

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner K
in the Mid-Western Regional Hospital
on 11th October 2013 while in the
custody of Limerick Prison**

***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
Office Ref: 2013/K

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into the circumstances surrounding the death of Prisoner K
in the Mid-Western Regional Hospital on 11th October 2013
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Presented to the Minister for Justice and Equality pursuant to
Part 5 of the Prisons Act 2007

Judge Michael Reilly
Inspector of Prisons

21st March 2014

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Preface

Prisoner K was 34 years old when he died in the Mid-Western Regional Hospital, while in the custody of Limerick Prison, on 11th October 2013 following an incident on 7th October 2013.

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

My Report is divided into 9 sections as follows:-

- General Information
- Sequence of events
- Standard Operating Procedures
- Investigation
- Interviews with prisoners
- Contact with the family
- Addressing the concerns of the family
- Findings
- 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

21st March 2014

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 34 year old married man who came from the Munster area. He is survived by his wife, his children, his father and his many siblings.
2. The deceased was last committed to prison on 28th January 2013 and his release date was to be 28th July 2014. Prior to this committal the deceased had served many terms of imprisonment.
3. The deceased had a history of depression. He had self harmed and had attempted suicide on several occasions. He also had a history of alcohol and drug misuse.
4. The deceased was known to the psychiatric services in the community and in prison. He had been an inpatient in a psychiatric hospital.
5. I had unrestricted access to all parts of the Prison, to all records held in the Prison, to prison staff and to prisoners. I also had access to relevant CCTV footage.

Sequence of events

6. On 28th January 2013 the deceased was committed to Mountjoy Prison.
7. A Committal Interview was conducted with the deceased on committal.
8. The deceased was assessed by Doctor A in Mountjoy Prison on 29th January 2013.
9. On 6th February 2013 the deceased was transferred from Mountjoy Prison to the Midlands Prison. He was assessed by Nurse Officer A. A Committal Interview was also undertaken.

10. On 7th February 2013 the deceased was seen by Doctor B.
11. During the assessment on 6th February referred to in paragraph 9 and at interview with Doctor B on 7th February referred to in paragraph 10 it was noted that the deceased had a history of depression, self harming, attempted suicide and alcohol misuse.
12. While in the Midlands Prison appropriate medical and therapeutic care was made available to and accepted by the deceased.
13. On 1st August 2013 the deceased was transferred from the Midlands Prison to Limerick Prison.
14. There is no record of an interview or assessment having been carried out on the deceased when he was transferred to Limerick Prison.
15. On 11th August 2013 the deceased attempted to self harm while on A Division in Limerick Prison. His cell mate alerted staff and on that occasion he was revived by staff and placed on the Special Observation List.
16. On 13th August 2013 the deceased was seen by a psychiatrist. The deceased explained that he had tried to hang himself with laces which he got from his shoes.
17. On 21st August 2013 at a Special Observation Review Group Meeting it was decided to remove the deceased from the Special Observation List.
18. On 10th September 2013 the deceased was again seen by a psychiatrist. The medical notes disclose that the deceased, at the time, was feeling stressed and anxious, was sleeping for two to three hours, his appetite was bad as was his concentration and he was drained of energy. He did state that life was worth living. He was hopeful. He felt guilty about self harming in the past. The psychiatrist found no psychotic features. The psychiatrist prescribed a certain medication and placed him on a review list for 3rd December 2013.

19. On 19th September 2013 the Prison received a report from the Prison Service Escort Corps (PSEC) that the deceased threatened to self harm while on prison escort. He was placed on the Special Observation List.
20. The deceased's status as a Special Observation Prisoner was reviewed at Special Observation Review meetings held on 25th September and 2nd October 2013 in Limerick Prison. The conclusion of such meetings was that the deceased was to remain on the Special Observation List.
21. There were no remarkable incidents between 2nd October and the afternoon of 7th October 2013. During that time the deceased shared a cell with Prisoner 1 – Cell 17 on C3 Landing.
22. At approximately 2.30pm on 7th October Prisoner 1 left Limerick Prison on transfer to Portlaoise Prison. At approximately 4.15pm Officer A spoke with the deceased on C3 Landing. He enquired if the deceased would be happy for Prisoner 2 to move into Cell 17 with him (the deceased) after tea that afternoon (after 5.30pm). The deceased was happy with this arrangement as Prisoner 2 was a friend. However, this never happened as events overtook the proposed arrangement.
23. At 5.38.34pm Officer B unlocked the deceased's cell – Cell 17 on C3 Landing. The officer did not look into the cell when he unlocked the door.
24. At 5.38.52pm Prisoner 3 entered the deceased's cell. He was a friend of the deceased's. At interview he stated that he had a conversation with the deceased at approximately 4.00pm. He had agreed to go to the yard with the deceased after unlock at approximately 5.30pm. When Officer B unlocked the doors on the landing he – Prisoner 3 - walked out of his cell which was opposite the deceased's and walked to the deceased's door and pushed it open. In his statement to me he described seeing the deceased suspended by a ligature (a shoe lace) which was attached to the top bunk. He ran in and tried, by lifting the deceased, to take pressure off the ligature. He called his brother

