OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr H

AGED 42

In Mountjoy Prison on 12th April 2018.

Date finalised: 9th June 2019

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GLOSSARY

AGS	An Garda Síochána
CCTV	Close Circuit Television
CPR	Cardiopulmonary Resuscitation
CTR	Compassionate Temporary Release
DSH	Deliberate self-harm
GP	General Practitioner
Inspector	Inspector of Prisons
IPS	Irish Prison Service
IoP	Inspector of Prisons
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
P19	Form that is completed by prison officer alleging possible breach of discipline by a prisoner
PHMS	Prisoner Health Management System
PICLS	Prison In-reach and Court Liaison Service
PIMS	Prisoner Information Management System
SHIV	Homemade knife-like weapon
SOC	Safety Observation Cell
SOP	Standard Operating Procedure

PREFACE

The Office of Inspector of Prisons (OIP) was established by the Department of Justice and Equality under the Prisons Act 2007 (the Act). Since 2012, the Minister has requested the Inspector of Prisons to investigate deaths in prison custody. In 2018, clarification was received that the Inspector is also requested to investigate the death of any person which occurs within one month of their temporary release from prison custody. The Office is completely independent of the Irish Prison Service (IPS). The Inspector and staff of the OIP are civil servants, however, they are independent of the Department of Justice and Equality in the performance of statutory functions.

We make recommendations for improvement where appropriate; and our investigation reports are published by the Minister for Justice and Equality, subject to the provisions of the Act, in order that investigation findings and recommendations are disseminated in the interest of transparency, and in order to promote best practice in the care of prisoners.

Objectives

The objectives for Inspector of Prisons investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the IPS;
- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- Assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. The Office of the Attorney General has informed the IPS and Inspector that the provisions of the Prisons Act 2007 in relation to accessing healthcare /medical records of deceased prisoners in relation to investigations of deaths in custody cannot be relied upon. As an interim arrangement pending legislative amendment, the IPS has agreed to release such records with consent from Next of Kin (NoK). This inevitably leads in some instances to a failure to review healthcare/medical records where NoK is unknown, cannot be located, or refuses to provide consent. Mr H's NoK provided consent to the Inspector to access his healthcare/medical records for the purposes of this investigation.

This report is structured to detail the events leading up to, and the response after Mr H passed.

Administration of the Investigation

The OIP was notified of Mr H's passing on the morning of 12th April 2018. An OIP representative visited Mountjoy Prison that day. Prison management provided a briefing and confirmed that CCTV footage for relevant areas of the prison had been saved. Mr H's cell was viewed and information requirements for the investigation were agreed.

All information that was requested was provided promptly and fully by the IPS. An initial draft report was provided to the IPS for review and comments on 26 September 2019 and a subsequent final draft report was provided to the IPS on 24 February 2020. On 9 June 2020 the IPS informed the Inspector that all four recommendations in the report were accepted and an Action Plan was provided.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Inspector of Prisons role when investigating a death in custody.

The Inspector met with Mr H's Next of Kin on 24th May 2018. Based on their understanding of the facts, the family raised several questions. These questions and our related findings are set out in more detail in the Summary of this report. In broad terms they related to Mr H's care while in IPS custody. The family also felt they were not treated with respect by the Prison Service.

Although this report is for the Minister for Justice and Equality it will also inform several interested parties. It is written primarily with Mr H's family in mind. My colleagues and I offer our sincere condolences to them for their sad loss.

I am grateful to Mr H's family and the Irish Prison Service for their contributions to this investigation.

PATRICIA GILHEANEY
Inspector of Prisons
9 June 2020

SUMMARY

Mr H was aged 42 and in custody for the first time. He had spent 25 days in custody (10 in Cloverhill prison and 15 in Mountjoy prison) when he passed on 12th April 2018.

Prior to his arrest Mr H attempted deliberate self-harm, therefore he received considerable psychiatric attention, both in hospital immediately after being arrested and also during his time in custody. Mr H's hospital discharge summary stated *"Deemed not at risk of self-harm to self or others and discharged from psychiatry service..."* Four psychiatrists who worked with the IPS subsequently reviewed Mr H during his time in custody and concurred that he did not show any evidence of major mental illness and he consistently denied suicidal intent.

Operational IPS managers and officers quite rightly took their steer from the psychiatric services. They recognised possible suicide risk when 'suicide notes' and an improvised knife were found in his cell. Mr H was therefore subject to special observation and he was held in a Safety Observation Cell for 24 hours after this find.

On the night that Mr H passed, officers conducted 24 separate checks on his cell. During this time, 48 checks should have been conducted in accordance with the then IPS policy. Six of the checks were conducted by three different officers after he was last seen alive at 04.30. None of these officers noted anything untoward. Mr H had carefully prepared a dummy bed to make them think he was lying asleep, on his side under the duvet. Photographs indicate this was a convincing strategy which enabled him to use the privacy of his bathroom area to complete his plan uninterrupted.

