

**A report by the Inspector of Prisons
Judge Michael Reilly into the circumstances
surrounding the death of Prisoner M
on 24 December 2014 in Wheatfield Prison**

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

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into the circumstances surrounding the death of Prisoner M
on 24 December 2014 in Wheatfield Prison**

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

Judge Michael Reilly
Inspector of Prisons

21 July 2015

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Preface

Prisoner M was a 23 year old man who died in Wheatfield Prison on 24 December 2014.

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

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

Judge Michael Reilly
Inspector of Prisons

21 July 2015

Inspector of Prisons investigation report

Introduction

1. The deceased was a 23 year old single man who came from the Dublin area.
2. He is survived by his mother and a brother.
3. The deceased had served numbers of periods of imprisonment commencing when he was approximately 18 years of age.
4. The deceased was last committed to prison on 14 August 2012. His release date was to be 5 December 2014 but prior to such release date he was again remanded in custody on further charges.
5. Prior to his committal to prison on 14 August 2012 the deceased was homeless.
6. The deceased started using illicit drugs at a young age – first smoking cannabis and taking tablets and then taking heroin.
7. I met with members of the deceased's family at an early stage of my investigation in order to ascertain if they had any particular concerns. In this report I endeavour to address issues raised by them. I would like to express my condolences to the immediate and extended family of the deceased.
8. 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 also had access to all CCTV footage that I requested. I received total cooperation from all persons while carrying out my investigation.

Brief summary of relevant facts

9. In order to place in context the remainder of this report it is necessary, at this juncture, to give a very brief outline of the chronology of events on 23 and 24 December 2014.
10. On 23 December 2014 the deceased had a visit from his girlfriend at approximately 10.50 hours.
11. During the course of this visit the deceased's girlfriend handed him a package.
12. Prison Officers who saw the package being handed over and saw the deceased place it in his mouth immediately confronted the deceased. He was restrained but refused to hand over the package.
13. The deceased was taken to Cell 12 on West 2 – a Close Supervision Cell.
14. The deceased was seen in Cell 12 on West 2 at 11.45 hours by Nurse Officer A.
15. The deceased was next seen by a member of the medical staff at 22.43 hours approx on 23 December by Nurse Officer B.
16. The deceased was found in an unresponsive state at approximately 08.10 hours on 24 December 2014. The deceased was pronounced dead shortly thereafter.

Meeting with the family

17. The family explained to me that the deceased suffered from epilepsy and needed constant medication.
18. His mother visited him while he was in prison – the last visit being on 18 November 2014.
19. The family told me that he was visited by his girlfriend on a weekly basis.

20. The family raised the following concerns:-
- (a) Are there recognised techniques to prevent a person swallowing an illegal substance as in this case?
 - (b) Knowing that the deceased had swallowed an illegal substance what action was taken by the prison authorities?
 - (c) Having swallowed a prohibited substance was he at greater risk as he also suffered from epilepsy?
 - (d) Should the family have been told that he had taken something in order that they could have talked to him?
 - (e) How often was he observed between the time that he took the substance and the time that he was found?
 - (f) Were efforts made to resuscitate him?
 - (g) When did he die?
 - (h) Did the prison authorities have any suspicion that his girlfriend was bringing in drugs. Was she searched?
 - (i) Who informed the papers of the deceased's death and gave them other information?

Deceased's status in prison

21. The deceased was a protection prisoner who was on the basic prisoner regime.
22. From 11.33 hours on 23 December to the time the deceased was discovered in an unresponsive state at approximately 08.10 hours on 24 December the deceased was classed as a special observation prisoner.
23. His status as a special observation prisoner referred to in paragraph 22 was confirmed by Governor A.

Monitoring of prisoners on special observation lists and/or in Close Supervision Cells

24. Special Observation Prisoners must be checked every 15 minutes in accordance with Standard Operating Procedures, Governors' and Chiefs' Orders.

