

**A report by the Office of the Inspector of
Prisons into the circumstances surrounding
the death of Prisoner J
on
4 December 2016 in Mountjoy Prison**

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**A report by the Office of the Inspector of Prisons into the
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Presented to the Minister for Justice and Equality pursuant to
Part 5 of the Prisons Act 2007

Helen Casey
Office of the Inspector of Prisons

22 December 2017

Preface

The deceased was a 21 year old man who died on 4 December 2016 in Mountjoy Prison while in the custody of the Irish Prison Service.

I offer my sincere condolences to the family and girlfriend of the deceased.

At page four of my Report, I set out abbreviations that are used throughout this Report.

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

Helen Casey

Office of the Inspector of Prisons

22 December 2017

Abbreviations used throughout this Report

ADHD	Attention Deficit Hyperactivity Disorder
ACO	Assistant Chief Officer
CPN	Community Psychiatric Nurse
CPR	Cardiopulmonary Resuscitation
CSC	Close Supervision Cell
DSH	Deliberate Self Harm
HSU	High Support Unit
IPS	Irish Prison Service
LSU	Low Support Unit
MAM	Multi Agency Meeting
PHMS	Prison Healthcare Management System
PIMS	Prisoner Information Management System
PRN	Pro-Re-Nata (As needed)
SOC	Safety Observation Cell

Investigation Report

General Information

1. The deceased was a 21 year old single man who came from the Leinster area. He is survived by his grandfather, father, siblings, girlfriend, son and extended family.
2. The deceased was committed to Prison on 17 April 2014 with a release date of 30 September 2017.
3. The deceased was discovered in an unresponsive state in his cell in the Medical Unit of Mountjoy Prison with a ligature around his neck, attached to the door of the cell, on 4 December 2016 at 03:08.
4. The deceased was pronounced dead in the prison at 05:28.
5. In carrying out my investigation I visited Mountjoy Prison on 4 December 2016 where I enquired into the circumstances surrounding the death of the deceased. I visited the deceased's cell and had access to all relevant prison records and to staff and prisoners. I subsequently examined relevant CCTV footage.
6. I met the deceased's Aunt, who is his next of kin, and his girlfriend, at an early stage in my investigation and have responded, where possible, in this Report to the concerns they raised.

Status of the deceased in Prison

7. The deceased was on the Basic Level of the Incentivised Regime at the time of his death. He was on the 'Special Observation' list and was accommodated in Cell 4 on F3 landing in the Medical Unit¹ in Mountjoy Prison.

¹ Nursing Staff attend the Unit from 08:00 to 20:00. The Night Nurse in Mountjoy Prison provides cover between 20:00 and 08:00. Doctors, Psychiatrists, Psychologists, Counsellors etc. attend the Unit between 08:00 and 17:00

8. The deceased was transferred to Mountjoy Prison from Wheatfield Place of Detention on 24 July 2015.
9. On foot of my enquires with staff from various disciplines within the prison and from my examination of prison records I ascertained that the deceased was frequently disruptive presenting with poor coping skills, had behavioural issues and was finding it difficult to adjust to the controlled environment of prison.
10. The records provide evidence that deceased deliberately self-harmed and had previously attempted to take his own life.

Meeting with Next of Kin

11. I met the deceased's girlfriend on 30 January 2017 and Aunt on 15 February 2017 to explain my role and to ascertain if they had any particular concerns relating to the deceased's death in custody.
12. I was informed that the deceased's mother died when he was quite young and he was raised by his grandparents and his grandmother had died in recent years.
13. They explained that the deceased had been committed to prison on a number of occasions in the past.
14. The deceased's Aunt told me that she had spoken to her nephew on the telephone two days before his death and he sounded very positive and was looking forward to his release.
15. His girlfriend told me that their relationship had broken up some months previously. She said the deceased made contact and asked her to visit him again, which she did on 3 December 2016.
16. The girlfriend stated that the deceased had told her that he was diagnosed as bipolar and schizophrenic. He suffered from ADHD when he was younger and had been on medication but alleged that the Psychiatrist told him he no longer needed that medication.

17. The deceased’s Aunt and girlfriend raised the following concerns:-

- (i) What medical diagnosis, if any, was made on the deceased while in custody?
- (ii) Was the deceased diagnosed as Bipolar and/or Schizophrenic?
- (iii) Was he on any medication for this/these illness(es)?
- (iv) Had he received psychiatric treatment?
- (v) Was the deceased depressed and did he ask for help?
- (vi) Did he get a “*hiding*” from the “*guards*” in prison?
- (vii) The Officers knew the deceased was suicidal – was he checked?
- (viii) Why was the deceased on his own in the cell?
- (ix) The aunt asked why she, as next of kin, was not informed of previous suicide attempts?
- (x) Was the deceased still receiving medication for ADHD?
- (xi) Did the deceased attend an Anger Management Programme?
- (xii) His girlfriend stated she had been told by a prison officer that the deceased had swallowed a razor blade the night before one of her visits. Can this be confirmed?