Mr H's protection status was successfully managed by the IPS and there was no indication that his placement in Mountjoy or threats from other prisoners played any part in his demise.
In relation to the queries raised by Mr H's family, our findings are below:

Did Mr H received proper medical and psychiatric care while in custody?

Records on the Prisoner Health Management System (PHMS) show Mr H received full medical assessments upon committal to both Cloverhill and Mountjoy Prisons. He also had medication reviews and was appropriately referred for psychiatric assessment in both prisons.

The psychiatric assessments were swiftly undertaken. Mr H was reviewed by a total of four psychiatrists on behalf of both prisons where he was held. Their assessments included a review of his personal history; and there was also an interview with his mother for collateral history.

Mr H's physical health needs were properly addressed. His wounds were dressed, he received his medication three times each day and had dental care. The IPS swiftly transferred him after committal to a more suitable prison that could accommodate his wheelchair.

On this basis it would appear that Mr H's psychiatric and medical needs were appropriately managed.

Why was an appointment at St James's Hospital rescheduled?

The appointment was rescheduled because the details had been sent to Mr H's home address. This is standard IPS practice in the interests of security. A review of records demonstrates that a new appointment was promptly arranged for 12th April 2018.

Why was he moved to Mountjoy Prison when he had been told he was going to Arbour Hill Prison? Who made the decision and on what grounds?

IPS records indicate that Mr H was bound for Arbour Hill Prison on 22nd March 2018, but this changed after his notes and improvised knife were found. Following significant deliberation, the IPS Operations Directorate decided Mountjoy Prison was more suitable because it was a designated remand prison and had a wheelchair-accessible cell available on the ground floor.

Was the cell he was placed in cleared for suicide potential and why was there an electrical cord in the cell?

Mr H was accommodated in a wheelchair accessible cell. His psychiatric assessments did not deem him to be suffering from a mental illness. Protective measures against suicide were noted and recorded in the PHMS. Mr H guaranteed his safety and denied suicidal ideation or intent. The electrical cable is a normal cell fixture which is provided to enable prisoners view television.

Why were the family not informed that he had been moved to Mountjoy Prison?

Standard IPS practice is for a prisoner to inform their family after they have been transferred to another prison. Prior notification is not provided in order to avoid a security breach.

Two of Mr H's uncles went to Cloverhill Prison for a booked visit on 28th March 2018, only to be told he was no longer there. When they subsequently went to Mountjoy Prison on a different date they were refused entry as their Public Service Cards were not an accepted form of identification.

The IPS has to identify visitors accurately and therefore only accept identification which contains the person's date of birth - passports or driving licences. Mr H's uncles Public Services Cards were accepted at Cloverhill because they were first time visitors. However they were advised that proper identification was needed thereafter. Documentary evidence of this was provided to the OIP. The family informed the Inspector that Mr H's uncles were not told that they needed to present any other form of identification.

In relation to the difficulty at Mountjoy Prison, the IPS explained it is difficult to schedule visits there because so many protection prisoners, such as Mr H, have to be kept apart. Saturday visits are most popular and booked up well in advance.

Mr H's family believed he had two periods of nine consecutive days without visits.

IPS records show Mr H received visits from his family and friends on the following dates:
Cloverhill Prison: 19th March 2018; 22nd March 2018; 23rd March 2018 and also a legal visit on 23rd March 2018
Mountjoy Prison: 4th April 2018, 9th April 2018, 11th April 2018.
Therefore, there was one period of 11 consecutive days without visits. As a remand prisoner, in accordance with Rule 35(3) of the Prison Rules 2007-2017, Mr H was entitled to one visit per day from relatives or friends of not less than 15 minutes in duration on each of six days of the week, where practicable, but in any event, on not less than on each of three days of the week.

The NoK were concerned when Mr H told them on 4th April that he had still not seen a psychiatrist; and when one went to see him, a prison officer told her he was asleep and sent her away.

The PHMS notes do not indicate any psychiatrist trying to see Mr H on 4th April 2018. However there is a record of a psychiatrist and two psychiatric nurses seeing him on 5th April 2018.

His NoK said Mr H was unaware that he could wear his own clothes in Mountjoy until they told him on a visit.

The IPS informed the OIP that all new prisoners are given an information booklet which sets out the prison rules. The clothing section says that, while a prisoner is required to change into prison issue clothing upon committal, they may be permitted to wear their own clothes. The IPS also stated that Reception staff normally provide this type of information verbally to new prisoners. There is no written evidence available to the OIP to verify that Mr H did or did not receive the information booklet.

The NoK complained they had not been notified of Mr H's passing by the IPS and they became aware of the news through social media.

