

**A report by the Inspector of Prisons  
Judge Michael Reilly into the circumstances  
surrounding the death of Prisoner E  
on 27 June 2014  
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 E  
on 27 June 2014 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

16 February 2015

## Preface

Prisoner E was a 33 year old single man who died in Mountjoy Prison on 27 June 2014.

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

My Report is divided into 10 sections as follows:-

- Information General
- by the family Issues raised
- deceased Status of the
- the medical concerns of the family Addressing
- efforts to detox Deceased's
- deceased between Mountjoy and Cork Prisons Transfer of
- events – 27 June 2014 Sequence of
- remaining issues raised by the family Addressing
- Findings
- Recommendations

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

Judge Michael Reilly  
Inspector of Prisons

16 February 2015

# **Inspector of Prisons Investigation Report**

## **General Information**

1. The deceased  
was a 33 year old single man who came from the Dublin area. He is survived by his parents and his two young children.
  
2. The deceased  
was committed to prison on 24 April 2014. His remission date was to be 21 January 2015.
  
3. The deceased  
had a long history of illicit drug use since his middle teens.
  
4. The deceased  
and his family made constructive efforts to help him deal with his drug problems. This entailed linking with therapeutic services both in the community and in recognised institutions. However, the deceased regularly relapsed.
  
5. The  
deceased's parents, by letter to the Minister for Justice and Equality, raised numerous issues that they wanted addressed. The family also raised these issues and others with me both in correspondence and in my meeting with them. The issues raised cover many aspects of this investigation.
  
6. I had  
unrestricted access to all parts of relevant prisons – Mountjoy Prison and Cork Prison, to all records held in the prisons, to all medical records and relevant CCTV footage. I also had access to all appropriate members of staff, others working in the prisons and prisoners.

### Issues raised by the family

7.

The

following are the concerns raised by the family:-

- (1) *“What happened on the night my son, I believe, assaulted a Prison Officer?”*
- (2) *“Did he receive some form of corporal punishment that went beyond that of simple restraint?”*
- (3) *“Was he whisked away to a relatively secluded place so that he could recover from over zealous punishment?”*
- (4) *“Who authorised my son’s transfer to Cork Prison?”.*
- (5) *“Why was he being administered Laroxyl?”*
- (6) *“Laroxyl is an antipsychotic drug and if (the deceased) was psychotic why was he not assessed and put in the Central Mental Hospital at the outset?”*
- (7) *“If (the deceased) was diagnosed as psychotic why was his father and I not informed?”*
- (8) *“What special facilities does Cork Prison have that necessitated him being moved there?”*
- (9) *“When he arrived in Cork Prison did he undergo any medical examination and if*

- so who was the examining doctor? What's the doctor assessment? Is there a copy of the doctor's report?"*
- (10) *"Did he undergo a psychiatric or psychological assessment in Cork? If so what was the name of the examining doctor? What was his diagnosis? Is this diagnosis available?"*
- (11) *"Who prescribed Laroxyl? What doses were prescribed and by what method was this drug to be administered?"*
- (12) *"Was he being administered any other drugs? If so, what were these other drugs and for what condition was (he) being treated?"*
- (13) *"While in Cork Prison why was no one allowed to visit him?"*
- (14) *"Why were RDRD (Ringsend and District Response to Drugs) and my husband both told that a visit to Cork Prison could only be arranged by agreement with the Governor there?"*
- (15) *"Who authorised (his) transfer back to Mountjoy?"*
- (16) *"Why was he transferred back to Mountjoy? Was his period of recuperation complete? Was his period of punishment completed? Was he cured of the psychosis for which he appears to have been treated?"*
- (17) *"What happened on (his) return to Mountjoy?"*
- (18) *"Did he undergo a medical examination and if so who was the examining doctor and where is his report?"*
- (19) *"Did he undergo a psychiatric or psychological examination and if so who was the examining doctor and what was his diagnosis or report?"*
- (20) *"Why was he placed under protection?"*
- (21) *"What are the procedures in place to monitor a prisoner under protection?"*
- (22) *"Were these procedures adhered to?"*
- (23) *"Who discovered (the deceased)?"*
- (24) *"What attempts were made to revive him, if any?"*
- (25) *"Who pronounced (the deceased) as dead? What state was his body in on examination?"*
- (26) *"Why were the family not informed until approximately 11.40 pm?"*

