

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner F
on 8 May 2015 in Mountjoy Prison**

***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 F
on 8 May 2015 in Mountjoy Prison**

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

Judge Michael Reilly
Inspector of Prisons

31 March 2016

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Preface

Prisoner F was a 40 year old man who died on 8 May 2015 in Mountjoy Prison while in the custody of Irish Prison Service.

I offer my sincere condolences to the family of the deceased.

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

Judge Michael Reilly
Inspector of Prisons

31 March 2016

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 40 year old man at the date of his death. He came from the Leinster area. He is survived by his partner, his young children and his many siblings.
2. The deceased was committed to Mountjoy Prison on 21 December 2012 having been on remand in Cloverhill Prison since 28 June 2011. His remission date was to be 29 April 2020.
3. The deceased was found in an unresponsive state, sitting on his bed in cell 17 in the B Basement of Mountjoy Prison, in the early hours of 8 May 2015.
4. I met the deceased's family on 12 June 2015 and have responded, where possible in this report, to the many concerns that they wished me to investigate.

Status of the deceased in Prison

5. The deceased was an ordinary prisoner. Ordinary prisoners must be checked every hour during times of lock down.
6. The deceased was on the incentivised regime in the prison.
7. He was a good worker who worked predominantly in the fabric shop. He was particularly proud to be associated with making "*bits and pieces*" for hospitals. He also worked as a cleaner.
8. He was well thought of by both his fellow prisoners and by prison staff.
9. At the time of his death he was accommodated in cell 17 in the B Basement of Mountjoy Prison. This was a refurbished ordinary accommodation single cell with in cell sanitation.

10. The deceased had no disciplinary reports within the period of six months prior to his death.

Meeting with family of the deceased

11. On 12 June 2015, I met the deceased's partner, five of his siblings and his nephew.
12. The family informed me that the deceased was not on protection and could associate with all prisoners in the B Basement.
13. They informed me that he telephoned his partner usually twice a day and one of his brothers once a day.
14. The family informed me that the deceased did not take drugs but that "*he had some issues with the drink*".
15. His partner informed me that she visited him at least once a week and at times brought their children. Her last visit with him was on 5 May – three days before he died.
16. His partner informed me that he telephoned her on 7 May, the day before he died, at approximately 12.30 pm. He told her that he had booked a visit for her and the children for the Friday – the day he died.
17. His brother informed me that the deceased had telephoned him at approximately 5.30 pm on 7 May and arranged that his brother would visit him on the Saturday – the day after he died.
18. In the telephone calls referred to in paragraphs 16 and 17 the deceased requested items of clothing and it was agreed that such clothing would be brought to the prison on the Friday and Saturday.
19. The deceased's partner and his brother informed me that "*there was nothing worrying him*" (the deceased). This was confirmed by other members of the family present.

20. In my meeting with the family of the deceased on 12 June 2015 they raised the following issues that they wished me to investigate:

- (a) Where are his clothes?
- (b) What happened to him?
- (c) Was he attempting to bang on the door or the walls of his cell as he had bruises and cuts on his knuckles?
- (d) When was he checked during the night?
- (e) If he was making a noise during the night why was he not taken from his cell by the officers and put in the 'pad'?
- (f) Why did he not receive CPR?
- (g) Was he dead for long?
- (h) Who pronounced him dead? Was it a nurse?
- (i) Where did he get the 'hooch'?
- (j) If checks were carried out by the prison staff why was the 'hooch' not observed and taken out of the cell?
- (k) Who released details of his death to the media? News of his death was on the 8 am news that morning giving full details of his name address and other salacious information.

21. In paragraph 54, I endeavour to provide answers to the questions raised by the family.

Focus of my investigation

22. It became clear that the deceased had no issues with other prisoners or the authorities while in prison. He did not express any concerns for his well being to his fellow prisoners or to any members of the prison staff. His family were of the opinion that nothing was bothering him.

23. Therefore, I decided that my investigation should focus on the events of 7/8 May 2015.

24. I also decided that I should examine the deceased's medical records.

Deceased's contact with the prison medical services.