The IPS reported that they requested An Garda Síochána (AGS) to notify the NoK. Prior to receipt of the information of Mr H's passing from AGS the family had become aware of the information through social media. The IPS suggested that prisoners using illegal phones may have disclosed the news of Mr H's passing on social media. The IPS accepts this is highly undesirable and they continue to take measures to prevent the use of mobile phones by prisoners.

The NoK asked for the identity of the prison officer who released information about Mr H's letters to the media.

The IPS said it was not possible to identify who might have released such information; and that for any staff member to do so would constitute a serious breach of discipline. This investigation has not identified any prison officer having released any such information.

There are four recommendations for improvement. All four have been accepted by the IPS and an Action Plan addressing the recommendations has been provided. Implementation will be monitored by the OIP.

RECOMMENDATIONS

1. The IPS should ensure that minutes of important meetings, such as Critical Incident Reviews, should identify significant facts such as dates, times, roles and responsibilities as well as personnel who did not attend, with explanations. The recommendations should allocate responsibility and timescales. (Para 3.11)

2. A 'hot debrief' following a critical incident is held in prisons on a custom and practice basis. Therefore, the IPS should prioritise the development of a Critical Incident Policy to ensure a consistency of approach in all prisons. The policy should include (and not limited to) debriefings post critical incident. In addition to a 'hot debrief' (on the day or night of the incident as applicable) consideration should be given to the inclusion of a cold debrief within 14 days of the incident to provide further opportunity for everyone involved, including prisoners where relevant. The purpose should be to identify learning, support everyone involved and assess progress in relation to actions that were identified at the hot debrief. (Para 3.11)

3. The IPS should ensure that prisoners (sentenced or on remand) are facilitated to receive the visits that they are legally entitled to under the Prison Rules 2007-2017

4. All prisons should have access to a wheelchair accessible cell.

MOUNTJOY PRISON

Mountjoy Prison is a closed, medium security prison for adult men. It has an operational capacity of 554 and is the main committal prison for Dublin city and county.

Prison Rule 63 aims to ensure the safety of prisoners who might be under threat if they are held within the general population. Mr H was subject to that Rule during his time in Mountjoy Prison.

Mountjoy Prison has a Visiting Committee whose role is to frequently visit the prison; meet with prisoners and hear their complaints; report to the Minister on matters of concern. Their 2017 Annual Report was published on 24th May 2018. It highlighted one issue that was relevant to Mr H: serious concern about the high numbers of prisoners on a Restricted Regime. Ireland was unique among Council of Europe Member States in having such high numbers of protection prisoners - the proportion in Mountjoy prison varied between 23% - 30% during April 2017

Mr H's was the second death of a Mountjoy prisoner in 2018; and the fourth death in IPS custody that year.

CHAPTER 1 BACKGROUND

1.1 Mr H was 42 years old when he was remanded in custody to Cloverhill Prison on 18th March 2018. This was his first time in prison. He had been charged with a serious offence.

1.2 After transferring to Mountjoy Prison, Mr H spent 15 days on protection at his own request for his safety from others. Therefore his time out of cell was limited.

1.3 Daily exercise was offered but records reviewed demonstrate that he mostly declined it. His healthcare records showed that his prescribed medications were administered three times each day.

1.4 Mr H was on the standard level of the IPS Incentivised Regime. He had a regular spending pattern and did not make any complaints. There was no evidence of drug or substance abuse during his time in custody. IPS staff who knew Mr H said he was usually mannerly and polite.

1.5 He was subject to an adjudication after suicide notes and an improvised knife were discovered in his cell at Cloverhill Prison. However the outcome was caring rather than punitive - he received a caution and advice.

1.6 Mr H enjoyed good support from family and friends while in custody: he made twenty phone calls, most of which were for the maximum permitted duration of six minutes.

1.7 IPS records show Mr H received visits from his family and friends on the following dates:
Cloverhill Prison: 19th March 2018; 22nd March 2018; 23rd March 2018 and also a legal visit on 23rd March 2018
Mountjoy Prison: 4th April 2018, 9th April 2018, 11th April 2018. There was a gap of 11 days between the last visit in Cloverhill Prison and the first visit in Mountjoy Prison.

1.8 IPS records show Mr H's aunt and uncle visited him in Cloverhill Prison on 19th March 2018, his parents visited on 22nd March 2018 and two uncles visited on 23rd March 2018. His two uncles went to Cloverhill Prison on 28th March for a scheduled visit, however Mr H had transferred to Mountjoy prison the previous day and Mr H had not notified his uncles about his transfer.

1.9 Mr H's uncles attended Mountjoy Prison on 2nd April 2018 to visit Mr H. They were denied entry as the IPS stated that they did not possess the correct photographic identification for the purpose of visiting a prisoner. The uncles used the same form of identification that had been accepted in Cloverhill Prison.

