

**A report by the Inspector of Prisons  
Judge Michael Reilly into the circumstances  
surrounding the death of Prisoner Q  
on 9 September 2015 in the  
Midlands 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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into the circumstances surrounding the death of Prisoner Q  
on 9 September 2015 in Midlands Prison**

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

Judge Michael Reilly  
Inspector of Prisons

18 May 2016

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## **Preface**

Prisoner Q was a 32 year old man who died in the Midlands Prison on 9 September 2015.

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

18 May 2016

## Inspector of Prisons Investigation Report

### **General Information**

1. The deceased was a 32 year old man who came from the Dublin area. He is survived by his partner, son, mother and extended family.
2. The deceased was sentenced to life imprisonment on 19 March 2014 and transferred to the Midlands Prison on 21 March 2014. His sentence was back dated to 8 May 2012 giving him credit for time served in custody while awaiting his trial. Between 8 May 2012 and 21 March 2014 the deceased was a remand prisoner in a number of prisons including Cloverhill, Wheatfield and Mountjoy. He had served a number of previous sentences.
3. On 9 September 2015 the deceased was discovered in an unresponsive state by his cell mate in their cell – cell 18 on D3 landing in the Midlands Prison. The deceased was pronounced dead at the scene at 9.45 am by the Prison Doctor – Doctor A.
4. I met the deceased's family on 14 January 2016 and have responded, where possible in this report, to the concerns that they wished me to investigate.

### **Concerns of the family**

5. The family informed me that the deceased had previous prison sentences for driving and drug related offences. He had a drug addiction but would not admit to it. They stated that he had "*gone down the wrong road*".
6. I was informed that the deceased worked, on and off, as a sheet metal worker and as a labourer on the buildings.
7. The family informed me that the deceased telephoned them on a regular basis and that they visited him. His sister informed me that she had spoken to him

on the telephone the day before he died, that they had a “*normal conversation*” and that he was in “*good form*”.

8. They informed me that he shared a cell with a “*life long friend*”.
9. The family wished me to state that when the deceased’s mother and sister visited the prison subsequent to his death they were met with kindness and consideration by the prison authorities and the Prison Chaplain. They appreciated the “*lovely ceremony*” conducted in the prison in memory of the deceased.
10. The family raised the following issues of concern to them that they wished me to investigate:
  - (a) Did the deceased see a Doctor prior to this death?
  - (b) Was the deceased depressed? Had he seen a Psychologist?
  - (c) What was the cause of death?
  - (d) If drugs were a factor, where did he get the drugs?

#### **Deceased’s contact with medical and therapeutic services**

11. I received permission from the deceased’s next of kin to examine the deceased’s medical records. I examined the medical records. I also sought information on any contacts that the deceased may have had with the psychiatric and/or psychology services while in prison.
12. Between 1 January 2015 and the date of his death the deceased was seen by members of the medical team in the Midlands Prison on a number of occasions when he sought medical attention for minor conditions not relevant to this investigation.
13. The deceased was not on any prescribed medication at the time of his death.
14. I am advised that the deceased first had contact with the In-Reach Psychiatric Services in Cloverhill Prison in 2012. He was also referred to the Prison Psychiatric Services while in the Midlands Prison. On both occasions the

psychiatric personnel concluded that there was no evidence of psychiatric illness.

15. The deceased did have a history of serious addiction to Cannabis, Cocaine and Benzodiazepines.
16. I am advised that the deceased was first referred to the Counselling Psychologist in Mountjoy Prison on 22 May 2013 whom he met on 14 June 2013 and 10 July 2013 for triage assessment. This assessment did not identify significant mental health difficulties.
17. I am further advised that the deceased was referred to the Psychology Service at the Midlands Prison by Doctor A on 2 December 2014 for mental health and offence focussed work. The referral was processed and paper work issued to the deceased on 2 December 2014 to enable him summarise his needs prior to triage assessment. He returned this paperwork detailing his needs. He received a letter explaining that he was on a waiting list for triage. He was sent a letter on 18 March 2015 advising him of an appointment with a Forensic Psychologist on 13 April 2015. I understand that the deceased declined to attend this appointment when called by an officer and no explanation was given for his non-attendance. On 22 April 2015 a letter issued to the deceased advising him that he had been removed from the Irish Prison Service Psychology waiting list due to non-attendance and that he should re-refer himself to the service in the future. No further correspondence was received by the Irish Prison Service Psychology Service.
18. I understand that the deceased did attend the addiction services in the initial stages of his most recent imprisonment but did not interact with them thereafter.

