



The
**Prisoner
Ombudsman**
for Northern Ireland

**SUMMARY AND RECOMMENDATIONS OF THE
REPORT BY THE PRISONER OMBUDSMAN
INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF**

JOHN MARTIN GERARD KENNEWAY

[DOB 12/05/1962]

IN MAGHABERRY PRISON

ON 8 JUNE 2007

10 December 2009

Please note the following points:

- 1. Where applicable, names have been removed to anonymise the following report, and;**
- 2. To ensure the integrity of the evidence on some occasions strong language has been referred to when using direct quotes.**

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SUMMARY

John Kenneway was a re-called Life Sentence Prisoner. He was released from the Maze Prison on 19 October 2000. His release was sanctioned by the Sentence Review Commissioners, following the Belfast Agreement.

Following John being charged with fresh offences, his Life Sentence Prisoner Licence was suspended and he was recalled into the custody of the Prison Service in February 2007. He was housed in the Special Supervision Unit (SSU) at Maghaberry Prison where he stayed for 122 days until his death on 8 June 2007.

The SSU has two main functions. It is used for prisoners who are confined to cell as a punishment following adjudication for serious misconduct and it is used to house prisoners under Rule 32¹ who, for their own protection or the protection of others, are required to be kept away from other prisoners. John was housed in the SSU under Rule 32 for his own protection. The regime in the SSU is designed to ensure that no prisoner has contact with any other prisoner. Prisoners do, at times, shout to each other through the windows.

Normal cells within the SSU are equipped with a single bed, mattress, pillow and duvet, in-cell sanitation, a plastic seat and a wooden bench attached to the wall. The windows of the cells on the first floor, where John was located, are covered by an opaque plastic film to prevent prisoners identifying other prisoners in the exercise yards. The cell windows open each side but have a metal grille at the openings to provide security and are intended to prevent items being passed between cells.

¹ Rule 32: Restriction of Association

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The Prison Service adhered to Prison Rules and regulations when reviewing and extending John's time in the SSU.

In line with Prison Rules, John was entitled to a daily shower and to use the telephone each day. He was also entitled to exercise in the SSU exercise yard for one hour each day. It is not clear from prison records how often John exercised but it is recorded that on 16 days John chose not to take exercise, nine of these were in May. The only date that it was recorded that John took exercise during his last week was 6 June. On 11 May, John told a friend on the phone that "*the yard is small and you have to get searched when you go out and searched when you come back, just like the phone*". It is unclear whether this was putting him off taking exercise.

John was allowed to order items from the tuck shop on a weekly basis including sweets, tobacco and newspapers. John also purchased a radio from the tuck shop and, in April, a PlayStation. John was refused permission to have his guitar in his cell.

John looked forward very much to visits from family and friends and was entitled to a visit every seven days. John actually attended seven visits in February, five in March, four in April and five in May. Visits normally last around an hour but, on every occasion, John was allowed longer than this. John also attended 13 legal visits.

On the days when he did not have a visit, John spent over 22 hours in each 24 hour period in his cell. On days when he did not exercise, he spent more than 23 hours in his cell.

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On a typical day, John would be brought breakfast at around 08.15 and given the opportunity to request use of the phone, exercise and a shower. In order to submit a request he would have to be up and dressed when breakfast was served. Showering took place in the morning. Lunch would be served from 11.30 to 12.30 and use of the phone and exercise would be organised during the afternoon. Tea (evening meal) would be served between 15.30 and 15.45 and John would then be locked down in his cell until 08.15 the next day.

John was on the Basic regime level of the Prison Progressive Regime and Earned Privileges Scheme² (PREPS) because he refused to participate in mandatory drugs testing. Under the Prison Rules that applied at the time, he was not, therefore, entitled to have a television in his cell. In the event, John did have a television for some of the days that he was in the SSU. This was because a prisoner who receives good staff reports for four consecutive weeks, is allowed a television until they are asked, and refuse, to take another drugs test. John's TV was taken away when he refused a drugs test on 15 March but it is recorded that he was given it back on 14 April. The TV and a PlayStation he had purchased in April, were taken away again on 3 May when he refused a further drugs test.

After 3 May, John remained on the Basic regime and did not have a television for the 36 days up to the time of his death on 8 June, except for the night of 5 June when it is recorded that he was given a TV for one night as a reward for handing in drugs he had found in the visitors area. It is not clear whether he actually kept the TV for one night or two.

