

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner E
in the Mater Hospital on 16th April 2013
while in the custody of Mountjoy Prison**

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

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into the circumstances surrounding the death of Prisoner E
in the Mater Hospital on 16th April 2013 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

31st March 2014

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Preface

Prisoner E was a 33 year old man who died in the Mater Hospital on 16th April 2013 having been moved there after a serious self inflicted incident in Mountjoy Prison on 14th April 2013.

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

My Report is divided into 8 sections as follows:-

- General Information
- Meeting with the family
- Interviews with Prisoners
- Sequence of events
- Relevant Standard Operating Procedures and Protocols
- Findings
- Addressing the concerns of the family
- Recommendations

I had unrestricted access to all parts of the Prison, to prison records including CCTV, to prisoners and staff working in the Prison.

Matters of concern are disclosed in this Report.

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

Finally, I would like to thank all those who assisted me with this investigation.

Judge Michael Reilly

Inspector of Prisons

31st March 2014

Inspector of Prisons Investigation Report

General information

1. The deceased was a 33 year old unmarried man at the date of his death. He came from the Dublin area. He was committed to prison on 13th April 2011. His release date was to be 16th December 2017.
2. The deceased was well regarded by both prison officers and his fellow prisoners.
3. The deceased was diagnosed with a inguinal hernia on 5th February 2013.
4. The deceased was found at 11.25pm on 14th April 2013 with a ligature around his neck in his cell – Cell 22 on B1 Landing in Mountjoy Prison. He was moved to the Mater Hospital where he died on 16th April 2013.
5. This Report does not disclose any significant incidents between 13th April 2011 and 5th February 2013, being the date that the deceased was diagnosed with a hernia. During that period the deceased's contact with the medical services in prison did not disclose any issues that could have pointed to periods of instability.
6. I met with members of the deceased's family and his partner at an early stage in my investigation in order to ascertain if they had any particular concerns.
7. In carrying out my investigation I had unrestricted access to all parts of the Prison, to all records, to all staff and to all prisoners. I received total co-operation from all persons while carrying out my investigation.

Meeting with the family

8. The family and partner of the deceased stated that he was very outgoing. They described him as being of an athletic build who kept himself fit by working out in the prison gym. He was very interested in music.

9. The deceased is survived by his parents, his young children, his partner and his siblings.
10. The deceased telephoned his children regularly.
11. One of the deceased's daughters was due to make her Confirmation the week following 14th April. Although the deceased would not be attending the Confirmation he was looking forward to seeing his daughter on the day and had booked a visit for that purpose.
12. The family and his partner stated that early in 2013 the deceased complained of pain in his groin area which was diagnosed as a hernia. They stated that he was in extreme pain from the hernia, that he found it hard to walk and that he "*was forced to give up going to the gym*". They stated that this upset him. They further stated that he wanted to have an operation for his hernia and in this respect wanted to have a hospital appointment organised but that nothing was being done for him in this regard in the prison.
13. The family wished that I would investigate the issue of the deceased's hernia and the response of the prison authorities to same.
14. The family brought to my attention media reports quoting anonymous sources to the effect that the deceased was being bullied to get drugs into the prison and that in order to do so he was to arrange to go to hospital under some pretext for the purpose of picking up drugs and bringing them back into the prison. The family did not believe this scenario but wished me to investigate the matter.
15. The family expressed other concerns which can be summarised as follows:-
 - (a) What did he die from?
 - (b) Was there a suicide note left?

16. I was given names of prisoners by the family who, I was informed, could help me with my investigation.
17. In view of the information given by the family referred to in paragraphs 12, 14 and 16, I made arrangements to interview prisoners in Mountjoy Prison.
18. Neither the deceased's family nor his partner could offer any reason for the deceased taking the action that he did apart from a perceived inaction on the part of the authorities to deal expeditiously with his hernia problem. They were also of the opinion that he would not have intended the fatal consequences of his action.