### **Status in prison**

19. The deceased was an ordinary prisoner who was on the enhanced status level of the incentivised regime since 9 August 2015. As an ordinary prisoner the deceased should have been checked every hour approximately during periods of lock down.

20. He worked as a cleaner on the landings.
21. He shared a cell with Prisoner A since 30 May 2015.
22. The deceased had been sanctioned on numerous occasions under the P19 procedure for infractions of the Prison Rules. His most recent P19 was in June 2015 for possession of 3.5 grams of a prohibited substance.

#### **Events prior to 8 September 2015**

23. I have already stated in paragraph 7 that the deceased maintained regular telephone contact with his family and that his sister spoke to him on the telephone on 7 September.
24. I examined the deceased's prison telephone records. The last recorded call to his sister was on 3 September 2015 at 11.19.29 hours. If the deceased telephoned his sister subsequent to that date such call/s was/were not made on the prison telephone system.

#### **Sequence of events of 8/9 September 2015**

25. Prisoner B occupied a cell on D3 landing. In the course of this investigation he stated:

*“Around 6.30 he came up to my cell, just the 2 of us. (The deceased) asked Prisoner C to leave us and give me and (the deceased) a few minutes. We talked. He was angry, something had gone missing from his cell. He seemed to have had something taken when he came into my cell, tablets or something. His favourite drugs were cannabis and tablets. He left my cell around 7pm, he was mobile, fine..... I went into his cell at lock-up, he was in with others chatting, he seemed fine. That was the last time I saw him alive”.*

26. Prisoner D was also accommodated on D3 landing. He described being with the deceased on the evening of 8 September in the following terms:

*“Myself and Prisoner E were the last ones to leave (the deceased’s) cell at lock-up. We smoked a few joints in his cell, just talking, he only came back to his cell after 7.15pm”.*

27. The deceased was locked in his cell at approximately 19.27 hours on 8 September.

28. It is relevant at this juncture that I should describe the layout of cell 18 – the deceased’s cell. I examined this cell at approximately 10am on 10 September when I visited the prison to commence my investigation. It is, to all intents and purposes, two cells with only one door. The door is positioned as though opening into the cell on the right and is similar to any door leading into any cell on the landing. A partial wall divides the two cells. The cell on the right as one looks from the landing has the bed positioned against the wall on the right. The cell on the left has the bed also positioned on the right parallel to and against the partial dividing wall. The observation hatch on the cell door gives a full view of the cell on the right but only a partial view of the cell on the left. Looking through the viewing hatch from the landing one can only see a portion of the bed in the left cell and only the bottom parts of a person’s legs when such person is lying on the bed. The deceased occupied the portion of the cell on the left. It is not possible to observe a prisoner lying in a conventional manner in this bed through the observation hatch.

29. There are CCTV cameras on D3 landing. **However, the cameras are so positioned and angled that there was no view of the deceased’s cell door.** It is possible to view activities of persons on D3 landing and in the general area of cell 18. I viewed the CCTV footage for the night of the 8/9 September. The following are the relevant activities as seen on the CCTV:

### **8 September 2015**

- 19.27.00 Officers lock back all prisoners for the night.
- 20.12.00 Officer on the landing checking cells.
- 20.58.43 Officer on landing checking cells.
- 21.53.00 Officer and nurse on the landing.
- 21.59.00 Officer on landing checking cells.
- 22.01.20 Officer finishes checks and dims lights on the landing.
- 22.56.02 Officer on landing checking cells.
- 23.16.41 Officer walks down landing – appears to check cells on the right hand side at far end of the landing. This is in the vicinity of the deceased's cell.
- 23.19.46 Officer walks back up the landing and leaves.
- 23.51.40 Officer on landing checking cells.
- 23.57.30 Two officers walk down landing to far end on the right. Appear to stop at a cell briefly and walk back up the landing.

### **9 September 2015**

- 00.52.11 Officer on landing checking cells.
- 01.51.23 Officer on landing checking cells.
- 02.53.08 Officer on landing checking cells.
- 03.50.43 Officer on landing checking cells.
- 04.50.37 Officer on landing checking cells.
- 05.51.59 Officer on landing checking cells.
- 06.37.40 Officer removes master locks from cells.
- 07.37.30 Officer on landing checking cells.
- 08.16.52 Four officers on landing. Two unlocking cells for breakfast.
- 08.47.16 Officer goes towards cell at end of landing.
- 08.48.00 Three nurses on the landing going towards cell at end of the landing. One carrying the emergency bag.
- 08.49.57 Another nurse and approximately 12 officers go to far end of the landing.
- 08.50.34 Chief Officer on the landing.