² PREPS: Progressive Regime and Earned Privileges Scheme

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When John refused his drugs test on 15 March and was reduced in regime, he appealed saying that he would have taken the test if he had known that refusing to do so would affect his regime. When he refused a further test on 3 May it is recorded that *“he said he is a Republican prisoner so will not be taking a drugs test”*.

It is evident from telephone calls made by John between 6 May and 8 June that John was, throughout this period, accessing non prescription, illicit drugs from visitors and other prisoners. It is not clear when John started to take drugs, whether he was taking them throughout his time in the SSU or how this might have influenced his decision to refuse drugs tests.

John's family were concerned that staff in the SSU treated John very badly. The evidence suggests that John had very limited contact with staff. A prison doctor who saw John on 7 June wrote when referring him to see a psychiatrist, *“he appears to be affected by his environment in that he only sees any officer who delivers meals to him.”*

Insofar as John did have contact with staff, he appears to have had a reasonable or good relationship with a number of officers but did not like the way he was treated by others. During phone calls made over the month of May, John says that some officers are *“alright,”* and *“acknowledge, talk to”* him. He talks about a new crew being on and says *“they don't seem too bad”* but that *“management are trying to get up my hole big time”*. He does not explain this comment. He clearly dislikes other officers and one in particular whom he calls *“the scumbag.”* He talks about officers being *“d***heads”* and *“slamming the door”* and says, on 12 May, that the night guards have been getting him up at 06.30. He says that *“they”* are trying to break him

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and talks also about one officer saying “*I can see it in your eyes John, you’re breaking*”.

A prisoner orderly working in the SSU commented, at interview, that John always had a good relationship with the prison officers and there is evidence that officers did show flexibility in applying prison rules relating to visits, phone calls and John’s access to a TV. John was also given good reports which are required in order for a TV to be considered. Staff reports typically described John as “*usually quiet*” and “*causing no problems*” and contained very few negative comments. The small number of unfavourable entries in the Staff Reports relate to John becoming angry or arguing.

In John’s last days, some staff were sensitive to changes in John’s demeanour and sought medical advice for him.

John is quite upbeat in many of his phone calls. His family believe that he tried to sound cheerful for their sakes. There is also, however, evidence that he found the conditions and regime in the SSU very difficult. He frequently refers to the number of days he has been held there. He talks about it “*driving him nuts*” and “*bonkers*”. He says that his “*head is f...ked*” and that he can “*only see the shape of the guy next door*”. He says on 11 May that he is going to get a family member to go on the Nolan Show to complain about the conditions they are keeping him in.

During his time in the SSU, John made applications on 9 February and 29 March to be moved out of the SSU to the Separated Republican Accommodation at Roe House. In April, he appealed a decision not to allow him to transfer to Roe House. These applications were assessed by the Prison Service. In considering them, advice was

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sought from the Police Service of Northern Ireland (PSNI) who advised on 16 February 2007 that intelligence was held that may indicate a possible Republican threat against John. Further advice was sought on 12 March and the PSNI replied on 20 March stating that no new intelligence had been received since the previous report. However, in the light of the information received in February, and in line with the published criteria in the separated prisoner compact³ on safety grounds, the Prison Service turned down John's requests for a move to separated accommodation.

On 23 March John applied to be moved to normal integrated prison accommodation stating "*I do not believe I am under threat. Being in the SSU is making me anxious*". This was in spite of the fact that, on 9 February, John had written on a Request Form "*I am under a death threat from loyalists*" and that his solicitor had sought assurances about his safety on the same date. The Prison Service said that they were concerned that John might be at considerable risk of a revenge attack in connection with his involvement in the death of Billy Wright. In light of this and the information received from the PSNI, this application was also refused.

John and his family did not believe that there was a Republican threat against him. John said in phone calls that he thought that the intention was "*to break*" him. A prison doctor wrote on 7 June that John "*perceives that the authorities are in some way punishing him*". However, the doctor also wrote that "*he perceives himself also to be under a definite threat from other paramilitaries*".

It is evident from John's phone calls that he very badly wanted to get out of the SSU. He was delighted to learn during the week before his

³ Prisoner Compact – A signed agreement.

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death that the Republican group, Teach na Failte, who had been trying to get John moved to separated accommodation, had written a letter saying that Republican groups had confirmed that John would be safe if he moved to Roe House, the Republican wing. He was subsequently told by a governor that he would have to get a letter from the PSNI confirming that he was not under any threat before he could be moved. Teach na Failte had said previously that they *“thought the police were playing games”*.

As the investigation report includes comments and observations from Teach na Failte, it was felt to be appropriate to give PSNI an opportunity to comment on the matters raised. In a meeting with PSNI, I was briefed on the reasons that they advised that there may be a Republican threat against John.