- (27) The family want an explanation as to why they did not see the body until the following Monday despite having been told by prison personnel that – “*you’ll see him in the morning*”.
- (28) “*Why was the deceased on his own in his cell as he was a high suicide risk?*”
- (29) “*How did he do it and what did he use?*”
- (30) The family require an explanation as to why they were told he was on 85ml methadone when they thought he was on 5ml.
- (31) On the Monday at 2.45 pm when they saw the body they were told the post-mortem had been carried out and found this strange as they did not identify him.
- (32) “*Did he leave a note?*”
- (33) “*What happened to new clothes that the family had left in to the prison for him?*”
- (34) The family had heard that a hose had been used on their son in his cell and wanted this investigated.
- (35) The family stated that in a telephone call to them on the Thursday before he died their son was in an agitated state which could have indicated his state of mind at the time.
- (36) The family wanted to know why their son was naked when he was transferred from Mountjoy Prison to Cork Prison on 20 May 2014.

8. I address all of the concerns raised by the family, referred to in paragraph 7, in various parts of this report. Where I address such concerns I reference my comments to the individual concerns being addressed.

### **Status of the Deceased**

- 9. The deceased was classed as an ordinary prisoner who was on protection.
- 10. The deceased had sought protection on his original committal to prison on 24 April 2014.
- 11. On 26 June the deceased stated that he did not wish to be accommodated on E1 landing in the Separation Unit as he was in disagreement with prisoners on

that landing. The records and statements of governors and officers indicate that he was happy to be accommodated on E5 landing – a protection landing.

12. The deceased could mix freely with prisoners on E5 landing subject to his protection status.
13. The prison authorities were obliged to check the deceased every hour during periods of lockdown.
14. The above paragraphs 9 to 13 address the issues raised in paragraphs 7.20 and 7.21.

#### **Addressing the medical concerns of the family**

15. The deceased was seen by Dr. A on 19 May 2014 who noted superficial abrasions on his left forehead around the eyebrow and a very superficial scratch mark on the right forearm. This refers to a C&R removal following an incident on 18 May 2014 when he, with another prisoner, was inciting prisoners to burn the Separation Unit. I have examined the CCTV and there is no evidence that the deceased was assaulted by prison personnel. Subsequent to this removal Nurse Officer A endeavoured to enquire if the deceased had any medical issue following his C&R removal. The deceased was aggressive and did not co-operate with the Nurse Officer. Approximately one hour later Nurse Officer B described the demeanour of the deceased in the following terms – “(the deceased) *refused to allow any medical review, became very aggressive and threatening in behaviour stating – ‘I am going to stab you all to death’, withdrew from cell for own safety, when outside observed (the deceased) pounding the cell wall and shouting threats towards us*”.
- (Paragraphs 7.1 and 7.2)

16. Subsequent to his arrival in Cork Prison on 20 May the deceased was assessed at Committal by Nurse Officer C. On 22 May the deceased was seen by Dr. B. The only issue raised by the deceased was his methadone which was confirmed at a dosage of 30mls. (Paragraph 7.9)
17. The deceased was seen by a psychiatrist – Dr. C in Cork Prison on 23 May 2014. The deceased refused to engage with the doctor as he also did on 27 May. The deceased was not diagnosed as psychotic. (Paragraph 7.7, part 7.10 and part paragraph 7.19)
18. Laroxyl or any other like drugs were not prescribed at any time for the deceased nor was he administered any such drugs. (Paragraphs 7.5, 7.6, 7.11 and 7.12)
19. The deceased met with the psychologist – Dr. D on 26 May 2014 in Cork Prison. This followed concerned contact between the deceased’s father and Governor A. No matter of concern was disclosed in that engagement. (Part paragraph 7.10 and part paragraph 7.19)
20. On 26 June the deceased underwent a committal interview in Mountjoy Prison which included a medical assessment by Dr. E. The only issue raised by the deceased was his methadone. The doctor confirmed his dosage at 5mls and that he could continue to use nicotine patches. (Paragraph 7.18)

**Deceased’s efforts to detox**

21. When the deceased was committed to prison on 24 April 2014 he stated that he was taking 90mls of methadone daily.
22. On 9 May the deceased stated that he wished to reduce his methadone intake to 40mls which he did against strong medical advice to the contrary.
23. On 14 May Dr. F advised against detoxing at the rate that the deceased was engaging in.

