They took over the care of Mr K and continued CPR in the cell for approximately thirty minutes. They subsequently transferred Mr K to the Mater Misericordiae Hospital by ambulance, where they arrived at 09.25.

5.9 While CPR was being applied, Mountjoy Garda Station called Chief D to enquire about the ongoing situation. At this time a second Code Red was sounded on Mountjoy's D3 landing. Some of the nurses who had arrived on the scene left to attend the second code red. Resuscitation attempts on Mr K continued. Chief D recollected that during this time an ambulance arrived followed by advanced paramedics who took over the care of Mr K.

Garda Síochána Involvement

5.11 Garda Sergeant A and two Scenes of Crime Officers arrived at Mr K's cell at 09.05. Once all medical personnel had left the cell, Sergeant A and the two Scenes of Crime Officers immediately entered the cell.

5.12 They examined the scene and took photographs. They seized the following items from a shelf above the sink and placed them in sealed exhibit bags: (a) a white plastic wrapper containing a brown substance; (b) white plastic wrapper containing substance; (c) white plastic bag wrapper containing twenty individually wrapped deals of brown substance in white plastic wrapper. The following items were also seized and placed in sealed exhibit bags: a black notebook from a green tray on the counter in the cell, a plastic pen on the counter beside the green tray and a black notebook from a cardboard box under the bed.

5.13 Scenes of Crime Officer Garda took possession of the items. Once AGS had completed their search, Chief Officer D arranged for the cell to be master locked and an officer placed outside the door with a log book.

5.14 A Certificate of an officer of Forensic Science Ireland, in accordance with Section 10 of the Misuse of Drugs Act 1984 identified diamorphine (heroin) in items (a) and (b). In relation to (c) a sample of six was analysed and diamorphine (heroin) was identified in all six. The total weight of brown powder in (a), (b) and (c) was estimated to be 1.965 grams. Diamorphine (heroin) is a controlled drug under the Misuse of Drugs Acts, 1977-2016.

5.15 On 10th May 2019 the OIP requested the following information from Governor A. When was Mr K's cell last searched prior to the Scene of Crime Garda search on 15 June 2018? Was B landing searched during the first half of 2018, if so, when? If searches took place were they conducted by OSG or prison based staff? Are such searches routine and unannounced?

5.16 Governor A informed the OIP on 13 May 2019 that a class officer carries out cursory cell inspection daily. B landing was not searched during the first half of 2018. General searches are unannounced and conducted in collaboration with OSG.

5.17 Apart from the cursory search referred to above there was no search of Mr K's cell or B Wing to indicate whether the substances in Mr K's cell might have been sought or found by IPS staff during cell searches. Given they were found on a shelf rather than concealed suggests a sense of impunity on the part of Mr K in relation to the likelihood of a cell search. Searching, both routine and unannounced, is a fundamental safety requirement in prisons.

Recommendation 5
The IPS should conduct regular routine and unannounced cell searches for illicit material. The results should be made available to the Inspector of Prisons for the purposes of Death in Custody investigations

5.18 Mr K did not leave any note or letter to be read after his death.

5.19 IPS staff subsequently heard a phone conversation between another prisoner and Mr Ks ex-girlfriend that took place on 17th June 2018. It referred to a rumour that Mr K *"took sleeping tablets… he was meant to get five Tranax tablets… he got them off A Wing…. I told him to give the gym a miss because he was a bit lit; and another prisoner who saw him in the gym said he was a bit out of his head."*

5.20 This rumour may explain the family's concerns for Mr K's wellbeing in the period shortly before his death. If so, then it is contradicted by CCTV footage from the gym and the impressions that four different IPS officers formed of Mr K in the period before he was found.

CCTV footage

5.21 Chief Officer A took positive pre-emptive action on 20th June 2018 by requesting that CCTV be saved, as it seemed likely that an IoP investigation would be required in this case. His request triggered a prompt effort to secure relevant footage.

5.22 In addition to the gym, the IoP requested CCTV footage from two areas - B3 landing and boxed visits - in order to assist this investigation. CCTV footage would be valuable in order to assess the quality of care provided to Mr K's and his removal from the landing, as well as his demeanour and conduct in visits.

5.23 It transpired that there had been a power outage in the boxed visits, which meant the cameras there stopped recording on 2nd June 2018 at 18.20. They did not start again until 11th June at 09.32. This was an 11 day gap, which was unduly long for cameras to be malfunctioning, especially in an area where prisoners who required protection took their visits.