John had a psychiatric history of repeated episodes of anxiety, insomnia, periodic depression and acts of deliberate self-harm/suicide attempts. As part of the investigation, two independent medical reviews of John's healthcare were commissioned. In one review, Professor Roy McClelland describes John as *“a vulnerable man, vulnerable to psychological distress”*. He points out that John's prison health records *“contain substantial evidence of mental health vulnerability, previous episodes of low mood and documented instances of deliberate self-harm, some of which appear to have had some degree of suicidal attempt”*. All of these he says are risk factors that would need to be considered in the context of mental health and behavioural problems in the course of the present committal.

At the time of John's committal to Maghaberry Prison in February 2007, it was noted that he had a history of depression, had been referred to specialist psychiatric services and that he had been

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prescribed an antidepressant by his General Practitioner. Medication was prescribed but no psychological or psychiatric assessment was planned or took place between his committal interview and a consultation with a Prison Doctor on 7 June.

In February and early April, John had difficulty sleeping and was given medication. On 20 April, John was seen by a nurse who noted in his records that he was having tension headaches on and off, was complaining of not sleeping and was having panic symptoms. This did not lead to subsequent concern or monitoring of mental health issues.

On 25 April, John was seen by a Probation Officer and told her that he was not sleeping and was having flashbacks about previous experiences. She made a referral to the Psychology Department asking for John to be assessed for suitability for counselling. John was on a waiting list for this assessment when he died.

John also told the Probation Officer that he had made a request to see a Psychiatrist. It is not clear whether, and if so when, he made this request, but the Probation Officer said that she relayed this information to Healthcare. No referral was, however, made until the consultation with the prison doctor on 7 June.

At the meeting on 25 April, the main concern noted by the Probation Officer related to how John was coping with being separated from his two young children. After the break up of his marriage, John went on to have two children with a new partner. After separating from his partner and before entering prison, John was involved in a serious incident and was not allowed to see his children. In his telephone calls there is evidence that John is very attached to his children. He

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speaks a number of times about getting a photo of them, talks about “*missing the kids like something shocking,*” and says that it “*broke my heart*” not to see her (his daughter) in her first play.

On 31 May, John was refused compassionate temporary release to attend the Christening of his grandchild on 10 June. John’s family said that John knew that he would not get out for the Christening, though there is evidence in phone calls the week before he died that he thought he might. Even before this, on 18 May, John tells a family member in a phone call that the NIO has got back to him, in connection with the Christening leave application, to say that he has to go back to court to get compassionate parole. John says that he thinks that this is a positive development because the Prison Service will be less likely to continue to refuse him if the leave is approved by the court.

On 6 June, John attended, via a video link, a compassionate bail hearing in connection with his request to attend the Christening. The compassionate bail application was refused. In reality, the Court could not have granted this because, as John was a recalled Life Sentence Prisoner, only the Secretary of State had the authority to authorise compassionate leave. John did appear to be accepting of the outcome and, in a telephone conversation on 6 June, jokingly tells a family member that he has “*got the bail*” before admitting that he hasn’t.

As well as receiving the Prison Service refusal for him to attend the Christening, John also had a family visit on Thursday 31 May and was delighted to see his grandson who was then just 18 months old.

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On 2 June, the Saturday before John died, staff noted a change in John. They recorded that he spent most of the day in bed and had said that he was not well the previous night. At interview, staff said that John complained that he had not slept well and described John as seeming “*under the weather*”. One member of staff said that, over these days, John’s “*temperament changed to a state where you had to drag a conversation out of him*”.

It is recorded in the staff reports that staff asked a medic (a nurse) to “*have a talk with him as he was acting out of character*”. It is recorded also that the medic visited him and said “*John was fine*”. There are no healthcare notes for this visit on 2 June.

On 3 June, staff recorded that John “*spent day in bed again*”. It is recorded that staff again requested a visit by the medic and that John was “*still ok according to medic*”. There are no healthcare records for this visit on 3 June.

On 5 June, staff recorded “*Kenneway is not well, he has requested the doctor twice*”. There is no evidence that the doctor attended and no healthcare entries.

What staff didn’t know was that, over these days, John appears to have been using drugs extensively. In a phone call on 29 May, John appears to check that cannabis will be collected from his supplier ready for his visit on 31 May. On 3 June, John says in a further phone call that “*we had a party and sure I was f**ked out of my head for two days*”. He explains that he woke up and found breakfast, lunch, dinner everything at his door. He said that the party was for one of the lads getting out. He says he is “*f**ing stoned*” and “*I am only after putting out a splif before those bas***ds came to the door*”.

