A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner M on 11 October 2017 while in the custody of Cloverhill Prison

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

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A report by the Office of the Inspector of Prisons into the circumstances surrounding the death of Prisoner M on 11 October 2017 while in the custody of Cloverhill Prison

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

The Investigation was conducted and the Report prepared by the undersigned.

Helen Casey
Office of the Inspector of Prisons

10 April 2018

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Preface

The aim of this investigation is to:

- Establish the circumstances surrounding the death;
- Examine whether any changes in operational methods, policy and practice, or management arrangements would help to prevent recurrence of a similar death or serious event; and
- Address any concerns of the family.

The deceased was a 39-year-old man who died on 11 October 2017 while in the custody of Cloverhill Prison.

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.

Details in relation to means of self-harm are omitted for the safety of others to prevent similar re-occurrences.

Helen Casey
Deputy Inspector of Prisons

10 April 2018

Investigation Report

General Information

1. The deceased was a 39 year old man who came from the Leinster Area.

2. The deceased is survived by his partner, five children and extended family.

3. On 7 October 2017, the deceased was remanded in custody to Cloverhill Prison. He was due to appear at Cloverhill Court on 11 October 2017.

4. The deceased was accommodated in Cell 5 on D1 Landing of Cloverhill Prison at the time of his death.

5. On the morning of the 11 October 2017 at 06:20 the deceased was found lying unresponsive on the floor of his cell with a ligature around his neck.

6. As part of my investigation I met with the deceased's partner.

7. I had unrestricted access to all staff, records, all areas of Cloverhill prison and to all relevant CCTV footage during the course of this investigation.

Status of the Deceased

8. The deceased was a Remand[1] prisoner who was on the Standard Level of the Incentivised Regime[2].

9. The deceased was on a restricted regime under Rule 63 of the Prison Rules 2007[3] pending a full assessment by Prison Management of his security and safety requirements.

10. There was also a pre-movement medical alert in place in relation to vital medication.

Meeting with the Next of Kin

11. I met with the partner of the deceased at an early stage of my investigation. I explained our role and enquired if she had any questions and/or concerns regarding her partner's time in prison.

12. We were informed that the couple "*had been together for 22 years and had five children*". She said [deceased] had moved out of their home a few weeks prior to his committal as he had been using drugs. She informed us that her partner had mental health issues. She said he was receiving treatment, was on anti-psychotic medication and had threatened self-harm previously. She also stated that her brother was in Cloverhill Prison and [deceased] had requested a transfer to her brother's wing but this had not occurred.

[1] In custody awaiting further appearance before the Court.
[2] The Incentivised Regime has three levels of privilege – Basic, Standard and Enhanced. Basic level provides the least amount of privileges (number of phone calls permitted, amount daily gratuity paid etc) while the Enhanced level offers the best privileges. All committals are placed on the Standard level of the Incentivised Regime
[3] Restricted regime which provides limited out of cell time to protect vulnerable prisoners.

13. We were asked to investigate the following issues of concern. I have responded later, in this report, to issues raised:-

a. "*Why was I notified by phone of my partner's death*?"
b. "*The reports in the papers stated that [*deceased*] was found under the sink, the Gardaí had informed the family he hung himself. What happened?"*
c. "*The newspapers and the Gardaí said* [deceased's] *bed was "stuffed with implements" to suggest he was in bed. Is that correct?"*
d. *"Can the sink be seen through the hatch in the cell door?"*
e. "*Was* [deceased] *checked by Officers every 15 minutes?"*
f. "*Why was my partner not accommodated "with my brother" or on the same landing?"*
g. "Did the prison look into my partner's medical background while in the Community? Was the anti-psychotic medication which he was on prescribed for him following committal?"

Sequence of Events following Committal

14. On 7 October 2017 at 16:15 the deceased was committed to Cloverhill Prison on remand to Cloverhill Court on 11 October 2017.

15. On committal the deceased was processed through the Reception Area where he was interviewed and his personal details recorded.

16. Nurse Officer A conducted a Health Assessment interview with the deceased on his committal which is recorded in the Medical Notes.

17. The records show that the deceased advised the Nurse that he was on prescribed medication, details of which she noted. Nurse Officer A placed the deceased on the list to see the Doctor.