Deceased’s attempts to self-harm in the months prior to his death

18. During the three months prior to the deceased’s death, he self-harmed on 11 occasions, detailed in the table hereunder. In paragraphs 19 to 79, I outline the interaction the deceased had with the medical and other Services.

Date	Incident	Action
04/09/16 at 00:50	Lying on floor of cell unconscious. Gradually recovered. Admitted taking unknown substances.	Taken to A&E Department, Mater Hospital.
04/09/16 at 18:00	Attempted to hang himself in Reception Holding Cell.	Officer cut ligature - moved to Safety Observation Cell (SOC).
04/09/16	Found lying on floor of SOC not initially	Taken to the A&E

at 20:00	responding. Blood on floor - stated he swallowed piece of metal.	Department, Mater Hospital but refused treatment and was returned to prison.
15/09/16 at 11:57	Swallowed something and said it was a razor blade.	Taken to A&E Department, Mater Hospital.
20/09/16 at 10:30	Set fire to his cell in B Base.	Moved to Holding Cell in Reception area.
20/09/16 at 11:18	Attempted to hang himself.	Given oxygen and reviewed by doctor. Taken to A&E Department, Mater Hospital and on return, placed in SOC.
24/10/16 at 17:10	Attempted to hang himself.	Placed on Special Observation in CSC.
24/10/16 at 17:50	Attempted to hang himself. Found unconscious on cell floor – gradually responded.	Taken to A&E Department, Mater Hospital and on return, placed in CSC.
26/10/16 at 18:10	Prisoner damaged cell by removing cell call switch from wall of the CSC.	Moved to an SOC.
26/10/16 at 18:30	Prisoner damaged glass in door of SOC.	Moved to another SOC.
04/11/16 at 23:00	Deceased cut his neck with glass. Minor cuts.	Treated by prison medical staff and placed in SOC.
04/12/16 at 03:08:58	Deceased found unresponsive with ligature around his neck.	Pronounced dead at 05:28.

Extracts from Prison Medical Records for the period 4 September 2016 to 4 December 2016

19. After midnight on 4 September 2016, the deceased was found lying on the floor of his cell, unconscious. He gradually “*regained some consciousness and admitted to taking an unknown substance*”. He was removed by ambulance to the A&E Department at the Mater Hospital at 00:50.

20. On 4 September 2016 at 07:53, the deceased returned from the hospital and later that morning was seen by the Prison Doctor and Nursing Staff. It is recorded that the deceased said he felt "*fit and well*". He was held in the Reception area of the prison for ongoing observation but no medical issues were identified at that time.
21. On 4 September 2016 shortly after 18:00, Nurse Officer A states he was called to the Reception area. The deceased had attempted to hang himself with a shoelace. Prison Officer A who was on duty had cut the lace and Nurse Officer A assessed the deceased. The deceased was "*coherent and alert*" It is recorded that the deceased stated that he attempted to hang himself as a protest against screened visits. He refused to give an undertaking that he would not do this again.
22. Nurse Officer A placed the deceased in a Safety Observation Cell and listed him for review by the Prison Doctor.
23. At 20:00 on 4 September 2016, Nurse Officer B was called to check on the deceased by the Night Guard. The deceased was found lying on the floor of the cell. It is recorded that blood was on the ground and it appeared to be from the deceased's mouth. The deceased did not respond when called at first, but "*began coughing and became orientated*". He stated he had "*swallowed a piece of metal from the mobile phone*" that he possessed illegally and which was seized earlier that day during a search.
24. In light of the previous attempt to take his own life, the deceased was again referred to the A&E Department at the Mater Hospital for further examination. Prison records show the deceased left the prison at 21:13.
25. According to the prison records, the deceased refused treatment at the hospital. On his return to Mountjoy Prison at 23:49 he signed a 'Refusal of Treatment' form. He was placed in the Safety Observation Cell with a referral to meet with the Prison Doctor the following morning.

