

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner C
on 10 March 2015 in the Mater Hospital
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 C
on 10 March 2015 in the Mater Hospital while in the custody
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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

15 March 2016

Preface

The deceased was a 23 year old single man at the date of his death.

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.

Judge Michael Reilly
Inspector of Prisons

15 March 2016

Inspector of Prisons Investigation Report

General Information

1. The deceased was a 23 year old single man who came from the Dublin area. He is survived by his mother, his siblings and his extended family.
2. The deceased was last committed to prison on 2 February 2015. His remission date was to be 16 December 2015.
3. On the morning of 5 March 2015 the deceased was discovered in his cell in an unresponsive state with a ligature around his neck which was attached to the bars of the cell window.
4. The deceased was removed to the Mater Hospital where he died on 10 March 2015.
5. I met the deceased's family on 9 April 2015 and have responded, where possible in this report, to the many serious concerns that they wished me to investigate.
6. **Serious issues of significant concern are raised in this Report.**

Issues raised by the family

7. The family informed me that the deceased was first committed to prison when he was 18 years of age and served a number of short sentences.
8. He started drinking in his late teenage years.
9. I was informed that he was anxious and paranoid. He took 'sleepers' that he bought on the black market on the streets but did not take other drugs. The family told me that "*he could not sit still for two minutes*".
10. I was informed that the deceased on being imprisoned on 2 February was committed to Wheatfield Prison where he was kept in isolation until transferred to Mountjoy Prison. They told me that they knew he was

“anxious” while in Wheatfield Prison and “was paranoid that people were looking in through his door in Wheatfield”.

11. The family told me that the deceased did not have his own clothes while in Wheatfield and that he felt suicidal. They stated that they knew something was wrong when telephone calls from him were reduced to one a week.
12. The family did not know why the deceased had been transferred to Mountjoy Prison and asked me to address their concerns.
13. The concerns of the family can be summarised as follows:
 - (a) Why was the deceased in isolation in Wheatfield Prison? Was this for his own safety?
 - (b) Why was the deceased transferred to Mountjoy Prison? Was this as a result of an incident of self harm? Was he assessed when transferred to Mountjoy Prison?
 - (c) Why was he transferred from the main prison block in Mountjoy Prison to Mountjoy West?
 - (d) Was he in a padded cell in Mountjoy Prison?
 - (e) Was staff in Mountjoy Prison aware that the deceased had spent a prolonged period in an isolation cell in Wheatfield Prison?
 - (f) Were the prison authorities aware that the deceased had self harmed on 2 March 2015? If they were what action was taken? What was the nature of this self harm? Was it attempted suicide? Was he seen by a doctor or psychiatrist following this self harm and if so was he prescribed medication?
 - (g) Was the deceased on suicide watch while in Wheatfield and Mountjoy Prisons?
 - (h) Was the deceased diagnosed with any mental illness while in the custody of the Irish Prison Service?
 - (i) On the night that he was found in an unresponsive state:
 - Had he pressed the alarm bell?
 - What did he use as a ligature?
 - What was it attached to?

- Did he mean to do it?
- What were the circumstances of his discovery?

The family are represented by Solicitors who have corresponded with me raising similar concerns.

The Investigation

14. In view of the concerns raised by the deceased's mother and the events of the night of 4/5 March 2015 (described in detail in paragraphs 88 to 111) I decided I should examine in detail the medical files maintained by the Irish Prison Service relating to the deceased.
15. I examined the movement history of the deceased through prisons and cells in prisons from the date of his last committal – 2 February 2015 to 5 March 2015. I refer to such movements in paragraphs 22 to 26.
16. The deceased was first committed to St. Patrick's Institution on 13 April 2011. I examined the deceased's medical file from the 13 April 2011 to the date of his death on 10 March 2015 having received written permission from his mother (next of kin) to do so. I refer to relevant medical information in paragraphs 27 to 47 and paragraphs 99, 104 and 107.
17. In paragraphs 49 to 52, I give details of the status of the deceased since his imprisonment on 2 February 2015.
18. I examined the circumstances of the transfer of the deceased from Wheatfield Prison to Mountjoy Prison. Such circumstances are referred to in paragraphs 53 to 74.
19. In paragraphs 75 to 87, I refer to relevant issues concerning the care taken of the deceased in Mountjoy Prison between 28 February and 4 March 2015.

20. I carried out a forensic investigation of all issues relating to the deceased from the time he was locked in his cell on the evening of 4 March until he was removed from his cell, in an unresponsive state, on the morning of 5 March 2015. I detail all relevant matters in paragraphs 88 to 111.
21. Throughout this Report I detail enquiries made by me of different organs of the Irish Prison Service relating to issues raised during my investigation which required further clarification together with the relevant responses to same.

Deceased's cell movement between 2 February and 4 March 2015

22. The following reflects the prisons and cells that the deceased occupied between 2 February and 4 March 2015. This information is taken from official records maintained in the prisons.
 - 2 February – on committal to Cloverhill Prison accommodated in cell 7 on A2 Landing (an ordinary accommodation cell).
 - 3 February – brought to Blanchardstown Court – committed to prison – arrived Mountjoy Prison at 16.20 hours and accommodated in cell 13 in the C Base (a committal cell) where he remained until
 - 5 February – transferred to Wheatfield Prison – accommodated in cell 14 on 8F Landing (an ordinary accommodation cell).
 - 6 February – moved to cell 9 on 10 G landing (an ordinary accommodation cell).
 - 6 February (later in the day) – moved to cell 4 on 10 G landing (an ordinary accommodation cell). Remained there until
 - 11 February – moved to cell 9 on 10G landing (an ordinary accommodation cell). Remained there until
 - 15 February – moved to cell 2 on 5G landing (an ordinary accommodation cell).
 - 16 February – moved to Safety Observation Cell on West 2 Wheatfield. Remained there until

- 18 February – moved to Close Supervision Cell on West 2 Wheatfield. Remained there until
- 25 February – attended Court. On his return was accommodated in cell 16 on 8F landing (an ordinary accommodation cell). Remained there until
- 28 February – transferred to Mountjoy Prison and accommodated in cell 5 in the C Base (a committal cell). Remained there until
- 3 March – moved to cell 3 on Mountjoy D3 West (ordinary accommodation cell).

