

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner F
In Mountjoy Prison
on 4th April 2012**

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

Office of the Inspector of Prisons
24 Cecil Walk
Kenyon Street
Nenagh
Co. Tipperary

Tel: + 353 67 42210
Fax: + 353 67 42219
E-mail: info@inspectorofprisons.gov.ie
Web: www.inspectorofprisons.gov.ie

**A report by the Inspector of Prisons Judge Michael Reilly
into the circumstances surrounding the death of Prisoner F
in Mountjoy Prison on 4th April 2012**

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

Judge Michael Reilly
Inspector of Prisons

29th October 2013

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Preface

Prisoner F was 30 years old when he died tragically while in the custody of Mountjoy Prison on the 4th April 2012.

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

My Report is divided into eight sections as follows:-

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

Matters of concern are disclosed in this Report.

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

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

Judge Michael Reilly

Inspector of Prisons

29th October 2013

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 30 year old unmarried man. He is survived by his father, mother and five siblings. He came from the Dublin area. He was committed to prison on the 20th October 2010. His release date was to be the 18th February 2015.
2. During my investigation I had unrestricted access to all parts of the prison, to all records held in the prison, to prison staff, to prisoners and others who worked in the prison.
3. The deceased had a serious drug problem and was known to the therapeutic services in the prison.
4. In paragraph 3, I stated that the deceased was known to the therapeutic services in the Prison. The deceased was offered assistance by such services during his time in prison and did avail of such services.
5. Despite availing of the services referred to in paragraph 4 the deceased continued to use drugs while in the prison.
6. It is clear from the records held in the prison that the deceased was actively involved in drug taking in the month before his tragic death. The following extracts from relevant records in March 2012 bear out this statement:-
 - “*The deceased* admitted to taking heroin in the recent few days”.
 - “Actively using illicit drugs”.
 - “Smoked heroin about once in 2 weeks and could smoke up to 3 or 4 joints”.
 - “His cannabis consumption was once or twice per week”
 - “He stated that he sometimes got benzodiazepines from other patients to help him sleep”.

Sequence of events

7. The deceased was accommodated in Cell 32 on B2 Landing from the 2nd November 2010 to the 1st April 2012. He was moved to Cell 6 on the same landing on the 1st April 2012. Cell 6 was a single occupancy cell.
8. The deceased was considered to be a well behaved prisoner and carried out duties in the prison as a cleaner and painter.
9. Between normal lock down time and 10.00pm on the evening of the 3rd April 2012 the deceased was carrying out his duties as a cleaner on B2 Landing. He carried out these duties in a normal manner.
10. At 10.00pm on the 3rd April 2012 the deceased was master locked into his cell by Officers A and B. The Night Guard - Officer A stated that he “saw nothing out of the ordinary in his demeanour. During my regular nightly checks I saw nothing out of the ordinary in his cell”.
11. There were CCTV cameras covering B2 Landing. There was no direct CCTV coverage of the door of the deceased’s cell or of a number of other cells.
12. It is clear from the CCTV footage that Officer A carried out regular checks of cells on B2 Landing during the night. These checks were carried out hourly at the following times – 11.34pm, 12.35am, 1.34am, 2.34am, 3.29am, 4.30am, 5.31am and 6.41am. He can be seen on CCTV carrying out such checks by viewing the cells through the viewing panel in the cell doors while reaching up to the night light switch. He checked every cell that can be seen on the CCTV and the intervals when he was out of coverage were such as to suggest that he must have continued checking during those times.
13. At 7.10am on the 4th April 2012 Officer A was relieved from his post on B2 Landing by Officer C - the Day Guard.
14. Officer C can be seen on CCTV carrying out checks on B2 Landing at approximately 7.25am.

15. At 7.26am, while checking cell 6, Officer C observed the deceased “half sitting up in bed with his head lying back”.
16. At 7.28am the master lock was removed from the deceased’s cell by Officers C and D. The deceased was unresponsive.
17. Officer C reported observing tin foil and other drug paraphernalia lying on the bed beside the deceased.
18. At 7.30am a Nurse Officer – Officer E arrived at the cell. The Nurse Officer stated that he observed the deceased lying on his bed in “a sitting up position”. He stated that the deceased was non responsive with no radial or carotid pulse and he was not breathing.
19. The deceased was moved onto the floor in order to commence CPR. Nurse Officer E assessed the deceased again and still could not find a pulse. He then placed the defibrillator pads on the deceased’s chest and the AED advised “no shock and start CPR”. CPR continued until the arrival of the Dublin City Fire Brigade.
20. At 7.55am the Ambulance personnel from Dublin City Fire Brigade arrived. Care was then handed over to the Ambulance crew.
21. At 8.13am the deceased was removed from his cell on a stretcher and taken to the Accident and Emergency Department of the Mater Hospital.
22. At 8.16am the cell log shows that three medics entered cell 6 and removed packaging and waste left behind by the Ambulance Crew. They left the cell at 8.20am.
23. At 8.20am the prison Chaplain made contact with the deceased’s next of kin.

24. At 9.51am the deceased was pronounced dead by a Doctor in the Mater Hospital.
25. The Post Mortem results show that the cause of death was:-
 - (a) Drug related death.
 - (b) Morphine and Diazepam intoxication.

Meeting with the family

26. I met with a representative of the deceased's family. The family, through the representative, reported that the deceased appeared well in prison, was not a troublesome prisoner and was engaged in the prison as a painter.
27. The family stated that they were not aware that the deceased was a drug user.
28. The family had questions that they wanted answered. They can be summarised as follows:
 - (a) What happened?
 - (b) What was the source of the drugs?
 - (c) Did the Night Guard notice anything untoward during the night?

Relevant Standard Operating Procedures and Protocols

29. I reviewed all Standard Operating Procedures (SOP) and Protocols that were relevant. The deceased was classed as an 'ordinary prisoner'. Therefore the relevant SOP was to the effect that the Night Guard should check the prisoner at regular intervals of approximately one hour.

Source of the Drugs

30. It is clear from the post Mortem results that the death of the deceased was drug related.
31. It is also clear that the deceased had drug paraphernalia in his cell at 7.28am.
32. Despite exhaustive enquiries I have been unable to establish how the deceased acquired the drugs that he used.

Findings

33. I am satisfied that the Night Guard carried out regular checks of all cells on B2 landing in accordance with the relevant SOP. I can deduce, for the reasons stated in paragraph 15, that cell 6 was checked in the same manner as other cells noted on the CCTV coverage.
34. I am satisfied that the deceased had a significant drug addiction and that he continued his drug use while in prison.
35. I am satisfied that CCTV coverage was not adequate but this did not hinder my investigation.

Addressing the concerns of the family

36. In paragraph 31, I set out certain questions that the family wanted answers to. In paragraph 37, I endeavour to provide such answers.
37.
 - (a) The deceased died as a result of ingesting drugs in his single cell.
 - (b) I am unable to say where the drugs came from.
 - (c) The Night Guard did not notice anything untoward during the night.

Recommendations

38. I recommend that any gaps in CCTV coverage be addressed.
39. The continuing influx of drugs into Mountjoy Prison and all prisons is a major issue. Innovative means of addressing this issue must be brought forward as a matter of urgency.