26. On the morning of 5 September 2016, the Chief Nurse Officer A sent a referral to the In-Reach Psychiatric Team and to Mountjoy Suicide Prevention Groups. According to records the deceased refused to fully engage with the Medical and Psychiatric Services.
27. The deceased remained in the SOC on the special observation list where he was subject to two hourly medical observation, 15 minute checks by operational staff and his food and fluids intake were monitored.
28. On 6 September 2016, Psychiatric Nurse A visited the deceased in the SOC. The deceased stated *“I’m not eating and drinking and won’t go anywhere unless you move me to Wheatfield Prison where my brother is - or the Training Unit”*. The deceased said he self-harmed as he was upset at the death of his grandparent and was only allowed screened visits with his girlfriend. Psychiatric Nurse A explained he would have to remain in the SOC if he continued to self-harm and that a transfer was an Operational decision and his behaviour would be considered for any such move.
29. On the morning of 7 September 2016 the deceased had cereal and interacted with Nurse Officer C who recorded that the deceased *“engaged well with good eye contact – denied suicidal thoughts and requested to return to his own cell”*.
30. Later that morning In-Reach Psychiatric Nurses A and B reviewed the deceased. They recorded that he engaged well, and told them that he was only threatening suicide to get back at the Irish Prison Service (IPS) because his mobile phone had been seized. He also said he *“didn’t have a death wish and was not depressed”*. The dangers of his actions were explained to him by the Psychiatric Nurses.
31. Psychiatric Nurse B recorded that the deceased had *“poor coping skills surrounding environment and grievance process”*. He also recorded that the deceased showed *“no evidence of major mental illness, no evidence of DSH/suicide”*.

32. It was decided to remove the deceased from the Psychiatric In-Reach caseload. He was referred back to the Prison Doctor, with the condition that he could be reviewed again by the Psychiatric Service if necessary.
33. Nurse Officer A recorded that the deceased had "*anger issues with prison service management*". The deceased was "*taking appropriate diet*". Nurse Officer A recorded that he would recommend the removal of the deceased from the SOC. The deceased was moved to cell 15 on F2 landing at 17:55 on 7 September 2016.
34. At 11:57 on 15 September 2016 Nurse Officer D was called to attend on the deceased. He had been removed to a holding cell in Reception from the Medical Unit. The deceased said he wanted to be placed in the '*pad*' and threatened to self-harm if he was not moved. He told the officers he had swallowed a razor blade.
35. At 12:14 the deceased was reviewed by Doctor A who noted "*blood seen on ground and on wall of cell*" and that the deceased informed him he "*swallowed 3 blades*". Records show the deceased was removed to the A&E Department of the Mater Hospital at 13:01. He was returned to the prison at 16:44 and remained in Reception until 19:00 when he is moved to cell 17 in the B Base of Mountjoy Prison.
36. On 20 September 2016 at 10:55 Nurse Officer E was called to Reception to review the deceased. He had been moved there after he set fire to his cell in B Base. The deceased's clothing was wet following the activation of the sprinkler system but it is recorded that he refused the dry clothes offered and that he appeared calm when the Nurse left.
37. Shortly after Nurse Officer E left the holding cell in Reception, Nurse Officer C reviewed the deceased and recorded that he had "*tried to hang himself in the cell and shoe-lace used*". Nurse Officer C recorded that the deceased was lying on the floor and was "*responding well to staff instructions and fully aware of his surroundings*". The deceased was reviewed by Doctor A and referred to the A&E Department at the Mater Hospital.

38. According to Prison 'External Movements Record' the deceased returned to prison at 15:47 that day. Following a risk assessment by Nurse Officer F he was placed in the SOC. Records state the deceased was "*agitated*" on his return and adamant that he would "*try to kill himself again if not put in the 'pad'....I will leave here in a box rather than on drugs*".
39. On 21 September 2016 – at 11:23, the deceased was reviewed by Doctor A who noted that the deceased "*had a high risk of self harm*" and sought a review by the Psychiatric Team.
40. In the early afternoon of 21 September 2016, Psychiatric Nurse A reviewed the deceased in the SOC. The deceased told him that his recent attempts to take his own life were as a result of "*not being able to see his grandmother on a visit before she passed away²*". He had admitted taking benzodiazepines whilst in prison but denied taking anything before his recent suicide attempt.
41. The deceased told Psychiatric Nurse A he wanted to engage in the Drug Treatment Programme and threatened he would attempt suicide if this request was not granted. Psychiatric Nurse A recorded that the deceased "*does not present with any major affective or psychotic illness. Behaviour likely driven by personality / illicit drug use and manipulation to have demands met. Substantial risk that behaviour and ongoing illicit drug use may result in successful suicide completion*". Psychiatric Nurse A noted that he discussed the deceased's case with the Psychiatrist, Doctor B who undertook to conduct a review and discuss at a Multi-Agency Meeting (MAM)³ the following day. The deceased remained in the SOC, on the 'Special Obs' list. Chief Nurse Officer A notified all relevant persons, including Medical Staff of the situation.

² November 2013

³ Attendees include representatives from Psychiatric Services, Psychology Services, Probation Service, Counsellor, Governor, Nurse Officer, Prison Doctor, and Discipline Staff.