25. On 28 June 2011 the deceased, having been remanded to Cloverhill Prison, was seen by Nurse Officer A who noted in the medical notes:

“Medical hx – has had asthma for several years. States attends g.p for tx for panic-attacks; had xanax and dalmane in possession. Has hx of cocaine, speed and alcohol abuse”.

26. On the same day the deceased was seen by Dr. A who noted in the medical notes:

“Hx of asthma and panic attacks. Abuses benzos”

The doctor referred the deceased for a psychiatric assessment because of the charge that the deceased was facing.

27. On 29 June 2011 the deceased was seen by Psychiatric Nurse A who carried out a comprehensive assessment. The nurse noted that the deceased stated that he had been drinking heavily and that he was attending an alcohol counsellor, that he used cannabis daily and used most drugs in the past such as heroin, cocaine, speed and MDMA but was not an IV user.
28. Between 29 June 2011 and 22 December 2012 the deceased had periodic contact with the prison medical services for minor issues not relevant to this investigation.
29. On 22 December 2012 he was examined as a new committal to Mountjoy Prison, having being committed the previous day. Nothing new of relevance was noted. The deceased did complain of headaches in the past, of having bronchitis, migraine and back pain. He also complained of an eye infection.
30. Between 22 December 2012 and 26 June 2014 the deceased had periodic contact with the prison medical services for minor issues not relevant to this investigation.

31. On 26 June 2014 Nurse Officer B attended to the deceased in his cell on B2 landing in Mountjoy Prison. The nurse's note timed at 01.46 hours reads:

“Attended to (deceased) on B2 in his cell. I found (deceased) fast asleep on the mattress on the floor. (Deceased) presented with one small superficial cut on the top of his head. No other injuries observed. He was intoxicated. Prison staff removed some drink containers from his cell. (Deceased) was very talkative when we woke him up. I checked his vital with the monitor in which B/p 183/78 and pulse 83.... There was no sign of any sickness/vomiting”.

32. On 7 July 2014 Nurse Officer C attended to the deceased in his cell in the B Basement of Mountjoy Prison. The nurse's note timed at 18.26 hours reads:

“Got a call to see (deceased) down in his cell on B Base as he was found by officers on the ground in his cell ? LOC. Was put lying down on the bed with pillow under his head. Obs done BP 130/84, pulse 100 SATs 88% R/A. Oxygen given and Naloxone given IM. (Deceased) was very drug effected when we went into his cell. I kept turning down the oxygen slowly till he was taken off it. Obs done again before we left BP 129/89, Pulse 92, SATs 98% R/A. (Deceased) still was claiming that he had taken no drugs when we were leaving”.

33. On 12 August 2014 Nurse Officer D attended to the deceased in his cell. The nurse's note timed at 21.16 hours reads:

“Asked to r/v by (ACO A) as ? unresponsive. (Deceased) appeared to be in a deep sleep. Difficult to wake but completely orientated TPP once awake. States that he is a deep sleeper and was “just relaxing”. Denies any illicit drug abuse”.

34. The deceased had some contact with the addiction services in Mountjoy Prison. He was self referred to the service, via another prisoner, on 18 February 2015 for 'offence focused work and addiction'. He was seen for

intake to the service on 15 April 2015 and offered a place on the Motivational Enhancement Therapy group which was due to commence on 20 April 2015. He attended the group session on 20 April but left before it started to go to the tuck shop. He was again called on 22 and 27 April for the group but declined. Thereafter he had no further contact with the addiction services.

Sequence of events on 7/8 May 2015

35. During the day of 7 May 2015 prisoner officers and prisoners reported that the deceased appeared in good spirits. This is corroborated by the statements of his partner and brother that *“there was nothing worrying him”* (referred to in paragraph 19).
36. The deceased was locked in his cell – cell 17 in the B Basement at 19.24.30 hours on 7 May 2015.
37. Prisoner A occupied cell 13 in the B Basement. The deceased was his uncle. This prisoner when interviewed stated:

“I was speaking with him before lock up and he was buzzing. He had taken ten tablets. I don’t know where he got them. Then he went into his cell. He was saying “ah I’ll be drunk tonight boys”. He was shouting “yee ha”. Then about 20 minutes after he was shouting to me..... I shouted back “save me some of that hooch”. He said “yeah, yeah, I’ll see you in the morning”. During the night he was shouting “Tíochfaidh ár lá” and singing. He seemed to quiet down about 11 o’clock. I didn’t hear anything until the next morning”.

