

**A report by the Office of the Inspector of  
Prisons into the circumstances surrounding  
the death of Prisoner E  
on 25 March 2017 in Mountjoy Prison**

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

Office of the Inspector of Prisons  
24 Cecil Walk  
Kenyon Street  
Nenagh  
Co. Tipperary

Tel: + 353 67 42210  
E-mail: [info@inspectorofprisons.gov.ie](mailto:info@inspectorofprisons.gov.ie)  
Web: [www.inspectorofprisons.gov.ie](http://www.inspectorofprisons.gov.ie)  
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**A report by the Office of the Inspector of Prisons into the  
circumstances surrounding the death of Prisoner E  
on 25 March 2017 in Mountjoy Prison**

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

Helen Casey  
Deputy Inspector of Prisons

15 March 2018

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## **Preface**

The aim of this investigation is to:

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

The deceased was a 28-year-old man who died on 25 March 2017 while in the custody of Mountjoy Prison.

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

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

Helen Casey

Deputy Inspector of Prisons

15 March 2018

## **Investigation Report**

### **General Information**

1. The deceased was a 28 year old single man who came from the Leinster area.
2. He is survived by his parents, two brothers, sister and young daughter.
3. The deceased was committed to Mountjoy Prison on 16 January 2017 with a remission date of 16 May 2017. He had served a number of terms of imprisonment prior to his most recent committal.
4. The deceased was accommodated in a single cell – Cell 3 on D2 Landing.
5. At 22:29 on 25 March 2017, the deceased was found unresponsive in his cell.
6. Dublin Fire Brigade Paramedics took the deceased to the Mater Misericordiae University Hospital where he was pronounced dead at 23:34 on 25 March 2017.
7. While carrying out this investigation we had unrestricted access to staff, prisoners and relevant records, including CCTV footage.

## Status of the deceased in prison

8. The deceased was an ordinary<sup>1</sup> prisoner who was on the Standard<sup>2</sup> level of the Incentivised Regime.
9. He was accommodated on D2 landing where prisoners are free to associate with one another.
10. The deceased had completed a 'food hygiene awareness' course and was due to start practical cookery classes on Friday 31 March 2017. He had approval to attend other educational classes but records show that his attendance was sporadic.
11. The deceased was a client of the Probation Service and had engaged well with his Probation Officer while in Prison.

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<sup>1</sup> Not on a restricted regime and free to associate with other prisoners.

<sup>2</sup> The Incentivised Regime has three levels of privilege – Basic, Standard and Enhanced. Basic level provides the least amount of privileges (number of phone calls permitted, amount daily gratuity paid etc) while the Enhanced level offers the best privileges. All committals are placed on the Standard level of the Incentivised Regime

### **Meeting with the next of kin**

12. We met with family members of the deceased at an early stage of my investigation.
13. The family informed us that they had daily contact with the deceased by telephone and visited him regularly.
14. They also informed us that on the night the deceased died they received a telephone call from a prisoner advising them that the deceased had been taken to hospital. They said that Prison Management did not ring them on the night. The family did not name the prisoner who made contact with them.
15. The family stated that other prisoners told them that the deceased was unwell in his cell between 20:00 and 22:45 on 25 March 2017 and had asked an Officer to take him to hospital, but was told "*there was no staff*".
16. The family raised the following issues of concerns which they asked us to investigate.
  - a. Why were they not notified by the prison when [deceased] was removed to hospital?
  - b. How did [deceased] get drugs in prison?
  - c. Did [deceased] request medical attention or ask staff to take him to hospital on the night he got ill?
  - d. Was [deceased] checked regularly in his cell?
  - e. Why was there such a delay in releasing the remains for the funeral?
  - f. Why did the prison tell my son's girlfriend rather than me, his Mother, that his personal property was ready for collection?