Interviews with Prisoners

19. Solicitors acting for the next of kin of the deceased supplied me with a list of names of prisoners which included those already supplied by the family who, they stated, might be of help to me in my investigation. I interviewed numbers of prisoners who I identified as having had significant contact with the deceased and in particular those prisoners referred to in paragraphs 20 to 25.
20. Prisoner 1 stated of the deceased – *“he was a guy that wasn't afraid to do jail but he was in pain and could hardly walk across the yard”*. On 14th April during morning recreation the deceased told Prisoner 1 that he was thinking of swallowing batteries *“to make them take him to hospital so that they would treat his hernia”*. The deceased had 2 batteries in his hand at the time. Prisoner 1 advised the deceased against this course of action. Prisoner 1 stated that the deceased then said – *“if that is what I have to do to get to hospital then that is what I will do”*.
21. Prisoner 1 stated that the deceased was, up to the time of his hernia, *“a happy outgoing guy”*. He never gave any indication that he would try to self harm or commit suicide.
22. Prisoner 2 stated that the deceased told him on numerous occasions that he needed to get to the hospital in order that he (the deceased) could get on a

hospital list to have his hernia dealt with. This prisoner stated that the deceased “*wanted to get himself sorted so he could enjoy his music and get back to the gym*”.

23. Prisoner 3 occupied a cell adjoining the deceased’s cell. He was also a friend of the deceased. He described the deceased as being “*full of life, very spiritual and into music and the gym*”. The prisoner stated that this all changed around Christmas when the deceased started to suffer with a hernia in his groin area and that he was in “*terrible pain*”.
24. Prisoner 4 described the deceased as trying to get to the hospital to get relief from his hernia. In the afternoon of 14th April the prisoner stated that he had met the deceased who told him that he (the deceased) had swallowed batteries.
25. Prisoner 5 stated that the deceased was suffering from a hernia and that “*it was affecting his mental health*”. He stated that it was constantly on the deceased’s mind. He stated that he couldn’t train or do anything. He stated that the deceased told him that “*he had to swallow the batteries in front of the medic to get to the hospital*”.
26. I specifically asked each of the above prisoners if the deceased displayed by word or otherwise his intention to take the action referred to in paragraph 4. They were emphatic that he never talked about taking his own life or gave any indication that he intended to do so. They were shocked and stated that it was completely out of character.
27. The views of all other prisoners that I talked to concurred with those of the five prisoners referred to in paragraph 26.
28. In paragraph 14, I referred to media reports that the deceased had been bullied to organise to take drugs into the prison. I specifically asked the prisoners that I interviewed for their opinion on this. They were emphatic that the deceased was not a man to be bullied.

Sequence of events

29. After his committal to prison on 13th April 2011 the deceased spent time in a number of prisons namely – Cloverhill, Castlerea, Midlands and Wheatfield Prisons prior to his transfer to Mountjoy Prison on 5th October 2012.
30. At the time of the incident referred to in paragraph 4 the deceased was and for some time prior to that had been accommodated in Cell 22 on B1 Landing. The B Division of the Prison had been recently completely renovated. All cells on the B Division had in-cell sanitation and were single cells.
31. Between the date of his transfer to Mountjoy Prison – 5th October 2012 and 14th April 2013 no requests were made by or on behalf of the deceased to engage with the Prison Psychiatric Services.
32. While in prison the deceased participated in the Motivational Enhancement Therapy and Anger Management Groups. He took steps to stop smoking. He commenced and finished a methadone detox programme. He took steps to address a pre-existing medical condition and engaged with the relevant services.
33. On 5th February 2013 the deceased was diagnosed with a Right Inguinal Hernia by Doctor A. Subsequent to his diagnoses on 5th February and 2.39am on 14th April 2013 the medical notes disclose that the deceased was seen twice by the medical personnel in connection with this diagnosis – once complaining about pain from his hernia and on the other occasion concerning his hospital appointment for same.
34. Subsequent to 5th February 2013 the deceased complained of pain and discomfort from his hernia to his visitors, his fellow prisoners, prison personnel and those he talked to on the telephone. He was unable to exercise in the gym.
35. At 2.39am on 14th April 2013 the medical notes record that the deceased was seen in his cell by Nurse Officer A as he was complaining of pain from his

hernia. He was offered medication and the Nurse Officer offered to place the deceased's name on the list for a doctor review later in the day.