23. At this juncture I should explain the difference between a Safety Observation Cell and a Close Supervision Cell.

- A Safety Observation Cell is commonly referred to as the ‘Pad’. Prisoners can only be placed in such cells for medical reasons by order of a nurse or a doctor and can only be cleared for transfer out of such cells by order of a doctor. Prisoners’ clothing is taken from them and they wear refractory clothing consisting of a poncho type garment. While in such cells prisoners must be checked every 15 minutes by the prison officers and every two hours by the medical personnel.
- A Close Supervision Cell can only be used on the authorisation of a Governor or his delegated staff. This placement must be for operational reasons and would occur typically where prison staff may believe that a prisoner has ingested drugs, for his own safety or the safety of the prison. Prisoners may be permitted to wear their own clothing unless in each individual case the Governor makes a determination that, for stated reasons, the prisoner should not be allowed his own clothes. In such cases the prisoner is issued with refractory clothing consisting of a poncho type garment. While in such cells prisoners must be checked every 15 minutes by prison staff.

24. I would like to point out that all movements of prisoners between prisons or between cells in a particular prison should be recorded on the prison computer system (PIMS) in order that any authorised person could track such

movements for a particular prisoner for a particular period of time. I was provided with a print out of the deceased's movement history for the period 2 February to 4 March 2015.

25. The record generated as described in paragraph 24 was incorrect in certain details. It purported to show that the deceased was accommodated in a holding cell in the Reception area of Mountjoy Prison between 3 February and 5 February whereas he was accommodated in cell 13 in the C Base. It also purported to show that the deceased spent three nights, commencing 28 February, in a holding cell in the Reception area of Mountjoy Prison whereas he was accommodated in cell 5 in the C Base. However, by examining all records for individual cells in the prison, I was able to ascertain the correct information. Therefore, I am satisfied that the movement history of the deceased for the period under consideration is correct as set out in paragraph 22.
26. I wish to point out at this juncture that the deceased was in a Safety Observation Cell for a period of two days only – 16 to 18 February 2015.

Deceased's contact with the medical services while in prison

27. The deceased was first committed to prison on 13 April 2011. On committal he was seen by the nursing staff who, having assessed him, found no medical or psychiatric issues.
28. He served numbers of terms of imprisonment subsequent to his first committal. He was seen by the medical staff on numbers of occasions for what could be described as 'everyday minor issues'.
29. The first significant medical intervention occurred on 14 June 2014 in Wheatfield Prison. He was assessed by Nurse Officer A who found him upset and tearful. The nursing notes disclose that he told the nurse "*his head was wrecked and didn't want to talk about it*". He relayed that he was going

to snap and hurt somebody and wanted “*people to intervene to stop this happen*”. He stated that he would harm himself by some means and needed somewhere to clear his head. Up to this he had not displayed any such intentions. Nurse Officer A carried out a Risk Assessment for Seclusion. She quantified the likelihood of the prisoner harming himself or others as ‘*quite likely*’. She quantified the impact of harm as ‘*significant injury to self or others*’. This measured the risk as being ‘*significant to major risk*’. Following her thorough assessment Nurse Officer A placed the deceased in a Safety Observation Cell. He was seen by doctors and nurses. On a number of occasions he mentioned self harming. He was moved from the Safety Observation Cell on 16 June 2014 having been examined by Doctor A.

30. On 13 July 2014 while in Midlands Prison the deceased told Nurse Officer B that he had thoughts of self harming. He was placed in a Close Supervision Cell. He was assessed by Doctor B on 15 July 2014 who cleared him to return to his own cell.
31. On 18 July 2014 the deceased was seen by Doctor A in Wheatfield Prison. He did not display any medical or psychiatric symptoms. He was “*fit and healthy*”.
32. Between 18 July 2014 and 2 February 2015, during periods of imprisonment, the deceased was seen by the medical staff in a number of prisons complaining of minor issues not relevant to this investigation.
33. The deceased was a new committal to Cloverhill Prison on 2 February 2015. He was assessed by Nurse Officer C who noted that he suffered from depression but “*denied any suicidal or DSH ideations*”.
34. On 4 February 2015 in Mountjoy Prison the deceased was assessed by Doctor C who noted that he had “*no mental illness*”.
35. On 15 February 2015 the deceased was reviewed in Wheatfield Prison by Nurse Officer D who noted that the deceased stated “*I’m under threat and I’m going to cut myself if you don’t move me to West 2*”. There are Safety Observation and Close Supervision Cells in West 2 in Wheatfield Prison.

Nurse Officer D placed the deceased on the 'special observation list' which meant that he was to be checked every 15 minutes. **He remained on this list until the date of his death.**

36. On 16 February 2015 the deceased was reviewed at 18.35 hours by Nurse Officer E. The medical notes read:

“stated that he was after receiving some ‘bad news’ today and that he felt he was in a very low place. Poor eye contact, appeared quite deflated, threatened to self harm if not moved to the ‘pad’. Stated that he was ‘going to cut himself’. Moved to the SOC for his own safety”.

Nurse Officer E had carried out a Risk Assessment for Seclusion similar to that carried out by Nurse Officer A on 14 June 2014 referred to in paragraph 29. He quantified the likelihood of the prisoner harming himself or others as “quite likely”. He quantified the impact of such harm as “significant injury to self or others”.

37. At 18.12 hours on 16 February 2015 there is a note in the medical notes generated by Nurse Officer E as follows – ‘SOC forms scanned on system and Register for Seclusion faxed to Director General and Healthcare’.
38. Between 18.35 hours on 16 February and 15.00 hours on 18 February the deceased was in seclusion in a Safety Observation Cell on West 2 in Wheatfield Prison. The records show that he was checked by the medical staff and prison staff in accordance with their obligations. At times he threatened self harm. At other times he stated that he wished to transfer to Mountjoy Prison.
39. Doctor A noted at 9.22 hours on 18 February that the deceased was ‘still emphasising suicidal attempt. Refer to Psych’.
40. At 13.25 hours on 18 February 2015 the deceased was assessed by Psychiatric Nurse Officer F and Consultant Psychiatrist A. The assessment was thorough. No major mental illness was detected. The deceased denied current TSH or suicidal ideation. He denied being threatened in Wheatfield

Prison. He was unhappy being there and would have preferred a transfer to Mountjoy Prison. The medical plan as a result of the assessment was that the prisoner should be moved to a normal cell on West 2 and be further reviewed. Consultant Psychiatrist A noted in the medical notes:

“I advised Governor A that he does not need to remain in a SOC from psychiatric perspective. I recommended that he move to a normal cell in West 2. Governor A reported that Chief A would go to see him to discuss placement options”.

The deceased was not reviewed by any member of the psychiatric team between the date of his assessment referred to above and the date of his death.