42. At 16:01 on 22 September 2016, Nurse Officer A records that the deceased was seen in the SOC by Doctor C. He noted “*no psychotic / paranoid behaviour evident, was coherent in conversation*”.
43. Chief Nurse Officer A recorded that the deceased had been discussed at MAMs and it was agreed at that meeting that he should be removed from the SOC and returned to a normal cell but should remain on the special observation list.
44. It is recorded in the medical record that the deceased was seen in the SOC on C1 landing by Psychiatrists, Doctors B and D and Psychiatric Nurse A. The deceased informed the team that he was “*taking handfuls of tablets (30-40) on a daily basis*” whilst in the general population. He stated that he would set fire to his cell in order to expedite his move to the Medical Unit. The deceased stated his actions were driven by the drugs. According to the medical records, he denied “*preceding thoughts or plans of self-harm and denied preceding low mood*”. He expressed regret at recent attempted self-harm and was hopeful for the future. He wanted to “*participate in a Drug Treatment Programme and to continue individual psychology sessions. He requested a transfer to the Medical Unit as he believes he would be less likely to use drugs there*”.
45. Psychiatrist, Doctor B’s *assessment of the deceased* concurred with that of Psychiatric Nurse A as outlined in paragraph 41 in that the deceased “*has a history of impulsive acts of self-harm whilst in custody acts of self-harm and vandalism in order to expedite a transfer to desired locations within the prison*”. The Psychiatric team concluded that there was no evidence of an “*imminent risk of self-harm or suicide. However, if he relapses into illicit substances misuse his risk of self-harm will increase*”. The Psychiatric Team formulated a care plan.
46. Cell movement records show that on 22 September 2016 the deceased was moved from the SOC at 18:10 to cell 2 on C1 Landing.
47. On 6 October 2016 a further review of the deceased was undertaken by the same In-Reach Psychiatric team. The deceased claimed that he had abstained for a week after leaving the SOC but he had relapsed into taking drugs as he had not

yet been seen by the Addiction Nurse. It is recorded that the deceased blamed peer pressure for his return to substance abuse and stated “*I’m just a young fella, I can’t say no*”. He denied any thoughts or plans to self-harm or to attempt suicide stating “*that only happens when I’m on tablets*”.

48. The Psychiatric Team provided the deceased with ‘Psycho Education’. This involved advising the deceased of “*high risk of self-harm associated with illicit substance abuse and encouraged him to abstain from further drug use*”. According to the records the deceased acknowledged that continued drug use was the biggest risk for further self-harm. He told the doctor he would still like to engage in a drug treatment programme in order to “*better myself*” before release.
49. The In-Reach Psychiatric Team, having reviewed the deceased a number of times, concluded that there was no evidence of the deceased having a mental illness or no evidence of depression or psychosis and that he misused illicit substances while in custody. They concluded that he should “*remain on special obs*” and be discharged to a Doctor but should continue to have Psychology input.
50. At 23:47 on 23 October 2016, Nurse Officer G recorded that he had attended to the deceased, who was transferred from C1 landing to the CSC in B Base for “*management reasons*” and recorded “*no medical issues*”.
51. On the morning of 24 October 2016 Nurse Officer H reviewed the deceased in the CSC. Blood was observed on the floor and walls of the CSC. The deceased would not engage and refused to let the nurse examine him.
52. Later that morning the Prison Doctor attended the cell of the deceased but he again refused to engage. However, he did inform the Doctor that he had bitten the inside of his mouth and spat blood on the floor and the walls of the cell.
53. At 17:10, Nurse Officer I was called to the cell of the deceased as he had attempted to hang himself. Vital signs were checked and he was stable. The deceased is recorded as stating that he would “*continue this behaviour while he*

was detained in the CSC". Nurse Officer I carried out a risk assessment and placed the deceased on "*New Spl obs*".

54. At 17:50 Nurse Officer I was again called to the deceased's cell as he had made a further attempt to hang himself. The Medical Records state the deceased was unconscious but he gradually responded. An ambulance was called and he was removed to the A&E Department at the Mater Hospital for further medical attention.
55. On his return from A&E the deceased was attended to in the CSC by Nurse Officer A. The deceased denied any further "*suicidal intent*" and asked to be let out of the CSC. He was told by the Nurse Officer that he needed to be reviewed by the Doctor first.
56. On the morning of 25 October 2016, Doctor A reviewed the deceased and again referred him to the In-Reach Psychiatric Team.
57. Later that morning the In-Reach Psychiatric Team reviewed the deceased. According to the Medical Records, the deceased stated he attempted suicide as he was angry because the officers "*moved me out of my cell and they took my TV. They wouldn't give my TV back and they were taunting me*". He said "*they told me I couldn't kill myself in the pad and I said that I could*". The deceased told the Psychiatric Team that he wasn't trying to kill himself but he was proving to the officers that he could if he wished.
58. It is recorded that the In-Reach Psychiatric Team again cautioned the deceased and highlighted the danger of his actions – and that the deceased acknowledged the danger and denied a wish to kill himself. He said he didn't want to cause upset to his family. He denied experiencing depression and any psychotic symptoms but admitted to "*smoking grass and taking a few tablets*". The nursing staff continued to carry out the required two hourly observation on the deceased throughout the night.