## Contact with the Medical and Therapeutic Services

17. We examined the prison medical records of the deceased from the date of his committal to prison on 16 January 2017.
18. On 16 January 2017, Nurse Officer A saw the deceased for a committal interview. Nurse Officer A recorded the deceased as saying he “*smokes and injects heroin....requesting detox*”. Nurse Officer A also recorded that the deceased had “*no thoughts of self harm now*” and that he “*guarantees own safety.*”
19. On 19 January 2017, Prison Doctor A examined the deceased, checked his heart and chest which he recorded as normal. Doctor A noted that there was “*no evidence of mental illness*” and further recorded that other than “*opiate*” use the deceased had no other medical problems at that time. Doctor A prescribed a methadone detox programme for the deceased.
20. The records show that the Pharmacist administered a 21-day sliding methadone detox programme from 19 January to 8 February 2017. The Pharmacy Service referred the deceased to the Addiction Specialist, Doctor B. On 8 February 2017, it is recorded that Doctor B spoke to the deceased about the “*sleeping tablet policy*” and alternative options.
21. The deceased was also referred to the Addiction Counsellor by his Probation Officer, he was on a waiting list.
22. On 21 February 2017, Doctor C treated the deceased for a “*chest infection and slight asthma*”, prescribing an antibiotic and a Ventolin Inhaler.
23. The 21 February 2017 is the last recorded engagement of the deceased with the Healthcare Services.



### Sequence of events 25 March 2017

24. On the 25 March 2017, the deceased availed of evening recreation. The CCTV footage shows the deceased, on his return to the landing, interacting with other prisoners on the landing until lock-up.
25. Officer A reports that following lock-up he was asked by the deceased to pass in a book from Prisoner A who occupied the next cell, cell 5. Officer A further reports that he went to cell 5, the prisoner passed a book out under the cell door and he checked through the book before pushing it under the deceased's cell door.
26. Prisoner A when interviewed stated that he had known the deceased "*for a good few years*" and knew he "*was a user of heroin and benzos*". Prisoner A reported that he had seen the deceased on the day of his death "*smoking heroin in another prisoner's cell and that he had also taken tablets, upjohns*".
27. Prisoner A further stated that he knew the deceased was "*smoking heroin in his cell after lockup*". He said the deceased "*asked (him) for tinfoil*". Prisoner A stated that he heard the deceased tell the Officer that he wanted to catch up on schoolwork and asked the Officer to get a book from him (Prisoner A). Prisoner A also stated that he passed the book out under the cell door to the officer but first had placed tinfoil from a sweet wrapper between the pages of the Health and Safety book he had for a hygiene course they were doing in the prison school.
28. Officer A reports that he "*performed a further check on (deceased) at approximately 9.15pm, and he was sitting on his bed and appeared to be watching television. I did not at that time note anything unusual or concerning about his demeanour. I had cause, at that time to kick the door to encourage a physical / verbal response which he did by looking at me. He appeared to be sleeping while seated on the bed. He did not express any concerns to me nor*

*did I have cause to have concerns about him at that stage. I did not observe anything unusual in the cell at this time.”*

29. Officer A stated that at about 22:15 he again checked on the deceased. Officer A reported that he looked into the cell and he observed the deceased “*slouched at the corner of the foot of the bed*”. Officer A continued to check the rest of the landing, but reported he “*felt that the deceased was sleeping / sitting in an awkward position I checked him again approximately 5 minutes after my initial check. I was not satisfied with the deceased positioning and checked again and called him by name. He did not respond. At this time I requested Officer B to assist me in checking the deceased as he appeared unresponsive*”.
30. Officer B in his operational report stated that he was Night Guard on B1 and B2 Landings on 25 March 2017 and reported that “*at approx. 10:20/10:25(pm) Officer A asked me to take a look into the deceased’s cell D2 cell 3 to form a second opinion regarding his welfare. Upon checking the deceased, I formed the opinion that he required medical attention. I called down to the circle to Officer C to call medics immediately. I contacted ACO A to inform him that he was required on D2 landing*”.
31. Officer C in his operational report stated that he was “*alerted by Officer B to call the medic and the ACO to D2 Landing at approx. 10.25pm.*” He reported that he was in the circle at the time, rang the medics and asked Nurse Officer B to come to D2 Landing with the emergency bag. Officer B also contacted ACO A, informed him of the situation and asked him to bring the D2 Master Key.
32. ACO A confirmed that he went to the landing and reported that “*at approx. 10:30pm I received a call that my presence was required on D2 Landing. I went to the area with Officers A and C and on the way met Nurse Officer B and Nurse Officer C who were also attending. We opened the cell door and found the deceased in an unresponsive state on the bed. He was attended to by the Nurse Officers and they advised that an ambulance would be required. I left the area and contacted control and directed an ambulance be called*”.