41. On 20 February the deceased was seen by Doctor A who noted – *“feels much better, communication is clear, gave up suicidal ideas”.*
42. Between 20 February and 24 February the deceased was accommodated in West 2. He was not in a Safety Observation Cell but was in a Close Supervision Cell. He was seen each day by members of the medical staff. He did not make any complaints and the medical staff did not note any matters of concern. The deceased did not wish to move from West 2 Landing.
43. On 24 February the deceased was assessed by Doctor A who noted –

“unhappy in Wheatfield, wants to transfer to Mountjoy Prison. No evidence of mental illness. Denied thoughts of self harm at time of assessment. Does not require ongoing management in SOC. Recommend transfer to normal cell in West 2”.
44. At 22.00 hours on 27 February the deceased who was in a cell on 8F Landing asked to see a member of the medical team. Nurse Officer G saw him in his cell just after midnight. The deceased stated that he was under the impression that he should have started on a course of antidepressants that

day. The nurse consulted the medical notes and confirmed that he had not been prescribed such medication.

45. At 22.17 hours on 28 February the deceased, having been transferred to Mountjoy Prison, was assessed by Nurse Officer H who recorded:

“medically well....States that his mind races and that he gets very stressed. Stated that he was in the ‘pad’ in Wheatfield for 8 days as he stated that he was going to DSH. He stated that the Dr in Wheatfield was going to prescribe anti-depressants for him. Denies any thoughts of DSH. Would like to speak to a Dr regarding ? anti-depressants that he thinks he was supposed to commence in Wheatfield”.

46. On 1 March the deceased was assessed by Doctor D in Mountjoy Prison. His medical notes are as follows:

“Transfer from Wheatfield

Review in cell

No medical history

Appendicectomy as child

No meds

No allergies

Was requesting antidepressants – was told he was going on these by Dr in Wheatfield – no dx of depression from Psy review last week.

Chest clear BS, No wheeze nor creps

HS III no AS/M

GCS 15/15 orientated tpp, speech and affect appear normal”

47. At 19.44 hours on 3 March Nurse Officer I visited the deceased in his cell on 3D landing in West 2 Mountjoy Prison Campus as the deceased had told prison staff that he was on anti-depressants and had not got them. The nurse consulted the medical notes and told the deceased that – *“he has been seen by Doctors and that they have not prescribed this type of medication”.*

48. On the night of 4/5 March the deceased had further contact with the prison medical personnel. Such further contact is referred to in paragraphs 99, 104 and 107.

Status of the deceased since his imprisonment on 2 February 2015.

49. At all times the deceased was a 'protection prisoner'. The obligation to check a prisoner 'on protection' is no greater than that which applies to an 'ordinary prisoner' - namely every hour during periods of lock down.
50. Between 2 February and 15 February the deceased was classed as an 'ordinary prisoner'. As an 'ordinary prisoner' he should be checked every hour during periods of lock down.
51. On 15 February 2015 the status of the deceased changed from that of 'ordinary prisoner' to that of 'special obs'. **He remained a 'special obs' prisoner until his death.** As a 'special obs' prisoner he should be checked every 15 minutes by prison staff irrespective of what type of cell he occupied.
52. While in a Safety Observation Cell a prisoner should be checked every 15 minutes by prison staff and every two hours by the medical staff.

Transfer of deceased from Wheatfield Prison to Mountjoy Prison.

53. During his imprisonment in Wheatfield Prison the deceased had, on numerous occasions, expressed a wish to be transferred to Mountjoy Prison as he stated that he would not require protection in Mountjoy Prison.
54. In paragraph 22, I stated that the deceased was in a Close Supervision Cell in West 2, Wheatfield Prison between 18 February and 25 February 2015. The prison records disclose that he did not wish to leave this cell despite having been cleared by the medical personnel to move to ordinary accommodation on this landing. However, Chief Officer B, in his report, stated that the deceased, on 18 February, was "*transferred to a Close obs cell on West 2 as*

a step down from the Special Obs Cell". The reference to the 'special obs cell' should be a reference to a 'safety obs cell'.

55. Chief Officer B in his report stated that in a conversation with the deceased on West 2 the deceased requested a transfer to Mountjoy Prison. The Chief Officer explained to the deceased that he "*could not transfer from West 2 cells, he had a protection issue and would not give any names of who this issue was with*". The Chief Officer went on to state that "*as he seemed in genuine fear I spoke to Mountjoy and arranged his transfer which took place on 28/2/15*".
56. The reference to 'arranging' the transfer by Chief Officer B in paragraph 55 refers to an old established procedure whereby Chief Officers could engage in what could be described as '*horse trading*' referred to as '*Chief to Chief transfers*' to transfer prisoners between their respective prisons. Irish Prison Service Headquarters Operations Directorate wished this arrangement to be placed on a formal basis. The present position is that the informal 'Chief to Chief' transfers must now be authorised by the Operations Directorate and are subject to specific procedures. An application must be made and if considered favourably will be approved.
57. In the instant case the application to the Operations Directorate for permission to transfer the deceased from Wheatfield Prison to Mountjoy Prison was timed at 10.20 hours on 27 February 2015. The reason given for the transfer was – "*Operational (Accommodation)*". Under the heading "*record comprehensive details of application*" appears "*Transfer to Mountjoy as Agreed Chief Officer C to Chief Officer B*". The movement date was stated to be 27 February. The application was recommended by Chief Officer D of Wheatfield Prison. The IPS decision was "*Approved*". There are no details for the decision except under "*Summary Description*" appears "*To ensure good governance of WF*". The 'approval' granted on 27 February was acted on on 28 February when the deceased was transferred to Mountjoy Prison.

58. There was no reference on the application to transfer to the vulnerability of the deceased or to the fact that he was a 'special obs' prisoner.
59. On the electronic application for transfer form referred to in paragraph 57 the following warning words appear in red – "*PMM Alert, Movement Caution*".
60. When the deceased was transferred to Mountjoy Prison on 28 February his status was still a 'special obs' prisoner.
61. I made enquiries of Chief Officers B, D and C as to their recollection of the circumstances of the transfer of the deceased to Mountjoy Prison and in particular if there had been any discussion of the fact that the deceased had been in a Safety Observation Cell or Close Supervision Cell in Wheatfield Prison.
62. Chief Officer B stated:

"I can state that I contacted Mountjoy Prison regarding the transfer of (the deceased). I spoke to C.O. C. Given the time past since then I am depending on my best recollection. I cannot recall any discussion about (the deceased) in the CSC or SOC. (The deceased) was seeking a transfer to Mountjoy to come off protection as he did not need protection in Mountjoy but he needed it here in Wheatfield. (The deceased) was not transferred from a CSC or SOC, he was on unit 8F having been in Court and was transferred from there".