25. Standard Operating Procedures provide that if prison staff believes that a prisoner has ingested drugs the prisoner must be placed in a Close Supervision Cell. The prisoner must, immediately, be referred to a member of the healthcare team for assessment.
26. A prisoner placed in a Close Supervision Cell must be visited by the doctor as soon as possible after placement.

Deceased's relevant medical history

27. The deceased was known to suffer from epilepsy and was prescribed medication in prison for this condition.
28. The deceased had periodic contact with the medical and addiction services while in prison. While of relevance at the particular time such contacts are not relevant to this investigation.
29. I have already stated at paragraph 27 that the deceased was prescribed medication for his epilepsy. It is clear from the medication's chart that while this medication was prescribed the deceased refused such medication on numerous occasions. It is also clear from the medical file that the deceased was advised on numerous occasions of the danger of declining his medication for his epilepsy. This investigation does not purport to be an investigation into the reasons for the refusal of the deceased to take his medication save for his failure to take same on the night of 23 December 2014 which is referred to in greater detail later in this report.
30. Having carefully perused all medical and ancillary documentation I am satisfied that the deceased's prior medical history is not relevant to this investigation.

Events prior to 23 December 2014

31. There were no specific events relating to the deceased, his interaction with other prisoners, his visits or his telephone calls that are relevant to this

investigation with the exception of two telephone calls referred to in paragraphs 33 and 34.

32. The deceased was in constant telephone contact with his girlfriend and received weekly visits from her.
33. At 10.41 hours on 20 December 2014 the deceased telephoned his girlfriend. It is obvious from the tenor of the telephone call that she was having certain difficulties sourcing some article or substance for the deceased. It is obvious also that the deceased was advising her of different sources for such article or substance.
34. In a telephone call made by the deceased to his girlfriend on 21 December 2014 it is obvious that the conversation refers to the conversation referred to in paragraph 33. There is a reference in this telephone conversation to payment for the article or substance being sourced and to the fact that she would be able to deliver it "*that week*".

Sequence of events 23 and 24 December 2014

35. I have had the benefit of access to all CCTV in Wheatfield Prison for 23 and 24 December 2014. In this report I refer to specific timelines. These times are taken from the CCTV footage.
36. This section of my report is divided into three segments, namely, an incident in the visiting box on 23 December, relevant events on West 2 Landing between 11.30 and 20.00 hours on 23 December and relevant events on West 2 Landing between 20.00 hours on 23 December and 08.30 hours on 24 December 2014.

Incident in visiting box on 23 December 2014

37. The following are relevant timelines concerning an incident in the visiting box of Wheatfield Prison on 23 December 2014:-

- 10.49.24 – deceased’s girlfriend arrived at security screening area of Wheatfield Prison.
- 10.49.44 – she proceeded through the airport style x-ray security scanner. She was also searched by prison staff using the hand held wand and was subjected to a full pat down search by a female officer. Her boots were put through the x-ray scanner.
- 10.52.59 – deceased arrived at visiting box 16.
- 10.53.4 – deceased’s girlfriend arrived at visiting box 16 and they embraced across the centre divide.
- 11.22.30 – both parties again reached across the centre divide to embrace.
- 11.22.36 – while embracing, an article was transferred to the deceased by his girlfriend.
- 11.22.58 – both parties finished embracing and each moved to their own side of the visiting box.
- 11.23.28 – two officers grabbed the deceased by his arms.
- 11.23.58 – deceased’s girlfriend left the visiting box and was escorted out of the prison.

38. Officer A who was monitoring the visits to prisoners in the visiting area observed that the deceased had received an article. In the course of my investigation he stated:-

“I witnessed (deceased) receive a prohibited article from his visitor (deceased’s girlfriend). I notified Officer B in charge of visits. Officers B, C and D then came along to remove (deceased) from visits. At this point I witnessed (deceased) place the prohibited article in his mouth and refuse to hand it over to staff when he was instructed to do so”.

39. Officer C corroborated the account given by Officer A in the following terms:-

“When prisoner (deceased) did see us he put a brown package into his mouth. Prisoner (deceased) was restrained, asked to hand up said package but refused. He was then removed from visits area and placed in visits search area using the correct control and restraint techniques”.