33. Nurse Officer B reported that *“at 22:28 I received a call from the Kardex to an emergency on D2 Landing and to bring the red bag. On arrival to the Landing Nurse Officer C and I were shown to the deceased cell. The deceased was in a slumped over position sitting on the bed.....The deceased was wearing no top, skin was warm to touch. We immediately lay the deceased back on the bed, no breath sounds or pulse were found.....”*. Nurse Officer C assisted with CPR which continued until the arrival of the Emergency services.
34. Prisoner A, in his statement, corroborated the reports provided by staff. Prisoner A reported that *“sometime after 10 o’clock the officer was checking my cell and he said to me I seen you on the phone and I’m going to get the ACO. I think he then went away but he must have checked (deceased’s) cell because a few minutes later I heard officers coming running. I thought they were coming to check my cell for a phone. But they didn’t come to me at all they went next door to (deceased’s) cell. I didn’t know what was happening but I could hear the defibrillator saying shock not working apply CPR. I could see out under my door that they were applying CPR to the deceased..... I could see the Dublin Fire Brigade Paramedics”*. Prisoner A stated, *“(the deceased) hadn’t raised concerns or looked for any help the night before. He obviously just overdosed by accident. He didn’t mean to do it”*.
35. Chief Officer A reported, that on his arrival to the prison at approx. 23:25 he was informed that a family member of the deceased had already telephoned the prison. He further reported that the caller stated that an inmate had alerted the deceased’s sister by telephone that her brother had been removed to hospital by ambulance. Chief Officer A further reported that he contacted Prison Chaplain A, asked him to come to the prison for a briefing and to meet the family. We were informed by Prison management that the Chaplain arrived at the prison at 00:30 and following a briefing immediately went to the Mater Hospital where he met the deceased’s mother and other family members.

## CCTV Footage

36. CCTV footage viewed corroborates the reports given by the staff and by Prisoner A. The following are the relevant times that we observed activity at the deceased's cell during the night of 25 March 2017:-

- 19:20:34 Deceased returns to his cell.
- 19:22:03 Officer to cell door – closes door.
- 19:22:39 Officer Master locks cell for night.
- 20:05:05 Cell call light activates at cell 3.
- 20:08:18 Cell call light activates at cell 5.
- 20:15:05 Officer to cell 3 – bends down and picks something up from bottom of cell 3 door, goes to cell 5.
- 20:15:17 Officer bends down outside cell 5 – appears to place something under the door – stands up and looks in viewer – bends down again and picks up a magazine/book that had been pushed out under the door. The officer checks through the pages.
- 20:15:49 Officer goes to cell 3 and pushes magazine/book under door and then walks down landing, checking cells.
- 21:18:30 Officer when checking landing, checks cell 3 - lifts flap looks in. Officer appears to kick bottom of cell door.
- 21:48:53 Officer walks past cell 5 – stops momentarily - moves on walking past cell 3 and off landing.
- 22:15:43 Officer to cell 3 – looks in viewer and moves on checking cells.
- 22:21:37 Officer goes to cell 5 – checks – spends time at door appears to walk away then returns stands outside door as if listening, looks in viewer with hand on light switch, leaves cell at 22:22:57.
- 22:23:00 Officer goes to cell 3, lifts flap, looks in and leaves. Walks back down Landing.
- 22:24:10 Officer walks back up Landing and goes to cell 3. Lifts flap looks in, kicks door once or twice, remains looking in.
- 22:24:53 Officer leaves the Landing (walking).
- 22:27:01 A second Officer goes to cell 3, lifts flap, looks in.