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On 4 June, John mentions in a phone call that he has found a bag of tablets in the visits room but says that he handed it in because he thought he was being set up. However in another phone call on 5 June, referring to finding the “*diazis*”, he explains that he got “*as many between my cheeks as possible and then called the screws*”. In a call at 15.50 he says that he is going back to bed, laughs and says “*I haven’t been awake since Friday*”.

Two days before he died, John checks in a phone call that his visitors will have cannabis for him at the visit planned for Friday 8 June and says “*I’m on a buzz here now if you can get that sorted for me*”.

On 31 May, John mentions in a phone call that two other prisoners in the SSU who he “*yarned away with*” are being moved out of the SSU “*just to get at me like*”. He mentions also that “*they are trying to break me, not a f***ing chance*”. Following the move of the prisoners he says on 2 June “*that’s me f***ed so it is. They moved my big mate away from me*” and “*I’m by myself again*”. On 4 June, John talks again about his “*two mates being moved away from me*” and says “*see what they’re doing with me; see the last person they done it with was one of Hitler’s men. They kept him in a prison with nobody else in it, the only ones he seen was his guards and he was there until he died*”.

There is nothing written on the staff record on 4 June but on the phone John is in good spirits. He has had a legal visit and has been made aware of the letter from the Republican group, Teach na Failte. John says that “*the reals and contos say that I’m under no threat from anyone and I should be moved straight to the Republican wing*”. He later says that the letter is “*a joint statement from three organisations*” and “*they reckon I’ll be moved within the next week or so*”. He tells a

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family member the “*good news*” that he should be getting moved in the next few days and will be able to “*get a bit of fresh air about me*”.

On 5 June, John says that he is “*waiting on word*” about when he will move and he has been talking to a governor. He says that “*things are looking a wee bit brighter*” and, apparently referring to being moved, he says “*the good thing is I got it at the beginning of the week so it’ll give me all week to look f**ing forward to it*”.

On 6 June, John explains that he needs his solicitor to get a letter from the PSNI saying that “*John Kenneway senior is not under threat from any Republican organisation*”. He says that he has been talking to the Security Governor who has explained that the problem is that the police are saying that “*I’m under attack*”. He adds that “*I need that done today. If I get that done today they’re going to move me in the morning*”.

On 5 June, it is also recorded that John was given a TV for one night as a reward for finding the drugs in the Visitors Area the previous day. It is possible that he may have had the TV for two nights. A family member said that John was upset on 7 June that the TV had been taken off him.

John’s daughter’s 4th birthday was on Wednesday 6 June. In the weeks before his death, John talks a number of times about arranging birthday presents for his daughter. He is annoyed that the presents have not been sorted out and frustrated that a photo he wants to get ready for the birthday has not been organised. During his last week, he talks about the birthday most days, asks a family member to send flowers to his daughter’s school and discusses plans to get a bike to her for her birthday gift from him. When he is told the next day that it

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is not possible to send flowers to the school because staff will then ring her mother, he arranges for £50 to be put in a birthday card for her. He asks a family member to “*give the kids a kiss for me and tell them I miss them*” and to “*whisper in her (his daughter’s) ear, your daddy really loves you and misses you*”.

On 7 June, John was taken by staff to the Healthcare Centre to see a prison doctor because he thought he might have a chest infection. In recording the consultation the doctor noted that John “*describes feeling of flashbacks of activities that he was involved in in the past. Appears to be quite troubled by them. Has had thoughts of self-harm/ending his life but is determined to stay strong on account of his 6 year old and 4 year old children*”. The doctor made a referral to a psychiatrist because he thought John may be suffering from Post Traumatic Stress Disorder.

Officers who escorted John back to the SSU after the consultation with the doctor reported that he was in “*reasonably good form*” and offered them sweets.

In a letter the prison doctor who saw John on 7 June said that “*from the flow of conversation he (John) appeared to be accepting of the fact that it was unavoidable due to threats that he was placed in the SSU*”.

John made two phone calls on Thursday 7 June. The first was to a close friend at 15.37 and lasted nine minutes. The second was to a family member at 15.48 and lasted just over four minutes. The time of the consultation with the doctor is not recorded but it is thought that the phone calls were made after the consultation. The recordings of the phone calls and three other calls made during the month of May are unavailable. I have seen no evidence that would suggest that this

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is for any reason other than a human or technical error. If, however, any new information comes to light in connection with this matter, I shall publish it as an addendum to the report.