09.00.00 Two ambulance paramedics on the far end of the landing

09.45.00 Doctor A on the landing.

30. Prisoner A, the deceased's cell mate described the events of the night of 8/9 September in the following terms.

*“Cell banged out, we had a few joints, about 4/5 between us. We put on a CD as we smoked. We're both on each others side (dividing wall between each). He played his music. I played golf on the playstation. At 9 o'clock, he came around to me.....saying “talk to you tomorrow bro”. He went back into bed in his clothes, he was in good form. Around 9.30pm, I went around to him for tobacco. I turned down his music. He was snoring on his back. He was a heavy snorer. I made a rollup, played one more game and I got into bed. He was still snoring when I got into bed. Next morning I woke up at 4.30am. I put on the TV. I knocked off the TV. I went back asleep. Later on, I got up, the cell door was closed at this stage (cleaners were out on the landing). I heard some commotion on the landing. I got my kit ready. I called (the deceased) 3 or 4 times. I was on my own side. I reached around the wall, grabbed his toe to wake him up. His toe was cold but he was cold like that before under the windows. I went around and called him to his face, he looked greenish/purple. I started shaking him. I checked for a pulse on his neck, there was none. I started crying. I lifted up his clothes. His body was purple”.*

31. Prisoner A went on to describe how he attempted to give mouth to mouth resuscitation and pumped his chest. He stated that he “*knew he was dead*”. He described screaming for an officer. He described officers and medics coming to the cell and how he helped lift the deceased onto the floor. Prisoner A was then taken out of the cell.

32. Officer A was on night duty on the night of 8/9 September. He described the duties that he performed as follows:

*“I was night duty in the Midlands Prison on the 8-9-15. I took up duty at 7.45pm. I did my checks as per report of duty. I found nothing unusual on each occasion I checked the landing”.*

Officer A detailed the duties he performed during the night in the Official Night Guard Journal. He described patrolling the landing in the following terms:

*“Patrolled the landings throughout the night checking on all inmates paying particular attention to those on the “spl obs” list”.*

33. Officer B was i/c D3 landing on 9 September. He described his duties in the following terms:

*“I unlocked the landing for breakfast at 8.15 approx. As I unlocked each door Officer C followed as would be his normal procedure to check for those who wanted breakfast. After the inmates who went for breakfast returned the landing was locked secure”.*

34. Officer C, referred to in paragraph 33, described the duties carried out by him on the morning of 9 September in the following terms:

*“At approx 8.15am Class Officer B began unlocking the prisoners’ cells. I assisted him by calling the prisoners for breakfast. At cell 18, I called (the deceased) and Prisoner A for breakfast. Both prisoners were in their beds and appeared to be asleep, neither proceeded to get breakfast. I then closed out the cell door. At approx 8.25am I did a numbers count on the right hand side of the landing and the numbers were correct”.*

35. Officer D described his actions on the morning of 9 September as follows:

*“At approx 8.45, I was alerted to shouting coming from D3 by the cleaners that I was needed on D3. I immediately went up to D3 cell 18 and looked in to observe Prisoner A what seems to be giving chest compressions to another prisoner who was lying on the bed.*

*I immediately radioed S. Officer E to bring up keys to D3 landing and to bring medical officers with him”.*

36. Officer E, referred to in paragraph 35, was the supervising officer/ breakfast guard in charge of the prison. He recounted his actions in the following terms:

*“At approximately 8.40am I received a call over the radio from Officer D breakfast guard on D Division stating I was required on D3 landing.... I immediately got on the radio calling Nurse Officers to D3 landing. I retrieved the D3 master key from the internal key room. I went to D3 landing with Nurse Officers A, B and C. I unlocked cell 18 on D3 landing finding prisoner (the deceased) on his bed with Prisoner A attempting to do CPR on him”.*

37. Nurse Officer B, referred to in paragraph 36, described her actions in the medical notes in the following terms:

*“On entering (the deceased’s) cell I found (the deceased) on the bed. His cell mate Prisoner A was doing chest compressions. (The deceased) had no respiratory effort, no pulse present. Cardiac ambulance requested. (The deceased) was cold to touch. (The deceased’s) left arm was crossed over his chest, his right arm was extended and both arms were rigid.*

*(The deceased) was placed on the floor. Chest compressions commenced immediately by Nurse Officer C. I applied the AED.*

*Nurse Officer A and I applied the Ambu bag and maintained airway. CPR was done at 30:2. AED advised no shock. CPR continued until ambulance crew arrived at approximately 09.00. Ambulance crew advised to cease CPR. Care handed over to ambulance crew”.*

38. The account given by Nurse Officer B was corroborated by Nurse Officers A and C.
39. Doctor A entered the cell at approximately 09.45.00. The body of the deceased was on the floor of the cell. He pronounced him dead at 09.45.00.