18. On completion of the committal process the deceased was accommodated in a single cell, Cell 6, on A2 Landing

19. ACO A stated in his Operational Report that he spoke with the deceased and advised him, for his own safety, to disclose if he had associations with any criminal gangs. He also stated he informed the deceased that he "*was going to keep him isolated from other prisoners until the Governor made a decision regarding where he was to be housed"*.

20. ACO A reported that at about 16:30 on 7 October 2017 he spoke with the deceased at the Servery on A1 Landing while he was collecting his evening meal. He stated they discussed issues such as phone card, visitor list, getting a newspaper, accessing his medication, shower and shaving arrangements.

21. Officer A who was present at the Servery informed the deceased that his medication should be available by 19:00 as it had not at that time arrived from the Pharmacy.

22. At about 17:45 the deceased was moved to A1 Landing where he again spoke with ACO A who stated "*Before prisoner* (the deceased) *made his phone call I spoke to him in the A1 Class Office. I informed him that he would remain in Cell 6 A2 until Monday at which time he would be moved. He signed a form stating that he did not want protection. I activated his visitor panel as he requested and informed him that he could have a shower after his phone call…During all my interactions with prisoner* (deceased) *his demeanour was good and he had a positive attitude".*

23. On Sunday 8 October 2017, ACO A reported that he consulted with Chief Officer A. ACO A was instructed to '*hold'* the deceased in Cell 6 on A2 Landing, keeping him away from contact with other prisoners until the Governor had a chance to assess the security and safety requirements of the deceased.

24. Officer B in his Operational Report stated that he was in charge of A2 Landing on 8 October 2017. He reported that the deceased was let out of his cell to get his breakfast at 08:30, to get his dinner at about 12:30 and to get his tea at 16:30. On all occasions he ensured that the deceased did not come into contact with other prisoners. He escorted the deceased to A1 Landing to make his phone call that evening and he also reported that he gave him a razor to shave following his shower.

25. Officer B stated that the deceased, on returning to his cell after receiving his medication, "*seemed happy"*. When locking the deceased in his cell for the night, he recalled the deceased saying *"thanks for that today officer"*.

26. On the morning of 9 October 2017 ACO B reported that he checked with Chief Officer A to see if the deceased was to remain in the Committal Area on A2 Landing. He was informed to retain the deceased on the Landing "*until instructed otherwise he was not to be unlocked or allowed to associate with any other prisoners while on this Division as his status was under review"*. ACO B further reported that "*this instruction was complied with at all times throughout the day"*.

27. At 16:00 ACO B stated that he was instructed by Chief Officer A to transfer the deceased to D1 Landing. ACO B reported that he unlocked the deceased's cell and "*informed him that he was being transferred to D1 Landing. He asked was this a protection landing as he was refusing to go on protection. I informed him that this landing was not for protection and his move was Operational. He was satisfied with this explanation and I escorted him to D1. I handed the prisoner over to staff on D1 and returned to A Division".*

28. Officer C reported that he was on duty on Monday 9 October 2017 at about 16:15 when the deceased was brought to D1 Landing and placed in Cell 5.

29. ACO C stated that he was in charge of D1 and E Divisions on Tuesday 10 October 2017. He reported that he was present when Governor A and Chief Officer B spoke with the deceased at Governor's Parade that morning. ACO C further stated that he "*was present when the prisoner was offered his meals and all appeared to be in order on each occasion"*.

30. Officer D in his Operational Report stated that on 10 October 2017 "*I was detailed to D1. I was on the yard gate when the deceased was given exercise and time to make a phone call in the morning…..about an hour later he asked could he go back to his cell and I told him in a while because other prisoners were on the Landing that can't mix with others. A short time later the deceased was brought in and given his dinner. In the afternoon he asked me for writing paper and I dropped some into his cell. This was the last interaction I had with the deceased"*.

31. Officer E in his Operational Report stated that he was in charge of D1 Landing on the night of 10 October 2017. At approximately 19:25 he took charge of D1 Class with a total of 16 prisoners in custody. He stated that at about 20:15 he was re-deployed to assist in Reception and he handed over charge of D1 to Officer F who was also in charge of D2 Landing.