59. On the morning of 26 October 2016 the deceased was again reviewed by Doctor A, accompanied by Nurse Officer J. The deceased again expressed the wish to be placed on the Drug Treatment Programme and asked to stay in Mountjoy West. He again denied any thoughts or intent to self-harm and stated that he was keen to make it up to his girlfriend and family for causing them pain. He gave a guarantee that he would inform the medical staff if he had any further thoughts of self-harm. Doctor A noted Psychology involvement and advised that he could be released from the SOC but that he should remain on special observation and advised the deceased to contact the surgery team any time.
60. The deceased was moved from the SOC later in that evening after he damaged the glass in the door of the SOC. The deceased stated he had damaged the door of the cell as he had not been moved promptly following the doctor's decision that he could be removed from the SOC.
61. On the morning of 27 October 2016 it is recorded that the deceased was reviewed by Doctor A and by Nurse Officer J "*as he had damaged both close supervision and safety observation cells*". The deceased informed them that he had no intent or plan to self-harm and stated he would only be at risk of doing this if he was sent back to the main prison where he would have access to drugs.
62. Later in the afternoon of 27 October 2016, the Psychiatrist Doctor E with Psychiatric Nurse A reviewed the deceased. The deceased denied having any suicidal ideation and expressed remorse. It is recorded that there was "*no evidence of mental disorder*". The deceased agreed to transfer to the High Support Unit (HSU) and requested a drug free landing. The deceased was to remain in the HSU until further review and remain on the special observation list.
63. On the afternoon of 1 November 2016 Psychiatric Nurses A and C and again reviewed the deceased in the HSU. They noted that the deceased was presenting as "*agitated and irritable*" and wanted a transfer to the main landing. He told them he was not taking any drugs and didn't want to remain in the HSU. According to the Medical Records, the deceased stated he "*had no thoughts to harm himself*". The Psychiatric Nurses noted that the deceased had "*risk of*

impulsive behaviour and history of serious attempts on his life and he was presenting as emotionally unstable and had poor coping skills.”

64. On 2 November 2016 the deceased attended the surgery in the medical unit at 15:00 where Nurse Officer K spoke to him at length regarding his impulsive behaviour / reactions. According to the Medical Records, the deceased stated he was *“feeling good and positive about life ... girlfriend and son.* He further stated that he *“was now off the drugs and anxious to get on the Drug Treatment Programme”*.
65. On 3 November 2016 the deceased was again reviewed in the HSU the by Psychiatrist, Doctor B with Social Worker A. The records state he was *“calm and appropriate throughout the interview”* and presented as being *“insightful into the negative consequences of a return to substance abuse”* and that he was hopeful of a place on the Drug Treatment Programme for which he was assessed the previous day. The deceased said he was frustrated with his placement in the HSU and wanted a transfer to the second floor of the Medical Unit in preparation for the Drug Treatment Programme. The In-Reach Psychiatric Team recorded that the deceased denied thoughts of self-harm. He told them *“I don’t want to harm myself, I have a son, I want to live”*. It was recommended that the deceased should continue with the Psychology Services and would *“benefit from the Drug Treatment Programme to address his drug dependency”*.
66. Records indicate that the deceased had been discussed at the MAM’s meeting on 3 November 2016 where it was agreed that he *“may be moved to general population where he should be placed on Special Observations”*.
67. On 4 November 2016, it is recorded in the ‘Internal Movements Record’ that the deceased was moved from cell 6 on F1 (HSU) to cell 4 on F3 landing in the Medical Unit at 23:00. Nurse Officer L who was on night duty in Mountjoy Prison answered a code red call from ACO A in the Medical Unit. The deceased had self-harmed. At 23:27 the deceased was moved to the SOC on F5 Landing. Nurse Officer L treated the deceased for several minor cuts he had inflicted to his throat with a piece of glass. The deceased would not engage in conversation

about the incident except to say that his head was wrecked. After dressing the wounds, Nurse Officer L recommended that the deceased be placed in a SOC and on special observation until he was seen by the Prison Doctor. The deceased was moved at 23:27 to the SOC on F5 Landing.