1.10 Cloverhill Prison informed the OIP that the Public Service Card had been accepted as a form of identification as it was a first visit. However, a caution had been given at the time of the visit that proper identification was needed otherwise visits may not be allowed. Documentary evidence to support the provision of the caution was made available to the OIP. The family members that met with the office of Inspector of Prisons stated that Mr H's uncles were not informed that an alternative form of identification was required.

1.11 The OIP asked Mountjoy Prison management to respond to family concerns regarding difficulty in accessing visits. The management response was that due to the large number of protection prisoners held in Mountjoy Prison it is very difficult to arrange for safe visits as a

large number of prisoners have to be kept apart and this creates difficulty in scheduling visits. Visits for protection visitors are usually arranged for each Monday, Wednesday and Saturday. Due to the number of visiting requests it can be difficult to get a Saturday visit as they are booked up weeks in advance. As a remand prisoner, in accordance with Rule 35(3) of the Prison Rules 2007-2017, Mr H was entitled to one visit per day from relatives or friends of not less than 15 minutes in duration on each of six days of the week, where practicable, but in any event, on not less than on each of three days of the week.

1.12 He had a visit from his mother on the afternoon of 11th April 2018, the day before he died. He made a telephone call to his daughter that evening.

1.13 He had several meetings with a chaplain from the pastoral team and a chaplain was also in contact with his mother.

CHAPTER 2 ARREST AND TIME IN CUSTODY

Arrest

2.1 Mr H was arrested on Friday 15th February 2018. At the point of arrest he engaged in deliberate self-harm with his injuries requiring a four week inpatient stay in a general hospital for surgery and postoperative care.

2.2 The hospital discharge letter on 16th March 2018 indicated that Mr H recovered well. It also said:*"Deemed not at risk of self-harm to self or others and discharged from psychiatry service with review on request."*

2.3 The letter specified the reason for Mr H's admission, progress during his stay, outpatient department follow-up and surgical procedures performed. It noted referrals during his in-patient stay to occupational therapy, dietician and psychiatry. A list of his current medications was also provided.

2.4 Upon leaving hospital Mr H was charged and brought to court, where he was remanded in custody to Cloverhill Prison on 18th March 2018.

2.5 His remand warrant was accompanied by a pro-forma document from the court which recommended Mr H should receive medical treatment in custody. Significantly it did not recommend he should receive psychiatric treatment - the form contained a tick box for psychiatric treatment but this was deleted, which suggests it was not considered to be necessary by the remanding court.

Cloverhill Prison 18th – 27th March

2.6 Mr H arrived in Cloverhill Prison on 18th March 2018. He required a wheelchair as his mobility was severely compromised due to the nature of the injuries he sustained and the subsequent surgical treatment. He had to wear surgical support boots. He was accommodated in an ordinary single cell in Cloverhill because there was no available cell that was adapted for a wheelchair-user.

2.7 He was interviewed by Nurse Officer A upon committal to Cloverhill. His mood appeared good and he denied thoughts of suicide. He said the suicide attempts at the point of arrest were a reaction to his circumstances at the time. Mr H identified family as his main protective factor. A request for the psychiatry clinic was created.

2.8 On 19th March 2018 he had an interview with GP Dr A. He found Mr H was pleasant and co-operative and his mood was "*euthymic*" (a stable mental state or mood). Mr H said his "*mood has been stable – no thoughts of DSH* (deliberate self-harm) *and feeling well.*" His medication was charted and it was noted that nursing staff would follow-up with the general hospital regarding his next orthopaedic appointment. A detailed medical history, including a history of illicit drug use was recorded. Referral to a psychiatrist was also recorded.

2.9 Mr H told medical staff he had no prior psychiatric history, though said he had been in Beaumont Hospital around ten years earlier to be treated for drug and alcohol abuse.

2.10 On 20th March Mr H was seen by Consultant Psychiatrist A and Psychiatric Registrar A from the Prison In-reach and Court Liaison Service Team (PICLS). A detailed record of the consultation was entered on the PHMS. It was again noted that he had "*no thoughts of dsh and feeling well*." The clinical impression was that Mr H did not present with active symptoms of major mental illness and he denied current suicidal ideation.

2.11 Psychiatric Registrar Dr A spoke with Mr H's mother on 21st March to obtain collateral history. The record of this discussion included Mr H mentioning anxiety about a possible transfer to Mountjoy Prison as he knew of some prisoners who were held there. However nothing to indicate likely DSH or suicide emerged from the discussion.

2.12 He was further remanded in custody on 21st March 2018 to appear again at Cloverhill Court on 18th April 2018.

2.13 He was prescribed medications and the records reviewed demonstrate that they were administered every day at the prescribed intervals.

2.14 On 21st March 2018 Nurse Officer B contacted St James' Hospital in relation to an orthopaedic appointment which had been arranged for Mr H on 29th March 2018. The original appointment had to be rescheduled for security reasons because it had been sent to Mr H's home address. A new appointment was arranged for 12th April 2018. Otherwise Mr H did not have any other external healthcare appointments.