38. Prisoner B occupied cell 19 in the B Basement. This cell was next door to that of the deceased. This prisoner when interviewed stated:

“I was speaking to him about five minutes before bang out. He was in great form. At around eight o’clock I heard his stereo blaring and him singing along. He was shouting at other fellas on the landing. I couldn’t make out what was being said because of his stereo. He was

just buzzing along and singing with the radio. I went asleep and heard nothing else that night”.

39. Prisoner C occupied cell 15 in the B Basement. This cell was next door to that of the deceased. This prisoner when interviewed stated:

“I saw him last night at lock up. He was in good spirits. I wasn’t talking to him. He went into his cell, his radio was on and he was singing along to it. He had a laugh with (named prisoner) and (named prisoner) on the door. At about 4.00 – 4’30 am I got up to go to the toilet and heard his radio was still on. I banged on the wall to tell him to turn it off but got no answer. Just after that I heard an Officer banging on his door five or six times and calling (prisoner name, prisoner name, prisoner name). I heard what happened when I was getting my breakfast”.

The reference to the two prisoners in the above statement is to Prisoners A referred to in paragraph 37 and Prisoner D referred to in paragraph 40.

40. Prisoner D occupied cell 14 in the B Basement. This cell was opposite that occupied by the deceased. This prisoner when interviewed stated:

“I was speaking to him last night at lock up. He was in good form. Nothing unusual at that time. When he was locked up for the night he had the music playing loudish and he was talking to me and (named prisoner) on the door. He was saying something along the lines of “I’m getting drunk” or “I’ll be drunk tomorrow”. He sounded happier as he was going along. He sounded as though he was getting drunk. Then he went quieter as he stopped shouting. (A named prisoner) was still shouting but (the deceased) was slow to reply. He did reply though but said he would see him in the morning”.

The reference to the prisoner in the above statement is to Prisoner A referred to in paragraph 37.

41. As an ordinary prisoner the deceased should have been checked by prison staff approximately every hour during the night of 7/8 May 2015.
42. The B Basement is covered by CCTV cameras. I had access to the CCTV footage for the night of 7/8 May. The activity in and around the deceased's cell can be clearly seen on the footage examined by me. The following are relevant times, taken from the downloaded CCTV, of activity in and around the deceased's cell:

7 May 2015

- 19.24.30 Deceased locked in his cell
- 20.06.22 Officer checked cell – lifted observation flap and looked in.
- 20.55.05 Officer checked cell – lifted observation flap and looked in.
- 21.56.53 Officer checked cell – lifted observation flap and looked in.
- 23.06.35 Officer checked cell – lifted observation flap and looked in.
- 23.43.47 Officer attended to cell beside deceased but did not check deceased's cell.
- 23.43.58 Officer checked cell beside deceased but did not check on deceased's cell.

8 May 2015

- 00.08.02 Officer checked cell – lifted observation flap and looked in.
- 01.07.23 Officer checked cell – lifted observation flap and looked in.
- 02.03.45 Officer checked cell – lifted observation flap and looked in.
- 03.09.48 Officer A checked cell – lifted observation flap and looked in with the aid of a torch. Officer kicked the bottom of the door with his right shoe. Officer again kicked the bottom of the door a number of times with his right shoe at 03.10.30. Officer left the cell at 03.10.47. See paragraph 43.
- 04.04.38 Officer B checked the cell – lifted observation flap and looked in with the aid of a torch. See paragraph 44.