32. At 22:25 Officer E reported that he returned to the D1 Landing and took back charge of the landing from Officer F. Officer E reported that "*at approx. 10:25pm prisoner* (deceased) *D1/5 was on his bed watching TV when I checked again at 11pm I observed him lying on his bed lying under the duvet. He remained in this position throughout the night whilst I was doing his checks"*.

33. Officer F was in charge of D2 and Officer E was in charge of D1 Landing. These Officers relieved each other during the course of the night. The checks on the deceased where conducted at different times by the individual officers.

34. Officer F reported that his "*last cell check on D1 before handing back to Officer E was at 10pm. At this time I observed prisoner* (deceased) *sitting on a chair watching television. I had no actual contact with him. He never put on the cell light. Everything seemed normal. Following on from actually seeing him sitting up watching tv at 10pm every other time I observed prisoner* (deceased) *he appeared to be asleep and comfortable under the covers of his bed. This would include my final check on the prisoner at 5.00am"*.

Discovery of the deceased and emergency response

35. On the morning of 11 October 2017 Officer E can be seen on CCTV checking all cells on D1 Landing at about 05:58.

36. In a report provided by Officer E he stated "*ACO D approached me at 6:20am and he issued me with the keys so as to remove the master locks. With that I started to remove the master locks starting on the left side Cell 1 and checking prisoners at the same time. When I came to Cell 5 which housed* (deceased) *I turned on the light".* Officer E further reported that "*from my experience on doing nights you always get some sort of movement or noise from the cell ...."* When Officer E unlocked the cell of the deceased, he reported that there was "*neither movement or noise coming from his cell, this did not sit well with me".* Officer E then reported that he "*called his name and kicked the cell door a number of times to get a response".* Officer E also reported that when he did not get a response he "*got a feeling that something was wrong, my senses took over and I reacted. I thought the best thing to do was check*

the prisoner straight away. I noticed my radio was not on me to call for assistance. I entered the cell anyway with the best interest of the prisoner at hand. After opening the door and springing the lock, I ran to the bed to shake the prisoner but he was not there. I pulled back the duvet to observe pillows in the shape of a body and at this stage I turned to find the prisoner with his face pressed against the sink …….. around his neck. I ran over to him and removed the .... from the ….". Officer E reported that he put the deceased *"on his back and started CPR".*

37. Officer E can be seen on CCTV footage entering Cell 5 having removed the master locks at 06:22:24. At 06:22:51 he can be seen exiting the cell and turning towards the Class Office.

38. Officer E reported that he went to recover his radio from the Class Office. He stated "*I ran to the surgery. I banged on the door. Nurse Officer B came to the door and I explained what happened. I said get the red bag. Then both of us ran back to D1. We both entered the cell and Nurse Officer B placed the bag on the pool table adjacent to the cell. I then radioed ACO D to report back to D1asap…Myself and Nurse Officer B started CPR"*

39. At 06:23:40 Officer E returned and entered Cell 5.

40. At 06:24:29 Nurse Officer B arrived to Cell 5 carrying the emergency response bag which she placed on the pool table outside Cell 5. She removed equipment from the bag and she entered the cell.

41. Nurse Officer B reported as follows *"On Wednesday 11 October I was called to D1 Landing by Officer E at approx. 6.20am to see an inmate* (deceased). *I ran immediately after with the emergency bag. On arrival inmate was lying on the floor of his cell room supine and lifeless. He was cold, white and non responsive, no*

pulse, no breathing. The ligature was hanging loosely around his neck with visible mark on his neck. I immediately asked the officer to call the ACO on duty to ring the ambulance and Doctor A. I quickly commenced CPR protocol with the assistance of Officer E. I applied AED and no shock was advised. I administered adrenaline injection and continued with CPR until the ambulance arrived at approx. 06:45 and took over".

