



The
**Prisoner
Ombudsman**
for Northern Ireland

**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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**PLEASE NOTE A SUPPORTING APPENDICES BOOKLET
ACCOMPANIES THIS REPORT**

PREFACE BY THE PRISONER OMBUDSMAN

This is my report into the circumstances surrounding the death of John Martin Gerard Kenneway in Maghaberry Prison on 8 June 2007.

I offer my sincere condolences to John's family for their sad loss. Brian Coulter, my predecessor, met with John's family a number of times and I have, since my appointment, also met with them on a number of occasions, shared the content of this report with them and responded to the questions and issues they raised.

I have with the agreement of John's family, referred to him throughout the report as John.

I took over responsibility for the investigation into the death of John Kenneway following my appointment in September 2008 and, as a result of emerging findings, determined that there was a requirement to re-examine all of the evidence available. I also decided to request further inputs from independent medical experts and a toxicologist.

My report contains this preface and a summary followed by an introduction and methodology, leading to my findings and associated recommendations. My findings are presented in 6 sections:

- Section 1: Background Information
- Section 2: Events 31 May to 7 June 2007
- Section 3: Events of 8 June 2007
- Section 4: Matters Related to John's Death
- Section 5: The Expert Clinical Reviews

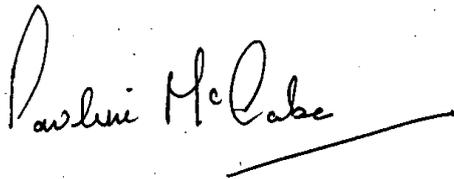
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- Section 6: Other Issues

I will, if required at a later date, add anything else which comes to light in connection with the investigation by way of an addendum to this report and notify all concerned.

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.

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

PAULINE MCCABE

PRISONER OMBUDSMAN FOR NORTHERN IRELAND

10 DECEMBER 2009

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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

¹ Rule 32: Restriction of Association

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provide security and are intended to prevent items being passed between cells.

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.

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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.

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

² PREPS: Progressive Regime and Earned Privileges Scheme

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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.

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

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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 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.

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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 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 compact 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*".

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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 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 this 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 this 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

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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 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.

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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 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

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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.

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.

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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*".

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*

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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 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

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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 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.

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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 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 this 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

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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 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*

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*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 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.

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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.*

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

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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.

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

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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.

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

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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 CPR³ 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.

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

³ 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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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 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"*.

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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 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

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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.

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 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.

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 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 this 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.

INTRODUCTION TO THE INVESTIGATION

Responsibility

1. As Prisoner Ombudsman⁴ for Northern Ireland, I have a responsibility for investigating the death of John Martin Gerard Kenneway, aged 45 years, in the Special Supervision Unit, Maghaberry Prison at 18.55 on 8 June 2007. My Terms of Reference for investigating deaths in prison custody in Northern Ireland are attached at Appendix 1.
2. I am independent of the Prison Service and my investigation as Prisoner Ombudsman provides enhanced transparency to the investigative process following any death in prison custody and contributes to the investigative obligation under Article 2 of the European Convention on Human Rights.
3. As required by law the Police Service of Northern Ireland continues to be notified of all such deaths.

Objectives of the Investigation

4. The objectives of my investigation into John's death are:
 - to establish the circumstances and events surrounding his death, including the care provided by the Prison Service;

⁴ The Prisoner Ombudsman took over the investigation of deaths in prison custody in Northern Ireland from 1st September 2005.

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- to examine any relevant healthcare issues and assess clinical care afforded by the Prison Service;
- to examine whether any change in Prison Service operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- to ensure that John's family have the opportunity to raise any concerns that they may have and that these are taken into account in the investigation; and
- to assist the Coroner's inquest.

INVESTIGATION METHODOLOGY

Notification

5. On Friday 8 June at 17.45 an on-call Prisoner Ombudsman investigator received a telephone call from an Officer in the Maghaberry Prison Emergency Control Room (ECR) advising that John Kenneway had been found hanging.
6. The Prisoner Ombudsman investigation began that evening when Notices of Investigation were issued to Prison Service Headquarters and to staff and prisoners at Maghaberry Prison announcing the investigation and inviting anyone with information relevant to John's death to contact the Investigation Team.

Family Liaison

7. A very important aspect of the role of Prisoner Ombudsman dealing with a death in custody is to liaise with the deceased's family. My predecessor, Brian Coulter, met with John's family on 25 June 2007. Further meetings were also held to discuss the progress of the investigation. The family were accompanied by their solicitor at these meetings. Since taking up my appointment, I have met with John's family on four occasions and spoken to them on the phone several times.

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8. It was extremely important to this investigation to learn more about John and his life from his family. I am grateful for the detailed insight provided by John's family.

9. Although my report may inform many interested parties, I write it primarily with John's family in mind, and to inform policy or practice which may make a contribution to the prevention of a similar death in future at Maghaberry Prison or elsewhere in the Northern Ireland Prison Service.

10. Along with other issues, it was important to establish whether or not John's family had any concerns over his care while in the custody of the Prison Service. At the first meeting with John's family and their legal representative, it was noted that they had several concerns. These included:
 - The decision to locate and keep John in the SSU.
 - The reasons for refusing to move John out of the SSU.
 - Issues around John's treatment by staff in the SSU.
 - Issues around the conditions in which John was held and the regime level he was subject to while in the SSU.
 - Issues around the supervision he received while in the SSU.
 - Issues around John's safety.
 - Issues around John's medical treatment and access to healthcare professionals.

All of these concerns are addressed in this investigation report.

Working together with interested parties

11. An integral part of any investigation is to work together with all the interested parties involved. To that end my Investigation Team liaised with and shared information with the Police Service of Northern Ireland and liaised with the Coroner's Service for Northern Ireland.

Prison Records and Interviews

12. My Investigation Team visited Maghaberry Prison on numerous occasions and met with prison management, staff and prisoners. All available prison records relating to John's period of custody, including his medical records were retrieved.
13. The Investigation Team carried out interviews with staff and prisoners in order to obtain information about John's death. My Team and the Police both viewed CCTV footage of the landing on which John's cell was located and shared witness statements to facilitate both investigations.

Telephone Calls

14. Recordings of telephone calls were provided for the period 6 May to 8 June 2008. All 53 calls/328 minutes were listened to. Tapes for calls made on 15 May, 21 May and 7 June were unavailable. I have seen no evidence that would suggest that these were unavailable for any reason other than 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 this report.