2.15 Although independent in carrying out daily living activities, Mr H's mobility was compromised and he needed to use a wheelchair. As the cells in Cloverhill were unsuitable for wheelchair use, early consideration was given to transferring him to a prison that could accommodate his wheelchair needs.

2.16 Initial concerns were about his wheelchair being unable to fit in a normal cell at Cloverhill; the risk in a fire or other emergency; and the fact he could not have outdoor time as the yard was downstairs.

2.17 Arbour Hill Prison was the initial preferred destination for a transfer. However on 22nd March, while packing his belongings in preparation for moving, Officer A found three suicide

notes and an improvised knife made from the handle of a tooth brush in Mr H's cell in Cloverhill. He was therefore placed in a Safety Observation Cell (SOC) in line with IPS Standard Operating Procedures and his transfer was suspended pending psychiatric review.

Safety Observation Cell and Adjudication

2.18 Officer A reported the suicide notes and improvised knife on a P19 Report Form, specifying the breach of prison discipline, which was in contravention of two sections of Schedule 1 of the Prison Rules 2007.

2.19 A P19 hearing convened on 23rd March 2018. Mr H said he regretted his actions and suggested they were prompted by psychiatric assessment which required him to recall difficult life events. He said he had been concerned for his safety due to media publicity and risks associated with particular prisoners in Mountjoy; and was looking forward to a transfer to Arbour Hill. Mr H stated he was feeling better and did not feel like harming himself anymore. The outcome was a caution and advice, which was a caring rather than punitive response.

2.20 At this time the IPS had a detailed seven page "Policy on Use of Safety Observation Cells." The emphasis was firmly on treating SOC occupants as "patients," with Healthcare staff taking the lead. In recognition of the psychological harm that can be caused by lengthy periods of isolation, the policy included a stated intent to reduce the use of SOCs. Other principles included:

- Use only in rare and exceptional circumstances, in the best interests of the patient and only when patient poses an immediate threat of serious harm to self and/or others, and all alternative interventions to manage the patient's unsafe behaviour have been considered;
- Use to be based on a thorough risk assessment, best available evidence and contemporary practice;
- Governors authority to direct that a prisoner be accommodated in a SOC was irrevocably delegated to medical practitioners and registered nurses;
- Confinement to a SOC entailed at least 15 minute observations and 24 hourly reviews, with a maximum of three renewals/72 hours continuous placement;
- Comprehensive details were to be recorded on the PHMS;
- Patients should be informed of likely duration of placement.

These sound principles, designed to regulate a form of containment that could have extreme effects guided Mr H's SOC placement and his duration of stay there.

2.21 Mr H was in the SOC for just over 24 hours - between 17.54 on 22nd March – 18.07 on 23rd March 2018. NO B reported his boots were removed and Mr H *"Was happy to be placed in the SOC. He expressed no concerns."* His personal apparel was replaced with anti-ligature clothing, something many prisoners dislike.

2.22 Mr H was reviewed in the SOC on 23rd March 2018 by the PICLS Team – Psychiatric Registrar A accompanied by Psychiatric Nurses A and B.

2.23 Their clinical opinion was that he did not present with active symptoms of major mental illness. Mr H attributed his impulsive thoughts to the psychiatric assessment on 20th March and lack of sleep. He said those thoughts had resolved following a phone call with a family member on 21st March 2018 and a good night's sleep on 22nd March 2018. Mr H said he "*felt stupid and embarrassed"* about his suicidal ideas. He denied thoughts of self-harm or suicidal ideation *"I have none of them thoughts at all"* Psychiatric Registrar A recorded that Mr H *"…repeatedly guaranteed his safety while in prison*". Mr H said he was hopeful about the future and identified significant people in his life who would prevent him from harming himself.

2.24 Psychiatric Registrar A discussed Mr H's case with Consultant Psychiatrist B. Following consideration of all known risks and from a psychiatric perspective Mr H was cleared to move from the SOC to a single cell on 24th March 2018.

2.25 Psychiatric Registrar A also recorded *"Although Mr H has presented with no evidence of major mental illness and no current thought or plans to self-harm or suicide; a future rational decision to self-harm or suicide, at an undefinable time, cannot be ruled out given his recent alleged xxxx charge."*

2.26 On 23rd March 2018 a letter was received by the IPS from Mr H's solicitors to say he *"…expressed very significant concerns as regards the medical treatment he has been receiving while under your care. Mr H instructs that the medication tends to be administered on an ad hoc basis and he further instructs that the pain relief is completely inadequate…"* Mr H was reviewed by general practitioner Dr B on the date the letter from Mr H's solicitors was received. The medication administration charts reviewed does not support the statement that medication was administered on an ad hoc basis.

2.27 Mr H's family informed the IOP that he had reported similar concerns to them and specified a date (11th April) when he complained all his medication for the day was dispensed at the same time. However IPS records indicate he received his medication on three separate occasions that day: at 08:00, 16:00 and 19:00.