40. Officer B who was in charge of the visits corroborated the accounts given by Officers A and C.
41. The deceased was immediately removed from the visiting area to the adjacent search area using recognised C&R techniques. This could be seen on CCTV. He was searched and asked to hand up any prohibited article. He refused to comply with this request.
42. Officer B briefed ACO A on the incident. ACO A made a decision that the deceased was to be removed immediately and brought to a close supervision cell on West 2 Landing.
43. Appropriate Control and Restraint procedures were employed in the removal of the deceased to West 2 Landing where he arrived at approximately 11.30 hours.

Relevant events on West 2 Landing between 11.30 and 20.00 hours on 23 December

44. Officer E, who was in charge of West 2 Landing, was briefed by ACO A who informed him of the reason for the deceased’s removal to a close supervision cell on West 2 Landing. This information was entered in the Close Supervision Cell Journal for cell 12.
45. In accordance with Standard Operating Procedures a request was made that a nurse officer would assess the deceased.
46. Officer E directed that the deceased be placed in the close supervision cell and searched for a prohibited article. The deceased was asked if he had a

prohibited article on his person. He denied that he had claiming that he did not receive any prohibited article while on his visit.

47. The deceased was placed in close supervision cell 12 at 11.30.48 and was searched in accordance with the direction referred to in paragraph 46. His clothes taken from him. He was given refractory clothing.
48. Nurse Officer A responded to the request referred to in paragraph 45. She arrived outside cell 12 at 11.31.52. She remained outside the cell for one minute and 30 seconds. During this time the deceased was being searched in the cell. While outside the cell door Nurse Officer A can be seen on CCTV talking to ACO A.
49. In his statement to me ACO A stated that he briefed Nurse Officer A:-

“telling her that he had received an article on visits and that he had placed it in his mouth and that he had been non compliant with the officers”

I asked ACO A to elaborate on this statement which he did in the following terms:-

“I informed Nurse Officer A prior to her assessing the prisoner in the Close Supervision Cell what had happened, that he had received an article and placed it in his mouth. This was done as a verbal report”.

50. Nurse Officer A stated that:-

“When I came in I was told that (deceased) had been relocated to West 2 for operational reasons. I was not informed that (deceased) had swallowed anything or that he may be concealing an illicit substance. I went to his cell”.

51. Nurse Officer A entered cell 12 at 11.33.24 and left again at 11.33.36 – a period of 12 seconds. Her statement to me as to what transpired in the cell is as follows:-

“I went into his cell; he was sitting down on the bed dressed in a refractory gown. I carried out a physical assessment on (deceased), precisely physical observation. His breathing was normal. No injuries were reported or observed. The colour of his eyes was normal and he was able to maintain eye contact. His speech was coherent because I asked him how he was and he responded that he was ok. I afforded (deceased) the opportunity to discuss any issues of concern to him. However (deceased) declined stating “I’m fine”. Based on my assessment of (deceased) and the collateral which I received, I was of the opinion that no further nursing intervention was required at that point in time.”

52. At 11.33.45 the deceased was locked in his cell. I have already stated that I had access to all CCTV for 23 December. I thoroughly examined the CCTV covering that part of West 2 Landing which is relevant to this investigation between the hours 11.33.45 and 20.00 hours on 23 December 2014.
53. The deceased had significant contact with prison officers during the period referred to in paragraph 52. This contact consisted of the observation by officers through the viewing hatch of the prisoner in his cell, the physical opening of the cell door for the purpose of bringing food, milk and extra bedclothes to the deceased, allowing the deceased out of his cell for the purpose of making a telephone call and allowing him out of the cell in order that he could smoke cigarettes. The deceased activated his cell call light on a number of occasions and this was responded to by officers.
54. However, on seven (7) occasions the deceased was not checked every 15 minutes as provided for in relevant Standard Operating Procedures.. The three (3) most significant failures in this regard occurred as follows:

13.01.02 to 14.05.40 – a period of 64 minutes

15.57.18 to 16.38.30 – a period of 41 minutes

16.38.30 to 17.31.06 – a period of 53 minutes

Relevant events on West 2 Landing between 20.00 hours on 23 December and 08.30 hours on 24 December

55. It is appropriate, at this juncture, that I detail all activity on West 2 Landing as it relates to the deceased and/or his cell between the times covered in this section as follows:-

20.12.56	Officer with torch checks the cell
21.01.05	Officer with torch checks the cell
22.01.32	Officer with torch checks the cell
22.33.01	Cell door unlocked. See paragraph 59
22.33.08	Nurse Officer B enters the doorway of the cell – 2 officers remain outside the doorway. See paragraph 61
22.33.26	Nurse Officer B exits the cell – closes the door and all 3 walk away down the landing. See paragraph 64
23.03.15	Officer checks the cell with a torch
23.30.23	Officer checks the cell with a torch
00.01.55	Officer checks the cell with a torch
00.30.18	Officer checks the cell with a torch
00.58.03	Officer checks the cell with a torch
01.25.29	Officer checks the cell with a torch
01.59.10	Officer checks the cell with a torch
02.02.46	Officer checks the cell with a torch
02.33.06	Officer checks the cell with a torch
02.57.48	Officer checks the cell with a torch
03.59.46	Officer checks the cell with a torch
04.59.20	Officer checks the cell with a torch
06.04.17	Officer checks the cell with a torch
06.58.35	Officer checks the cell with a torch
07.48.58	Officer checks the cell with a torch

08.11.44 3 officers go to the cell with food – Alert is raised and the officers exit. See paragraph 66

08.14.31 Nurse Officer C enters the cell. See paragraph 68

Other officers and members of the medical team enter the cell at various times.

56. In paragraphs 57 to 71, I detail relevant events that occurred during the night of 23/24 December 2014 on West 2 Landing that are relevant to this investigation.

57. Officer F was the officer in charge of West 2 and West 3 Landings on the night of 23/24 December. He stated that when he took up duty at 19.35 hours he was informed by Officer G that – “*there were three prisoners in the CSC’s (Close Supervision Cells)*”.

58. Officer F stated that:-

“At 21.00, I commenced my watchtours. These continued until 07.00 and were conducted on the hour, every hour. In addition to pressing those clocks situated on West 2 and West 3, I also visually observed every prisoner on both units. I also conducted extra observations on those prisoners classed as SPL. OBS throughout the night”.

The officer also maintained the Night Guard Journal referred to in paragraph 83.

59. At 22.33.01 three officers assembled outside cell 12. They were Officer F, ACO B and Nurse Officer B.

60. ACO B was the senior officer in charge of the prison on the night of 23/24 December. He stated that when he took over duty at approximately 19.40 hours he was told that the deceased was suspected of receiving a prohibited article earlier on in the day at about 10.30 hours on a visit from his girlfriend.

61. At 22.33.08 the cell door was opened. Officer F described what happened as follows:-

“The cell door was unlocked by ACO B. Prisoner (deceased) was called and offered his medication. Prisoner (deceased) shook his head in response. The cell door was closed and masterlocked”.

62. ACO B described the sequence of events after he arrived outside cell 12 referred to in paragraph 59 in the following terms:-

“When I looked through the spy-hole he was sleeping with his back against the wall at the back of the cell. I turned on his light and opened his door. I called his name a couple of times and told him the nurse was there to see him. He nodded his head, went back to sleep and I closed the door”.

63. Nurse Officer B was on his medication rounds at the time. The deceased was scheduled to receive his medication for his epilepsy. I have already referred in paragraph 29 to the fact that on occasions the deceased refused his medication. However, it is well documented in the medical notes that on many occasions the deceased was warned of the dangers of not taking his medication for his epilepsy.

64. At 22.33.08 Nurse Officer B entered the doorway of cell 12. He can be observed on CCTV in the doorway until 22.33.26 when he exited the cell and the door was closed. The Nurse Officer remained in the doorway for 18 seconds.