Clinical Reviews

15. As part of this investigation, two expert Clinical Reviews of John's healthcare needs and medical treatment while he was in custody in Northern Ireland were commissioned, at an early stage in the investigation, by my predecessor. I am grateful to Dr Neil Lloyd-Jones and Professor Roy McClelland who carried these out. In May 2009, I provided the clinical experts with additional information not provided at the time of commissioning and asked them to update their reports to take account of this information as they deemed appropriate. I also commissioned a recent toxicology report to further inform the investigation.
16. The Clinical Reviews and Toxicology Report are discussed at Section 5 Subsections 23 and 24 of this report and are included as Appendices 4 and 5. The response of the prison doctor to the findings of the Clinical Reviews is also in Section 5 Subsection 23.
17. **Prison Rules and Policies**

A summary of Prison Rules and Procedures referred to in the report are attached at Appendix 2. Full copies are available from the Prisoner Ombudsman Office on request.

Factual Accuracy Check

18. Before completing my investigation I submitted a draft report to the Director of the Northern Ireland Prison Service for a factual accuracy check. The Prison Service responded with a list of comments for consideration. I have fully considered these comments and made amendments where appropriate.

MAGHABERRY PRISON

Maghaberry Prison

19. Maghaberry Prison is a relatively modern high security prison which accommodates adult male long-term sentenced and remand prisoners, in both Separated and Integrated conditions. Maghaberry Prison was opened in 1987 and major structural changes were completed in 2003. The complex includes four Square Houses - Bann, Erne, Foyle and Lagan. Roe and Bush Houses were built in the late 1990's and were used for several years for "ordinary" remand and sentenced prisoners, before half of each block was given out to separated accommodation in 2004. Roe House also has a separate wing dedicated to accommodating prisoners on committal where they undergo an induction programme before being transferred to an appropriate residential location within Maghaberry. It is one of three Prison establishments managed by the Northern Ireland Prison Service.
20. There are two lower risk houses within the Mourne Complex of Maghaberry Prison, called Wilson and Martin Houses. These are used specifically to house lifer prisoners nearing the end of their sentence, as a stepping stone to the Pre-Release Assessment Unit (PAU) located at Crumlin Road, Belfast.
21. There are currently approximately 890 Prison Staff in post covering all grades and specialism's. The prison accommodates an average of 850 adult male prisoners.

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22. The regime in Maghaberry Prison focuses on a balance between appropriate levels of security and the Healthy Prisons Agenda – safety, respect, constructive activity and addressing offending behaviour. Purposeful activity and Offending Behaviour Programmes are critical parts of the resettlement process. In seeking to bring about positive change, staff manage the development of prisoners through a Progressive Regimes and Earned Privileges Scheme (PREPS).
23. The last reported inspection of Maghaberry Prison by HM Inspectorate of Prisons was in January 2009. The report of this inspection was published in July 2009. I noted the content when preparing this report.

Special Supervision Unit (SSU)

24. The SSU at Maghaberry Prison was previously known as the Punishment Unit. However, following a serious assault on 2 members of staff in the SSU in early 2000, the Governor ordered a review of the staffing, procedures, regimes and the physical structure of the SSU. This review resulted in a construction project and the introduction of new procedures and regimes under the control and management of the Search/Standby Team (SST). The SSU currently has 19 regular cells, 3 dry cells and 2 special observation cells for prisoners deemed at risk of serious self-harm/suicide. At the time of John's death, there were no special observation cells.
25. The main functions of the SSU include the management of the prisoner Adjudication Process and the housing of prisoners

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serving periods of restriction of association under Prison Rules 32 for their own safety and protection or for reasons related to good order and discipline. Prisoners who are held in the SSU under cellular confinement for good order and discipline following adjudication can be subject to loss of privileges including TV, radio, reading materials and cigarettes and are not allowed association with other prisoners, for up to 14 days. They do have an entitlement to one hour's exercise each day.

26. Normal cells (i.e. not dry cells which have no in-cell sanitation) within the SSU are equipped with a single bed, mattress, pillow and duvet, in-cell sanitation, a plastic seat and wooden bench attached to the wall. The cells on the ground floor have windows that open out to a narrow alley where a partition has been erected to block the view to the exercise yards. The windows of the first floor cells have an opaque plastic film to prevent prisoners identifying other prisoners out in the exercise yards. This is described as being essential, especially in the interests of the security of prisoners who have been placed on Prison Rule 32 for their own protection. The cell windows open at each side but a metal grille at the openings provides security and a deterrent for the passing of unauthorised items. There are no curtains on any cell windows. My investigator was advised that this was because they have been used in the past by prisoners to make ligatures.

27. At the time of John's death, the Prison Service had recognised the need to provide additional facilities and provide more opportunities for time out of cell for prisoners held under Rule 32 in the SSU for their own safety. A construction project was

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underway and has resulted in the following facilities that were not available during the period of John's stay in the SSU.

- A small gymnasium
- A recreation room
- A dedicated visits area
- A visiting library trolley
- 2 observation cells

Revised Management of SSU Procedures

28. In August 2007, the Prison Service issued a set of revised procedures and actions that must be followed in relation to the accommodation, care, discipline and control of prisoners whilst in the SSU. This is described in Section 6, Subsection 28 of this report.

FINDINGS AND CONCLUSIONS

SECTION 1: BACKGROUND INFORMATION

1. Decision to locate John in the SSU

John 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 by the authorities with fresh offences, he was recalled into the custody of the Northern Ireland Prison Service at Maghaberry Prison in February 2007 resulting in the suspension of his Life Licence.

John was deemed to be at risk from other prisoners and was therefore, from 7 February 2007, housed in the Special Supervision Unit (SSU) for his own protection under Prison Rule 32. The SSU is designed and organised to ensure that no prisoner comes into contact with any other prisoner.

On 9 February 2007, when completing a Request Form to be moved to the Republican Wing at Maghaberry John himself noted that *"I am under a death threat from loyalists"*.

On 9 February 2007 also, John's solicitor wrote to Maghaberry Prison saying *"our client is concerned about his personal safety whilst currently detained in the Prison. Please advise us of what steps you are taking to ensure our clients safety"*. The Prison

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Service responded saying “*I can confirm your client is held under Prison Rule 32 and as such will have minimal contact with other inmates*”. The Prison Service also sought advice from the Police Service of Northern Ireland (PSNI) about possible threats to John.

The Prison Service has stated that the decision to place John in the SSU under Rule 32 was based on information provided by the PSNI relating to possible threats to John’s life along with considerations arising from his involvement in the murder of Billy Wright. A security governor advised that a risk assessment on 10 February 2007 concluded that John could be at serious risk of a revenge attack.

The evidence provided by the Prison Service and the PSNI confirms that the PSNI advised the Prison Service on 16 February 2007 that intelligence was held that may indicate a possible Republican threat to John.

Processes followed by the Prison Service in reviewing and extending the restriction of John’s association under Prison Rule 32 were examined as part of this investigation. The Prison Service adhered to the specified procedures and regulations when carrying out the review and extension of Rule 32 – Restriction of Association.

John was housed in the SSU under Prison Rule 32 from 7 February 2007 until the time of his death on 8 June 2007. He occupied a single cell. This was a total of 122 days.