Transfer deliberations

2.28 Discussion within the IPS about the best location for Mr H continued evidenced by significant e-mail and telephone exchanges between operational and Healthcare managers in IPS HQ, Cloverhill, Arbour Hill and Mountjoy Prisons.

2.29 While Arbour Hill had initially been the preferred placement, there was obvious unease in Arbour Hill about accepting him following discovery of Mr H's handwritten notes and weapon in his cell in Cloverhill. On 22nd March 2018 an Arbour Hill Nurse Officer C recorded *"Informed by Chief A that he received a phone call from Cloverhill Chief to say inmate Mr H is to come to Arbour Hill this evening. Chief and I unhappy to take inmate until written report from psychiatrist that this inmate is not currently suicidal… plan now is that inmate will not be transferred today until clear reassurance that this man is safe for transfer to the cell we can provide."* She was later informed that Mr H would not be transferred to Arbour Hill.

2.30 A range of emails to (or copied to) and from IPS Operations Directorate, National Operational Nurse Manager, Director of Care and Rehabilitation , Governors of Cloverhill and Mountjoy Prison regarding the transfer of Mr H to a prison with a wheelchair accessible cell were exchanged.

2.31 On 26th March 2018 it was agreed and approved by IPS HQ to transfer Mr H to Mountjoy Prison on humanitarian grounds so that he could access a wheelchair accessible cell and therefore use the toilet facilities in a dignified manner.

2.32 On 26th March 2018 Mr H was reviewed by GP C. He concluded *"Has written numerous suicide notes. See scanned documents which suggests either premeditation or manipulation."*

2.33 Consultant Psychiatrist B and Psychiatric Nurse B also reviewed him on 26 March 2018 in his cell on Cloverhill's D2 landing. Their opinion was similar to those of 20th and 23rd March 2018. There was no indication for psychiatric hospitalisation or psychotropic medication; and Mr H absolutely denied any thoughts or plans of self-harm or suicide. He was to be referred to the Psychiatric In-Reach Team in Mountjoy Prison for follow up.

2.34 Psychiatric Nurse B reported that Mr H *"…described his mood as good today and reported that he felt much better since he was cleared out of the SOC on Friday. He said his sleeping pattern was disrupted due to other inmates making noise during the night."*

2.35 Mr H's transfer was therefore approved by the IPS Operations Directorate and the following day, 27th March 2018, he was transferred to Mountjoy Prison. The official IPS rationale was that Arbour Hill was not a remand prison; and the Operations Directorate decided Mountjoy Prison was more suitable as it was a designated remand prison and had a wheelchair-accessible cell available on the ground floor.

Mountjoy Prison 27th March – 12th April 2018

2.36 On transfer to Mountjoy Prison on 27th March 2018 Mr H was immediately accommodated in a specially adapted cell. It was larger than a standard cell and had a shower, hand basin and toilet adjoining the living area. While large enough for a wheelchair to manoeuvre easily, the interior layout contained a blind spot when viewed through the spyhole from outside: it was possible to observe the entire living area including the bed, but a large part of the shower area was not within sight in order to protect the occupant's privacy.

2.37 A nursing committal interview took place the same day Mr H arrived in Mountjoy. His mental state was assessed and he again denied any thoughts of self-harm or suicide.

2.38 His medical committal interview took place the next day, 28th March 2018, when it was once more recorded that he had no active suicidal thoughts.

2.39 A transfer letter was sent from Cloverhill Forensic Psychiatric Nurse B to Mountjoy PICLS nurses C and D. It said *"Seen by PICLS on 20th March. Clinical impression was that he did not present with active symptoms of major mental illness on assessment. He denied suicidal ideation on review…. Seen by the PICLS on 23rd March after the suicide notes and shiv were found in his cell. They reached the same clinical assessment. Cleared from SOC to single cell on D2 landing on 24th March…. Last seen by Consultant Psychiatrist B and Psychiatric Nurse B on D Wing*

on 26th March. No indication for psychiatric hospitalisation or psychotropic medication. Mr H absolutely denied any thoughts or plans of self-harm or suicide. Mr H has been cleared from a psychiatric perspective to move to another prison which is wheelchair friendly."

2.40 Mr H was seen regularly by medical staff while he was in prison as he was taking prescribed medications and had wounds that required dressing.

2.41 He was placed on the Special Observation List. Chiefs Order 5/2010 sets out 14 specified duties relating to the Special Observation List for night staff. These include frequent and irregular checks.

2.42 He was also placed on "*Protection from all other Prisoners*" status when he arrived in Mountjoy Prison. He requested protection due to fear of certain prisoners who were held there; and also because of extensive media coverage of his case.