65. Nurse Officer B described the sequence of events in the following terms:-

“I went to (deceased’s) cell on West 2 at approximately 22.30 with ACO B and Officer F. The cell door was opened and (deceased) was called for his medication. (Deceased) was lying supine in the bed sitting up supported by pillows. (Deceased) responded when called, he

shrugged his shoulders and shook his head. This indicated to me that he declined his nocte medication. (Deceased) appeared drowsy, this presentation and my clinical judgment led me to believe he was under the influence of unprescribed medication. (Deceased) appeared comfortable, colour was normal and respirations were normal. From my assessment of (deceased) at that point in time my clinical judgment was that (deceased) was stable and required no further medical input. The cell door was closed.

Before I left the landing I enquired as to why (deceased) was moved to West 2. ACO B informed me that (deceased) was moved there earlier in the day as he was suspected of obtaining a prohibited article on a visit. I had no further interaction with (deceased) on the night”.

The Nurse Officer entered the following in the Medical Notes on the PHMS:-

“Nocte meds declined by prisoner, appeared to be under the influence of unprescribed medication, declined any medical intervention at this time”

66. At 08.11.44 on 24 December Officers H, I and J went to cell 12 with breakfast for the occupant. Officer H described the scene when the cell door was unlocked as follows:-

“(Deceased) was unresponsive when we called him for breakfast. I then went over to prisoner (deceased) as he was lying on his bed and touched his arm to get a response. His arm felt cold to the touch and no response came from the prisoner. I told Officer J there was no response from prisoner (deceased)”.

67. The officers, referred to in paragraph 66 immediately raised an alert.
68. At 08.14.31 Nurse Officer C entered cell 12. She described the situation in the medical notes on the PHMS as follows:-

“I was contacted by radio to attend west 2 at approximately 08.10am for medic immediately. I was shown to cell 12 on west 2. On entering the cell I could see (deceased) lying in prone position on his bed, head tilted to one side. I called (deceased’s) name, unresponsive to verbal and physical stimuli. I checked for radial and carotid pulse, no pulse. No chest movements, no signs of respirations. Pupils fixed and dilated, body cool to touch. I called for code red over the radio. My assessment found him to be incompatible with life. No response from radio call. I then left cell and went to the surgery to seek assistance. I was accompanied back to west 2 by N/O D and N/O E who carried out assessment, his position was changed for this.....After this we left the cell and contacted the duty doctor”.

69. Nurse Officers D and E concurred with the assessment of Nurse Officer C that the prisoner was *“incompatible with life”*.
70. In view of the assessments of the three nurse officers CPR was not a viable option.
71. At 09.15 hours Dr A pronounced the prisoner dead. The doctor noted in the medical notes on the PHMS that when he examined the deceased in cell 12 he observed – *“tongue: two little, 5-6 mm x 2-3 mm white paper-like something”*. He stated that these were *“shown to the Garda”*.

Other relevant information

72. I have been informed that on an examination of the deceased’s cell, traces of an unknown white substance, traces of a brown substance and a wrap of brown substance were found.
73. A Post Mortem examination was carried out on the deceased by the State Pathologist. I understand that there was no evidence of concealment of a quantity of drugs in his person.

74. I understand toxicology tests proved positive for the presence of heroin and diazepam.
75. Lights on the West 2 Landing were turned off for periods of time on 23 and 24 December 2014 as follows:-

Lights out at 12.23.19 and back on at 14.11.03 on 23rd.

Lights out at 16.13.34 and back on at 17.27.20 on 23rd.

Lights out at 19.20.05 and back on at 22.32.41 on 23rd.

Lights out at 22.35.06 and back on at 08.11.08 on 24th.

During periods of darkness – while the lights on the landing were out it is extremely difficult to identify individual officers when such officers are checking individual cells.

Relevant prison records

76. I examined all prison records relevant to this investigation. I wish to draw attention to two such records, namely, the Close Supervision Journal for Cell 12 on West 2 Landing and the Night Guard Journal for West 2 and West 3 Landings for the night of 23/24 December 2014.