42. At 06:43:05 Paramedics from Dublin Fire Brigade arrived at the cell and took over from Nurse Officer B and Officer E. Nurse Officer B in her statement reported that Paramedics advised that *"there was no need to continue CPR after reassessing the patient".*

43. At 06:56 Doctor B entered the cell and pronounced death.

Deceased Contact with Medical Services in the Prison

44. The deceased was assessed by Nurse Officer A on his committal to prison on the evening of 7 October 2017.

45. The Nurse recorded that the deceased had a history of anxiety/depression and attended a day centre for treatment and medication. She noted details of the medication that the deceased said he was prescribed. It is further recorded that the Nurse spoke to the deceased about the "*Benzo Policy*" in the prison. It is on record that the deceased denied any thoughts of self-harm/suicide and the Nurse placed him on the list for Committal Review with the Doctor.

46. On 8 October 2017 Doctor C recorded in the medical notes that he conducted a Committal Assessment of the deceased. The Doctor made a similar note to that of the Nurse regarding a history of anxiety/depression and he noted that the medication was to be confirmed with the Pharmacy.

47. Nurse Officer C recorded on 8 October 2017 that she spoke with the Pharmacy and confirmed the medications that the deceased was prescribed while in the community.

48. On checking the deceased's Medication Chart I can confirm that the medication as prescribed was administered to the deceased on the 8, 9 and 10 October 2017.

49. The deceased had no other interaction with the Healthcare Staff until Nurse Officer B responded to the emergency call to his cell at 06:20 on 11 October 2017 when he had been found unresponsive.

CCTV Footage

50. The sequence of events concerning the deceased and activities in the vicinity of his cell were recorded on CCTV for 10 and 11 October 2017. I outline hereunder these events as viewed on the CCTV footage.

16:07:40	Deceased can be seen walking from his cell with a tray to collect his tea.
16:08:16	Deceased returned to his cell with food, the cell is closed and locked by an Officer.
16:31:43	Officer checked the cell – lifted the viewing flap and looked in.
16:51:57	Officer checked the cell – lifted the viewing flap and looked in.
17:51:29	Officer checked the cell – lifted the viewing flap and looked in.
18:52:03	Officer checked the cell – lifted the viewing flap and looked in
18:56:50	Officer accompanied by Nurse Officer with medications trolley arrived to cell. Cell opened, deceased exited cell. He can be seen taking medication. He returned to cell, cell door is closed and staff move on.
19:06:38	Officer to cell. Lifted the viewing flap and looked in and master locked the cell.
19:32:23	Officer E to the cell. Lifted the viewing flap and looked in.

20:55:36	Officer F checked the cell. Lifted the viewing flap and looked in.
21:28:16	Officer F checked the cell. Lifted the viewing flap and looked in.
21:58:30	Officer F checked the cell. Lifted the viewing flap and looked in.
22:23:09	Officer E checked the cell. Lifted the viewing flap and looked in.
22:52:10	Officer E checked the cell. Lifted the viewing flap and looked in.
23:19:58	Officer E checked the cell. Lifted the viewing flap and looked in.
23:45:09	Officer E checked the cell. Lifted the viewing flap and looked in.
00:15:27	Officer E checked the cell. Lifted the viewing flap and looked in.
00:58:13	Officer F checked the cell. Lifted the viewing flap and looked in.
01:28:23	Officer F checked the cell. Lifted the viewing flap and looked in.
01:58:22	Officer F checked the cell. Lifted the viewing flap and looked in.
02:29:09	Officer E checked the cell. Lifted the viewing flap and looked in.
02:54:05	Officer E checked the cell. Lifted the viewing flap and looked in.
03:25:11	Officer E checked the cell. Lifted the viewing flap and looked in.
03:59:13	Officer F checked the cell. Lifted the viewing flap and looked in.
04:29:52	Officer F checked the cell. Lifted the viewing flap and looked in.
05:00:32	Officer F checked the cell. Lifted the viewing flap and looked in.