The family member who received a call on 7 June could not remember in detail the content of the call because of the passage of time. He said, however, that John was very low, was "*the worst I have heard him*" and said that "*they had broken him*". The family member could not recall whether John had asked whether his solicitor had been contacted and asked to approach the PSNI for a letter to confirm that he was not under any threat. He recalled that John may have made some reference to the solicitor early in the conversation.

The family member also said that the conversation became heated as he tried to point out to John that the situation was also very difficult for John's family and that his kids were worried about him. He said that he told John that one family member in particular was having to talk to people she would not have had dealings with previously, in order to try and help get John moved.

Another family member said that she had tried to contact John's solicitor on the 6 June, as John asked, but had been unable to speak with him until the 7 June. She said that she asked the solicitor about getting a letter from the PSNI and that he had said that he would see what he could do. The family member who spoke with John on 7 June was not aware of this approach to the solicitor.

On 8 June, when staff went to deliver breakfast for John he remained lying on his bed. He did not get up to request exercise or a shower and one officer commented that he was surprised that John did not

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want to wash as he was due a family visit and would usually like to shower.

In the event, John's family missed the expected visit that day. It appears that a family member phoned the prison and said that there had been a problem with the car. John had previously shown frustration in a phone call on 29 May with the way the family organised visits. A member of staff said at interview that on 8 June John was "*livid and did not believe*" the reason offered by the family for missing the visit. That day John made two telephone calls to a family member at 14.42 and 14.56 and another call to a friend, at 14.49.

There is much evidence in phone calls of John being close to his family and of how much he cared for them. During the telephone calls on 8 June, however, John is extremely angry and upset with members of his family. He says that "*I get one visit in f***ing weeks I don't see anybody else's f***ing face*", "*I am stuck in hell, I don't see anybody*" and that it is "*driving me crazy*". He also says "*anything I ask my family to do is not done*".

John talks to his friend about feeling let down. He says "*I am at the lowest part of my life. I mean that. I have no one, nobody. Do you know what I mean when I say to you I have nobody? The only two things I had to, that I could honestly f'ing say that I had to look forward to was my two babies and then see when they took them from me, I've nothing left*".

On the phone, on 8 June, John also talks about the cannabis he was supposed to get at his visit. He asks his friend to tell the person who supplies it that he'll still get it picked up the next day or some day the

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next week. At the end of his last call he repeats "*I'm stuck in f***ing hell*".

Immediately after returning to his cell having used the phone, a Governor spoke to John from his cell door. This was a routine check. At interview, the Governor said that "*John indicated that everything was okay and asked the officers for some tobacco*".

When John was offered his evening meal at 15.50, staff reported that "*he just took the biscuits and not the main meal saying he was not hungry*".

From prison records and CCTV, it is evident that John was last seen alive at 16.00 when he was observed through the door by an officer carrying out a headcount check. At 17.15, an officer checked John's cell and saw him hanging.

The Prison Service's Revised Self Harm and Suicide Prevention Policy 2006 states as its aim "*to identify prisoners at risk of suicide or self-harm and provide the necessary support and care to minimise the harm an individual may cause to himself or others*". In the event that a prisoner is deemed at risk of self-harm, any member of staff may trigger the opening of a Prisoner at Risk (PAR 1) booklet. This action should initiate a response of increased observation of the prisoner, responsiveness to vulnerability and healthcare input.

The notes on the PAR 1 Booklet describe "*distress signals*" that would alert staff to a possible problem. The list includes: *Showed signs of distress at being alone; disturbed sleep; change/loss of appetite; lack of physical energy for no apparent reason; feeling powerless; feeling hopeless; have leave refusal or knock back; has not been receiving visits, has had an unhappy visit or received bad news.*

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These distress signals were relevant to John in the days leading up to his death. Staff were not aware of the distress signals indicated by the content of John's phone calls on the day he died because calls are not routinely monitored. They did not interpret the distress signals that they were aware of, as indicating the need to open a PAR 1.

Staff were, however, sensitive to changes in John's demeanour and behaviour. They did seek medical inputs. They were twice assured by a nurse that John was fine and they were not given any indication after John's consultation with the prison doctor on 7 June that they should be more vigilant in their management of John. There is also no evidence that staff were aware of John's history of self harm and did not know that some of the behaviours they were noting had featured many times in John's previous medical notes in connection with mental health problems. John had not self-harmed at any other time during his period in the SSU.

At the consultation with the prison doctor on 7 June, John showed evidence of having psychological symptoms including flashbacks which it was noted he appeared to be quite troubled by and said that he had had thoughts of self-harm and suicide.

