

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner A
In Mountjoy Prison
On 17th January 2012**

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

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**A report by the Inspector of Prisons Judge Michael Reilly
into the circumstances surrounding the death of Prisoner A
In Mountjoy Prison on 17th January 2012**

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

Judge Michael Reilly
Inspector of Prisons

16th October 2013

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Preface

Prisoner A was 27 years old when he died by suicide whilst in the custody of Mountjoy Prison on 17th January 2012.

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

My Report is divided into eight sections as follows:-

- General Information
- Sequence of events
- Meeting with the family
- Relevant Standard Operating Procedures and Protocols
- Review of records
- Findings
- Addressing the concerns of the family
- Recommendations

Matters of concern which are of 'public interest' 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

16th October 2013

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 27 year old unmarried man. He is survived by one child, his parents and two siblings. He came from the Dublin area. He was committed to prison on the 20th December 2011. His release date was to be the 18th December 2014.

2. I had unfettered access to all parts of the Prison, to all records with the exception of those referred to in paragraph 32(d) held in the prison, to prison staff and to prisoners. I also had access to relevant C.C.T.V. footage. I was afforded all facilities by prison management.

Sequence of events

3. On the night of his committal (20th December 2011) the deceased was assessed by a Nurse Officer – Officer A. His situation was reviewed by Doctor A the following morning. The assessment identified that the deceased had a history of drug and alcohol abuse. He also had a history of seizures and was prescribed medication for this. It was noted that in all other respects he was healthy and had no mental health issues.

4. Between the 20th December 2011 and the 16th January 2012 the deceased presented as a normal prisoner. Prison management, prison officers, medical personnel and fellow prisoners had no concerns for his wellbeing.

5. On the 16th January 2012 the deceased, who was at that time accommodated in Cell 13 on D2 Landing (a single cell), reported ‘sick in cell’ and remained in his cell all morning and did not collect his breakfast. In his statement Officer B, who had been on duty on D2 Landing that day, stated that:-

“At 8.00am I unlocked for breakfast as normal procedure. *The deceased* stayed in bed and did so for the am, I’m unsure if the prisoner collected his dinner when unlocked at 12.00pm. At unlock at 2.00pm the prisoner

was up and went out for the afternoon, he was locked in his cell at 4.30pm as usual. At 5.20pm unlock the prisoner was showing for nights and went out to the yard and when I went to get him he refused to come back to his cell. I wrote a P19 on this matter. He was master-locked in cell at 8.00pm as per normal procedure”.

6. In fact the deceased was locked in his cell at 7.32pm.
7. There are C.C.T.V. cameras which cover D2 Landing. They clearly focus on the doors of the cells on the landing and there is no difficulty in identifying the cell occupied by the deceased on the night of the 16th/17th January 2012. All C.C.T.V. coverage is timed by an integrated clock. All times referred to, in this Report, have been taken from the C.C.T.V. clock. I cannot vouch for the absolute accuracy of the C.C.T.V. clock.
8. The C.C.T.V. footage records that a number of prisoners who were working on the landing were seen outside the deceased’s cell door that night. Two prisoners in particular – Prisoner 1 and Prisoner 2 can be clearly seen on C.C.T.V. spending time obviously talking to the deceased through the locked door and trying to pass something under the door.
9. At 9.25pm Prisoner 2 can be seen at the door apparently talking to the deceased.
10. At 9.36pm Prisoner 1 can be seen at the door apparently talking to the deceased. He is joined shortly afterwards by Prisoner 2. They can be seen trying to push something under the door. To assist them in their efforts they took a name card from the door of Cell 9. They remained at the door until 9.46pm. They were not approached by any officer.
11. In his statement Prisoner 1 stated:- “I went to *the deceased’s* cell door as he asked me for a ‘smokes and skins’. I tried to put it underneath the door but I wasn’t able to. I called another cleaner to help me push it through, which I did. I was talking to *the deceased* for a few minutes and he seemed ok to me. He did

not seem anyway unusual to me. He told me he had taken some tablets during the day”.

12. In his statement Prisoner 2 stated:- “I was at *the deceased’s* cell door because he asked me to get him some ‘skins’ and I didn’t have any to give to him. I did not notice anything unusual during these two visits to his door. He seemed fine to me”.
13. The deceased’s cell was not checked by prison officers between 7.32pm and 11.32pm on the night of the 16th January and again between 4.39am and 6.34am on the morning of the 17th January. However during this period regular checks were carried out on the cell next to the deceased but no other cells in the immediate vicinity were checked during those times. The night guard for D2 Landing on the night of 16th/17th January was Officer C. The Supervising Officer was Officer D.
14. At approximately 6.30am on the 17th January Officer C signed out the D1 and D2 master keys for the purpose of deactivating the master locks on all cells on D1 and D2 Landings. In order to carry out this deactivation the Officer had to attend at each cell. At 6.34am Officer C, while removing the master lock on Cell 13 on D2 Landing (the deceased’s cell), saw the deceased slumped on the floor of his cell. He saw a ligature (bed sheet) attached to the window of the cell but not attached to the deceased. Part of the ligature could be seen protruding from under the body of the deceased.
15. At 6.34am the door of the deceased’s cell was opened by Officer C. An emergency alert was put out requesting assistance from other prison officers and from the medical staff.
16. The prison medical staff arrived at the cell at 6.40am. The deceased was unresponsive. CPR was administered to the deceased in his cell.
17. An emergency ambulance was called at 6.42am and on arrival at 6.45am the ambulance crew attended to the deceased in his cell but no vital signs were

detected by the medical personnel. Resuscitation was not possible and the Prison Doctor was requested to attend.