63. Chief Officer D in reply to my request for information stated:

"I have no email or other contacts with Chief Officer C in relation to inmate (the deceased) in relation to his transfer to Mountjoy from Wheatfield on 27 February 2015. I was on duty on this date and was to arrange the transfer which had been previously agreed between Chief Officer B (WFLD) and Chief Officer C (MJOY). I was simply the person who recorded the movement application on PIMS in order to get the approval for the transfer".

64. Chief Officer C in reply to my request for information stated:

“There was no notes generated in relation to the transfer of (the deceased) to Mountjoy. I spoke with C.O. D and (the deceased’s) transfer was agreed on a swap basis for protection prisoners. I was not informed that (the deceased) was in a special cell in W/field and there was no concerns in relation to any health issues or any information to (the deceased’s) vulnerability passed on to me”.

65. Contemporaneous records of the conversations or the arrangements made between the Chief Officers were not generated.

66. I have been informed by the Operations Directorate of the Irish Prison Service that transfer applications are provided for under the following operational circulars issued to all Governors and Chief Officers – OPS/02/2012, OPS/13/2014 and OPS/08/2015.

67. In layman’s terms all applications for the transfer of prisoners are made electronically on PIMS (the Prison Service computer system). These applications are adjudicated on by an authorised officer in the Operations Directorate of IPS headquarters having delegated authority from the Minister for Justice and Equality. When the adjudication has taken place the result of same is posted on PIMS and is the authority to effect the transfer. The requesting prison is obliged to provide full details of the reasons for the proposed transfer and also other appropriate significant information. This information would be within the knowledge of the requesting prison.

68. Except in exceptional circumstances and where clarification of the request to transfer is required are telephone communications between the requesting prison and the Operations Directorate made. There was no evidence provided to me of such telephone conversations having taken place in the instant case.

69. It is clear from my investigations that Chief Officer B of Wheatfield Prison, conscious of the desire of the deceased to return to Mountjoy Prison for his

own safety, reached agreement with Chief Officer C of Mountjoy Prison that the deceased should be returned to Mountjoy Prison when he could be accommodated on a Protection Wing. However this information was not recorded on the application to transfer. Neither was the fact that the deceased was a 'special obs' prisoner. Despite this the transfer was approved as stated in paragraph 57.

70. Operations Circular OPS/13/2014 requires the following of all stakeholders in the transfer process:

“Consideration and knowledge of-

- i. The capacity of the receiving prison to accommodate a given prisoner.*
- ii. The timing of transfers.*
- iii. The need to consider the healthcare requirements of the prisoners to be transferred.*
- iv. The best interest of the prisoners”.*

71. Included with Operations Circular OPS/02/2012 is *“A document outlining the standards and the scope of information required for entering certain information in PIMS including what information is required for applications such as TR, transfers etc”.*

72. Paragraph 5.6.2 of the document referred to in paragraph 71 above states:

“Where a prisoner’s file is marked with a medical marker in Special features it is compulsory to contact Healthcare before moving the prisoner. This is to ensure that vulnerable prisoners are not moved without arrangements been taken by Healthcare regarding essential medication, risk of self harm etc been taken into consideration”.

Paragraph 5.6.2 goes on to warn:

“External independent investigations are now taking place into deaths in custody. Should a movement take place without contacting

Healthcare where a medical marker was indicated and the prisoner subsequently is put at risk or dies the subsequent investigation team may look for reasons as to why procedures were not followed.

All such contacts or efforts to contact Healthcare should be recorded accurately on the prisoner's file”.

73. In the instant case I was informed by the Care and Rehabilitation Directorate that:

“A Special Feature on PIMS of ‘Medical Special Obs’ was activated on PHMS from Wheatfield 15th of February 2015 until deactivated on the 10th March 2015 following notification of his death by the Mater Hospital”.

74. I have not been provided with any documentation that could confirm compliance with the instructions set out in paragraph 72.

Relevant issues concerning the care of the Deceased between 28 February and 4 March 2015

75. On 28 February the deceased was transferred to Mountjoy Prison on foot of an order by the Operations Directorate referred to in paragraph 57.
76. The deceased was a ‘special obs’ prisoner when transferred on 28 February. The rationale for his designation is referred to in paragraphs 35 and 36. As I have already stated the risk assessment carried out on 16 February identified the likelihood of the deceased harming himself or others as “quite likely” and quantified the impact of such harm as “significant injury to self or others”. This assessment gave rise to the “Special Feature” on PIMS referred to in paragraph 73.

77. The deceased was accommodated in cell 5 (a committal cell) in C Base in Mountjoy Prison. He was seen by Nurse Officer H as referred to in paragraph 45.
78. On 1 March 2015 the deceased was seen by Assistant Governor A who noted in the ‘Mountjoy Committal Custody Record’:

“Transfer from Wheatfield Prison.

R & R explained (referred to Rules and Regulations).

No further charges.

Requires protection – says fighting with people in Finglas and elsewhere”.

The deceased’s protection request was granted and noted in the Mountjoy Committal Custody Record.

79. On 1 March the deceased was also seen by Doctor D referred to in paragraph 46.
80. On 2 March the deceased was seen by the ISM officer.
81. At approximately 19.00 hours on 3 March the deceased was moved from cell 5 in the C Base to cell 3 on D West in the Mountjoy Campus. It should be noted that the deceased had been in the Committal Unit in the C Base for approximately 72 hours. The stated aim of prison management is that prisoners should only remain in the Committal Unit for a maximum of 24 hours as apart from yard exercise prisoners in this area have no access to other services or regimes.
82. Chief Officer E was in charge of D West, Mountjoy Campus at the time that the deceased was moved there as referred to in paragraph 81. Chief Officer E, in his statement, states as follows:

“On 3/3/15, I was Chief Officer I/C of St. Patrick’s Institution and Mountjoy West. During the course of my duties on that date a number of vacancies arose on D West which is a protection wing.

I contacted ACO A who was I/C of the committal unit and took from him a list of inmates who he advised had requested protection.

One of those inmates was (the deceased). I reviewed the PIMS record for this inmate and noted that he had transferred into Mountjoy from Wheatfield as agreed between CO D and CO C. I also noted that a note of his protection assessment had not been entered on PIMS and his status had not been changed to protection. I asked ACO A to ensure that these were done. I noted he was special obs but noted nothing else recorded that would give rise to particular concern.

A list of 4 inmates to transfer from the committal unit to D West along with the relevant landings that they were to move to was sent by me to mjoy and st pats healthcare and mjoy chief officer by email for records and to ensure proper handover of any healthcare issues and the orderly follow on of any medication.