36. According to medical notes recorded at 10.39am on 14th April 2013 the deceased was seen by Doctor B when he again complained of pain from his hernia. The doctor was able to confirm to the deceased that he (the deceased) had an appointment in the Mater Hospital within the 'next few weeks'. He also advised him that he should take the medication prescribed for the pain.
37. On 14th April 2013 at approximately 12.20pm the deceased asked to speak to a medic and was taken to the Medical Area on B1 Landing to see Nurse Officer B. While Nurse Officer B was speaking to the deceased he (the deceased) suddenly placed what the Nurse Officer believed to be two 'AAA' batteries into his mouth and swallowed them. He then said to Nurse Officer B – *“now I done that because youse are doing nothing for me about this pain”*.
38. In the medical notes Nurse Officer B states – *“I re-iterated the advice given to him this morning by healthcare staff. I explained to him that he should use the prescribed analgesia and rest as advised. He refused analgesia and shook his head when I advised him about resting as much as possible”*.
39. Nurse Officer B, in his statement, has stated that he spoke with Officer E and ACO A and explained that there would be no medical intervention required following the swallowing of the batteries. He did state that he would be available to review the prisoner at any time should it be required.
40. ACO A in his statement has stated that he was asked to attend the surgery on B Division (paragraph 37 and 39). He goes on to explain – *“I met prisoner (named) who was speaking with Nurse Officer B. I was informed by Nurse Officer B that prisoner (named) had swallowed two batteries in an attempt to be discharged to hospital. I enquired as to the size of the batteries and was informed that they were 'AAA'. Nurse Officer B stated that the prisoner had swallowed these batteries in his presence and had done so before he could intervene. I enquired as to the likely medical requirements for the prisoner*

and was informed by Nurse Officer B that the batteries would not cause any harm and would eventually pass naturally. I enquired whether or not anything could be given to prisoner (named) to help this process and Nurse Officer B said he would provide something shortly.”

41. On being informed that he would not be discharged to hospital the prisoner became agitated and stated that he would – “*cut the f***ing thing out with a knife*”. ACO A assumed that the prisoner was referring to his hernia and ordered Officer E to return the prisoner to his landing and that he was to be placed on Special Observations.
42. The deceased was returned to his landing as ordered by ACO A.
43. At approximately 3.32pm Nurse Officer C was called to see a prisoner on B1 Landing who alleged he had fallen down the stairs. The deceased was lying at the bottom of the stairs. The fact of the fall on the stairs was corroborated by a number of prisoners. The relevant CCTV camera covering that portion of the prison was malfunctioning and therefore of no benefit to me. However, the lack of CCTV evidence did not hamper me in my investigation of this fall. The incident happened towards the bottom of the stairs and the deceased’s fall was cushioned by a fellow prisoner. My investigation did not disclose any rational reason for this fall. Nurse Officer C stated that the deceased claimed that he had hurt his arm but had no pain anywhere else, that he walked to the C1 Surgery, that he had full range of movement in his right arm, had no swelling or deformity, that he declined analgesia and that no further medical intervention was required.
44. At 7.17pm the deceased was locked back in his cell for the night.
45. The CCTV footage shows that the deceased was checked by prison officers at the following times:-
 - 8.05pm – officer lifting inspection flap and looking in.
 - 8.54pm – officer lifting inspection flap and looking in.

9.29pm – officer lifting inspection flap and looking in.

9.38pm - the officer can be seen at the door for some seconds and appears to be having a conversation with the occupant.

10.02pm – officer lifting inspection flap and looking in.

10.59pm – officer lifting inspection flap and looking in.

11.24pm – officer lifting inspection flap and looking in.

46. At 11.24pm on 14th April 2013 Officer F can be seen on CCTV conducting a check on B1 Landing. The CCTV footage shows Officer F checking Cell 22 and then moving on to check the remaining cells.

47. At 11.25pm the CCTV footage shows Officer F returning to the deceased's cell (cell 22) to check him again.

48. Officer F refers, in his statement, to the two checks referred to in paragraphs 46 and 47 in the following terms:-

'At approximately 23.25pm while conducting a check on B1 cell 22, I thought that (named prisoner) was standing with his back to the door obscuring my view of the cell. I continued to check the remainder of the landing but decided to return to cell 22 to converse with (named prisoner). It was at this stage that I noticed what I believed to be a cord around his neck'.

49. Officer F immediately raised the alarm and staff responded.

50. At 11.26pm ACO B opened the cell and with help from another member of staff cut the ligature around the deceased's neck and medical assistance was administered. The ligature had been attached to a conduit pipe attached to the ceiling of the cell.

51. At 11.27pm Nurse Officer D arrived and continued administering medical assistance. An Ambulance was called and the Gardaí were notified.

52. At 11.31pm Nurse Officer A arrived to assist.
53. At 11.40pm Dublin Fire Brigade arrived at the Prison and assisted in administering medical assistance.
54. At 11.55pm the deceased was taken by Ambulance to the Mater Accident and Emergency Department. I was informed that he was placed on a life support machine.
55. On 16th April 2013 the prison authorities were informed by the Mater Hospital that the deceased had died at approximately 7.30pm that evening.