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- 1a. The Prison Service risk assessment in February 2007 concluded that John could be at risk of a revenge attack in connection with his involvement in the murder of Billy Wright.**
- 1b. John said that he was under a death threat from Loyalists.**
- 1c. The Prison Service were informed on 16 February 2007 by the PSNI that intelligence was held that would indicate a possible Republican threat to John.**
- 1d. On the basis of the available information, the Prison Service housed John in the SSU for his own protection.**

2. Requests for transfer to normal location and separated accommodation

On 9 February 2007, John made a request to be moved to Roe House, the Separated Republican Accommodation⁵, in Maghaberry Prison.

The Prison Service had sought guidance from the PSNI in connection with John's safety and received a written response dated 16 February 2007 which said that intelligence was held that may indicate a possible Republican threat to John.

John was interviewed on 20 February 2007 by a governor and acting governor and he signed an Application for Separated Accommodation form. John was interviewed again on 21 February 2007 when he formally withdrew his application for Separation.

It is recorded in the staff report for 21 February 2007 that John went *"to Antrim Road PSNI for police interview. On return withdrew application to Roe House"*.

It is later recorded, but not signed or dated, on a sheet attached to an Application for Separated Accommodation form, that John had *"stated at interview that previous application was withdrawn until he checked with his solicitor regarding his representation to life sentence commissioner and the potential to*

⁵ Separated Accommodation - Two residential Houses within Maghaberry Prison (Bush House and Roe House) used to accommodate Separated Republican and Separated Loyalist prisoners

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be classed as dissident Republican which he states he had broken links with”.

Further advice was sought from the PSNI on 12 March 2007. The PSNI replied on 20 March 2007 stating that no new intelligence had been received since the previous report on 16 February 2007.

On 23 March 2007, John made a request to move from the SSU into the integrated prison population. On his request form he stated *“I wish to be located within the normal prison population. I do not believe I am under threat. Being in the SSU is making me anxious”*. This request was passed to the security governor for a decision. The request was refused on 24 March and it is recorded that *“information available to security suggests that you remain under threat. As such you will remain in the SSU”*.

This decision was, again, based on the information received from the PSNI on 16 February 2007 and also the belief that John could be under considerable threat of attack if located in normal location because of his involvement in the death of Billy Wright.

On 29 March 2007, John submitted another request to be moved to Separated Republican accommodation in Roe House.

On his request form, John stated *“I respectfully ask to be moved to Roe separated landings as I have been refused a move to normal locations as the prison management fear for my safety*

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there. I have no doubts that I will be safe on the separated landings and will be able to receive a better regime there”.

John was interviewed by two governors in connection with this application, on 2 April 2007.

On the same day, a governor in Custody Support completed an assessment of the request and concluded that the *“application does meet the laid down criteria and I therefore recommend his application for separation”.*

The application was refused by a security governor at Prison Service Headquarters on 3 April 2007. The refusal stated that the decision was made *“taking all relevant factors into account”.* At interview the governor explained that his decision was based on the information provided by the PSNI on 16 February 2007 which it was felt required the Prison Service to be cautious. It is recorded that John was informed of the refusal on 4 April.

On 19 April 2007, John appealed against this decision not to place him in Separated Accommodation. The appeal was refused by a senior governor at Prison Service Headquarters on 26 April 2007. The governor recorded his reasons for the refusal saying *“having given this case full consideration including a review of all the information surrounding it, I am refusing this request to be transferred to separated accommodation. I regret that the decision could not have been more favourable”.* John was informed of the decision on 30 April 2007. The decision was also reported to the Good Order Steering Group meeting chaired by the Prison Service Deputy Director of Operations.

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On 4 May 2007, John's solicitors wrote to the Prison Service asking for them to fully outline in writing the reasons for refusing John's application to move to Separated Accommodation. The Prison Service responded on 20 May stating that:

"Paragraph 3.3 of the Revised Compact Information Book states that a prisoner will be admitted to separated conditions in Bush or Roe House only if the Secretary of State is satisfied that:

(e) admitting him to separated conditions would not be likely to prejudice his safety".

This was the part of the criteria that the Prison Service took the view that your client did not meet".

The Prison Service advised the investigation that the Minister was kept apprised of John's position.

Teach na Failte

John's family advised the investigation that the Republican group Teach na Failte had been making representations to the Prison Service, on John's behalf, in relation to his applications to transfer to Separated Accommodation. Teach na Failte were contacted as part of this investigation and advised that they had informed representatives of the Prison Service and the Northern Ireland Office that they were concerned about John's isolation and treatment and that he should be moved. A record of a phone call from the Prison Service to a representative of Teach na Failte dated 16 May 2007 confirms that a call was made to explain that John's application for separated accommodation

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had been refused and that the Teach na Failte representative said he was *“disappointed”, “could not understand”* and *“thought the police were playing games”*.

On 22 May 2007, Teach na Failte wrote a letter *“to whom it may concern”* supporting the move of John and another prisoner to the Republican Wing stating *“we have spoken to the Republican Prisoners and do not foresee any problems arising out of this move”*.

The Prison Service security governor advised that Teach na Failte’s inputs were considered but, in the light of the information provided by the PSNI, it was felt that John could not be moved to separated Republican accommodation.

John’s view of reasons for holding him in the SSU

John’s family said that John did not believe that he was under threat from Republicans and he believed he was being held in the SSU to *“break him”*.

In a telephone call on 31 May 2007 John says to a family member *“I mean I know they are trying to break me. Not a f**king chance. F**k them”*.

On 4 June 2007, he says in a telephone call to a friend *“see what they’re doing with me, see the latest person they done it with was a German prisoner, 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 till he died”*. Later in the conversation

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he talks of an officer saying *"I can see it in your eyes John you're breaking..... I says you'll take a heart attack before I'll break"*.

Following a consultation with a Prison Doctor on 7 June the doctor said that John *"perceives that the authorities are in some way punishing him"*. However, the doctor also said that John *"also perceives himself to be under definite threat from other paramilitaries"*.

Given the comments included in this report from Teach na Failte, it was considered to be appropriate to give PSNI an opportunity to comment on the matters raised.

In a meeting with the PSNI I was briefed on their reasons for advising the Prison Service that there may be a Republican threat against John.

- 2a. John made a number of applications / appeals between 9 February 2007 and 30 April 2007 to be moved out of the SSU into separated or normal integrated prison accommodation.**

- 2b. The Prison Service considered all of these requests but refused on the basis of their own risk assessment and the information provided to them by the PSNI.**

3. SSU – Regime

Before and up to the time of John's death the regime in the SSU at Maghaberry Prison was similar for those prisoners being held under Prison Rule 32 for their own protection and for those being held for good order and discipline. John's family were very concerned about his regime.