- Prisoner 2 for help. He described placing the deceased on the lower bunk and his efforts to remove the ligature. He describes Prisoner 4 entering the cell. He described the floor as slippery as though shampoo or a like substance had been spilled.
25. Prisoner 4 described how, at approximately 5.30pm, he was going out to the yard. He noticed the door of the deceased's cell part open. He described glancing in and seeing Prisoner 3 holding the deceased up off the ground and calling for help. He described seeing Prisoner 2 in the cell. He described shouting at Prisoner 2 to get a knife. He described his efforts to assist the removal of the ligature and the other assistance that he gave. He also described slippery substance such as shampoo on the floor.
26. As soon as the deceased had been found an immediate and appropriate response from Officers, the Medical Staff and Prison Management followed. The deceased was removed by ambulance to the Mid-Western Regional Hospital. I am informed that he was placed on a life support machine.
27. On 11th October 2013 the deceased died in the Mid-Western Regional Hospital.

Standard Operating Procedures

28. All Prisoners must be checked hourly during periods of lock down. **All prisoners classed as Special Observation Prisoners must be checked every 15/20 minutes.**

Investigation

29. I examined all records, including medical records, held by the prison authorities from the time of his committal to prison on 28th January 2013 to the date of the incident – 7th October 2013, that were relevant to the deceased. I also interviewed two prisoners. I am satisfied that, in setting out the 'sequence of events' in paragraphs 6 to 26, I have accurately reflected such records and the circumstances of the finding of the deceased.

30. Nothing was disclosed in the records or in my interviews with the prisoners (paragraph 29) or raised as issues by the family of the deceased (paragraph 40) which suggested that I should carry out any further investigation of any matter during this period.
31. Therefore, the remainder of my investigation centred on the events of 7th October 2013.
32. I sought to ascertain the movements of the deceased in the period prior to him being found as described in paragraph 24. This entailed a perusal of CCTV footage.
33. I have stated in paragraph 5 that I had unrestricted access to, *inter alia*, relevant CCTV footage. The CCTV coverage of part of C3 Landing, relevant to this investigation, was of a reasonably high quality. I initially examined the CCTV footage for the period 12 noon to the time that the deceased was found by Prisoner 3 at 5.38.52pm (see paragraph 24). This indicated, *inter alia*, that the deceased had not been checked for a period of 1 hour 23 minutes and 2 seconds immediately prior to being found by Prisoner 3 instead of every 15/20 minutes as provided for in Standard Operating Procedures for the checking of prisoners on the Special Observation List (paragraph 28). The CCTV footage also indicated that for a further period of 1 hour 24 minutes 19 seconds commencing at 2.33.06pm the deceased had similarly not been checked.
34. In view of the evidence referred to in paragraph 33, I decided, in the interest of compiling a comprehensive, fair, transparent and robust report, I should view all CCTV footage of C3 Landing for the period commencing 12 midnight on 6th/7th October and terminating with the removal of the deceased to the Mid-Western Regional Hospital in order that I would have an accurate picture of the regime under which the deceased was held as a Special Observation Prisoner. Accordingly I set out hereunder all relevant movements of the deceased and activities at and around the deceased's cell (Cell 17 on C3 Landing) as recorded on CCTV paying particular attention to the recorded times:-