68. On the morning of 5 November 2016 Doctor F reviewed the deceased in the SOC in the Medical Unit and noted the deceased was "*not really engaging*".
69. The deceased remained in the SOC and was checked regularly by the nursing staff. He told them he cut himself as he "*got bad news yesterday*", but would not elaborate.
70. On 6 November 2016 the deceased was seen by the Prison Doctor. There were no medical concerns and he remained in the SOC.
71. On 7 November 2016 the deceased was reviewed in his cell by Doctor C who noted that there were no concerns.
72. On 8 November 2016 at 11:35, the deceased was seen in the SOC by Doctor A and Nurse Officer M who recorded that the deceased "*was conversing well and had no complaints*". The deceased admitted that he is impulsive if things don't go his way. He admitted taking tablets on the landings but said he had not taken any for three weeks or more. He said he didn't find psychology beneficial. The deceased was removed from the SOC and accommodated on F3 landing, Cell 4.
73. The prescription record shows that on 8 November 2016 Doctor A prescribed medication from "*8/11/2016 to 12/11/2016*".
74. On 9 November 2016 Nurse Officer M who was on night duty recorded that the deceased refused to take his medication, saying that the medication prescribed by Doctor A were "*lillies*" and that he didn't want them. He said he was going to get "*sleepers*" from "*Dr. G*" tomorrow. The record of prescriptions confirm that Doctor G prescribed additional medication.

75. The prescription records show that on 10 November 2016 Doctor A prescribed a further 5 days course of the initial medication “*from 11/11/2016 to 15/11/2016*”. There is no record of any further medications being prescribed for the deceased after this date.
76. Nurse Officer M recorded on 13 November 2016 that she spoke with the deceased on the landing and he appeared to be coping well. Later that evening the deceased was agitated and lashing out as he had been deprived evening recreation and he was angry.
77. On 17 November 2016, Psychiatrist, Doctor B attended the prison to meet the deceased. However, the deceased was attending Court that day and the meeting did not take place.
78. On 24 November 2016 Psychiatrist, Doctor D and Psychiatric Nurse A reviewed the deceased. They noted that the deceased refused to sit down during the interview, stating that his mood was “*grand*”. He told them that he was staying away from illicit drugs and had recently completed a detox of tablets and that he was due to commence the Drug Treatment Programme shortly. The deceased denied any thoughts of self-harm or any suicidal ideation and said there was nothing wrong with him - “*It’s just the drugs, I go off my head on drugs*”. It is noted in the records that the deceased said he “*no longer wants to engage with Psychiatry, and that he would prefer to be seen by the GP and if his mood deteriorates he would agree to engage with Psychiatric Services again*”. The Psychiatrist recorded “*no mental illness and will discuss at MAMs with a view to discharging case back to GP*” stating, the deceased “*has currently no acute symptoms of major mental illness*”.
79. On 1 December 2016, Addiction Counsellor A recorded that he had a good session with the deceased who presented and engaged well. He noted the deceased spoke of his intention to undertake the Drug Treatment Programme and that he was “*overall in a good mood*”.

80. On 4 December 2016 Nurse Officer N responded to a code red call from the medical Unit at approximately 03:00. On arrival at Cell 4, F3 landing he observed the deceased lying on the floor of his cell. The deceased had obvious ligature marks around his neck. Nurse Officer N noted, “*on checking for carotid pulse and signs of breathing, neither were present*”. Nurse Officer N began CPR with the help of ACO B and Nurse Officer O until Paramedics from Dublin Fire Brigade took over at 03:14. They continued CPR until 03:36 when they conceded that the prisoner was dead.
81. Doctor H attended the prison and pronounced the deceased’s death at 05:28.

Sequence of events of 3 and 4 December 2016

82. On 3 December 2016 Officer B, who was supervising visits, reported that the deceased had an argument with his girlfriend with “*both leaving the visit box*”, and “*within a short period of time they returned to the visit box and finished the visit with no other problems*”. Officer B stated that he asked the deceased what the problem was with his visitor. In reply, the deceased told him “*she is not (my) girlfriend any more, but I still wanted to know what she was doing outside, and to keep in touch, as friends*”. The officer said the deceased was smiling as he left the visit box.
83. Prison Officer C, Class Officer in the Medical Unit, reported that he allowed the prisoner to use the exercise yard for his hour exercise. He stated that the deceased “*was upbeat and appeared quite happy*” and when he returned to the landing following his exercise, was “*chatting freely and gave no cause for concern*”.
84. Prisoner A who was friendly with the deceased said he had been talking to him throughout the day and said that at 18:15 approximately “*a few of us went out....(to the exercise yard)....he seemed to be grand*” – “*he didn’t say anything that would be out of the ordinary or anything that would make me think something wasn’t right with him*”. Prisoner A stated that there were no issues and “*at lockup time he went in, no problem*”.