The doctor did not ask for John's medical notes, which held significant information about John's mental health and self-harming history. These were held in the filing room in the healthcare centre. In the absence of any notes being made on the medical file by the nurse who saw John on 2 June and 3 June, the doctor was unaware of these consultations.

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There is also no evidence, in the absence of an open PAR 1 Booklet, which always moves with a prisoner and is an important channel of communication that the prison doctor was made aware of the “*danger signals*” that staff would have been aware of. He was also unaware that John was using non prescription, illicit drugs.

The prison doctor should have been aware of the symptoms of a “*tension headache*”, “*not sleeping*” and “*having panic symptoms*” noted by the nurse on 20 April because it is recorded that she spoke to the same doctor at the time to ask for a prescription of Phenergan to help John sleep. The nurse’s note, in connection with this, was also on the new electronic medical record system which was under development and which the doctor had immediate access to. The information recorded at the Committal Screening, that John had a history of depression and that a psychiatric referral had been made, was in the medical file but not on the electronic system.

On the basis of the discussion at the consultation and John’s demeanour, the prison doctor did not see thoughts of self harm as current. He said that John was relaxed and didn’t show any signs of anxiety or low mood. He did not assess John as being at risk or feel that there were any indicators to suggest the need to open a PAR 1.

Both clinical reviewers felt that consideration should have been given to the introduction of the PAR 1 process as a safety net.

In the absence of an open PAR 1 Booklet, staff checks on John on 8 June were still over and above those required by Prison Service policy for a prisoner not on a PAR 1.

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Staff checked John 7 times, speaking to him through the cell door on two of these checks, as well as delivering his meals to him. A Governor spoke to John through his open cell door at 14.57. John did, however, spend less than 20 minutes out of his cell that day and there was only one occasion when an officer entered his cell, to check that it had been properly cleaned.

John committed suicide by hanging himself using a shoe lace attached to the grille at the opening of the cell window. He was discovered by an officer at 17.15.

In August 2006, a Senior Officer in the SSU had written to a Governor expressing staff concerns that prisoners had, in the past, used the window grilles as ligature points. He asked that the Prison Service consider removing the windows with grilles and installing anti-ligature vents in the SSU, of the type that he had seen on a visit to Hydebank Wood Prison.

When John was discovered at 17.15, it took one minute for officers to access the keys and enter John's cell. Officers commenced CPR⁴ and a cardiac ambulance was called. At 17.19 healthcare staff arrived, placed a defibrillator on John and continued CPR for a further 16–18 minutes before the ambulance crew paramedics arrived and took over. From a statement provided, the Emergency Medical Technician who arrived at the scene and observed John's appearance knew immediately that his life was extinct. John was pronounced dead by a doctor at 18.55.

⁴ CPR – abbreviation for cardiopulmonary resuscitation: a method used to keep someone alive in a medical emergency, in which you blow into their mouth then press on their chest and then repeat the process.

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There was speculation at the time, about the circumstances of John's death. CCTV footage shows, without ambiguity that the account of the events of the day given by prison staff are accurate.

Concerns were also raised about anxieties that John may have had in respect of a requirement to give evidence to the Billy Wright enquiry. John was advised in a letter dated 20 June 2005, by the Chairman of the Billy Wright Inquiry that the Inquiry would wish to interview him. On 3 October 2006, John's solicitors confirmed that John was prepared to be interviewed. However, on 12 February 2007, a further letter was sent to the Inquiry, by John's solicitors, advising that he was no longer prepared to be interviewed. The Inquiry wrote to John's solicitors on 7 June 2007 to ascertain whether John's position remained the same and to advise that the Inquiry would have to consider using its compulsory powers to require a written statement. This letter arrived with John's solicitors on 8 June, the day John died. John was, therefore, unaware of it.

I found no evidence that concerns related to giving evidence to the Billy Wright Inquiry contributed, in any way, to John's death.

As part of the police investigation into John's death, a search was carried out of his cell. Among the items retrieved was a photograph with a note on the back addressed to his four children which said *"Sorry but I can't go on like this, so please forgive me for what I have to do but I have always loved yous and always will forever, Daddy"*. Forensic analysis of the note confirmed that John wrote the note but it was not possible to say when the note had been written.

Examination of CCTV footage of events following the alarm being raised and consultation with the PSNI identified some concerns

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relating to how the preservation of the scene was managed. In any emergency, certain personnel must have immediate access to the scene. However, from evidence provided by CCTV, it would appear that there were a number of staff present at the scene when there was no requirement for them to be so. The PSNI reported that this resulted in the scene being contaminated.