05:30:46	Officer E checked the cell. Lifted the viewing flap and looked in.
05:58:49	Officer E checked the cell. Lifted the viewing flap and looked in.
06:21:51	Officer E removed master locks. Lifted the flap and looked in. Officer remained looking into cell for some time.
06:22:17	Officer E unlocked cell door, opened same and can be seen entering the cell at 06:22:24.
06:22:50	Officer E exited the cell and ran down the landing.
06:23:39	Officer E ran back up the landing to the cell and entered.
06:24:06	Nurse Officer B can be seen running towards the cell carrying the emergency bag which she placed on pool table on landing outside door of Cell 5.
06:24:28	Nurse Officer B entered the cell carrying equipment. Officer E had exited and now re-entered the cell.
06:24:55	Officer E exited the cell and ran down the landing.
06:25:22	Officer E ran towards cell using the Tetra Radio and he entered the cell.
06:26:10	Officer F arrived at the cell doorway.
06:26:17	ACO D arrived to cell doorway. Nurse Officer B exited the cell and took equipment from the emergency bag on pool table and re-enters the cell.
06:27:45	Three further officers arrived on the landing and remained in vicinity of cell.
06:42:26	Paramedics from Dublin Fire Brigade arrived and entered the cell.
06:55:40	Doctor B, Emergency Paramedic, arrived on landing and entered cell.
06:58:20	Doctor exited the cell.

Responding to the concerns of the Next of Kin

51. I used the same sequence to respond to the concerns raised by [deceased's] partner as used in paragraph 13 of this report

a. **"*Why was I notified by phone of my Partner's death?*"**

The prison records had an address for the next of kin in the north Midlands. Given the distance from the prison it was decided by Prison Management that the Chaplain should telephone the next of kin to ensure they were notified of the death by Irish Prison Service personnel rather than an unauthorised source. During the course of the telephone conversation the Chaplain became aware that the next of kin were not at the address on file but were at a much closer location. Following the telephone conversation Cloverhill Prison Management visited the family personally.

b. **"*The reports in the papers stated that [deceased] was found under the sink, the Gardaí had informed the family he hung himself. What happened?"***

The deceased was found lying under the sink with a ligature around his neck. This is referred to in paragraph 36.

c. "*The newspapers and the Gardaí said [deceased's] bed was "stuffed with implements" to suggest he was in bed. Is that correct?"*

The Officer who discovered the deceased when unlocking reported that there were pillows under the duvet. When he did not get a response when he removed the master lock he stated that he "*ran to the bed to shake the prisoner but he was not there. I pulled back the duvet and to observe pillows in the shape of a body"*. See further details in paragraph 36.

d. ***"Can the sink be seen through the hatch on the cell door?"***

The sink is visible to the right as one looks through the cell door viewer. The bed is on the left of the cell and also visible from the cell door viewer.

e. "*Was [deceased] checked by Officers every 15 minutes?*"

Officers checked the deceased's cell regularly during lock-back. Checks were at intervals of approximately every half hour. The actual times the checks were carried out are as outlined in paragraph 50. There was no obligation on staff to carry out 15 minute checks as the deceased was not on Special Observation. Checks were carried out in accordance with Irish Prison Service Policy.

f. "*Why was my partner not accommodated "with my brother" or on the same landing?"*

The Governor informed me that the safety of the deceased was the primary concern and reason for accommodating him on D1 landing. He was in a more secure area on D1 pending a full security and safety review regarding any possible risk(s) to his safety, which was underway.

g. "*Did the prison look into my partner's medical background while in the Community? Was the anti-psychotic medication which he was on prescribed for him following committal?"*

The prison medical team carried out an assessment on Committal and consulted with the Pharmacy in the Community. The medication the deceased had been prescribed prior to committal was administered to him. I refer to this is paragraphs 17, 20, 45, 46, 47 and 48

Findings

52. The deceased was a Remand prisoner who was due to appear at Cloverhill Court on the day he died.

53. The deceased was alone in a single cell on D1 Landing at the time of his death.

54. The deceased was assessed by the prison Doctor and was receiving prescribed medications while in Cloverhill Prison.

55. The deceased gave no indication to staff that he was going to self-harm.

56. The deceased had been in contact with his family by phone on the morning of 10 October 2017.

57. There were regular checks of the deceased's cell by the officers on duty on 10 and 11 October 2017.

58. The deceased had written two notes which were found in his cell when searched by Gardaí. The Gardaí took possession of these notes.

59. The cause of death is a matter for the Coroner.

Recommendations

1. For their own safety and that of their colleagues prison officers conducting checks should, at all times, be in possession of an official radio enabling them to immediately call for assistance should the need arise.