24. On 17 May the deceased reduced his intake of methadone by 5mls to 35mls against the pharmacist's advice.
25. On 19 May the deceased informed the pharmacist that he intended stopping his methadone completely the following day. The pharmacist strongly advised against this.
26. On 22 May the deceased reduced his methadone by a further 5mls to 30mls.
27. On 27 May the deceased reduced his intake to 20mls against medical advice from Dr. G.
28. On 10 June the deceased reduced his methadone to 10mls against the advice of Dr. G who explained the risks of detoxing at this rate.
29. On 17 June the deceased reduced his intake to 5mls as he informed Dr. G that he was feeling well and his "*sleep was good*".
30. On his return to Mountjoy Prison on 26 June, the deceased was continued on 5mls by Dr. E. (Paragraph 7.30)

### **Transfer of deceased between Mountjoy and Cork Prisons**

31. On 20 May the deceased was the subject of a P19 Disciplinary Hearing following an incident on 18 May in the Separation Unit referred to in paragraph 15. Sanctions were imposed in respect of this misconduct which included, *inter-alia*, a prohibition on personal visits or telephone calls.
32. On 20 May the deceased was transferred to Cork Prison for operational reasons following the incident on 18 May in the Separation Unit of Mountjoy Prison referred to in paragraph 31. He was accommodated in a single cell with in-cell sanitation. (Paragraph 7.3)

33. In view of the issue raised by the family referred to in paragraph 7.36, I reviewed the considerable documentation and other evidence available to me in Mountjoy Prison, on the journey to Cork Prison and his arrival in Cork Prison. I have also taken operational reports from relevant prison officers. The deceased refused to wear prison clothes during his transfer from Mountjoy to Cork Prison. These clothes travelled with him in the prison van and could have been worn by him at any stage. The deceased was dressed in a vest, his underpants, socks and runners and had the use of a poncho. The escort to Cork Prison stopped at Portlaoise Prison where the deceased was given food which he accepted and the use of toilet facilities which he refused. He was asked at Portlaoise Prison to dress himself but he refused.
34. I accept that RDRD (Ringsend and District Response to Drugs) sought access to the deceased while he was in Cork Prison in relation to his addiction issues as this organisation had previous contact with him. RDRD was not known to the prison authorities or to the Governor in Cork. The Governor correctly sought the verification of the *bone fides* of this organisation but by the time he was satisfied as to their credentials the deceased had been transferred back to Mountjoy Prison.
35. Although part of the sanctions imposed on the deceased at the disciplinary hearing, referred to in paragraph 31, Governor A would have facilitated a visit from the deceased's father.
36. On the evening of 25 June 2014 the deceased was transferred back to Mountjoy Prison. This was an operational decision of the Operations Directorate of the Irish Prison Service as the deceased was required in the Criminal Courts of Justice in Dublin on 27 June 2014.
37. The deceased was returned to Mountjoy Prison at approximately 8.20 pm on 25 June. He was seen by all services on the morning of 26 June including, *inter alia*, Governor B, Chief Officer A and ACO A. He was informed that he was to be accommodated in the Separation Unit and was transferred to this Unit at approximately 6.00 pm on 26 June. He was to be accommodated in a

single cell on E1 landing but would not agree and wanted to go to E5 landing where he had been prior to his transfer to Cork Prison. It was agreed that he could be accommodated in cell 2 (a single cell) on E5 landing but was subsequently moved to cell 3 (a single cell) on the same landing as the toilet was leaking in cell 2.