Exercise

Prison Rules specify that John was entitled to a one hour exercise period each day in the SSU yard. In order to request exercise, John was required to be up and dressed when breakfast was served. It is recorded, on two dates that John was refused exercise because he was not up and dressed at breakfast time. It is recorded that on 16 occasions that John was offered exercise but refused it, nine of these refusals were during the month of May 2007. No reasons were recorded for his refusal. It is only recorded four times that John took exercise during the month of May 2007. On the other days, it is unclear from prison records whether John exercised or not. The only date that it is recorded that John took exercise during his last week, was 6 June 2007. On 11 May 2007, 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 get back, just like the phone*". It is unclear whether this was putting him off taking exercise.

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At a consultation with a Prison Doctor on 7 June 2007, the doctor noted that John commented that he had "*only just started to exercise again*".

On 22 February 2007, John's solicitor wrote to the Prison Service asking what facilities were being provided for John to exercise. A Governor replied on 8 March 2007 saying that John was allowed "*one hour of association each day which is offered to him in the exercise yard*". He also says in the letter that, following a case conference the previous day, provision has been made for John to be offered one period of gym each week.

It is not evident whether or how often John attended the gym, or was offered the opportunity and refused. However, in a telephone conversation on 29 May 2007 he says that he is depressed and that "*it's the same old s**t they won't even let me go down to the gym*".

- 3a. John was entitled to one hour's exercise a day. It is recorded that John refused exercise on 16 occasions and was refused exercise on 2 occasions. It is unclear on how many other days John took exercise. It is also unclear whether John attended the gym after 7 March 2007, when it was agreed he could do so.**

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PREPS/Access to a Television

The regime for prisoners housed in the SSU under Prison Rule 32 allows for prisoners to have privileges determined by the regime level they are on as part of the PREPS⁶. There are three regime levels under PREPS - Basic, Standard and Enhanced. All prisoners on committal automatically go onto the Standard regime. John entered the SSU on the Standard regime, however, due to his refusal to participate in mandatory drug testing, he was demoted to the Basic regime level.

John refused his first drugs test on 15 March 2007 and it is recorded in the Staff Report for that day that he was "*reduced to Basic*". Staff confirmed at interview that John was initially on Standard regime, pending his drugs test.

John appealed the demotion saying that he would have done the test if he had known that it would affect his PREPS. He was told that, in line with Prison Service Rules, he would require four weeks of good reports in order to move back up to Standard regime. John had signed a PREPS Introduction form on 4 February 2007 saying that he had been provided with a copy of and understood, the PREPS regime.

On 3 May 2007, John again refused a drugs test and it is recorded in the Staff Report that "*he said he is a Republican Prisoner so will not be taking a drug test*".

⁶ PREPS – Progressive Regime and Earned Privileges Scheme

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Evidence from telephone calls available for May and June clearly shows that John was taking drugs throughout that period. It is not clear when John started to take drugs in prison and whether this influenced his refusal to complete drugs tests. This is discussed fully in Sub Section 5, page 69 of this report.

Prisoners on the Standard and Enhanced regime levels are entitled to have a television in their cell. Prisoners on Basic regime are not. However even though John was on Basic regime he did, on occasions, have a TV. This was because, after four weeks of good reports, prisoners are permitted to have a television pending a further drugs test being arranged.

It is unclear how many days during his time in the SSU John had a television but records would suggest that it was around 63. John signed a TV rental agreement on 4 February 2007 and appears to have been on Standard regime until he was demoted on 15 March 2007 when he lost his TV. It is recorded that he got his TV back on 14 April 2007 (four weeks after his last test refusal) and appears to have kept it until 3 May 2007, when he again refused a test. It is recorded in the Staff Report on 13 April 2007 that John had ordered a PlayStation from the tuck shop and complained because no order sheet had been received by the tuck shop.

If John had been located in Separated Republican Accommodation, he would have been entitled to a television on all days. It is recorded on 1 April 2007 that John thought that because he had applied for separated accommodation, he should not be kept on the Basic regime.

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After 3 May 2007, John remained on the Basic regime level and did not have a television, until the time of his death. However, staff in the SSU did provide John with a television on the night of 5 June 2007 as a reward for finding a quantity of drugs in the visits area within the prison when he attended a legal interview on 4 June 2007. One officer said at interview that *“he seemed a bit down so we let him keep the TV for a few days to see if it would lift him a bit”*. John’s family were concerned that John then had his TV and PlayStation taken from him again.

3b. John refused to take drugs tests and because of this, he was kept on the Basic regime level of the PREPS.

3c. During his 122 days in the SSU it is estimated that John had a television on around 63 days. From the 3 May 2007 until his death on 8 June 2007 John appears to have only had a television for 1-2 days. John did not have a television on the other days because of his refusal to take drugs tests.

Shower/Telephone

John was entitled to use the shower and telephone each day. Staff Reports indicate that John regularly took a shower and used the telephone. John’s family had raised some concerns around John being refused access to the telephone. On a few occasions it is recorded that John did not make any morning requests, which would normally include a request to use the telephone. It is twice recorded that John was refused requests

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because he was not up and dressed at breakfast time. On 18 April 2007 it is recorded on the Staff Report that the phone was out of order. No other evidence was seen that would suggest that John had difficulty using the phone at any other time. From 6 May 2007 to 8 June 2007 when recordings of calls are available, it appears to be the case that John used the phone on all but three days. On 5 June 2007, John was late using the phone and did mention in a call that staff *“forgot about me for the phone”*.

3d. John regularly used the shower and telephone in the SSU.

Prison Shop

On a weekly basis, John could order purchases of items such as newspapers, tobacco and sweets from the prison shop. John also purchased a radio from the prison shop and staff said that one officer lent John a radio whilst he was waiting for the delivery of his purchase.

3e. John could purchase newspapers, sweets, cigarettes and other goods on a weekly basis.

Use of Guitar

It is recorded in the Staff Reports on 13 March 2007 and 14 March 2007 that John asked if he could have a guitar in his cell. He was told on 25 May 2007 that, *“as a basic prisoner, he wouldn’t be getting his guitar in but could use one from the education department”*.

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Visits

John's family were concerned that John may have been "messed around" in connection with his visits. John looked forward very much to his visits. John was entitled, in line with Prison Service policy, to one visit every seven days and also attended legal meetings or video links. He actually had seven visits in February 2007, five in March, four in April and five in May. Over his whole period in the SSU John also attended 13 legal visits. Visits from family/friends normally last around one hour. On every occasion staff allowed John more than one hour and, on one occasion, allowed him over 2 hours. John asked for, and was permitted to have, an extra visitor, on the occasion of his birthday.

3f. John had visits from family/friends at least every week.

Time in Cell/Daily Routine

An examination of John's daily staff reports show that on most of the days when he did not have visits he, in common with other prisoners in the SSU, spent more than 22 or 23 hours (depending on whether he exercised) in each 24 hour period, in his cell.

The investigation also established that the evening meal in SSU is served at 15.30 pm and prisoners are then confined to cell until 08.15 am the next morning when breakfast is served. Meals are delivered to the prisoner in cell by a prison officer and usually passed through the chained door.