18. At 7.15am members of An Garda Síochána arrived at the prison.
19. At 8.47am the deceased was pronounced dead by the Prison Doctor – Doctor A.
20. A note written by the deceased was found in his cell.
21. The deceased's next of kin and his ex-partner were informed.
22. The State Pathologist, following a Post Mortem, certified the cause of death as by hanging.

Meeting with the family

23. I met with the deceased's Mother, Father and one of his siblings. They stated that the deceased suffered from epilepsy and had seizures at least once a month. The family were always worried that he would be left on his own in the Prison. They stated that they did ask their Solicitor to contact Mountjoy Prison when he was committed to Prison on the 20th December 2011 to express their fears that he was not to be left on his own. However, the family are satisfied that their Solicitor did not make contact with the Prison.
24. The family stated that the deceased had a history of self harming. They did not bring this to the attention of the prison authorities.
25. The family had questions that they wanted answered. They can be summarised as follows:-
 - (a) The time that the deceased died.
 - (b) What he used to hang himself with?
 - (c) Was he left hanging or dead for some time?
 - (d) Why was he in a cell on his own when he was known to suffer from epilepsy take seizures?

(f) What tablets/medication had he taken?

Relevant Standard Operating Procedures and Protocols

26. Chief's Order No 4/2011 dated 14th January 2011 states:-

“All prisoners who declare themselves “sick in cell” shall be recorded in the Health and Safety Daily Check List Journal provided for each landing.

A copy of this list shall be brought to the medical area and handed to the Nurse Officer/Medic who has been detailed i/c of the wing to which the prisoner belongs. The Class Officer shall then record in the Health and Safety Daily Check List Journal, the name of the Nurse Officer/Medic who has been informed of the list of prisoners declaring “sick in cell”. It will then be the responsibility of the Nurse Officer/Medic i/c of each area to visit each prisoner on this list so as to ascertain their illness.

All prisoners who have declared “sick in cell” shall be kept locked back for the day – including the reserve period for bed rest.

It shall be the responsibility of each Class Officer to check each prisoner locked back “sick in cell” at regular intervals and if leaving their area of responsibility for whatever reason hand over this list to one of the other Class Officers on that division so check can be maintained. The ACO must also be informed who is taking charge of that area.

Under no circumstances is a prisoner to be locked back and an entry of “no medic required” be entered in the Health and Safety Daily Check List Journal”

27. A Governor's Order dated 29th July 1998 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...”

Review of records

28. I reviewed the deceased’s prison file and in particular the intelligence section. There was nothing to suggest to the prison that the deceased was a vulnerable person who had, in the past, attempted to self harm. The family accepted that they did not alert the prison or any member of staff to their fears or to the fact that the deceased had attempted to self harm in the past and especially on the day before his last committal.
29. The assessment which was carried out when the deceased was committed to Mountjoy Prison on the 20th December 2011 was thorough. Such assessment did not suggest that the deceased was vulnerable or that he might try to self harm. The deceased did not tell those assessing him that he had tendencies to self harm.
30. The deceased was not on the special observations list in the prison at the time of his death, nor was he on this list at any time since the date of his committal. On the 30th December 2011 the deceased was placed in the Special Observation Cell but this was for a medical reason associated with his medical condition.
31. I reviewed all other journals held in the prison that were relevant to this investigation.

Findings

32. (a) Chief’s Order No. 4/2011 dated 14th January 2011 referred to in paragraph 26 was not complied with in that the appropriate records were not kept and therefore the deceased was not visited by a Nurse Officer/Medic as should have been the case.
- (b) The level of activity described in paragraphs 8 to 12 was allowed to go unchecked. This activity did not appear to raise any concerns.

- (c) The Governor's Order dated the 29th July 1998 referred to in paragraph 27 was not complied with in that the deceased was not checked for prolonged periods during the night of 16th/17th January 2012.
- (d) The Proxy Pens records (recording clock) used by officers working on D2 Landing were not made available to my office due to a 'technical difficulty'. However, the unavailability of such records did not hamper my investigation as the C.C.T.V. was in fact the 'best evidence'.
- (e) Correct records were not maintained by Officer C the Night Guard on duty on 16th/17th January. The Night Guard Report for D1 and D2 Landings for the night of the 16th/17th January 2012 states:-

“Patrolled the landings throughout the night finding all correct”.

Addressing the concerns of the family

- 33. In paragraph 25, I set out certain questions that the family wanted answers to. In paragraph 34, I endeavour to provide such answers.
- 34.
 - (a) I cannot say at what time the deceased died. He was unresponsive when the medical staff examined him at 6.40am. He was checked at 4.39am. As he was next checked at 6.34am all that can be presumed is that he died sometime between those two times.
 - (b) The deceased used a sheet as a ligature which he attached to the window of his cell.
 - (c) I cannot say for how long the deceased was left hanging or dead. The ligature had broken but I cannot speculate as to when this happened.
 - (d) He was placed in a single cell only after a thorough assessment.
 - (e) The medical notes disclose that the deceased was on appropriate medication for his epilepsy. The Pathologist in her report under the

heading 'Toxicology' stated:- "Samples of blood and urine were retained for toxicological analysis and these showed no evidence of alcohol or drugs of abuse".

Recommendations

1. The Irish Prison Service should develop an appropriate management and governance structure to ensure that SOP's, Governors' and Chiefs' Orders are (a) known to all staff and, (b) implemented to the letter at all times.
2. The Governor of Mountjoy Prison should ensure that appropriate records are kept in the Prison. He should ensure that a regular audit of all records is carried out to ensure compliance.