38. At 6.39.27 pm on 26 June the deceased telephoned his parents and spoke to his mother and father. His parents indicated to me, as part of their concerns, that he was agitated while talking on the telephone and that this may have indicated a state of mind. I have listened to this telephone conversation and I am satisfied that there is no suggestion either directly or by implication that the deceased was in an agitated state. The telephone call lasted for 6 minutes and 43 seconds. The deceased stated that he had put on a few pounds, that he was getting back into training and was looking forward to an upcoming visit. I am satisfied that the deceased did not directly or indirectly indicate to any person, prison staff or fellow prisoners, his intention to take his own life. (Paragraph 7.28)

39. In Paragraphs 31 to 37, I address the issues raised in paragraphs 7.4, 7.8, 7.13, 7.14, 7.15, 7.16, 7.17, 7.35 and 7.36.

#### **Sequence of events - 27 June 2014**

40. On the morning of 27 June the deceased attended Court at the Criminal Courts of Justice, leaving the prison at 9.40 am and returning to the Separation Unit at approximately 2.10 pm.

41. The deceased's progress through the Separation Unit is captured on CCTV. At approximately 2.15pm the deceased can be seen going towards the ACO's office on E2 landing where he sought tobacco and a shop order. He then remained in the vicinity of this office for approximately 5 minutes while officers were reporting to the ACO's office for duty following their lunch break.

42. At 2.21 pm the deceased can be seen in the vicinity of the ACO's office. Some sort of a verbal altercation occurred and at 2.21.30 pm Prison Officer A can be seen on CCTV catching the deceased by the right arm and pulling him back towards the stairs where he is assisted by Prison Officers B and C. Prison Officer A is then seen catching the deceased in a headlock with the deceased's head under his arm. Prison Officers B and C are holding the deceased by the arms. The deceased is then brought, in this form of C&R, with Prison Officer A walking forward, with the deceased's head under his right arm in a headlock, up the flights of stairs to E5 landing and placing the deceased in cell 2. I have been unable to ascertain what the verbal altercation entailed. However, the reaction was swift and the deceased was taken under restraint as described to his cell. Prison Officers who witnessed the removal all stated that proper C&R techniques were used. CCTV footage of the events described in this paragraph is clear.
43. At 2.18 pm Prison Officer D smelled smoke coming from E5 landing. On investigation the smoke was coming from Cell 2 – that which was occupied by the deceased at the time. He found that the deceased was setting fire to the cell. The fire hose was prepared in case it was needed.
44. Prison Officer D spoke to the deceased through the cell door and told him to *“stamp out the fire and come to the door to talk”*. When the cell door was unlocked the deceased asked *“why did you put me back in the cell – I'm allowed to mix on the landing?”* The deceased was informed that the officers had not unlocked the landing and that he would be allowed out when the landing was unlocked. He appeared satisfied with this explanation.
45. As the fire hose was not required it was rewound on its reel without being used. This is clear from the CCTV footage.
46. The deceased can be seen on CCTV coming and going around the E5 landing until he was locked in cell 3 at 7.25.28 pm. Cell 2 was out of commission due to the earlier incident and because of flooding in the cell as a result of water seeping from the toilet due to damage to same. During this time he had his hair cut and mixed with and talked to other prisoners. He had his tea with

other prisoners in the recreation room which was at that time being used as a 4 person cell. He did not display any signs of anxiety at that stage to either prison staff or his fellow prisoners. I have confirmed this in the course of my investigation.