(The deceased) moved from the committal unit to D3 West at approx 7 pm that evening. My attention was not drawn to any issues with this movement and no reports were made to me of any concerns with this inmate”.

83. On 4 March at approximately 11.10 hours the deceased was visited in his cell by Assistant Governor B. His statement is as follows:

“I was on duty on Wednesday 4th March 2015 and I was conducting my Governor’s Parade on D3 West. I was accompanied by Chief Officer F. The class officer on D3 West informed me that (the deceased) was transferred from the committal unit area Mountjoy the previous evening and was placed on protection until seen by a Governor, which I was informed was at his own request.

When I finished the D3 West parade at approx 11.10 am I went to cell number 3 where (the deceased) was housed and went into the cell to speak with him. I was accompanied by Chief Officer F. I asked him why he was on protection and he replied that he was fighting with a number of prisoners in Mountjoy but declined to mention any names to me, he also said he felt safer on his own. He requested a transfer to Wheatfield Prison and I instructed Chief Officer F to contact Wheatfield Prison with a view to a transfer there for (the deceased).....”.

84. There was no documentation made available to me to suggest that a comprehensive assessment was carried out subsequent to the transfer of the deceased to Mountjoy Prison on 28 February, that relevant personnel were consulted, that the deceased’s vulnerability was considered, that the status of the deceased as being on ‘special obs’ was taken into account, that a care plan was formulated or that directions were given as to the appropriate accommodation or care for the deceased.
85. Prior to the finalisation of this Report I emailed the co-ordinating Governor for this investigation, on 4 March 2016 in the following terms:

“Further to previous correspondence I still require answers to questions raised by me in my letter of 21 December 2015.

When the deceased was transferred to Mountjoy Prison on 28 February 2015 he was accommodated in cell 5 in the C Base. He was seen by Nurse Officer H on 28 February. He was seen by Assistant Governor A, Dr. D and a Chaplain on 1 March and by the ISM officer on 2 March.

I require answers to the following questions which are straightforward questions the answers to which should be readily available.

1. *Was an assessment carried out on the deceased on 28 February or on any date thereafter? If the answer is in the negative the following questions do not need to be addressed.*
2. *If such an assessment was carried out please give the name of the person carrying out such assessment.*
3. *If such an assessment was carried out what documentation, persons or services were consulted as part of this assessment?*
4. *If such an assessment was carried out were the deceased's vulnerability and his status as a 'special obs' prisoner considered as part of this assessment?*
5. *If the deceased's vulnerability and his status as a 'special obs' prisoner were considered as part of the assessment was a care plan put in place for the deceased?*
6. *If such an assessment was carried out what directions were given by the person who carried out the assessment to ensure appropriate accommodation and care for the deceased? If such directions were given please give details of the persons charged with responsibility for the implementation of such directions.*

In the event that an assessment was carried out I require details of this assessment which should include contemporaneous notes. I also require documentation to corroborate answers given to questions 2 to 6 but only if an assessment was carried out”.

86. In reply to my email referred to in paragraph 85, the co-ordinating Governor confirmed that an assessment did not take place but that a committal interview did take place between Assistant Governor A and the deceased and that the notes in the Mountjoy Committal Custody Record referred to in paragraph 78 reflect this interview. Assistant Governor A has provided further clarification by stating *“I was not aware of his status as a ‘special obs’ prisoner, he did not present to me as a vulnerable prisoner on committal”*. I should point out at this juncture that the status of the deceased as a ‘special obs’ prisoner was, on 1 March 2015, a feature on the PIMS

system and available to anyone having access to such system such as an Assistant Governor.

87. My reasons for explaining, in detail, the procedure that should be adopted in inter prison transfers and the requirement for an assessment are to point to the failure to adhere to directions in the first case or to adhere to best practice in the other **particularly** when it was obvious on PIMS, (see statement of Chief Officer E referred to in paragraph 82) that at all relevant times the deceased was a 'special obs' prisoner and therefore entitled to appropriate care.

Events of 4/5 March 2015

88. The deceased was accommodated in a single cell – cell 3 on 3D landing in Mountjoy West. The cell had in cell sanitation. It was equipped with a call bell. When a call bell is activated a light flashes outside the cell. This light remains active until attended to at the cell by a member of staff who is able to turn off the call light and reset the call bell system.
89. The times of all activations and resets of the call bell are recorded electronically. The recorded times may not, in all cases, correspond with the times recorded on other electronic equipment such as CCTV or in fact with real time. However, in all cases all electronic equipment operates on a 24 hour clock which is accurate having regard to its time of calibration.
90. The CCTV coverage of the particular landing and of the deceased's cell, while not as clear as it might be, was of sufficient clarity to enable me note with certainty various movements associated with the deceased's cell. The times referred to in the following paragraphs are times taken from the CCTV recordings and the call bell activation records.
91. Assistant Chief Officer B was night guard in charge of Mountjoy West on the night of 4/5 March 2015. According to Assistant Chief Officer B's

statement the following prison personnel were also on duty – Prison Officers A, B, C, D, E and Medical Officer A.

92. The deceased was locked into his cell for the night at 19.00.28 hours on 4 March. He was the only occupant of this cell. Prior to that he could be seen on the landing walking around and talking to one or two prisoners.
93. There was considerable activity in and around the deceased's cell during the night of 4/5 March. In many cases this consisted of prison officers checking the deceased in his cell. The times of all relevant activity as seen on CCTV for the period are set out in **Appendix A**. The times of all call bell activations emanating from the deceased's cell and the times of responses to same are set out in **Appendix B**.
94. The deceased was a 'special obs' prisoner and as such should have been checked every 15 minutes during periods of lock down. In the period between 19.00.28 on 4 March when he was locked in his cell and 02.02.18 on 5 March when Assistant Chief Officer B and others entered cell 3 the deceased was checked 28 times by prison personnel. Many of these checks occurred within minutes of each other. At times such checks occurred subsequent to the deceased activating his call bell. These times are clear from a perusal of the CCTV. However, the intervals between checks exceeded 15 minutes on the following eight occasions on the night of 4/5 March 2015:

Between 19.13.57 and 19.50.53 – an interval of – 36 minutes 56 seconds.

Between 19.50.53 and 20.43.54 – an interval of – 53 minutes 1 second.

Between 20.43.54 and 22.05.40 – an interval of – 1 hour 21 minutes 46 seconds.

Between 23.06.07 and 23.25.10 – an interval of – 19 minutes 3 seconds.

Between 23.37.34 and 00.08.20 – an interval of – 30 minutes 46 seconds.

Between 00.08.20 and 00.32.55 – an interval of – 24 minutes 35 seconds.