A post mortem was carried out on Saturday 9 June 2007. The cause of John's death was hanging. A second post mortem was carried out on Wednesday 13 June 2007 at the request of John's family. This further post mortem recorded *"that natural disease would not appear to have played a part in the death and that the examination results were consistent with a middle aged man who died by hanging"*.

It was evident from the Post Mortem Forensic Science Report that John had cannabis and non-prescribed diazepam in his blood at the time of his death. In view of this, and in the light of the evidence available relating to John accessing and taking drugs, an expert Forensic Toxicologist was asked to interpret all of the information available and advise as to how John's behaviour in the last few days might have been affected by the substances he was taking.

The findings suggest that John was making either very light use of cannabis within a few hours of death or heavier use many hours or even days before death, but it would be unlikely that he would have been under the influence of cannabis at the time of his death.

In respect of diazepam, the results analysed are consistent with John having taken diazepam on a regular basis and having taken his last dose, possibly within the last day or two before his death. He had not, however, taken a very recent dose of diazepam. Symptoms of

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withdrawal from diazepam may include anxiety, depression, headache and irritability. "Pseudo withdrawal" could possibly be experienced in circumstances where it was believed that access to the drug was being cut off.

The blue tablets found by John in the visits area on 4 June were not analysed by the Prison Service. The Forensic Report clarifies that drugs referred to as "blues" are often diazepam 10 milligram tablets which are blue in colour. However the report also notes that tablets called "loyalist blues" are, said to contain ecstasy (MDMA) and ketamine. No MDMA was evident in John's samples but if he had taken it a day or two before his death it is possible that, although it had been eliminated from his body, he may still have been experiencing some of the side effects at the time of his death. MDMA is reported to produce feelings of euphoria and benevolence to others, with a blunting of inhibitions, heightened awareness of sensory stimuli and an altered perception of time. The stimulant effects may be followed by fatigue, depression and reduced physical performance which can result in impaired judgement. The Forensic Report concludes that the tablets referred to were probably diazepam tablets.

From the findings and information included in the Expert Forensic Science Report, it is not possible to say how, if at all, non prescription drugs may have affected John's mood and behaviour on 8 June. It is also not possible to say what part, if any, they may have played in John's death.

Post Script

In August 2007, the Prison Service issued a set of revised procedures to be followed in relation to the accommodation, care, discipline and

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control of prisoners in the SSU. The procedures recognise that prisoners held in the SSU may be especially vulnerable and include a requirement that every prisoner is treated with humanity and as an individual. The revised procedures are described in Section 28 of the report.

Section 29 of the report explains that in July 2008, the Prison Service produced a report on minimising the supply of drugs in Northern Ireland Prisons which details the results of a project carried out to research areas of concern. As a result of the findings of the Project Group, 28 recommendations were made.

Recommendations

As a result of my investigation I make **19** recommendations to the Northern Ireland Prison Service and its South Eastern Health and Social Care Trust partners. The recommendations relate to: the conditions, facilities and regime in the SSU; staff training; the emergency unlocking of cells and availability of a Hoffman Knife; the SSU windows; the communication and transfer of information; guidelines for the opening of a PAR 1 Booklet and the supply of drugs in prison.

There are also a number of recommendations relating to the provision of healthcare, arising out of both my own findings and those from the expert Clinical Reviews.

Recommendation 1

I recommend that the Prison Service reviews the accommodation for prisoners who are held in the SSU at Maghaberry prison under

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Prison Rule 32 for their own protection and, as soon as possible, provides a more suitable environment.

Recommendation 2

I recommend that the Prison Service carries out an audit in all Northern Ireland Prisons of the implementation of the procedures for the Management of Special Supervision Units issued in August 2007 and report its findings. This should include a review of the implementation of the procedures in respect of prisoners held pending an adjudication or confined to cell as a disciplinary penalty following adjudication.

Recommendation 3

I recommend that a further review of the regime in the SSU, for prisoners placed there under Prison Rule 32 for their own protection, is carried out to identify additional adjustments that could be made to enable individual prisoners, to spend more time out of cell and more time engaged in purposeful activity. This is particularly important in the case of prisoners held for long periods. Options that might be assessed include: one to one training/tutoring; distance learning opportunities; the provision of a computer; increased access to varied reading materials; allowing prisoners to collect their own meals; facilities to make tea/coffee; access to educational material and musical instruments.

Recommendation 4

I recommend that staff in the SSU are encouraged and supported to interact with all prisoners both during in cell and out of cell

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time. I further recommend that all supervisory checks are interactive/conversational rather than observational.