- 12.46.15am – Cell 17 checked by officer who lifted the observation flap and looked in.
- 3.37.11am - Cell 17 checked by officer who lifted the observation flap and looked in.
- 6.46.00am – Master lock unlocked on Cell 17 but cell not checked.
- 6.52.23am – Cell 17 checked by officer lifting flap and looking in.
- 7.25.51am – Cell 17 checked by officer lifting flap and looking in.
- 8.12.01am – Cell 17 unlocked. Deceased and Prisoner 1 leave the cell to collect their breakfast.
- 8.15.14am – Cell 17 locked with prisoners inside.
- 8.16.35am – Cell 17 checked by officer lifting flap and looking in.
- 8.42.09am – Cell 17 checked by officer lifting flap and looking in.
- 9.27.51am – Officer goes specifically to Cell 17 and unlocks cell. Deceased exits and walks down the landing. Prisoner 1 exits the cell and stands on the landing at the railing.
- 9.29.34am – Deceased returns and talks to Prisoner 1 and they both enter the cell.
- 9.55.24am – Deceased and Prisoner 1 are locked back in Cell 17. Not all cells are locked.
- 10.09.48am – Cell 17 checked by officer lifting flap and looking in.
- 10.10.38am – Cell 17 unlocked and deceased exits and walks the landing. Prisoner 1 also exits the cell.
- 10.20.48am – Deceased enters Cell 17 and the cell door is locked. The deceased is alone in the cell.
- 10.26.36am – Prisoner 1 is allowed into the locked cell by an officer who then relocks the cell having checked same.
- 10.49.01am – Officer walks the landing. Some prisoners are cleaning and walking the landing. Other prisoners are locked in their cells.
- 11.12.32am – Officer walks the landing but does not check the cells.
- 11.57.50am – Officer unlocks Cell 17 but does not check the cell.

- 11.58.01am – Deceased exits Cell 17 with a box of waste and leaves it on the landing beside the rubbish bin. Prisoner 1 exits Cell 17. He and the deceased stand on landing talking to other prisoners.
- 12.16.01pm – Deceased and other prisoners go to collect their dinner.
- 12.18.28pm – Officer walks the landing.
- 12.19.35pm – Deceased and Prisoner 1 enter Cell 17 with their dinners.
- 12.19.47pm – Cell 17 is locked with both prisoners inside.
- 12.44.21pm – Cell 17 is checked by officer lifting flap and looking in.
- 1.35.17pm – Cell 17 is checked by the dinner guard lifting flap and looking in.
- 2.11.53pm – Cell 17 is unlocked but not checked by the Prison Officer.
- 2.12.00pm - Deceased exits Cell 17.
- 2.22.40pm – Deceased returns to Cell 17 and officer locks cell. The deceased is alone in the cell.
- 2.24.10pm – Officer walks the landing but does not check the cells.
- 2.29.48pm – Prisoner 1 is returned to Cell 17 which the officer unlocks and leaves open. The deceased momentarily looked out the cell door but did not exit.
- 2.32.09pm – Prisoner 1 leaves the cell carrying a bag of clothes on transfer to Portlaoise Prison. The deceased can be seen assisting Prisoner 1 with his belongings.
- 2.33.06pm – The deceased returns to the cell accompanied by an officer who closes and locks the cell door. The deceased is alone in his cell.
- 3.57.25pm – Officer unlocks Cell 17 and pushes the door open.
- 3.57.45pm - The deceased exits the cell and speaks with prisoners on the landing.
- 4.15.50pm – The deceased is locked back into Cell 17 having previously spoken to an officer on the landing and the prisoners in Cell 16. The deceased is alone in his cell.
- 5.33.09pm – An officer walks past Cell 17 opens Cell 18 and continues down the landing. Some prisoners can be seen on the landing. They were cleaners.

- 5.38.34pm - Officer B unlocked the deceased's cell. The Officer did not look into the cell when he unlocked the door.
- 5.38.52pm - Prisoner 3 entered Cell 17 followed at 5.39pm by Prisoner 2.
- 5.39.39pm - Prisoner 2 exits cell obviously seeking an officer's attention.
- 5.39.50pm - Officer B enters the deceased's cell following Prisoner 2.
- 5.40.24pm - Prisoner 4 enters Cell 17.
- 5.42.04pm - Two officers enter the cell followed by four more officers.
- 5.42.36pm - Prisoner 4 exits the cell with an officer followed by Prisoner 2.
- 5.43.21pm - Prisoner 3 and Officer B leave the cell.

Subsequently appropriate medical staff and others can be seen entering and exiting Cell 17. In view of my findings referred to in paragraph 46 and based on my observations in paragraph 26, it is not necessary for me to detail such activities.