Between 01.05.57 and 01.31.25 – an interval of – 25 minutes 28 seconds.

Between 01.31.25 and 02.00.08 – an interval of – 28 minutes 43 seconds. **It should be noted that it was during this period that the deceased attempted to take his own life.**

95. During the course of the night of 4/5 March three significant events occurred. I refer to these in detail in paragraphs 96 to 110.

First significant event

96. At 22.08.30 Prison Officer A checked the deceased's cell by looking through the viewing hatch. She had a conversation with the deceased which she described in the following terms:

“At 10pm when I went to D3 landing.... (the deceased) stated that he needed to ‘get off this landing’ and that there was a ‘hit on him as his name was mentioned in a book of evidence in a murder charge.....He was agitated and pacing in the cell.....I found it hard to hear him through the door so told him I would return with the ACO”.

97. Prison Officer A contacted Assistant Chief Officer B who came to 3D Landing and entered the deceased's cell at 22.12.32 and remained in the cell until 22.16.58. In his statement Assistant Chief Officer B outlined the sequence of events which led to him entering the deceased's cell and his conversation with the deceased as follows:

“At 10.00pm Officer A asked me to come to D3 cell 3 to speak to prisoner (deceased). (The deceased) was highly agitated, he told me there was a serious threat on his life and asked me to move him to C3. I told him C3 was full to capacity and that the prison was entirely locked up and no one could get to him. I changed him from the group he was in to protection from all others and wrote this on his cell card. At this point he was still agitated so I asked him to explain why he felt there was a threat on him. He said a (named prisoner) came to his cell and said he was going to cut him up because he ratted on a prisoner who transferred from Cloverhill that day called (name of prisoner)”.

98. Assistant Chief Officer B checked on the prison computer system and ascertained that neither of the prisoners mentioned by the deceased was on D3 landing. The second named prisoner was not in custody in any prison. Assistant Chief Officer B returned to the deceased's cell. In his statement he stated:

"I assured him no prisoner would get to him and that I would inform the Governor and Chiefs of his request to transfer from 3D".

Assistant Chief Officer B went on to state:

"I sent an email to Gov. B, CO E, CO F and ACO C i/c D Division to inform them of the situation. I instructed staff to consider him special obs and to keep regular checks on him".

This email was timed as being dispatched at 23.20 hours on 4 March and reads as follows:

"At 10.20 pm last night I was called to D3 cell 3 to speak with prisoner (the deceased). The prisoner was highly agitated and asked to be moved off D West. He claims there is a serious threat to his life. He says a prisoner came to his door and accused him of giving information to the guards and that they would get him and cut him. I explained to him I could not move him now, however I changed him from the yellow group to protection all others. I advised him to see the Governor tomorrow. I instructed the night staff to keep him on special observations".

99. At 22.46.37 Assistant Chief Officer B returned to cell 3 with Medical Officer A. They entered cell 3 and remained there for 6 minutes and 12 seconds.

Medical Officer A recorded in the medical notes:

“Seen in cell along with ACO B. Was in an anxious state saying his life was under threat from another inmate (name of inmate). ACO B informed (deceased) that he had checked the computer and no prisoner of that name was in custody. (The deceased) still not happy with this and thought that there were prisoners on the landing that would get into his cell. Explained to (the deceased) that all prisoners were locked up at this time but all he would say was that he wanted out of his cell and be accommodated elsewhere. Explained to him that there was no other cells available and that his best course of action was to see Gov in the morning re a transfer. Still not very happy with this but realised that he had no alternative. Is on Spl Obs and staff informed to keep a good watch on him”.

Second significant event

100. At 00.38.28 two officers approached the door of cell 3. One of the officers was Prison Officer B who called Assistant Chief Officer B on his radio. Both officers remained at the door of the cell.

101. Prison Officer B in his statement described the situation as follows:

“While on night duty there was an incident on D3 involving inmate (deceased) at approximately 12.35am on Thursday morning 5th March 2015. Inmate (the deceased) was found lying on his cell floor with a loose ligature around his neck”.

102. At 00.39.22 Assistant Chief Officer B and Medical Officer A with another officer arrived at the door of cell 3. Assistant Chief Officer B and Medical Officer A entered the cell. Assistant Chief Officer B described the situation as follows:

“(The deceased) was lying on the floor at the foot of his bed with a torn piece of bed sheet wrapped loosely around his neck. All staff were

present including MO A. I removed the piece of bed sheet and (the deceased) sat up on his bed. He asked me again if he could go to C3 and again I told him C3 was full and that there was no prisoner by the name of (named prisoner). I reassured him he was quite safe and his situation would be reviewed in the morning. I did not think this was a serious suicide attempt because the bed sheet was very loose and asked MO A for his opinion; he agreed and felt the inmate was trying to manipulate the staff in order to transfer off the landing. As a precaution I told staff to strip out the cell including his shoe laces. I once again asked all officers to keep regular checks on him”.

103. Prison Officer B in his statement, stated:

“ACO B, who was in charge on the night, asked myself and the other night staff present to strip out his cell to prevent any other incident happening. All items were removed from (the deceased’s) cell leaving him with just a mattress, pillow without its case and duvet without its cover. I personally checked his runners and removed the laces from same. All of the items were placed in a bag and put in the D3 class office, as he would be getting his property back that morning when the day staff came on duty. This is the reason as to why there was no inventory taken”.

104. Medical Officer A recorded in the medical notes:

“Called to cell by staff where inmate was found lying on the floor with his head under the bed and a small length of bed sheet tied loosely around his neck. No marks on neck. When asked what he was doing he said he just wanted to get out of this cell as he feared he was going to be harmed. The cell was stripped of all items, flexes bed clothes and trays and cutlery and inmate again advised that there was no alternative accommodation available. I asked him if he would like to see the MO in the AM but he declined saying ‘I don’t need the fucking

doctor'. Advised him that if he needed to talk I was available all night".

105. During the course of my investigation I sought an inventory of the items taken from the deceased's cell on the morning of 5 March but no such inventory existed.

Third significant event

106. At 02.00.08 the deceased was checked by Prison Officer A. She could be seen on CCTV calling to Prison Officer D who was on the other side of the landing. She was joined by Prison Officer D at 02.00.41 outside cell 3. Prison Officer A in her statement described the scene in the following terms:

"At 2am myself and Officer D started to check the D Division. It is common practice on nights for the night guards to check in twos as it is easier to check both sides of the landing together. When I reached (the deceased's) cell I observed (the deceased) with a ligature around his neck that was tied to the bars of his window. I told Officer D to call for the ACO on the radio and I began to call (the deceased's) name to see if I could get a response".