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At interview, an officer explained the normal daily routine in the SSU as follows:

“Prisoners are offered their breakfast usually at 08.15. Requests are taken for phone, yard and showering. They are given 10-15 minutes for their breakfast and then slopping out starts⁷. John Kenneway, in general, was co-operative and he was no problem whatsoever, he always slopped out and showered. Slopping out and showering takes place on an individual basis up until about lunch time from 11.30-12.00 when everyone is back in their cells. Anyone who has requested the phone can use it in the afternoon. After 14.00 we let anyone use the phone and exercise yard on an individual basis if they have requested it. Tea is normally served (evening meal) about 15.30-15.45. There is medication after that and they are locked down from 16.00 onwards. They are on their own from 16.00 through to 08.00 the following morning.”

3g. On days when he did not have visits, John was, in common with other prisoners in the SSU, in his cell for more than 22 or 23 hours each day.

3h. Prisoners held in the SSU are served dinner at 15.30 and then confined to cell from 16.00 until 08.15 am the next day when breakfast is delivered.

⁷ Cells are fitted with in-cell sanitation so this term is used incorrectly. The officer is referring to in-cell cleaning.

4. Staff Treatment of John

It is evident that John had very limited contact with staff. A referral to a psychiatrist by the prison doctor on 7 June 2007, the day before John died, records "*he appears to be affected by his environment in that he only sees any officer who delivers meals to him*".

John's family expressed concerns about John's treatment by staff. This included concerns that an officer(s) may have been spitting in John's water, that he may have been physically abused and that he was not allowed to shower/change clothes during his first five weeks in prison.

Staff Records

Most of the staff daily and weekly reports completed in connection with John's time in the SSU describe John as a prisoner who caused "*no problems*".

The only references to any problems are:

- 4 March 2007 (Daily Report) John was not dressed at unlock and lost his temper because he lost his right to requests (for shower, exercise, telephone);
- 5 March 2007 (Weekly Report) A note says "*can be disruptive if he thinks things are not going his way*".

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- 2 April 2007: John is unhappy because he believes that as he has applied for separated accommodation, he should not be on a basic regime. It is recorded that he *“still has a tendency to question staff forcefully when things do not go his way”*.
- 5 April 2007(Daily Report) A note says *“his behaviour remains volatile. He asks questions then erupts when he does not get the desired response”*.
- 7 April 2007 (Weekly Report) A note says *“prisoner remains quiet but does show temper on occasions”*.
- 20 April 2007 (Daily Report) A note says *“was at legal visits to receive instructions from PSNI. Was abusive and agitated but pulled up short of being restrained. Also had headaches”*.

John is described as *“quiet”* or as having a *“quiet day”* and causing *“no problems”* dozens of time in the reports. No references are made to any incidents involving staff. A few positive comments are also recorded including *“went on a visit pm and was happy and talkative on return”*, *“in good form, polite to staff”*. It is recorded on 9 May 2007 that John was *“granted an extra adult on Saturday visit to celebrate his birthday, good form”*.

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From 2 June 2007, notes suggest that staff were sensitive to changes in John's behaviour and demeanour and responsive to John. The notes for the days before John's death are as follows:

2.6.07 – *“spent most of the day in bed. Said he had not slept well last night, we asked the medic to have talk to him as he was acting out of character, said he was fine”.*

3.6.07 – *“spent today in bed again, requested the M.O. Still ok according to the medic”.*

5.6.07. – *“Kenneway is not well, he has requested the doctor twice, still not seen one. Used shower and phone, given T.V for one night as reward for finding 250 pills in visits area”.*

6.6.07 – *“Prisoner is being more like himself today. Spent the morning in the videolink, went to yard pm and used the phone. Was interviewed by Governor this afternoon”.*

7.6.07 – *“Still not well, seen by doctor pm, used phone, otherwise ok”.*

Telephone Calls

John makes some references to staff during the 53 calls listened to. These calls cover the period 6 May 2007 to 8 June 2007.

John's view of his treatment by staff appears mixed. He says that some of the *“warders are alright”* and *“acknowledge”* and

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“talk to” him. Others he says are *“dickheads”* and *“slam the door”*. No reference is made to physical abuse by staff.

On two separate dates, John mentions that an officer he calls *“the scumbag”* is on duty. In one of these calls, a family member prompts his response by asking if *“the asshole is on”*, suggesting that there may have been earlier conversations about a particular officer. John does not provide any information about his reasons for referring to the officer in this way.

In a further call, John talks about *“a new crew”* being on and says that they *“don’t seem too bad”* but that *“management are trying to get up my hole big time”*.

In a call on 4 June 2007 John talks about an officer *saying “I can see it in your eyes John, you’re breaking”*.

Staff Interviews

At interview, staff generally made statements that suggested that they had a reasonable or good relationship with John. This was clearly within the parameters of very limited contact with staff and some officers did appear to talk to John more than others.

One officer said *“On occasions he would have interacted and joked with staff. John had a good relationship with staff. John never caused any problems and on occasions staff would have operated a degree of latitude in the operation of the regime. John was grateful of this and would have thanked staff. An example*

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of this would be when John was given a TV while not entitled to one and he was also given the lend of a SSU radio while his own was being ordered”.

A second officer said “I had a reasonable relationship with John Kenneway and he was quite respectful to me. We open the cell door at 8am each morning. John was usually up and dressed and quite chirpy”.

Speaking about John’s last week he said: “On Tuesday John was given a TV as a reward for 24 hours. We sensed he was a bit down so we let him keep the TV for a few days to see if it would lift him a bit. Another officer and I advised him to walk about the cell, read a book, watch TV, don’t get into bed to try to get his sleep pattern sorted out. On Thursday we took him over to the hospital wing to see a doctor. He actually offered us a sweet for looking after him”.

A different officer said: “I had very little in the way of conversation with prisoner Kenneway during his time in the SSU. The only time he would enter into any sort of conversation with prison staff was when he wanted something. In the last couple of months I can only recall him really speaking to me on two occasions. Once when he wanted his glasses left into the prison and on another occasion when some of his tobacco went missing and I got that sorted out for him”.

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Prisoner Interviews

A prisoner who worked as an orderly in the SSU commented at interview that John “*always had a good relationship with the prison officers*”.

John’s First Weeks in Prison

John’s family expressed concerns that staff did not allow John to wash or change his clothes for five weeks after arriving in prison in February 2007.

John was located in the SSU on the evening of 7 February 2007 after spending nearly five days on the committal wing in Roe House. In the two weeks that followed, it is not recorded whether John took a shower on 7, 9, 11, 14, 18, 19 and 21 February. It is recorded that John was offered and refused a shower on 8, 10, 15 and 17 February. It is recorded that John took a shower on 12, 13, 16, 20 and 22 February.

It is recorded on 12 February 2007 that John was seen by two priests and complained to them about his clothing not being brought over. The note says that “*the priests went to reception and brought his clothing over*”. It would appear that John did not receive his clothes until he had been in the SSU for five days. It is unclear why a visiting priest, and not staff, should have had to resolve this difficulty.