5.24 Even more concerning was the fact that no footage was available from any of the six B3 cameras. The company which provided the IPS CCTV system analysed those failings on 15th June 2018 and reported that pictures had not been present for over a month. They established the fault was either fibre cards or fibre cable. On 19th June 2018 they obtained replacement parts from the IPS stores and installed them on 21st June 2018. Pictures then returned to the system.

5.25 These CCTV failures are concerning in several respects:

- Absence of camera cover compromised the security of everyone on B3 and in boxed visits –

- They call into question the entire CCTV monitoring process within Mountjoy. It is difficult to understand how nobody noticed complete failure of all cameras on the landing for a month; or in the boxed visits for 11 days;
- If prompt corrective action had been taken, then the length of time – one month and 11 days - is unacceptably long and needs to be addressed;
- They also call into question the processes for routine maintenance of IPS CCTV systems. There needs to be clarity about who is responsible for fault-finding, routine maintenance and ensuring prompt remedies.

5.26 A query to the IPS about whether staff in the Control Room should have noticed the camera failures received the reply: *"In relation to your query about whether staff should have been aware neither Electrical Inspector A nor myself can answer that question as we don't work there."* (E-mail from Operational Directorate A on 20th November 2018). This is an inadequate response.

5.27 The absence of CCTV footage makes it impossible to provide an informed, independent opinion of Mr K's demeanour in the days leading up to this event and subsequent interventions.

Recommendations 6 and 7

In relation to CCTV

- ***The IPS should urgently review its quality control processes for CCTV monitoring in Mountjoy and throughout the prisons estate;***
- ***It should satisfy itself that staff who monitor CCTV footage are trained and competent to fulfil all their duties and take any action necessary to remedy deficient practice.***

Recommendation 8

The IPS should review its external contracts to ensure they are fit for purpose and delivering against all requirements. Those that impact upon safety and security should be prioritised.

CHAPTER 6 POST INCIDENT

Contact with Mr K's family while in hospital

6.1 Staff from the Mater Hospital's Accident & Emergency Department notified Mr K's family that he had been admitted. The family said they had already been told of his move by a friend. Within a few hours of admission he was transferred to the Intensive Care Unit, where he remained until 25th June.

6.2 Governor A informed the OIP that on the morning of the incident Chaplain A contacted Mr K's mother sometime between 10:00-11:00 on 15th June 2018.

6.3 Governor A attended the Mater hospital on 15th June at 15:00 and met with Mr K's mother. She conveyed to him that she had heard that her son had died on Facebook. The Governor informed the OIP that unfortunately due to the nature and location of the event a significant number of prisoners were aware of the incident. He stated *"… a number of prisoners may have put information on Facebook and may also have contacted members of the deceased's family prior to official notification from our chaplain but I have no way of confirming this. Unfortunately due to the prevalence of illicit mobile phones, it is difficult to prevent this happening again.*"

6.4 Throughout his time in hospital Mr K had regular visits from family, friends and clergy. There were no apparent difficulties with access or duration of visits and it appears the family were facilitated in a humane and decent way by IPS staff.

Hot and cold debrief meetings

6.5 A hot debrief should take place as soon as possible after the incident and involve all who were present. The purpose is to provide staff and any prisoners who were involved with an opportunity to share views in relation to how the situation was managed, and identify any additional support or learning that could have assisted.

6.6 A Critical Incident Review Meeting took take place on 26th June 2018, the day after Mr K passed. It was chaired by Deputy Governor A. Ten others participated.

6.7 The meeting examined the emergency response and noted there was nothing unusual in relation to Mr K on the day prior to the incident.

6.8 Chief Nursing Officer A commended all staff involved for their quick response as there was the additional pressure of another Code Red at the same time.

6.9 There is no evidence that a cold debrief was held.

Recommendation 9

A cold debrief should be conducted within 14 days of the incident to provide further opportunity for everyone involved, including prisoners where relevant. The purpose should be to identify learning, support everyone involved and assess progress in relation to actions that were identified at the hot debrief.

Staff Wellbeing

6.10 As soon as the healthcare staff arrived, Recruit Prison Officer A was ordered off-site and told to get a cup of tea. He was spoken to by ACO A in his capacity as a Staff Support Officer and was subsequently relieved from duty for the remainder of the day.

6.11 However no similar response was evident in the case of Nurse Officer A or other first responders.

6.12 The post-incident process could be enhanced by consistent support being offered to everyone that was involved, and by conducting a cold debrief as well as a hot debrief.

Recommendation 10
The IPS should ensure all staff are cared for after a critical incident, including those who are experienced and appear to cope well at the time.