107. At 02.02.18 Assistant Chief Officer B accompanied by other officers and Medical Officer A entered cell 3.

Assistant Chief Officer B described the scene in the following terms:

"Officer D contacted me over his radio and asked me to come to D3 cell 3 again. When we entered the cell (the deceased) had a ligature made of string around his neck tied to the bars of his cell window. He appeared to be unconscious. All staff attended, Officer D retrieved the Hoffman knife from the keys office and cut the string. MO A administered first aid. Officer D called the ambulance".

Medical Officer A's contemporaneous medical note states:

“On arriving at cell 3 D3 inmate (deceased) was hanging from a lace tied to the window bars, with the assistance of ACO B inmate was taken down from the window and lace cut from his neck with a Hoffman knife, no pulse or signs of breathing immediately instructed staff to call an ambulance and bring the Defibrillator from the surgery, commenced chest compressions and rescue breaths with a Pocket Mask, DeFib brought to cell and applied to inmate no shock required, compressions and rescue breaths continued this occurred x 3 until ambulance arrived and handover given, assisted ambulance crew and inmate was transferred to A/E at 2.45 hrs”.

108. At 02.15.43 Dublin Fire Brigade paramedics entered cell 3.
109. At 02.37.01 the deceased was removed from cell 3 by the Dublin City Fire Brigade and taken to the Mater Hospital where he died on 10 March 2015.
110. The ligature already referred to was a blue coloured lace. It was affixed to the window bars of the deceased’s cell. The provenance of the lace has not been established. However, in photographs of the interior of cell 3 taken subsequent to the removal of the deceased to hospital two runners are visible on the floor of the cell. They are coloured dark and light blue and would have laces of the type and colour of that which was used as a ligature.
111. I have neither investigated nor taken a view on the adequacy of the prison response (prison staff and medical staff) to the first two significant events referred to in paragraphs 96 to 105 as these are matters more appropriate for investigation by the Coroner at the forthcoming Inquest.

Addressing the concerns of the family

112. In paragraph 13, I set out issues raised by the family that they wished me to investigate. In paragraph 113, I address such issues. I have adopted the same numbering sequence as in paragraph 13.

- 113.
- (a) This is explained fully in the body of this Report.
 - (b) The circumstances of his transfer and his assessment are comprehensively dealt with in this Report. He was not transferred as a result of an incident of self harm.
 - (c) The reasons are set out in paragraphs 53 to 74.
 - (d) He was not in a padded cell.
 - (e) There is no documentary evidence to suggest that they were so aware. However all movements of the deceased were documented on PIMS as was his status as a 'special obs' prisoner.
 - (f) There is no evidence that the deceased self harmed on 2 March 2015.
 - (g) Between 15 February 2015 and the date of his death the deceased was a 'special obs' prisoner who should have been checked every 15 minutes. While the term 'suicide watch' is understood by many to mean different things it is not a term applied in prisons for the obvious reason that it is difficult, in a prison setting, to define. If the term 'suicide watch' is understood to mean that a person should be present with a prisoner at all times this did not occur.
 - (h) This is dealt with in that section of this Report that refers to the deceased's contact with the medical services.
 - (i) The bullet points hereunder follow the sequence as in paragraph 13 (i):
 - Yes as referred to in this Report and in Appendix B.
 - A lace.
 - The window bars.
 - He was the only person in the cell and while this is more a matter for consideration by the Coroner in my view the attaching of the ligature must have required some conscious decision on the part of the deceased.
 - These circumstances are comprehensively set out in this report.

Findings

114. The recorded cell movements of the deceased on PIMS between 3 February and 5 February and between 28 February and 3 March were incorrect in certain details.
115. The Irish Prison Service procedures for inter prison transfers of prisoners were not followed in the instant case when the deceased was transferred to Mountjoy Prison on 28 February on foot of a transfer request made and approved on 27 February 2015.
116. The paucity of information contained in the application for approval to transfer the deceased to Mountjoy Prison dated 27 February 2015 and the absence of any evidence of clarification by telephone or otherwise suggests that the order approving such transfer could be said to be little more than a rubber stamping exercise.
117. Healthcare staff in Wheatfield Prison was not contacted prior to the transfer of the deceased to Mountjoy Prison in accordance with Operations Circular OPS/02/2012.
118. A perusal of PIMS at any time between 15 February and 4 March 2015 would have disclosed that the deceased was a 'special obs' prisoner at all times during this period.
119. No assessment was carried out on 28 February 2015 when the deceased was transferred to Mountjoy Prison or on any date thereafter despite his status as a 'special obs' prisoner being flagged on PIMS.
120. A care plan for the management of the deceased was not put in place on or after 28 February 2015 despite his vulnerability.
121. No enquiry was made as to the reasons for the continuing status of the deceased as a 'special obs' prisoner on 28 February 2015 or on any date thereafter which would have elicited evidence of his vulnerability.

122. Throughout the night of 4/5 March 2015 the deceased was described variously as being agitated to being highly agitated. He expressed various concerns for his own safety and for his life. He asked to be moved from his cell to another part of the prison. Despite assurances being given he continued to express such concerns. He was not moved to another location.
123. The deceased was checked by prison staff on 28 occasions during the night at regular and at times irregular intervals. As a 'special obs' prisoner he should have been checked every 15 minutes. On eight occasions the time intervals between such checks exceeded 15 minutes with intervals ranging from 19 minutes 3 seconds to 1 hour 21 minutes and 46 seconds.
124. The deceased activated his call bell on eight occasions between 22.27.16 hours and 23.39.16 on 4 March 2015. The time range between the activation of such calls and the arrival of an officer or officers at the deceased's cell was between 1 minute 4 seconds and 29 minutes and four seconds.
125. As a result of significant events which commenced respectively at 22.08.30 hours on 4 March and 00.38.28 hours on 5 March 2015 and referred to in paragraphs 96 to 105 the officers on duty were instructed to "*keep a good watch on him*" and to "*keep regular checks on him*".
126. Subsequent to the instructions given as set out in my finding referred to in paragraph 125 the time interval between checks on the deceased exceeded 15 minutes on three occasions with intervals ranging from 24 minutes 35 seconds to 28 minutes 43 seconds. It was during the latter interval that the deceased attempted to take his life.
127. The deceased was not checked in accordance with Standard Operating Procedures every 15 minutes.
128. The ligature used was a lace which was tied to the window bars.