### **Other significant evidence**

40. I was informed that members of An Garda Síochána searched the clothing of the deceased and found approximately 16 tablets in his pocket. I understand that during the subsequent post mortem 21 small drug wraps were found in a pocket of the deceased’s track suit bottoms. I understand that these items were submitted for testing. I am not aware of the results of the toxicology results of such tests.
41. The deceased’s cell had been searched a number of times in the past. Drugs, a telephone and a memory stick were found.
42. The cell call bell from cell 18 had been activated on the morning of 9 September at 08.37.26.

### **Findings**

43. The deceased was an ordinary prisoner on the enhanced regime at the date of his death.
44. He had no medical problems.
45. He shared a cell with Prisoner A.

46. The deceased had been taking illicit substances on the evening of 8 September prior to lock down for the night and subsequent to lock down.
47. What appeared to be illicit substances and drug paraphernalia were found in the deceased's clothing subsequent to his death.
48. Illicit substances found in the deceased's cell previously.
49. Cell 18 was checked every hour during the night of 8/9 September in accordance with Standard Operating Procedures. However, this was a hollow exercise in so far as checking the deceased was concerned, having regard to my comments in paragraph 28. Apart from possibly observing the deceased's legs under his duvet the observing officers could not observe the deceased's body.
50. As soon as the alarm was raised there was an immediate response from the prison officers and the medical personnel.
51. The deceased was pronounced dead at 09.45.00 on 9 September 2015.
52. While it is a matter for the Coroner it would appear that the deceased had been dead for some time prior to being discovered in an unresponsive state on the morning of 9 September 2015.
53. While the cause of death is a matter for the Coroner I understand that the deceased died as a result of a lethal cocktail of drugs principally heroin and alprazolam.
54. The CCTV coverage of the D3 landing was totally inadequate..

#### **Addressing the concerns of the family**

55. In paragraph 10, I set out concerns that the family wished me to investigate. In this paragraph I endeavour to answer such concerns. I adopt the same numbering sequence as in paragraph 10.

- (a) The deceased was not seen by a doctor for some considerable time prior to his death and then for matters unconnected with his subsequent death
- (b) There was no indication that he was depressed.
- (c) This is a matter for the Coroner. However, I have partially addressed this query in paragraph 53.
- (d) I have been unable to establish the provenance of the drugs. I talked to many prisoners who would only say, off the record, that the availability of drugs was not a problem but would go no further.

### **Significant matter of concern**

- 56. The deceased's cell mate Prisoner A was a '*special observation*' prisoner. He had been placed on the '*special obs*' list on 5 September 2014 and remained on this list from that date up to 9 September and beyond.
- 57. As a '*special observation*' prisoner Prisoner A should have been checked every 15 minutes during periods of lock down.
- 58. In paragraph 29, I detail the times that officers checked the cells on D3 landing during the night of 8/9 September. Prisoner A was not checked every 15 minutes in accordance with Standard Operating Procedures.
- 59. The Night Guard Journal completed by Officer A is misleading and inaccurate.
- 60. The line management structure in the Midlands Prison was either not functioning or not sufficiently robust to ensure that Standard Operating Procedures were adhered to.

## **Recommendations**

1. The Governor of the Midlands Prison must ensure that a functioning line management structure is in place to oversee the implementation of Standard Operating Procedures.
2. Prison staff must understand that it is a serious matter to generate official documents that are misleading and/or inaccurate.
3. The Governor of the Midlands Prison must carry out an investigation to ascertain the provenance of the drugs available to the deceased, his cell mate and other prisoners on 8/9 September 2015.
4. The Governor of the Midlands Prison must carry out an investigation to ascertain how it was possible for prisoners during periods of un-lock to gather to consume drugs on a landing patrolled by prison officers.
5. The Governor of the Midlands Prison must take all reasonable steps to eliminate the supply of drugs to the prison.
6. The Governor of the Midlands Prison must carry out an immediate audit of all CCTV cameras to ensure that all relevant areas of the prison are covered. This audit must also address the picture quality of the CCTV and ensure that CCTV footage from all cameras is stored for a minimum of 28 days. I have, in the past, raised this issue.
7. The Governor of the Midlands Prison must ensure that when officers are checking prisoners during periods of lock down they have a clear view of all parts of the prisoners' cells apart from those parts where privacy must be respected.