35. In examining the times in the preceding paragraph it is clear that the deceased was not checked during times of lock down for the following periods which would suggest breaches of relevant Standard Operating Procedures for the checking of prisoners categorised as being on Special Observation, namely every 15/20 minutes:-

- 2 hours 50 minutes 56 seconds between 12.46.15am and 03.37.11am
- 3 hours 08 minutes 49 seconds between 3.37.11am and 6.46.00am
- 33 minutes 28 seconds between 6.52.23am and 7.25.51am
- 46 minutes 10 seconds between 7.25.51am and 8.12.01am
- 25 minutes 34 seconds between 8.16.35am and 8.42.09am
- 45 minutes 42 seconds between 8.42.09am and 9.27.51am
- 1 hour 31 minutes 25 seconds between 10.26.36am and 11.58.01am
- 24 minutes 34 seconds between 12.19.47pm and 12.44.21pm
- 50 minutes 56 seconds between 12.44.21pm and 13.35.17pm

- 36 minutes 36 seconds between 1.35.17pm and 2.11.53pm
- 1 hour 24 minutes 19 seconds between 2.33.06pm and 3.57.25pm
- 1 hour 23 minutes 02 seconds between 4.15.50pm and 5.38.52pm

36. During the times mentioned in paragraph 35 none of the other cells on the deceased's landing – C3 Landing – which were visible on CCTV were checked.

Interviews with prisoners

37. I identified three prisoners – Prisoners 2, 3 and 4 who I considered relevant to the investigation. Unfortunately Prisoner 2 was not available to me.

38. Prisoner 3 described finding the deceased as detailed in paragraph 24. He also described his efforts in assisting the deceased and described the condition of the floor of Cell 17. He described the deceased as a man who got on well with other prisoners and with staff but stated that he (the deceased) was - *“Never a man who could do jail”*.

39. Prisoner 4 described his role after the deceased had been found by prisoner 3 as detailed in paragraph 25. In reference to the deceased he stated – *“He couldn't do jail”*.

Contact with the Family

40. I met with the deceased's family. They expressed concerns which can be summarised as follows:-

- (a) What exactly happened to the deceased?
- (b) Could they be provided with a copy of the post-mortem results?
- (c) What did he use to hang himself with?
- (d) Are his belongings still in the prison?
- (e) Who found him?
- (f) What medication was he on?

Addressing the Concerns of the Family

41. In paragraph 40, I outlined numbers of concerns that the family wished to have addressed. In this paragraph, I endeavour to provide answers for the family.
- (a) I have addressed this issue in paragraphs 23 to 27 and 29 to 35.
 - (b) This will be a matter for the Coroner.
 - (c) As I have already stated he used a shoe lace.
 - (d) This matter should be taken up by the family with the prison authorities.
 - (e) Prisoner 3 found the deceased. Prior to the publication of this Report I will inform the family as to the identity of this person.
 - (f) For privacy reasons I do not intend disclosing the medication that the deceased was taking. However, I will inform the family of the medication prior to the publication of this Report.

Findings

42. The deceased had a history of depression and self harming. He had attempted suicide on several occasions.
43. The deceased had a history of alcohol and drug misuse.
44. The deceased was a Special Observation Prisoner from 19th September up to and including the date of the incident – 7th October 2013.
45. The deceased was not checked in accordance with Standard Operating Procedures. Prior to being found at 5.38.52pm the deceased had not been checked for 1 hour 23 minutes and 2 seconds when he should have been checked every 15/20 minutes. In fact, between midnight and 3.57.25pm, there was a failure to check the deceased during **eleven other** separate periods ranging from 24 minutes 34 seconds to 3 hours 8 minutes and 49 seconds when he should have been checked every 15/20 minutes.

46. Not alone were the 15/20 minute checks not carried out but **hourly checks were not carried out on the deceased on five separate occasions** in the period referred to in paragraph 35.
47. **It is clear from my findings referred to in paragraphs 45 and 46 that a line management structure either did not exist or was deficient which would have adequately supervised the proper implementation of relevant Standard Operating Procedures particularly relating to the checking of prisoners during periods of lock down.**
48. There is no reference recorded of an interview with or assessment of the deceased, if same took place, following his transfer to Limerick Prison on 1st August 2013.
49. Once the deceased was found all appropriate protocols were followed.
50. Prisoners 2, 3 and 4 acted responsibly and appropriately.

Recommendations

1. **The Irish Prison Service should develop line management structures and procedures which would ensure the proper supervision of the implementation of Prison Rules, Health Care Standards, Standard Operating Procedures, Governors' and Chiefs' Orders etc.**
2. Standard Operating Procedures governing the checking of prisoners must be strictly observed.