129. I have been unable to ascertain the provenance of the lace. However, it is clear that the lace was in the deceased's cell despite the order to strip the cell as described in this report.
130. There was an immediate and appropriate response by the prison staff and medical staff when the deceased was found in an unresponsive state at 02.02.18 hours on 5 March 2016.
131. The investigation of the adequacy of the prison response (prison staff and medical staff) to the first two significant events, referred to in paragraphs 96 to 105, is more appropriately a matter for consideration by the Coroner at the Inquest.
132. The cause of death is a matter for the Coroner at the Inquest.

Recommendations

1. A clear functioning line management structure must be put in place in all prisons to ensure compliance by all staff with rules, procedures and instructions.
2. Inter prison transfers of prisoners should only be approved following adherence to procedures. Adequate, accurate and transparent information should be made available when requests for approval to transfer such prisoners are being made.
3. Appropriate assessments must be undertaken in every prison when a prisoner enters such prison whether on remand, on committal or on transfer from another prison. Such assessments must be informed not only by the interviews conducted with prisoners by all services but by reference to appropriate records maintained either in hard copy or electronically. The deliberations of such assessment procedures and conclusions reached following such assessments must be recorded. The names of all persons contributing to such assessments must be recorded. A care plan must be

formulated for all prisoners following assessment. If prisoners are deemed 'vulnerable' or on 'special obs' such care plans must take these matters into consideration. The communication of such care plans should be documented and prison management should ensure that the line management structure for the delivery of such care plans is robust.

4. Proper, adequate and appropriate records must be maintained.
5. When the status of a prisoner is documented as 'special obs' this must be taken seriously as it suggests an element of vulnerability.
6. Prison personnel, of all grades, must be aware that the management of 'special obs' prisoners or those considered 'vulnerable' carries a high degree of responsibility.
7. Introduce a Standard Operating Procedure (SOP), across all prisons, placing an obligation on staff to take an inventory of all items removed from a prisoner when placed in a Special Observation or Close Supervision cell. The inventory to include date, time, list of items removed, date returned.
8. Management of the Prison should ensure that all cameras are properly aligned and that all relevant areas of the Prison are covered.
9. The relevant Director attached to Irish Prison Service HQ who has oversight of CCTV installation and upkeep to arrange for annual audits of the CCTV systems by suitably qualified person(s). This audit to include quality of footage, location and positioning of the cameras and should note concerns of local management. A log of all such audits should be retained at IPS HQ and locally.
10. The Director General of the Irish Prison Service must ensure that where a significant event occurs in prison, such as in the instant case, a comprehensive review is undertaken by a Governor of sufficient seniority

and that where deficiencies are identified, appropriate action is taken up to and including disciplinary measures where such are justified.

Appendix A

Relevant activity on 3D Landing on night of 4/5 March 2015 as noted on CCTV

Time	Nature of activity
19.00.28	Deceased locked in cell 3.
19.02.48	A prisoner at door of cell 3 appears to be speaking to deceased through door.
19.03.48	Officer opens cell 3 for few seconds, closes same and leaves the area.
19.13.57	Officer checks cell 3 – looks through viewing hatch and leaves the area.
19.50.53	Officer checks cell 3 – looks through viewing hatch and leaves the area.
20.43.54	Officer checks cell 3 – looks through viewing hatch and leaves the area.
22.05.40	Officer checks cell 3 – looks through viewing hatch and leaves the area.
22.08.30	Officer checks cell 3 – looks through viewing hatch and leaves the area.
22.12.32	ACO enters cell 3.
22.16.58	ACO exits cell 3 and closes door.
22.28.47	Officer checks cell – remains at the door until
22.29.30	Officer leaves the cell door and leaves the area.
22.29.52	Officer checks cell 3 – looks through the viewing hatch and remains at the door until
22.31.50	Three officers arrive and can be seen talking to the officer at the door.
22.32.08	ACO and another officer enter cell 3 and remain until
22.35.49	Officers exit cell 3 and close door.
22.46.37	ACO and Medical Officer enter cell 3 and remain until
22.52.49	ACO and Medical Officer exit the cell.
22.55.05	Two officers check the cell. ACO (being one of the officers) speaks to the deceased.

- 22.58.28 Officer responds to call bell, looks in viewing hatch and leaves the area.
- 23.01.58 Officer responds to call bell, looks in viewing hatch and leaves the area.
- 23.06.07 Officer responds to call bell, looks in viewing hatch and leaves the area.
- 23.25.10 Officer responds to call bell, looks in the viewing hatch and leaves the area.
- 23.37.34 Officer responds to call bell, looks in viewing hatch and leaves the area.
- 00.08.20 Officer responds to call bell, looks in the viewing hatch and leaves the area.
- 00.32.55 Officer checks the cell – looks through viewing hatch and leaves the area.
- 00.36.27 Officer checks the cell – looks through viewing hatch and leaves the area.
- 00.37.29 Officer checks the cell – looks through the viewing hatch and leaves the area.
- 00.38.28 Two officers check the cell – One looks through viewing hatch and both remain at the door until
- 00.39.22 Two officers arrive at the door. ACO and Medical Officer enter the cell.
- 00.45.45 All officers exit the cell, lock the door and leave the area.
- 00.53.17 Officer checks cell – looks through viewing hatch and leaves the area.
- 01.03.21 Officer checks cell – looks through viewing hatch, appears to speak to the prisoner and commences to place items from the cell into a plastic sack.
- 01.04.05 Officer checks cell – looks through viewing hatch and leaves the area.
- 01.05.57 Officer checks cell – looks through viewing hatch and leaves the area.
- 01.31.25 Officer checks cell – looks through viewing hatch and leaves the area.
- 02.00.08 Officer checks the cell – looks through viewing hatch. Calls to another Officer.
- 02.00.41 Officer joins another Officer at the door of the cell and looks through viewing hatch.

- 02.02.18 ACO arrives with keys and opens the cell and enters follows by other officers including Medical Officer.
There is then general activity with officers coming and going from the cell.
- 02.15.43 Dublin Fire Brigade paramedics enter the cell.
- 02.37.01 Deceased removed from the cell and taken to the Mater Hospital.

Appendix B

List of call activations from cell 3 on night of 4/5 March 2015

Time call bell activated	Time call bell reset	Time interval
22.27.16	22.28.38	00.01.22
22.54.11	22.55.15	00.01.04
22.56.06	22.58.19	00.02.13
22.59.17	23.01.46	00.02.29
23.03.02	23.06.01	00.02.59
23.09.50	23.25.17	00.15.27
23.36.01	23.37.24	00.01.23
23.39.16	00.08.20	00.29.04

On each occasion the call was responded to seconds before the call bell was reset.

These times are corroborated by the CCTV evidence set out in Appendix B