- 22:27:20 The second Officer leaves the cell and walks through the gate at end of Landing – he immediately turns around and goes back towards cell 3.
- 22:27:33 The second Officer goes to cell 3, lifts flap, looks in and then leaves landing through iron gate.
- 22:29:33 Two Officers, accompanied by an ACO and two Nurse Officers arrive at cell 3. The ACO and Nurse Officers enter cell.
- 22:30:07 Officer speaks to the ACO at the door of the cell and leaves – can be seen speaking on his Tetra Radio.
- 22:30:15 ACO and Officer leave the cell. ACO leaves the landing while the two Officers return to cell 3.
- 22:31:17 Another Officer returns to the landing and goes to cell 3 where he speaks to the two officers outside cell 3.
- 22:40:05 Dublin Fire Brigade paramedics arrive at cell 3.
- 22:53:10 Paramedics remove the deceased from D2 Landing.

## **Addressing the issues raised by the family**

37. In paragraph 16, we set out a number of matters the family wished me to investigate. In this paragraph, we endeavour to address these issues

**a. Why were we not notified by the prison when [deceased] was removed to hospital?**

Prison Management informed me that a family member contacted the prison enquiring about the incident that they were aware that the deceased had been removed to hospital. This call was received in the prison before Prison Management had an opportunity ring the family.

**b. How did [deceased] get drugs in prison?**

We were unable to ascertain from whom the deceased acquired the drugs.

**c. Did [deceased] request medical attention or ask staff to take him to hospital on the night he got ill?**

We found no evidence that the deceased sought or was refused medical assistance on the evening of the 25 March 2017.

**d. Was [deceased] checked regularly in his cell?**

The deceased was checked in accordance with Standard Operating Procedures. The exact time of checks is addressed in paragraph 36.

**e. Why was there such a delay in releasing the remains for the funeral?**

The release of the remains to the Undertaker is a matter for the Coroner. Perhaps this could be addressed at the Inquest.

**f. Why did the prison tell my son's girlfriend rather than me, his Mother, that his personal property was ready for collection?**

We could find no records to indicate the reason why the prison made contact with the deceased's girlfriend to notify her that his property was available for collection.

## **Findings**

38. The deceased was accommodated in a single cell at the time of his death.
39. The deceased had completed a Food Hygiene Course and was also due to attend a Cookery Course.
40. The deceased completed a methadone detox programme and was on a waiting list for Addiction Counselling.
41. Another prisoner witnessed the deceased in possession of illicit substances on the day of his death.
42. The deceased was checked hourly, in accordance with the Irish Prison Service Standard Operating Procedures.
43. The Prison Staff responded promptly when the alarm was raised.
44. The cause of death is a matter for the Coroner.

## **Recommendations**

1. The availability of illicit drugs in Mountjoy Prison continues to be a matter of serious concern. Prison Management must address this at every possible opportunity.
2. Those who complete detox programmes should be provided with immediate focused follow up support by the appropriate Service(s) for a specific duration as determined by the relevant Professional Services involved in the detox programme.
3. In the event of a death in custody or where an incident may result in a death, Prison management, at an appropriate level, should make every effort to contact the next of kin as soon as practicable following the incident irrespective of whether a family member has contacted the prison regarding the situation.
4. A record should be maintained by the Prison Governor when the next of kin is contacted to collect the personal belongings of a deceased. This record should contain details such as; name of deceased, name of officer making contact, person(s) contacted, date contacted, itemised list of property, date the property is collected, by whom collected and a signed receipt acknowledging collection of the property. If, in any circumstances, a person other than the person nominated by the prisoner as next of kin is contacted, the reason should be stated.