A report by the Inspector of Prisons Judge Michael Reilly into the circumstances surrounding the death of Prisoner H in the Mater Hospital on 30th August 2013 while in the custody of 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 H in the Mater Hospital on 30th August 2013 while in the custody of 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

10th June 2014

Preface

Prisoner H was a 40 year old man when he died in the Mater Hospital on 30th August 2013 following an incident earlier that day in Mountjoy Prison.

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

My Report is divided into 7 sections as follows:-

- General information
- Concerns of the family
- Status of the deceased and relevant Standard Operating Procedures
- Sequence of events
- Findings
- Addressing the concerns of the family
- Recommendations

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

Judge Michael Reilly
Inspector of Prisons
10th June 2014

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 40 year old unmarried man who came from the Munster area. He is survived by his daughter, his mother and his siblings.

2. The deceased was committed to prison on 16th January 2004. His release date was to be 20th February 2016.

3. Since his committal to prison on 16th January 2004 the deceased spent time in Wheatfield Prison, Cork Prison, Portlaoise Prison and Mountjoy Prison since 25th November 2010.

4. During his early life the deceased was a drug user. I have being informed that while in prison in 2004 he began taking heroin for the first time. I am unable to corroborate this statement. He sought help for his drug addiction in 2006 while in Wheatfield Prison. The deceased was apparently drug free in or around September 2010. This was supported by urine analysis results.

5. In the early part of his incarceration the deceased was involved in various incidents of antisocial behaviour. However, in his latter time in prison this reduced to the extent that senior prison staff spoke well of the deceased.

6. Since his transfer to Mountjoy Prison in 2010 the deceased adopted a routine within the Prison which helped him. He made use of the gymnasium. He read and availed of relevant services.

7. The deceased got on well with his fellow prisoners and prison staff.

8. Governor A described the deceased in the following terms:-

> "The deceased *registered for school but only participated for a short while. He frequented the library on a regular basis as he loved to read. He was impulsive at times but generally didn't present any difficulty for prison staff and management. He was a happy easy going lad. He didn't cause any issues for the staff and was considered a likeable character to both other prisoners and prison staff*".

9. The deceased was referred to the Motivational Enhancement Group in February 2012. He completed this course in April 2012.

10. The deceased had initially engaged with the Parole Board process but in 2013 he indicated that he was not willing to participate further.

11. In August 2012 the deceased expressed an interest in participating in the Drug Treatment Programme in the prison. The Addiction Service worked with him on the course content and outlined the entry route to the programme. I have been informed that the deceased saw this as a long term goal. In May 2013 he was informed that he could participate in the Drug Treatment Programme but he stated that he could not see the point of this and declined further assistance in this regard.

12. On 2nd May 2013 the deceased spoke about a friend's suicide and his emotional reaction after same. At other times he also spoke about feeling overlooked by the system and believing that he needed to focus on learning new skills and moving on.

13. On 16th May 2013 the deceased stated that "*he had resigned himself to the fact that he would remain in Mountjoy and not be given the option of the Training Unit*". He stated that he felt "*institutionalised*".

14. The deceased enjoyed significant family support from his immediate family and in particular that of one of his siblings and his mother.

15. The deceased availed of the Medical Services in the prison. These are documented in the deceased's Medical Notes.

Concerns of the family

16. I met with the deceased's mother and three of his siblings in their home in the Munster area.

17. The family explained that they visited him in prison. These visits took the form of ordinary visits, family visits and ultimately open visits in a setting outside the prison.

18. I was informed that the deceased telephoned his mother practically every day. I have confirmed this to be true by checking records of the deceased's telephone activity. His mother reported that he expressed himself happy to be in Mountjoy Prison and to have a cell on his own.

19. The family stated that the deceased was in excellent health and that they had no concerns for him.

20. The deceased was visited by one of his siblings approximately two weeks before his death.

21. The family raised issues with me that they wished me to address. These concerns can be summarised as follows:-

    (a) Why did the deceased visit the Doctor on the date of his death – was there follow up to this visit?
    (b) The family were told by a Governor that the deceased was found slumped in his chair in a sitting up position, that he had been checked every 20 minutes and that there was CCTV to verify this. They wished to know if this statement was correct.
    (c) Was it usual for an Ambulance and the Fire Brigade to be called?
    (d) Who visited him in the last two weeks before his death?

(e) On hearing of the incident the family immediately went to Dublin. They were first of all kept waiting at reception and then taken to the Governor's Office. They were told that they could go to the Mater Hospital but were kept waiting at the gate of the prison while those escorting them had to attend to other business. When they got to the hospital they were told that the body had been taken to the Morgue and that they could not view the body at that stage. They stated that the Coroner or somebody from his office told them that if the prison had telephoned the hospital they would have held the body. The family want an explanation for the delay.

(f) The family stated that it was reported in the newspapers that the deceased was slumped over and tin foil was found. Why weren't the family told of this when they arrived at the prison and who told the papers?