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Lost Tobacco

On 13 April 2007, John reported that 2oz of his tobacco had been stolen from his property placed outside his cell door. It is recorded that the incident was investigated and a decision taken to replace the tobacco. The notes by a Senior Officer record *“there is an ongoing problem with Night Guard staff and items going missing. Currently I can not prove they are involved but I recommend these items be replaced”*.

Full Body Searches

John’s family were concerned about the number of times full body searches were carried out on John. They believed it was excessive and a way of mistreating him.

A prison security officer advised that normal practice in the SSU is to carry out a full body search on prisoners whenever they leave the SSU, for example, to attend a visit and when they return back to the SSU. He also advised that it is normal practice to carry out a rub down search, similar to the searches routinely carried out at airports, when a prisoner leaves and returns to their cell for the purpose of exercising or using the phone.

Between 3 February 2007 and 4 June 2007 it is recorded on the “Searches Carried Out” sheets for John that full body searches were carried out 27 times. Eight searches were in February, 5 in March, 7 in April, 5 in May and 1 in June. It is possible to link all but 4 of these searches to specific activities such as

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family or legal visits. It is possible that the remaining searches may have been carried out in connection with activities not recorded.

Given that it is recorded that John attended 34 family and legal visits over this period and left the SSU also to attend the doctor and to attend a police interview, it would seem that either searches were not carried out on all occasions or searches that were carried out were not recorded.

It is also recorded that John received 2 routine cell searches.

No evidence was found that John was searched other than in accordance with normal arrangements. In a phone call on 11 May 2007 when John is asked by a friend if he gets out to the yard, he does say that the *“yard is small and that you have to be searched when you go out and searched when you come back in, just like the phone”*. It appears that he may view the searches as a reason for not visiting the yard.

Hostage Taking Incident

John's family were concerned that there was a prison officer working in the SSU who was involved in an incident in April 1997 when John and another prisoner took a prison officer hostage at Maghaberry Prison. During the incident a gun was pointed at the officer. The investigation confirmed that an officer working in the SSU had been caught up in the hostage taking incident and did have a gun pointed at him.

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At interview the officer said that he never discussed the incident with John during his time in the SSU and that it “*never affected me carrying out my role professionally in my care towards John Kenneway*”.

Interview with John’s Solicitor

The solicitor who regularly met with John during his period in the prison recalled that John would sometimes complain about staff and that he recalled him referring to one member of staff as a “*scumbag*”. He said that John never asked him to write to the prison in connection with staff treatment.

PREPS Regime

There is evidence that some officers showed flexibility in providing John with a television whilst he awaited a drugs test and in the application of prison rules for family visits. Officers also provided the good reports necessary for the provision of a TV to be considered and lent John a radio.

- 4a. John’s family were concerned that he was treated badly by staff.**
- 4b. Phone calls available from 6 May 2007 to 8 June 2007 suggest that John’s view of staff treatment of him is mixed.**
- 4c. There is evidence that some officers appeared to treat John well, showed some flexibility in the application of prison rules and were responsive when John felt unwell.**

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- 4d. There is evidence that, on occasions, some staff were not helpful to John and he was unhappy with the way he was treated by officers. He appeared to particularly dislike one officer.**

5. John's Access to/and Use of Drugs

Background

At the time of his committal, it is recorded on the Governors Interview Form that John said that he last used drugs in December 2006. The Type of Drug Used was noted as "*cannabis*" and the Method of Taking was noted as "*smoked*".

There are no notes in the Staff Reports suggesting, at any time, that staff were concerned that John was accessing or using drugs.

John refused drugs tests on 15 March 2007 and 3 May 2007. When he was reduced in regime following his refusal on 15 March, John appealed the decision saying that he would have taken the test if he had known that refusing to do so would affect his regime. It is recorded in the Staff Reports that when he refused the test on 3 May 2007 "*he said he is a Republican Prisoner so will not be taking a drug test*".

The Autopsy Forensic Science Report indicated that John had cannabis and non-prescribed diazepam in his blood at the time of his death.

Evidence from Phone Calls

Recordings of telephone calls made by John are available for the period 6 May 2007 to 8 June 2007. It would appear, from the calls, that John was obtaining drugs from visitors and other

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prisoners throughout this period. References to drugs are made on 18 of the 27 days for which calls are available. The drugs are referred to as “*smokes*”, “*diazes*” and “*canaries*”, (the word he appears to use as a code for Cannabis). John refers, a number of times, to sleeping during the day because he has taken drugs.

The following are telephone references to drugs in the days before John died:

Sunday 3 June 2007

- Someone John calls tells him he “*sounds a lot better today.*” He then asks what he sounded like the previous day and she replies “*doped*”.
- In another call John says that he was “*out of my head*” for two days. He says that he woke up and found breakfast, lunch, dinner, everything at his door. He says that the reason was that “*we had a party sure I was f**ked out of my head here for two days*”.
- In another conversation John says that he is “*fing stoned*” and hasn’t got out of bed yet (14.48). He explains that they had a party for one of the lads getting out this morning – “*been at it since yesterday*”.
- Someone says “*stoned to the eyeballs are ya?*” John replies “*stoned to fing eyeballs ... still walloped so I am.*”

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*"I'm only after putting a splif out before those bas****s came to the door".*

Monday 4 June 2007

- John talks to someone about *"getting me them there canaries"*. She tells him *"there's no problem"*.
- John tells someone else that he has found a *"massive bag of tablets"* but says that he told staff because *"I was the last on in it (the visits box), they had to be f'ing found and I'm the last one in it, who would have got the blame of it"*.

Tuesday 5 June 2007

- John tells someone else about the bag of tablets that he found in the visitors area on 4 June 2007 and handed into staff. He says that he thinks he was *"being set up"* and handed them in. He calls the tablets *"diazis"*. However, he goes on to say that *"I got as many between my cheeks as possible (laughs) before I called the screw"*. He then says *"do you know where I'm going back to now? Bed, I haven't been awake since Friday (laughs)"*.

The Prison Service has confirmed that 300 unidentified blue tablets were found by John in the Visits area on 4 June 2007. No analysis of the tablets was undertaken.

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Wednesday 6 June 2007

John complains that he does not know what is wrong with his nose “*you feel like an alcoholic or something, its going all f'ing red*”. The person he is speaking to confirms that another person has “*the canaries*”.

John says “*I'm on a buzz here now if you can get that sorted for me*”. (John has a visit arranged for Friday 8 June 2007)

John also says that he took a walk in the yard and “*found two big bars of chocolate and everything*”. (It is not clear whether or not this really means chocolate, which he can purchase from the tuck shop.) John adds “*I swear to f**k this is unbelievable*”.

Clinical Review/Toxicology Report

Information relating to the taking of drugs by John was provided to the experts carrying out clinical reviews as part of this investigation.