Recommendation 5

I recommend that the Prison Service reviews the training and refresher training for all staff working in the SSU. This should include training in the support and management of vulnerable prisoners and training in suicide awareness. This recommendation should extend to all Northern Ireland Prison Service establishments and all units where vulnerable prisoners are held.

Recommendation 6

I recommend that the Prison Service reviews the times that meals are delivered to prisoners within the SSU and ensures that the evening meal is served no earlier than 17.00.

Recommendation 7

I recommend the Prison Service reviews the procedures in place under Rule 32 – Restriction of Association for a prisoners own protection, to incorporate the requirement for constant review and updating of a personalised Action Plan and/or Exit Strategy for prisoners placed in the SSU under this rule.

Recommendation 8

I again recommend that the Prison Service reviews the current procedures in place for the emergency unlocking of cells and give

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consideration to measures that would allow immediate entry in an emergency situation where a life may be at risk.

Recommendation 9

I reiterate that the Prisoner Ombudsman's previous recommendation that staff should be provided with the appropriate equipment to enable life saving procedures in an emergency should now be implemented. This should include access to a Hoffman anti-ligature knife.

Recommendation 10

I recommend the Prison Service takes immediate steps to ensure all SSU cells at Maghaberry Prison have anti-ligature type windows installed.

Recommendation 11

I recommend that following the agreed joint review with the PSNI of Incident Scene Preservation guidance, the Prison Service takes steps to ensure all staff are made aware of the revised guidance and receive appropriate training on crime scene preservation.

Recommendation 12

I recommend that the Prison Service comprehensively audit the implementation of the Prison Service Action Plan produced in response to the recommendations of the Report on Minimising the Supply of Drugs in Northern Ireland Prisons produced in July 2008.

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Recommendation 13

I recommend that the Prison Service and its South Eastern Health and Social Care Trust partners (SEHSCT) ensure that it is a specific requirement of every committal review that consideration is given to the need for a further comprehensive healthcare assessment to establish a clinical baseline for healthcare management and that an appropriate plan for any review is put in place. This is particularly relevant in the case of vulnerable prisoners or those who, because of their circumstances, will be deprived of association.

Recommendation 14

I recommend that the Prison Service and its (SEHSCT) partners take action to ensure that where prisoners presents with mental illness symptoms and/or mentions thoughts of self harm a more comprehensive clinical psychiatric history is taken, or arranged, to determine whether increased supervision is needed and to determine management requirements.

Recommendation 15

I recommend that the Prison Service and its SEHSCT partners take immediate steps to ensure that all staff are referred to the information contained in the PAR 1 Booklet (or the replacement SPAR documentation being progressively implemented) and reminded of the circumstances where they need to give serious consideration to the opening of a PAR1/SPAR Booklet.

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Recommendation 16

I recommend that the Prison Service and its SEHSCT partners also review the adequacy of existing operating guidelines for the opening of a PAR1/SPAR Booklet by any member of staff and amend prison policies, guidelines and staff training to address any shortfalls identified.

Recommendation 17

I recommend that the Prison Service and its SEHSCT partners ensure that medical notes are routinely available at medical consultations.

Recommendation 18

I recommend that the Prison Service and its SEHSCT partners review arrangements for communicating relevant information (for example, evidence of “danger signs”) between prison service staff and healthcare staff in circumstances where there is no open PAR1/SPAR Booklet. I recommend also that the need for such communications is included in suicide awareness training.

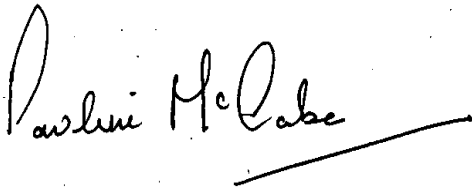
Recommendation 19

I recommend that the Prison Service and its SEHSCT partners take action to ensure that all healthcare staff record medical information resulting from any visits to prisoners in the SSU and Residential Houses on the prisoner EMIS medical record and on the open PAR1/ SPAR Booklet, if applicable.

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The Prison Service and South Eastern Health and Social Care Trust have developed an Action Plan in response to the recommendations listed above. This includes target completion dates for the outstanding actions and I will subsequently request confirmation, at appropriate intervals, that targets have been met.

A handwritten signature in black ink that reads "Pauline McCabe". The signature is written in a cursive style and is positioned above a horizontal line.

PAULINE MCCABE

PRISONER OMBUDSMAN FOR NORTHERN IRELAND

10 DECEMBER 2009