(g) The family stated that they were told that this was a sudden death. Why were they not told the whole story?

(h) The family thought that the deceased was safe in prison. If he was safe why did he die?

(i) The family wished to know if the deceased had made contact with me as my name and telephone number were found amongst his possessions. They wished to know if he had made any concerns of his known to me.

(j) The family stated that a report appeared in electronic form on a Social Media Site to the effect that there was a fire in the deceased's cell. Was there a fire?

(k) Why were there drugs in Mountjoy Prison and how did the deceased get illicit drugs?

(l) What was the cause of death?

Status of the deceased and relevant Standard Operating Procedures

22. The deceased was classed as an ordinary prisoner which, in layman's terms, means that he was not subject to enhanced surveillance and was not considered a risk to himself or to others.

23. The relevant Standard Operating Procedure (SOP) specifies that ordinary prisoners shall be checked at least once every hour during periods of lockdown.

Sequence of events

24. The deceased was accommodated in Cell 13 on B3 Landing in Mountjoy Prison. This was a newly refurbished single cell with in-cell sanitation and a wash hand basin.

25. As I have already stated in this Report the deceased was well regarded by both prison staff and his fellow prisoners and did not present as a difficult prisoner.

26. The CCTV coverage of B3 Landing was adequate. It shows clearly the landing outside Cell 13. I set out hereunder the relevant activities commencing at 7.00pm on 29th August 2013 on B3 Landing and in particular those activities that relate to Cell 13.

7.00.00pm – Prisoners on landing prior to lockdown.
7.24.16pm – Deceased locked in his cell.
7.26.10pm – Prisoner 1 working as a cleaner on landing.
7.43.45pm – Prisoner 1 goes to door of Cell 13 and appears to be conversing with the occupant through the cell door.
7.44.50pm – Prisoner 1 leaves the vicinity of Cell 13.
7.46.21pm – Prisoner 1 again goes to Cell 13 and appears to converse with the occupant.
7.48.36pm – Prisoner 1 leaves vicinity of Cell 13 and goes to Cell 11 and appears to converse through the door with the occupant.
7.48.48pm – Prisoner 1 returns to door of Cell 13 and bends down at the door.
7.50.03pm – Prisoner 1 stands up and walks away from Cell 13. I interviewed Prisoner 1. He explained his actions in the following terms – "*I remember after the rest of the lads were locked up I was out on the landing after that because I work on B3 as a cleaner.* Prisoner 2 *in Cell 3 was also out as he was a cleaner with me. I remember* (the

deceased) *called me. He was looking for skins – that's cigarette papers. I went and got a couple of skins and shoved them under the door of the cell. He seemed in good form and nothing seemed out of the ordinary. He was a fella that didn't smoke a lot and I wasn't surprised he was looking for skins or even a bit of tobacco. He was a likable sort of a fella and got on well with other prisoners and also with the officers*". Prisoner 2 in his statement said – "*he seemed his usual self. He was in good form. I didn't see him that night after 7.30pm*".

Prisoner 1 can be observed between 7.50.03pm and 8.11.45pm walking up and down B3 Landing where he occasionally stopped at cell doors and appeared to converse with the occupants of such cells.

8.14.19pm – Officer checks Cell 13. It is noted that the officer immediately ceases checking cells and walks back down the landing from the direction that he had come from.
8.15.27pm – Officer resumes checking cells and rechecks Cell 13.
8.16.55pm – Officer leaves B3 Landing through the barred gate.
9.32.50pm – Officer checks Cell 13.
9.57.57pm – Officer checks Cell 13.
Officer A came on duty at 10.00pm.
11.20.09pm – Officer A checks Cell 13. The Officer did not note anything unusual.
12.17.18am – Officer A checked Cell 13. The Officer spent 47 seconds at the door of Cell 13 and appeared from the CCTV footage to be striking the door with his foot. The Officer noted that the deceased was "*sitting up on the side of the bed with his head resting on the vanity screen. He appeared to be fast asleep*". When questioned by me the Officer agreed that he may have kicked the door in order to get the deceased to get back into bed. The Officer said that this would be quite normal. However, the Officer noted the cell number and decided

that he would call back to check that the prisoner had gone to bed when he had finished his checking of other cells.

12.33.40am – Officer A checked Cell 13. In his statement to me he stated that the deceased was still in the same position and as he could not get a response he proceeded to the keys office to draw the relevant keys to open the cell.

12.38.50am – Officer A accompanied by Nurse Officer A and another Officer arrive at Cell 13. Officer A stated "*I was unable to get a verbal response from the prisoner*". Nurse Officer A stated "*on arrival to his cell he was in a slouched position beside his bed with his head between his legs. As I proceeded towards* (the deceased) *his ears and neck were grey in colour.* (The deceased) *was unresponsive to verbal stimuli, skin was cold and clammy to touch, no breath sounds and absent pulse*". The Ambulance Service was called. The deceased was laid on the floor of the cell and CPR was commenced by Nurse Officer A who was assisted by Officers B, C and D (a Medical Orderly). Officer D (a Medical Orderly) inserted an oral airway and oxygen was administered.