2.43 The consequences of being on protection included being held in a separate area of the prison and spending lengthy periods locked alone in his cell. There was no indication that he felt discomfited by the deprivations of such isolation and he was reported as *"Happy to be on protection."* He saw the governor every day, which provided an opportunity to reconsider his protection status, though he did not do so at any time. Nor was there any indication that Mr H wanted to appeal his placement in Mountjoy prison rather than Arbour Hill Prison; or that he felt his safety was compromised in Mountjoy Prison.

2.44 On 28th March 2018 a GP, Dr B recorded Mr H was *"Stable at the moment. No active suicidal thought. Plan Special Obs."*

2.45 The internal IPS debate about his placement did not end after Mr H transferred to Mountjoy. On 29th March 2018 Governor A in Mountjoy Prison wrote to IPS Operations Directorate seeking consideration of the appropriateness of transfer of Mr H to Arbour Hill Prison as it was ".*extremely difficult to provide him with any out of cell time" as Mr H stated he was in conflict* [with specified factions in Mountjoy Prison]."

2.46 The IPS Operations Directorate considered and denied the request. Consequently Mr H remained in Mountjoy Prison.

2.47 On 3rd April 2018 Nurse Officer D's review concluded that Mr H should remain on special Observations.

2.48 Also on 3rd April 2018 his solicitor wrote again on Mr H's behalf to say *"Neither phone calls nor visits were being facilitated adequately and his X Ray was cancelled…."* The next day Mr H again saw a GP Dr B in relation to this correspondence. Dr B documented *"No concerns noted."*

2.49 Mr H was seen by a Consultant Psychiatrist C and members of Mountjoy PICLS Psychiatric Nurses C and D on 5th April 2018. He again denied any thoughts of self-harm, though indicated he was finding it difficult to adjust to being in prison. Their clinical assessment recorded no evidence of mental disorder.

2.50 On 8th April 2018 Nurse Officer E reviewed Mr H's case and noted he had told the In-reach Team he was finding it difficult to settle in. Nurse Officer E concluded *"Keep on Special Obs."*

2.51 On Saturday 9th April 2018 Mr H's Special Observation status was again reviewed by nurses. They decided it should remain.

11th-12th April 2018

2.52 Officer B was the Class Officer in charge of D1 landing on 11th April 2018. He recalled that Mr H's demeanour was - as usual - mannerly and polite and gave no reason for concern. He accepted all his meals and medications. He declined exercise as he had a family visit; and made a phone call to his daughter that evening.

2.53 During the night of 11th- 12th April 2018, Mr H was one of 18 prisoners in Mountjoy Prison who were on "*Special Observations - Medical*" status.

2.54 Officer B checked Mr H in his cell before he left the landing at approximately 19:20.

2.55 Analysis of CCTV footage showed 24 checks were conducted on his cell from 20:05:54 hrs on 11 April 2018 to 08:11:10 hrs on 12 April 2018. The intervals between checks was from 8 minutes to 62 minutes. The IPS Policy that was in place at that time required 48 checks to take place during this period.

2.56 Officer C was assigned D1 Night Guard duty on 11th-12th April 2018. He reported on his first check that Mr H was sitting in his wheelchair at the desk at the end of the bed watching television. He checked Mr H at approximately half-hourly intervals until 00:40 when he was relieved for a meal break by Officer D. Mr H was awake at each check and had moved from the wheelchair to his bed just before midnight.

2.57 Officer D checked Mr H twice. On both occasions he was sitting up in bed, watching television.

2.58 Officer C returned to the landing at approximately 02:00. He checked Mr H who was still sitting in bed watching television. At each subsequent check until 04:30 Mr H remained awake, watching television.

2.59 At 05:00 Officer C noted that Mr H had turned off the television and was asleep in bed. He observed his body shape in the bed. Officer C reported that he checked Mr H a further three times and nothing appeared amiss.

2.60 Officer C remained in charge of D1 landing until he was relieved by Officer E - who was on an early morning relief duty - at approximately 07:00.

2.61 Officer E checked Mr H's cell around 07:25. He thought all was correct as he saw a body shape in Mr H's bed. After completing his check he went to await the arrival of the Class Officers for hand over. At 08:05 he handed over charge of D1 landing to Officer F.

2.62 Officer F carried out cell checks and again noted a body shape in Mr H's bed and his wheelchair alongside the bed. He proceeded to report the numbers as "*Correct*" to the Chief Officer. He then collected Mr H's medication and breakfast and brought them to his cell.

2.63 On his return to D1 landing he was met by Officer G and Officer H who were coming to escort Mr H for his outpatient hospital appointment. Officer F handed the breakfast and medication to Officer H so that he could open the cell door. When making his way to the bed Officer F noticed Mr H in his peripheral vision. He was in the bathroom area of the cell, with a ligature around his neck.

2.64 Photographs show Mr H's bedding was carefully arranged to suggest he was lying entirely under the duvet, on his side.