An expert toxicologist was also asked to interpret the findings of the Autopsy Forensic Science Report in the light of a) John's prescribed medication and b) the available information about John's use of illicit and non-prescribed drugs.

The findings of the expert reviews are presented in Section 5 of this Report.

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- 5a. Throughout the month of May 2007 John appears to have been accessing illicit and non-prescribed drugs from visitors and other prisoners.**

- 5b. The Autopsy Forensic Science report indicated that John had non-prescribed drugs in his blood at the time of his death.**

- 5c. The Prison Service appeared to be unaware that John was accessing and taking drugs.**

6. John's Well Being in the SSU

Staff Reports

Staff reports do not indicate any concerns about John's well being whilst in the SSU until 2 June 2007 when it was noted that he was "*acting out of character*" and spending a lot of time in bed. Staff asked a nurse to see John.

John's family have indicated that they were very concerned about the effect that John's treatment and regime in the SSU was having on him.

Healthcare Records

There is evidence on John's healthcare records that on 26 February 2007 and 2 April 2007 John was having difficulty sleeping. On 20 April 2007, he is reported as complaining of dizzy symptoms and a tension headache which "*comes and goes*" over the previous two weeks and of feeling as though the room is closing in on him and he is having a panic attack. He also referred to domestic difficulties and was reported as not sleeping. John was given medication to help him sleep. No other action was taken in response to these symptoms.

John had a consultation with a prison doctor on 7 June 2007 who made a referral to a Consultant Psychiatrist. John mentioned flash backs and having had thoughts of self harm to the doctor. The doctor noted that John "*appears to be very*

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affected by his environment in that he only sees any officer who delivers meals to him”.

Probation Assessment

At the time of his committal, John was seen by a Probation Officer who noted no concerns. However when the Probation Officer met with John on 25 April 2007 she said at interview that he had difficulty sleeping and was having flashbacks about previous experiences. She said, however, that John's main issue was coping with being separated from his two young children.

John told the Probation Officer that he had made a request to see a Psychiatrist and the Probation Officer agreed to follow this up, which she did by contacting healthcare. It is unclear when or if John made this request. The Probation Officer also sent a memorandum to the Psychology Department at Maghaberry Prison on 25 April 2007 asking for John to be assessed for suitability for counselling.

John was not referred to and did not see a psychiatrist between 25 April 2007 and 7 June 2007. A Prison Doctor did, as stated earlier, make a referral to a psychiatrist following a consultation on 7 June 2007.

John was, also, not assessed for counselling. A forensic psychologist at Maghaberry explained that she and a colleague were providing a limited counselling service for referrals such as the one made by the Probation Officer. She confirmed that

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John was on the list but died before they had a chance to speak to him.

- 6a. John reported in February and April 2007 that he had difficulty sleeping.**
- 6b. In April 2007 John mentioned to a nurse that he felt as though he was having a panic attack. He mentioned to a probation officer that he was having flashbacks about previous experiences and was finding it difficult coping with not seeing his young children.**
- 6c. The probation officer made a referral to Psychology requesting an assessment of John's suitability for counselling. This assessment had not taken place when John died.**
- 6d. The probation officer contacted healthcare in connection with a statement by John that he had asked to be referred to a psychiatrist. No referral was made to a psychiatrist until 7 June 2007 when John saw a prison doctor.**

Telephone Calls 6 May – 8 June 2007

In many of John's phone calls he seems in good humour as he chats to his family and friends. His family said that they felt that he would try to be upbeat for their sakes. John's solicitor also confirmed that he was generally in good form at their regular meetings. However John did, in telephone calls, refer to his feelings of boredom and describe how difficult he found his

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time in the SSU. His sense of isolation was particularly apparent in late May and early June 2007.

The following is a summary of references to the adverse impact of his regime and conditions, made in phone calls 6 May – 8 June 2007.

- 8 May - 14.40: Says his head is *"f**ked"*.
- 10 May - 15.07: Talks about being in for 99 days and it being hell for him. (He often refers to the number of days he has been in the SSU.)
- 11 May - 14.15: Talks about being in for 100 days and it *"driving him nuts"*. His friend says he sounds tired or down and he says he has no interest, he doesn't see anyone or anything. He can *"only see the shape of the guy next door"*. He says that he is going to get his daughter to go on the Nolan show to complain about the conditions they are keeping him in. He states it's *"driving him bonkers"* and says they are *"trying to break him"*.
- 19 May - 15.03: Says that someone is blocking him and another prisoner from going to Roe House. (Republican wing.)
- 20 May - 15.12: Says that they are talking about building something for visits at the back of the SSU
-

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which scares the life out of him, because it'll mean he won't move at all. He asks a family member to call his solicitor and says he has to have "*some f'ing reason for getting out of this place*".

23 May - 14.14: Says a governor met him yesterday and knocked him back for compassionate parole (to attend his grandchild's christening). He is annoyed because he says he has been turned down before he put in his request. He mentions also sorting out his move to the separated wing.

23 May - 14.21: Asked by caller if he's cheered up any and he says he has.

27 May - 15.08: Talks about being bored.

29 May - 14.31: Says that his life is crashing down on top of him and that this place is driving him nuts. Is also annoyed that a visit hasn't been arranged and is annoyed that his little daughter's birthday present hasn't been sorted out.

29 May - 14.37: When asked how he is, says he isn't too bad but depressed. He says "*it's the same old shit they won't even let me go down to the gym*".

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30 May - 14.14: John mentions that he's really tired and that he's only just up.

His friend comments that he's not sounding great but John says that his chest is sore.

31 May - 14.49: John says he's been in there 120 days and that they're trying to break him but he says "*they can try*". He repeats this later in the conversation.

John says he is "gonna head back to the cell then put his feet up, put the radio on and watch it (laughs) I can't even see out the window never mind put me hand out of it".

4 June - 15.00: John says "*See what they're doing with me, see the last person they done it with was a German prisoner, 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 till he died*".

Later John says about a member of staff "*That's what he said to me last week, he says I can see it in your eyes John you're breaking ... I says you'll take a heart attack before I'll break*". (Laughs)

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8 June - 14.42, 14.49, 14.56: John is upset about a missed visit and makes three phone calls during which there is evidence he is feeling very low. Comments include: *"This is driving me f'ing crazy. I see f'ing nobody – I'm in isolation".*
"I'm at the lowest part of my life, and I mean that, I have no-one. Do you understand now what I mean to you when I say to you I have nobody." *"I'm stuck in f'ing hell".*

6e. In telephone calls to his family during the month of May 2007, John sounded in good spirits for much of the time. His solicitor confirmed that he was generally in good spirits at their meetings.

6f. Telephone calls throughout May and June also provide evidence of John's feelings of loneliness and isolation as a result of his regime and conditions in the SSU.