12.39.08am – Defibrillator brought to the cell and placed in position. It did not activate a shock but instructed to continue CPR. CPR was continued until the arrival of the Dublin Fire Brigade Ambulance.

12.57.40am – Two paramedics to the cell.

1.03.04am – Two Dublin Fire Brigade Officers to the cell. They continued the CPR.

1.11.50am – Dublin Fire Brigade Officers moved the deceased to the Mater Hospital accompanied by Officer E. The deceased was later pronounced dead at 1.27am.

1.30am – According to his statement the ACO received a call from Officer E to the effect that a small quantity of contraband (tablets) had been taken from the deceased's personal clothing.

2.08.16am – Two members of An Garda Síochána arrive at the cell. I have been informed that the Gardaí found and removed from the cell "*a small brown substance and a piece of tin foil from a locker within the cell*".

The Operational Support Group (OSG) also conducted a search of the cell and found items of contraband which they removed from the cell.

Between 12.38.50am and 1.18.30am many officers arrived in the vicinity of Cell 13. A number of these officers entered the cell.

Findings

27. The deceased had been a user of drugs for many years. He had sought help for his drug addiction in 2006 in Wheatfield Prison and was reported to be drug free in 2010.

28. In his latter years in prison the deceased was a well behaved prisoner and was spoken well of by staff and other prisoners.

29. The deceased was a fit man who made use of the gymnasium facilities in the prison.

30. In 2012 the deceased completed a Motivational Enhancement Course.

31. The deceased had initially engaged with the Parole Board but in recent times had not participated further.

32. In 2012 the deceased had expressed an interest in participating in the Drug Treatment Programme in Mountjoy Prison. However, in 2013 he did not take up the offer of a place on the programme.

33. The Gardaí removed items from the cell which I am informed included a small brown substance and a piece of tin foil. I have not spoken to members of An Garda Síochána as the evidence that they harvested is evidence more appropriate to the Inquest.

34. The OSG removed contraband from the deceased's cell as referred to in paragraph 26.

35. The deceased had significant family support. He telephoned his mother virtually every day and had frequent visits including open visits as described in paragraphs 17 and 18.

36. The deceased was in excellent health and his demeanour did not raise any concerns in his family, his fellow prisoners or prison staff.

37. The deceased expressed himself happy to be in a newly refurbished single cell in Mountjoy Prison.

38. When locked in his cell at 7.26.16pm the deceased was in perfect health.

39. Cell 13 was a newly refurbished single cell with suitable facilities, which met best international standards for the safe and secure custody of prisoners.

40. During the course of my investigation I am satisfied that despite the efforts taken by management the availability of drugs is still a problem in Mountjoy Prison.

Addressing the concerns of the family

41. In paragraph 21, I detailed the concerns of the family. My findings referred to in paragraphs 27 to 40 answer some of these concerns. In this paragraph I address the specific concerns of the family and in that connection use the same numbering system.

(a) According to the medical notes the deceased did not visit the prison Doctor on the date of his death. His last contact with the doctor was on 28th August 2013 when he complained of back pain.

(b) The deceased was found as described in paragraph 26. He was not checked every 20 minutes. The requirement to check the deceased is set out in paragraph 23. The times he was checked are detailed in paragraph 26. There is no CCTV in any of the accommodation cells.

(c) When an emergency call is made the procedure is that an Ambulance from the Dublin Fire Brigade is dispatched with additional support being provided by a fire tender. A Hospital Ambulance may also be dispatched.

(d) In the two weeks prior to his death the deceased was visited by three people. In order to comply with Data Protection Legislation I cannot disclose such names.

(e) Delays as outlined by the family should not have occurred. It is outside my remit to enquire as to the reasons for such delays but prison management should address this issue.

(f) The deceased was found as described in paragraph 26. Tin foil was also found. I cannot account for the family not being told of this at the time. I also cannot account for how this became a news item.

(g) I cannot account for the reason why the family were not given all details except to say that at times such as this an effort to consider the sensitivities of the family can often lead to inadequate information being given.

(h) It is difficult to give an objective answer to this real concern of the family. It is not part of my mandate to make a determination in this regard. I have addressed part of this concern in paragraph 39. The cause of death is a matter to be determined at the Coroner's Inquest.

(i) The deceased did not make contact with my office.

(j) There was not a fire in the deceased's cell.

(k) In common with virtually all prisons worldwide drugs are a feature in the prison life of Mountjoy Prison. Despite exhaustive enquires I could not ascertain the source of such drugs.

(l) This is a matter for the Coroner.

Recommendations

1. All efforts should be made to reduce the ingress of drugs into the prison.

2. Prison management must, at all times, be conscious of the vulnerabilities of family members at a time of crisis such as described in this Report.

Management must ensure that delays as outlined by the family in this case do not occur in the future.