Close Supervision Journal

77. This journal is an official document which is meant to record all relevant activities as they relate to the prisoner and the cell, such as, the reason for the placement of the prisoner in the cell, the times the prisoner was visited by the doctor and Governor, the times that the prisoner was checked by staff or others and the times that the prisoner was observed in accordance with the Close Supervision Procedures.
78. In the instant case the reason for the placement of the deceased in the Close Supervision Cell is documented and acknowledged by ACO A.
79. There is no record of ACO B and Nurse Officer B visiting the deceased at 22.33.08 on the night of 23 December.

80. The journal contains entries to the effect that the deceased was observed every 15 minutes from 11.30 hours on 23 December to 07.30 hours on 24 December.
81. There is an entry to the effect that the deceased was given his dinner at 12.00 hours but another entry is to the effect that the deceased declined his dinner.
82. There are no other significant entries in the journal. The journal was signed off on by senior officers.

Night Guard Journal

83. The Night Guard Journal for the night of 23/24 December was maintained by Officer F. The relevant entries are as follows:-

“10.30 pm ACO B and NO B to see prisoner (deceased) W2 cell 12”.

“Patrolled the units throughout the night paying particular attention to ‘SPL.OBS’. Reported all correct to ACO C”.

Addressing the concerns of the Family

84. In paragraph 20, I set out the concerns of the family that they wished investigated. In this paragraph I endeavour to address such concerns. For ease of reading I adopt the same numbering sequence as in paragraph 20 as follows:-
 - (a) There are no recognised techniques. The officers were at some distance from the incident and could not prevent the deceased from placing the article in his mouth.
 - (b) The deceased was taken to a Close Supervision Cell on W2 Landing. He was also asked to hand up the illegal substance.
 - (c) This is a matter more appropriate to the Coroner’s Inquest.
 - (d) This would be impractical. It must be borne in mind that the deceased was of full age and therefore entitled to make decisions as they might affect his health.

- (e) This is accurately documented in this report.
- (f) As the deceased's condition was incompatible with life when found CPR was not a viable option.
- (g) He was pronounced dead at 09.15 hours on 24 December 2014. The actual time of death is a matter more appropriate for the Coroner's Inquest.
- (h) The deceased's girlfriend was searched, as described in paragraph 37. This was a thorough search.
- (i) I have been unable to ascertain how information of this nature found its way into the public press.

Findings

85. At this juncture I wish to point out that the standard of proof required to make findings in an investigation such as in the instant case is the Civil Standard, in other words, on the balance of probabilities. My findings are divided into those that support my major finding referred to in paragraph 86 and other findings.
- 86. The Irish Prison Service failed in its duty of care to the deceased in that:-**
- (a) despite being suspected of ingesting a prohibited substance, the deceased was not appropriately medically/clinically assessed at 11.30 or 23.30 hours approximately on 23 December 2014 or at all,**
 - (b) despite being suspected of being under the influence of un-prescribed medication at 23.30 hours approximately on 23 December 2014 was not appropriately medically/clinically assessed at 23.30 hours or at all, and,**
 - (c) despite being a Special Observation Prisoner suspected of having ingested a prohibited substance was not monitored on 23/24 December 2014 in accordance with Standard Operating Procedures.**
87. My finding referred to in paragraph 86 is supported by the following findings in paragraphs 88 to 103.