47. The CCTV coverage of E5 landing and especially the area around the doors into cells 2 and 3 was of excellent quality.
48. At 7.52.58 pm Prison Officer E checked the deceased in his cell as the call light for the cell was flashing. He spoke to the deceased, confirmed that everything was in order and turned off the call light and left the door at 7.53.10 pm.
49. At 8.52.15 pm Prison Officer F checked cell 3. The officer stated that he observed the deceased who appeared to be hanging from the window. The officer can be seen kicking the door on 4 occasions in rapid succession to try to get a response. The officer immediately left to get assistance.
50. At 8.52.45 pm Prison Officer F returned to cell 3, briefly looked in and walked swiftly towards the barred gates on the landing and out of view.
51. At 8.56.47 pm Prison Officer F returned to cell 3 with ACO, B. They unlocked the cell and entered same at 8.56.47 pm. The deceased was hanging from the window by means of a ligature made from shoe laces. The deceased was alone in his cell. The officers immediately lifted the body, cut the ligature and laid the body on the floor of the cell. After approximately 30 seconds both officers left the cell and remained on the landing.
52. At 8.57.47 pm Prison Officer F accompanied by Nurse Officer D and ACO C entered the cell.
53. Nurse Officer D immediately commenced CPR and continued CPR until the arrival of 3 paramedics from Dublin City Fire Brigade at 9.07.09 pm who then took charge of the prisoner. The Nurse Officer also attached the defibrillator to the prisoner and used same in accordance with the operating instructions.

54. At 9.15.01 pm the deceased was taken from the cell by the paramedics and laid on the landing floor where the paramedics continue CPR.
55. At 9.28.15 pm CPR was discontinued as the paramedics had determined that the prisoner was dead and the deceased was removed from the landing by the Dublin City Fire Brigade personnel.
56. The deceased was pronounced dead at 10.49 pm by Dr. H.
57. In paragraphs 40 to 56, I address the issues raised in paragraphs 7.22, 7.23, 7.24, 7.25, 7.28, 7.29 and 7.34.

#### **Addressing remaining issues raised by the family**

58. In paragraphs 59 to 63, I endeavour to address the remaining issues raised by the family and referred to in paragraphs 7.26, 7.27, 7.31, 7.32 and 7.33.
59. The deceased was not pronounced dead by a doctor until 10.49 pm. Thereafter, prison personnel had to make arrangements and travel to the family home. (Paragraph 7.26).
60. At that stage the Coroner had jurisdiction over the body. I cannot address this issue further as this is outside my remit. (Paragraph 7.27).
61. This is a matter for the Coroner's Court. (Paragraph 7.31).
62. The deceased did not leave a note. (Paragraph 7.32).
63. This issue should be taken up by the family with the prison authorities. (Paragraph 7.33)

## Findings

64. The deceased was not assaulted before being transferred to Cork Prison on 20 May 2014.
65. The deceased was transferred to Cork Prison and returned from Cork Prison to Mountjoy Prison for operational reasons.
66. The deceased was not prescribed Laroxyl or any other antipsychotic drug.
67. The deceased had considerable contact with the medical services in Mountjoy and Cork Prisons as set out in this report.
68. Despite strong medical advice to the contrary, given on numerous occasions, the deceased insisted on reducing his intake of methadone at a dangerous rate.
69. The deceased did not travel naked when transferred to Cork Prison on 20 May 2014. He refused to wear prison clothes which travelled with him. At all times he wore his vest, underpants, socks and runners. He also had the use of a poncho.
70. Despite the sanctions imposed at the P.19 Disciplinary Hearing on 20 May 2014 a family visit to Cork Prison would have been facilitated by the Governor of Cork Prison.
71. The deceased was a protection prisoner at his own request. He was accommodated on E5 landing where he could associate with other prisoners on that landing.
72. A verbal altercation took place between the deceased and prison officers at approximately 2.21 pm on 27 June 2014.
73. The C&R techniques employed at approximately 2.21.30 pm on 27 June 2014 did not accord with recognised C&R procedures and best practice.
74. A fire hose or other like apparatus was not used on the deceased on 27 June 2014.

75. The deceased was checked in accordance with Standard Operating Procedures during the relevant period of lock down, namely, on the evening of 27 June 2014.
76. The deceased used a ligature made of laces tied to the window of his cell to take his own life.
77. The deceased did not leave a note.
78. As soon as the deceased was observed hanging in his cell an immediate response followed. The prison medical staff commenced CPR until the medics from the Dublin City Fire Brigade took over.
79. The deceased was pronounced dead by the doctor at 10.49 pm on 27 June 2014.

### **Recommendations**

1. C& R techniques should only be employed where appropriate.
2. When C&R techniques are employed such techniques should accord to recognised C&R procedures and best practice.