- 05.05.28 Officer C checked the cell – lifted the observation flap and looked in. The officer spent 10 seconds looking into the cell. See paragraph 45.
- 06.06.30 Officer C checked the cell – lifted observation flap and looked in with the aid of a torch. See paragraph 45.
- 06.29.27 Officer D who was removing the double locks from all cells lifted the observation flap and looked in. He kicked the door several times. See paragraph 46.
- 06.33.18 Officer D walked down the landing to cell 17, lifted the observation flap, looked in and remained at the door for 12 seconds.
- 06.36.51 Officer D, with keys in his hand and accompanied by Officers C and B, opened the door to cell 17 and entered the cell at 06.36.53.

Over the next three minutes a number of officers arrived at the cell and entered. They exited at different times.

- 06.39.54 Nurse Officer E entered the cell carrying the emergency bag. She was followed by Medical Officer A.
- 07.00.32 Dublin City Fire Brigade personnel entered the cell.

43. Officer A in his statement states:

“While carrying out a check on B Base 3 on the night of 7-5-15 at approx 03.05, I observed prisoner (deceased) sitting in an upright position on his bed. I gave the door a kick and was satisfied that I got a response so I carried on with the rest of my checks”.

The check referred to in the above statement was carried out at 03.09.48.

44. Officer B confirmed that he had relieved Officer D, who was taking his break, at approximately 04.00 on the morning of 8 May and had checked the B Base

landing. He stated that the deceased *“was sitting upright on his bed and looked to be asleep”*.

The check referred to in this paragraph was carried out at 04.04.38.

45. Officer C described his contact with the deceased on the morning of 8 May in the following terms:

“I carried out two further checks in the B Base at 5.05 and 6.05 and I observed prisoner (deceased) asleep sitting on his bed with a bottle in his hand. Shortly after 6.30 am Officer D asked me to enter (deceased’s) cell with him and Officer B. We found the prisoner unresponsive sitting on his bed with a bottle in his hand”.

The checks referred to in the above statement were carried out at 05.05.38 and 06.06.30.

46. Officer D who checked the deceased at 06.29.27 on 8 May stated:

“At 6.30 am while removing the master locks I checked the cells. I felt there was something unusual with (the deceased’s) cell so I returned and checked it again. It was after this check that I requested ACO B’s permission to enter the cell. I was accompanied by Officers B and C. As we entered the cell we found (the deceased) sat up on the bed with a mineral bottle. As we approached he was found unresponsive”.

47. Nurse Officer E arrived at the deceased’s cell at 06.39.54. She described the scene as follows:

“At approximately 6.35 am I received an emergency call for B Base. On arrival there prisoner (deceased) was in a sitting position, as if asleep, on his bed in the cell. On closer examination he was unresponsive to verbal or physical stimuli. He was pale and cold to the touch. Contacted colleague (Medical Officer) A for medical assistance from NMU. It appeared that rigor mortis had set in.

Unable to insert airway as his jaw was completely locked and I was unable to open. There was pooling of blood round his side and back. There were no vital signs evident. DFB ambulance personnel arrived and they were unable to detect any vital signs. It was apparent there was no sign of life”.

48. Medical Officer A corroborated the account given by Nurse Officer E referred to in paragraph 47.

49. Dr. B attended at cell 17 and pronounced the deceased dead at 08.56 hours. He described the deceased’s position in the cell as follows:

“Patient slumped on bed in semi upright position”.

The doctor also noted the deceased’s condition. The details of his observations are more relevant to the Coroner’s Inquest save that he observed ‘*rigor mortis had set in*’.

Additional Investigations

50. I understand that toxicology tests carried out revealed the detection of high levels of alcohol in the deceased’s blood and urine. The deceased’s blood was also found to contain a high therapeutic level of Diazepam and Morphine derived from Heroin.

51. The deceased had not been prescribed and was not taking prescribed Diazepam in prison.

52. I was unable to establish the provenance of the drugs referred to in paragraph 50.

53. I endeavoured to ascertain the source of the alcohol (hooch) referred to earlier in this Report. As with my endeavours to ascertain the source of the drugs, referred to in paragraph 51, while I was informed that drugs are available and that ‘hooch’ is brewed that was as far as anyone was prepared to commit themselves.