Relevant Standard Operating Procedures and Protocols

56. I reviewed all relevant Standard Operating Procedures, Protocols and Governors'/Chiefs' Orders.
57. The relevant Governor's Order dated 29th July 1987 states:-

'Officers on night duty shall patrol all the landings, etc constantly during the night and check prisoners according to instructions, i.e. those on special observation at least every 15/20 minutes, all others at irregular intervals at least hourly.'
58. I checked the Night Guard Report Book for B1 and B2 Landings for the relevant period. The relevant entry is as follows:-

'Prisoners on Special Ob's to be checked every 15 minutes'

Findings

59. Prior to 5th February 2013 the deceased did not present with any significant medical problems while in prison.
60. The deceased did not suffer from any psychiatric problems either while in prison or in the community.

61. The deceased was diagnosed with a Right Inguinal Hernia on 5th February 2013.
62. Prior to developing the hernia referred to in paragraph 61 the deceased was a fit athletic man who worked out in the gym on a regular basis.
63. The deceased referred to pain from his hernia when talking to a wide range of people, namely, fellow prisoners, prison personnel, medical personnel, his family, his partner and those that he talked to on the telephone.
64. Despite assertions that he experienced great difficulty in walking or moving because of the pain referred to in paragraph 63 observation of his movements on CCTV, albeit limited, do not support these contentions.
65. The deceased was unable to work out in the gym because of his hernia.
66. The deceased was anxious to have his hernia operated on and in this connection wished to be brought to hospital.
67. The medical notes disclose that the prison medical personnel were aware of the deceased's stated discomfort from his hernia and were taking relevant steps to procure hospital treatment.
68. The deceased swallowed two 'AAA' batteries in front of Nurse Officer B at 12.20pm on 14th April 2013. The deceased took this action in an effort to be brought to hospital. He was not transferred to the hospital on advice from Nurse Officer B.
69. Between 12.20pm when he swallowed the batteries and 11.35pm when he was found in his cell the deceased did not complain to any nurse officer or prison officer of any adverse reaction to his ingestion of the batteries.

70. Despite the deceased's stated claims that he suffered great discomfort and pain from his hernia the medical notes disclose that he inexplicably refused offers of analgesia for some on a number of occasions between the time that he was diagnosed with his hernia and the evening of 14th April 2013.
71. The ingestion of the batteries, *per se*, (referred to in my finding at paragraph 68) did not contribute in any way to the death of the deceased.
72. Having fully investigated the deceased's fall on the stairs on 14th April as referred to in paragraph 43, I am satisfied that the deceased did not suffer any significant injuries and that the decision of the Nurse Officer that no further medical intervention was required was a reasonable decision in the circumstances.
73. The deceased was classed as a Special Observation Prisoner as referred to in paragraph 41.
74. The checking of the deceased, referred to in paragraph 45, was carried out in accordance with accepted practice. However, the deceased was not checked every 15/20 minutes as required by Standard Operating Procedures for those on special observation and referred to in paragraphs 57 and 58 during 5 separate periods of time as follows:-
- 49 minutes between 8.05pm and 8.54pm.
35 minutes between 8.54pm and 9.29pm.
24 minutes between 9.38pm and 10.02pm.
57 minutes between 10.02pm and 10.59pm.
25 minutes between 10.59pm and 11.24pm.
75. I found no evidence that the deceased was being bullied in the prison to bring drugs into the prison as referred to in paragraph 14. I must point out that a finding of proof of bullying is difficult without corroboration and in any case as bullying is a subjective concept it differs in fact and perception from individual to individual and from situation to situation.

76. The deceased gave no indication either directly or otherwise to his family, his partner, his fellow prisoners or the staff in the prison that he intended taking his own life.
77. While a finding of a cause of death is a matter for the Coroner the suspected cause of death was Cerebral Hypoxia due to hanging. The ligature was affixed to a conduit attached to the ceiling of his cell.
78. A suicide note was left by the deceased which indicated that he intended that his actions would be final.

Addressing the concerns of the family

79. In my findings in paragraphs 59 to 78, I have addressed the concerns of the family and the partner of the deceased.

Recommendations

1. Standard Operating Procedures must be strictly observed.
2. Prison management must ensure that structures and procedures are in place which ensure the proper supervision of the implementation of Prison Rules, Healthcare Standards, Standard Operating Procedures, Governors' and Chiefs' Orders etc.
3. Management of the Prison should carry out an audit of all CCTV cameras and recording equipment to ensure that all cameras are properly aligned, that all relevant areas of the Prison are covered and that recording equipment is operating and functioning to the highest standard.