88. The deceased was suspected of ingesting a prohibited substance that was passed to him during a visit mid morning on 23 December 2014.
89. In accordance with Standard Operating Procedures the deceased was immediately removed from the visits area and placed in a Close Supervision Cell on West 2 Landing.
90. In accordance with Standard Operating Procedures a member of the medical staff was asked to assess the deceased following his removal to West 2 Landing.
91. A Nurse Officer responded to the request referred to in paragraph 90.
92. There is conflicting evidence as to whether the Nurse Officer referred to in paragraph 91 was informed that the deceased was suspected of ingesting a prohibited substance. The conflicting evidence available to me is referred to in paragraphs 48 to 51.
93. I am satisfied that the Nurse Officer referred to in paragraph 91 was informed prior to her assessment of the deceased at 11.33 hours on 23 December that he, the deceased, had received an article during a visit and had placed same in his mouth. I find corroboration for this finding in the following:-
 - (a) The ACO in charge of visits adhered to Standard Operating Procedures in that he ordered the removal of the deceased from the visits area to a Close Supervision Cell on West 2 Landing.
 - (b) The ACO referred to at (a) above briefed the Officer in Charge of West 2 Landing of the reason for the removal of the deceased from the visits area to a Close Supervision Cell on West 2 Landing. He acknowledged this fact by signing the relevant Close Supervision Cell Journal.
 - (c) The Officer in Charge of West 2 Landing directed that the deceased be placed in a Close Supervision Cell and searched for a prohibited article.
 - (d) In accordance with Standard Operating Procedures a member of the medical team was asked to assess the deceased in his cell on West 2 Landing.

- (e) The ACO referred to at (a) above can clearly be seen on CCTV talking to the Nurse Officer referred to in paragraph 91 outside the deceased's cell and prior to her entry into the cell.
94. No medical clinical assessment, having regard to the suspected ingestion of a prohibited substance, was carried out at 11.33 hours or 23.30 hours on 23 December or at any time thereafter as provided for in Standard Operating Procedures.
95. The deceased was next seen by a member of the medical staff at 22.33.08 in his cell – eleven hours later. The sequence of events relating to the Nurse Officer going to the deceased's cell is documented in paragraphs 61 to 65.
96. The Nurse Officer who attended the deceased at 22.33.08 was there for the purpose of administering night medication. The deceased refused such medication as described in paragraphs 61, 62 and 65.
97. The Nurse Officer referred to in paragraph 95 observed the deceased at 22.33.08 and was of the opinion that he, the deceased, was under the influence of un-prescribed medication.
98. Subsequent to his visit to the deceased in his cell but before he left West 2 Landing the Nurse Officer enquired as to why the deceased had been moved to West 2. He was informed by the ACO that the deceased was suspected of obtaining a prohibited article on a visit earlier.
99. No medical clinical assessment was carried out on the deceased subsequent to 22.33.08 on 23 December 2014.
100. The deceased was classified as a 'Special Observation Prisoner' at all times when he was accommodated in the Close Supervision Cell on West 2 Landing.
101. The deceased was not checked every 15 minutes in accordance with Standard Operating Procedures. A distinction should be drawn between his

accommodation up to 20.00 hours on 23 December and his accommodation thereafter up to the time he was discovered in an unresponsive state at approximately 08.11 hours on 24 December 2014.

102. In the period between 11.30 hours and 20.00 hours on 23 December while the deceased was not checked every 15 minutes in accordance with Standard Operating Procedures he was checked on a regular basis and in many instances at intervals of less than 15 minutes. Officers also responded to the activation of his cell call light.
103. In the period 20.00 hours on 23 December to 08.30 hours on 24 December the deceased was not checked every 15 minutes. The times that he was checked are documented in paragraph 55. At times the deceased was not checked for periods in excess of one hour.

Other findings

104. Prior to 23 December 2014, the deceased was making efforts to have some contraband brought to him in prison.
105. A package was transmitted between the deceased's girlfriend and the deceased during the visit as described at paragraph 37.
106. Certain entries in official documents (namely, the Night Guard Journal and Cell Journal for cell 12) are incorrect, misleading and do not accord with the facts in that they purport to show that the deceased was checked every 15 minutes in accordance with Standard Operating Procedures.
107. The provenance of the drugs that were in the deceased's cell on the morning of 24 December is not known. However, it is reasonable to assume that their origin was the package transferred to the deceased at a visit mid morning on 23 December 2014.

108. The time and cause of death are matters for the Coroner's Inquest. However, I understand that toxicology tests confirmed that the deceased had taken heroin and diazepam.

Recommendations

1. An appropriate line management structure must be in operation to ensure compliance with Prison Rules, Standard Operating Procedures, Governors' and Chiefs' Orders.
2. All prison personnel must appreciate that official documents must reflect the truth of actions taken by officers.