85. Prisoner B said he was in the company of the deceased later that evening and said the deceased “*seemed to be really good form – he borrowed two CD’s from me before lockup*”.
86. Officer D was the Night Guard on duty stated he began his checks at approximately 02:55. This is confirmed by CCTV footage. The officer stated he “*observed (the deceased) hanging by a ligature behind the door of cell 4 on F3 landing and immediately called ‘code red’*”. Officer D was helped by ACO B and Officer E to take the deceased down and place him on the floor.
87. ACO B in his Operational Report, states “*at approximately 3am I was alerted to a call for a code red by Officer D. He came to the office door for the masters. He also called for the Hoffman*”. ACO B said he gave Officers D and E the master keys and they proceeded to the cell on F3 while he searched for the Hoffman Knife which he failed to locate. He proceeded to the cell and on arrival he saw that Officers D and E had entered the cell. ACO B stated “*I saw (the deceased) hanging from the back of the cell door. I immediately lifted his torso, to attempt to relieve the weight on the ligature. I told Officer D to use his lighter to burn through the ligature, as it was a shoelace and very thin.....we placed the deceased onto the cell floor and removed remaining ligature. I checked for a pulse and found none*”.
88. Nurse Officer N received a code red call at approximately 03:00 and went directly to the deceased’s cell. He began CPR, with the assistance from Nurse Officer O. They continued CPR until the Dublin Fire Brigade and Ambulance personnel arrived at 03:14.

Other Relevant Facts

89. During our investigation we consulted with personnel in various services, who had involvement with the deceased, including Probation, Psychology and Chaplaincy. We were informed during discussions that some services are operating with limited or no access to their clients’ files on PHMS.

90. Records dated 10 November 2016 show that the Probation Officer A had ongoing concerns in relation to the deceased's mental health and his risk regarding suicidal and deliberate self-harm ideations. Probation Officer A discussed the case with a member of the Psychology Service on 9 November 2016, who had similar concerns. It was the view of these officials that there had been a dramatic decline in the deceased's presentation and ability to cope. In the view of the Probation Officer, the deceased was presenting as depressed, hopeless and despairing about his future and there was nothing to indicate that he had consumed any mood altering substances. Probation Officer A supported by Psychology, looked for an in-house case conference to be convened on the deceased as soon as possible. I noted from the records received that due to the unavailability of some personnel involved in the care of the deceased, a date after 15 December 2016 was proposed for the case conference. It is recorded that *"In the interim it may be best if deceased remains in the Medical Unit"*.

Sequence of Events as detailed on CCTV footage

91. I viewed CCTV footage to ascertain the movements of the deceased prior to his death. Hereunder is an account of footage from the evening of 3 December 2016 to 4 December 2016, when the deceased was found unresponsive.

3 December 2016

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| 18:08 | Cell 4 of F3 landing in the Medical Unit is unlocked and the deceased exits his cell, he visits other cells and associates freely with other prisoners on the landing. |
| 19:11 | The deceased returns to his cell. |
| 19:12 | An Officer is locking cells on the landing for the night locks cell 4. |
| 19:51 | An Officer checks on Cell 4, he lifts the viewing flap and after a few moments he returns to Cell 3 where he bends down and collects cigarette papers / tobacco which had been pushed out under the cell door. The officer takes this and pushes it in under the door of cell 4 to the deceased. He stands at the door for a few moments, would appear to be speaking with the deceased and then he moves on. |

20:56 An Officer checks the cells on the landing and he checks cell 4 – lifts flap and looks in.

21:49 Officer carrying a torch checks cell 4, lifts flap and looks in.

22:38 The cell call light for cell 4 flashes on.

22:39 Officer goes to cell 4 lifts flap and looks in. Switches off the call light and leaves the landing.

22:40 An Officer walks the landing – passes cell 4 but does not check and leaves the landing.

23:07 Officer checks landing – checks cell 4 – lifts flap and looks in.

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00:08 Officer enters landing – checks cell 4 and leaves landing.

00:18 Officer walks down landing and out of camera shot – does not check cells. Returns down landing – does not check and leave landing.

01:02 Officer checking landing – checks cell 4 – lifts flap and looks in.

01:32 Officer walks landing – does not check cells.

02:04 Officer checks landing – checks cell 4 – lifts flap and looks in.

02:30 Officer walks down landing – does not check cells.

02:32 Officer returns down landing – does not check – leaves landing.

02:57 Officer on landing checking cells – checks cell 4 – immediately can be seen on the radio.

02:57:20 Officer leaves landing using his Tetra Radio.

02:58:04 Officer returns running down landing accompanied by another Officer. They unlock cell 4 and enter.

02:58:56 ACO goes to cell, running.

03:03:10 Nurse Officer carrying emergency bag runs to cell 4.

03:05:56 Another Nurse Officer arrives at cell 4 to assist.

03:14:44 Paramedics from Dublin Fire Brigade Ambulance arrive at cell.

92. It is clear from examination of CCTV footage that the deceased was not checked in accordance with Standard Operating Procedures for Special Observation Prisoners, which states that “*Special Observation Prisoners must be checked every 15 minutes*”.