Addressing the concerns of the family

54. In Paragraph 20, I set out issues raised by the family that they wished me to investigate. I have endeavoured to address such issues in this paragraph. I have adopted the same numbering sequence as in paragraph 20.

- (a) This is a matter that the family must take up with the prison authorities. It does not fall within my remit.
- (b) While this is a matter more appropriate to the Coroner's Inquest it appears that the deceased ingested alcohol and drugs prior to his death and that the combination of both led to his death.
- (c) There is no evidence to suggest that he was attempting to bang on his cell door or elsewhere to attract attention.
- (d) The times that the deceased was checked during the night of 7/8 May are set out in detail in paragraph 42.
- (e) Prisons are, by their nature, noisy places. Prisoners are entitled to play music in their cells. There is also a considerable amount of 'banter' between prisoners during periods of lock down. It would not be the practice in prisons to take a prisoner from his/her cell in these circumstances.
- (f) This is explained in paragraphs 47 to 49.
- (g) This is a matter more appropriate for the Coroner's Inquest.
- (h) He was pronounced dead by Dr. B. While the Nurse Officer found "*no vital signs evident*" and that "*It was apparent that there was no sign of life*" it was the doctor who pronounced the deceased dead.
- (i) I was unable to ascertain the provenance of the 'hooch'.
- (j) The 'hooch' was in bottles. Prisoners are entitled to keep a variety of articles including bottles of water and drinks bought in the tuck shop in their cells. Any checking of cells during the night would not necessarily disclose the presence of 'hooch'.
- (k) I was unable to ascertain how the media became aware of the details of the incident and the death of the deceased.

Findings

55. The deceased was a model prisoner.
56. The deceased had a history of drug taking and alcohol abuse.
57. The deceased had access to both drugs and alcohol in Mountjoy Prison at times prior to 7/8 May 2015.
58. The deceased ingested both drugs and alcohol on 7 May 2015 and possibly on 8 May 2015. The provenance of such drugs and alcohol is unknown.
59. The deceased was not depressed and was in a 'happy mood' on the night of 7/8 May 2015.
60. The 'banter' between the prisoners following lock down on 7 May 2015 did not excite the curiosity of officers.
61. The deceased was checked in accordance with Standard Operating Procedures approximately every hour during the night of 7/8 May 2015.
62. The deceased was observed by officers at 03.09.48, 04.04.38, 05.05.38 and 06.06.30. At all such times the officers observed that he was sitting upright on his bed and in their words appeared to be asleep. This was the same position that the deceased was in when found in an unresponsive state at 06.36.51 hours on 8 May 2015.
63. The adequacy of the 'checking' referred to in paragraph 61 and more particularly in paragraph 62 is a matter more appropriate to the Coroner's Inquest.
64. The time of death is a matter that will be investigated by the Coroner at the Inquest. However, it would appear that the deceased may have been dead for some time prior to his discovery in an unresponsive state at 06.36.51 hours on 8 May 2015 particularly in view of the nursing notes referred to in paragraph 47 and the doctor's notes referred to in paragraph 49.

65. There was an appropriate and immediate response from the prison staff and medical personnel subsequent to the discovery of the deceased in cell 17 in an unresponsive state at 06.36.51 hours on 8 May 2015.

Recommendations

- 1 The prison authorities must take all reasonable steps to eliminate the ingress of drugs into Mountjoy Prison.
- 2 The prison authorities must ensure that 'hooch' is not brewed in Mountjoy Prison.
- 3 Where prison officers have any concerns for the well being of a prisoner during times of lock down they should (a) have his/her cell opened to check on the well being of the prisoner **AND** (b) share their concerns with their fellow officers working in the same area.
- 4 All concerns referred to in Recommendation 3 must be documented.
- 5 Officers must take cognisance of 'banter' between prisoners during periods of lock down. If this 'banter' can be heard by prisoners in other cells on the landings it should be heard by officers. Officers should act on any intelligence gleaned from such 'banter'.