2.65 Matters arising from the events of that night:

- Officers were aware that Mr H required Special Observation and he was not observed in accordance with the then IPS Policy;
- CCTV Footage on D1 landing from 20:05:54 on 11th April 2018 until 08:13:07 on 12th April 2018 shows a total of 24 checks throughout the night at Mr H's cell. These consisted of an officer looking in through the spy hole in the cell door. Torches were used on nine of these occasions during the darker hours. These included three after 04.30, which was the last time Mr H was seen alive, in his bed watching television;
- After 04.30, Mr H's cell was checked a further six times by three different officers. None of them noted anything untoward;
- At 06:19 the lights were fully on, with good visibility on the landing. Three further checks were undertaken before Mr H was found at 08.11;
- The checks were carried out at intervals of between 8-62 minutes.
- The reports of Officers C,D,E and F corroborate each other's versions of events in relation to the fact that Mr H appeared to be asleep in bed when in fact he had stuffed the bedclothes to mislead observers;
- The reports of two more officers - who had arrived to take Mr H to his medical appointment - also confirm the impression that he was asleep under the duvet. "*We were… sure he was in the bed. The bed clothes had been built up to look like a body shape;"*
- The landing lights were turned off at 23:43:34. This restricted visibility on the landing.

CHAPTER 3 EVENTS AFTER MR H WAS FOUND

3.1 Prison Officers and Healthcare staff responded quickly when the Code Red alert was raised by Officer F at 08:11 on 12th April 2018.

3.2 Officer F checked for a pulse, but was unable to get one and Mr H was cold to the touch. The officers removed the ligature with difficulty and placed Mr H on the floor.

3.3 Chief Officer B, Assistant Chief Officer A and a number of healthcare staff arrived. At that point there were several people present. Chief Officer B asked all who were not involved to step out of the cell and Officer F left along with several others.

3.4 Nurse Officer E was administering morning medications on the D wing landings and had just given Officer F Mr H's medication when she was alerted to the Code Red. She went straight to Mr H's cell.

3.5 On first appearance there appeared to be no signs of life. She asked the staff to release Mr H and place him on to the floor. Three other Nurse Officers F, G and H arrived to assist. She could not find a pulse nor signs of respiratory effort, and pooling was observed. Due to Mr H's clinical presentation the decision was made that Cardio Pulmonary Resuscitation (CPR) was not warranted.

3.6 At 08:55 General Practitioner Dr D arrived. Following examination he pronounced Mr H deceased. He said he had an *"…impression that the prisoner had taken his own life and this probably happened a few hours earlier."*

3.7 Officer C who had been the Night Guard on 11th – 12th April 2018 was shocked to receive a call from the prison informing him that Mr H had been found dead. His immediate reaction was that it had happened after he had left the prison since he thought he had seen him in bed when removing the master locks that morning.

3.8 When Mr H's cell was searched three letters written to family and friends were found. Open capsules of prescribed medication were also found.

3.9 AGS informed Mr H's mother of his passing at 10.30 on 12th April 2018; and a Mountjoy Prison chaplain phoned her at 11.55. However she had already heard the news because it was in the media. Governor A also phoned Mr H's mother later that morning.

3.10 The family were devastated, both by Mr H's death and also by the fact that they heard the news via media outlets. The governor apologised but explained the difficulties the IPS faced in trying to prevent prisoners accessing social media via illicit mobile phones. The family requested Mr H's clothes, wedding ring and money.

Critical Incident Review

3.11 A Critical Incident Review was held and a copy of the minutes (undated) were provided. It was attended by five governors, two chiefs, a nurse officer, chaplain, consultant psychiatrist and a psychiatric nurse.

Recommendations

The IPS should ensure that minutes of important meetings, such as Critical Incident Reviews, should identify significant facts such as dates, times, roles and responsibilities as well personnel who did not attend, with explanations. The recommendations should allocate responsibility and timescales.

A 'hot debrief' following a critical incident is held in prisons on a custom and practice basis. Therefore, the IPS should prioritise the development of a Critical Incident Policy to ensure a consistency of approach in all prisons. The policy should include (and not limited to) debriefings post critical incident. In addition to a 'hot debrief' (on the day or night of the incident as applicable)

consideration should be given to the inclusion of a cold debrief within 14 days of the incident to provide further opportunity for everyone involved, including prisoners where relevant. The purpose should be to identify learning, support everyone involved and assess progress in relation to actions that were identified at the hot debrief.

3.12 Consultant Psychiatrist C reported Mr H was *"very coherent, no psychological issues… considerable planning to carry out this suicide. If someone is determined to kill themselves, they will set out to deceive you and succeed."*

3.13 It is noted that Chief Officer B instructed that landing lights were not to be switched off during the night.

3.14 All first responders were assigned a Staff Support Officer.

3.15 A series of "Recommendations" were set out in the minutes.

3.16 The cause of death is a matter for the Coroner.