93. The following are intervals between checks that are in breach of the above SOP.

- 53 minutes between 20:56 and 21:49
- 50 minutes between 21:49 and 22:39
- 28 minutes between 22:39 and 23:07
- 54 minutes between 00:08 and 01:02
- 62 minutes between 01:02 and 02:04
- 53 minutes between 02:04 and 02:57

Addressing the concerns of the Next of Kin

94. In Paragraph 17, I set out certain concerns the next of kin wished to have addressed. In this paragraph, I endeavour to address those concerns. I adopt the same numbering sequence as in paragraph 17, as follows:-

- (i) There was no specific diagnosis recorded in prison medical notes. However, the deceased had ongoing psychiatric and medical reviews during his detention as outlined in paragraphs 19 to 79
- (ii) There was no evidence in the medical records reviewed that the deceased was diagnosed as bi-polar and/or schizophrenic.
- (iii) Not relevant, having regard to the above.
- (iv) Yes, the deceased was reviewed regularly by the Psychiatric team.
- (v) This is addressed at paragraphs 19 to 79.
- (vi) I found no evidence that the deceased was assaulted by staff.
- (vii) While in custody the deceased had regular ongoing reviews by the Healthcare, Psychiatric and Psychology Services. On the night of his death he was checked hourly. This is referred to at paragraphs 91 to 93.
- (viii) All cells in the Medical Unit at Montjoy prison are single occupancy cells.
- (ix) The Prison Service had two contact telephone numbers for the deceased's next of kin, aunt and girlfriend. I was informed that the latter was contacted as there was no response was forthcoming from his Aunt's listed telephone number.
- (x) There is no record on the papers received of the deceased having been prescribed medication for ADHD.

- (xi) The records indicate that deceased was generally uncooperative and would not fully engage with the Psychology Service in their efforts to support him address his issues. The deceased regularly failed to attend for one to one counselling with the Psychologist and on many occasions when he did attend according to the records he left the session early. The deceased did not undergo an anger management course.
- (xii) I refer to this at paragraph 34 and 35 of this report.

Findings

- 95. The deceased was an ordinary prisoner on the basic regime. He was on the Special Observation list at the time of his death.
- 96. The deceased was accommodated in a single cell on F3 Landing at time of his death.
- 97. The deceased self-harmed on several occasions while in custody and attempted to take his own life on a number of these occasions.
- 98. The deceased had ongoing regular assessments by Medical, Psychiatric, Psychology and Probation Services. In the three months prior to the deceased's death he was frequently reviewed at multi-disciplinary meetings including MAM's (weekly meeting), Suicide Awareness, Addiction and Special Observation meetings.
- 99. Having reviewed the deceased on a number of occasions the In-Reach Psychiatric Team found "*no evidence of mental disorder*".
- 100. The record show that the deceased presented with behavioural issues and found the prison environment difficult, resulting in a number of disciplinary breaches.
- 101. The deceased had an addiction to illegal substances but indicated his wish to address his addiction issues.

102. The deceased was not checked in accordance with Standard Operating Procedures every 15 minutes.
103. When the deceased was found unresponsive on 4 December 2016, there was an immediate response by the prison staff.
104. The ligature used was a lace, attached to the hinge of the cell door.
105. The Hoffman Knife could not be located in the Medical Unit by the staff on duty at the time of this emergency.
106. The deceased was pronounced dead at 05:28 on 4 December 2016 in the Medical Unit Mountjoy Prison.
107. The cause of death is a matter for the Coroner.

Recommendations

1. Notwithstanding that the Healthcare, Support and Intervention Services individually provided consistent care to the deceased he continued to self-harm, ultimately resulting in his death. In cases where the needs of the prisoner are complex and multiple, such as the instant case, s/he will require joined-up multidisciplinary focused and coordinated intervention. I recommend that in similar future cases that the Governor in-charge of the prison convene a multidisciplinary meeting to formulate a 'Dedicated Shared Care Plan' to jointly and consistently address the complex care needs of the prisoner.
2. Furthermore, I recommend that any such future 'Dedicated Shared Care Plan' be regularly reviewed and evaluated for its outcome(s) so as to ensure that the most appropriate intervention(s) is/are provided.
3. I recommend that an urgent review be undertaken on the Prisons Healthcare Management Service access to ensure that all relevant Services can access

appropriate fields in order for them to effectively manage their client's progress in a coordinated way.

4. The Hoffman Knife should be located in a similar location on each prison landings, e.g. secure press in Class Office, thus ensuring that all staff are aware of its location and have immediate access when required.
5. Senior Prison Management should undertake a full assessment of all clothing and footwear supplied to prisoners who are known to self-harm or who threaten suicide. Items such as draw strings, laces or other articles easily adapted for ligatures should be assessed as to their suitability for issue to such prisoners.
6. As raised in previous Reports, Management must continuously review their methods to prevent/eliminate the ingress of illegal substances into prisons.
7. Prison personnel, of all grades, must be aware that the management of 'special obs' prisoners carries a high degree of responsibility and must ensure that the Standard Operating Procedures are complied with.