Teach na Failte Statement

After John's death a representative of Teach Na Failte sent a statement to the Prisoner Ombudsman's Office saying that he had, at a funeral, become *"aware of the conditions endured by John. He was on Rule 32 in the notorious SSU and the screws were exacting a vengeance on him... This was having a detrimental effect on his mental well-being, isolated and alone"*.

The representative recorded that *"I immediately set up contacting officials from the NIO. I impressed upon them the serious nature*

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of John's fragile mental condition and pressed for his transfer to the republican wing".

As part of this investigation I spoke with the representative of Teach na Failte who submitted the statement. He explained that he had discussed concerns about John's isolation with a representative of the Prison Service and one from the NIO. He said that he had had a number of conversations with one of them in particular, who indicated that he had passed the information to the Prison Service.

Teach na Failte said that they were told that John did not meet the criteria for a move to the Republican wing at Maghaberry and that PSNI had blocked his move.

The two representatives confirmed contacts with Teach na Failte during the period that John was in the SSU. It appeared to be the case that Teach na Failte spoke to the NIO representative who passed to the Prison Service the information that Teach na Failte were anxious for John to be moved out of the SSU and into separated accommodation. It was the Prison Service representative who then rang Teach na Failte to inform them that John's application to move had been refused. The Prison Service representative provided a record of a phone call to Teach na Failte on 16 May 2007, explaining that John's request to move to separated accommodation was being turned down.

It was also recorded that, having been given this information, Teach na Failte were "*disappointed*", "*could not understand*" the

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decision and wanted to know “*what the long term plan for John was*”.

6g. Teach na Failte raised concerns about John’s isolation with the NIO and the Prison Service and asked for him to be moved to the Republican Wing.

6h. Teach na Failte were advised on 16 May 2007 that it was not possible to move John to the Republican Separated accommodation because of fears for his safety.

7. John's Younger Children

After the breakup of his first 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 as a result was not allowed to see his children.

On 25 April 2007, John was seen by a Probation Officer in prison who noted that John's main issue was coping with separation from his younger children. She made a request to Psychology to assess John's suitability for counselling.

In his telephone calls there is evidence that John is very attached to the children.

On 7 May 2007, he talks about getting presents for them and throughout the month makes several references to trying to get a photo of them.

On 24 May 2007, he says he is "*missing the kids something like shocking*".

On 29 May 2007, he says that he "*broke his heart that he couldn't see her (his daughter) in her first play*". He wants to send flowers to school for her birthday.

Wednesday 6 June 2007 was the date of John's daughter's 4th birthday. On 30 May 2007, John asks a family member to try and get a photo of his little girl from one of his old phones. He

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says he has to get a photo done ready for the birthday. He talks again about sending flowers to school and asks if *“you can do that for a four year old”*. In another call he is told by the caller that she saw his little girl out playing. John says that it is *“breaking his heart”* not to see them.

On 4, 5 and 6 June 2007, John discusses the fact that he is getting a family member to take birthday presents, including a bike, to his young daughter and to pretend that the gifts are from the rest of the family, not from him. He asks the family member to buy *“a birthday card for a daughter and put £50 in it”*, for his daughter.

On 5 June 2007, John also tries to sort out the flowers to be sent to his daughter’s nursery school on the morning of 6 June. However on 6 June, the family member explains that she could not send the flowers because she found out that the school would ring the child’s parents before giving them to her.

A number of times John asks *“give the kids a kiss for me and tell them I miss them”*. He asks the family member to *“whisper in her (his daughter’s) ear your daddy really loves ya and misses ya,”* when she goes over with the gifts.

In a call on the afternoon of 8 June 2007, the day that he died John says *“the only two things that I had, 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”*.

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- 7a. As a result of an incident prior to entering prison John was not allowed to see his two younger children in prison.**

- 7b. John was very attached to his two young children and was very upset about not being able to see them.**

8. Application for Compassionate Leave

On 31 May 2007 John was refused permission to attend the christening of a grandchild. The Prison Service refused this request stating that *“your request falls outside the criteria of the compassionate temporary release scheme, it has been considered on its merits against the general provision of Rule 27(1) of the Prison and Young Offenders Centres Rules (Northern Ireland) 1995 and the specific provisions of Rule 27(2)”*. Detailed reasons were provided in a letter.

John’s family said that John did not expect to be allowed to attend the Christening. However in phone calls on 3 and 4 June there is evidence that John still thought that he may get bail for the Christening. John attended a court video link in support of an application for compassionate bail on 6 June. This was refused. It was, in fact, the case that as a recalled Life Sentence Prisoner, the court would not have had the power to grant bail. This would have been a matter for the Secretary of State and the Prison Service had already issued a refusal.

John does appear to be accepting of the outcome and, in a telephone conversation on 6 June 2007, jokingly tells a family member that he has *“got the bail”* before admitting that he hasn’t.

8a. On 31 May 2007 John was refused compassionate leave to attend the christening of a grandchild.

9. John's Healthcare in Prison

Background

In his Clinical Review Report, Professor Roy McClelland summarises John's healthcare background as follows:

Mr Kenneway, from a psychological perspective, was a rather vulnerable man with a poor self-image. From time to time he manifested symptoms of psychological difficulty and distress. There are also several documented instances of deliberate self-harm. On at least one occasion within the prison system, when describing low mood, he was placed on special observation. He used prison health services frequently throughout his periods in prison and seemed concerned about his physical well-being".

Committal in February 2007

The committal assessment in February 2007 notes that John has a history of depression, has had a psychiatric referral with complaints of poor sleep, and has been prescribed an antidepressant (Efexor).

Healthcare Records

26 February 2007: A record states that John had difficulty sleeping, had been on Efexor and that a script had been ordered.

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2 April 2007: It was again noted that John was having sleeping difficulties and night sedation was prescribed.

20 April 2007: A nurse records that John, complained of dizzy symptoms and a tension headache and that he felt himself to be having a panic attack. John also referred to domestic difficulties and was complaining of not sleeping well. The nurse records that she spoke with the prison doctor regarding ear wax removal and also that a prescription of Phenergan 25 mg for seven nights was initiated. Although Phenergan is primarily an anti-histamine it is also prescribed for mild insomnia.

John was seen on three subsequent occasions during May 2007 by staff nurses, exclusively related to ear symptoms. No mention in the record is made of further mental health symptoms or screening for such symptoms. Also in May 2007, it was recommended that John be seen by the prison doctor because of his ear symptoms.

Staff Reports

It is recorded in the staff reports that a nurse saw John on 29 May, 2 June and 3 June 2007 when staff were concerned about him. There is no healthcare record of these three referrals. Healthcare staff advised that when visiting prisoners on landings, their normal practice was to make a record only if an intervention was required or implemented.

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The staff report for 5 June 2007 records that John is “*not well*” and that he had requested to see the doctor twice. There is no evidence to suggest that he saw a doctor.

Consultation with Prison Doctor on 7 June 2007

On Thursday 7 June 2007, John had a consultation with a prison doctor. John initially presented to the prison doctor because he felt he may have a chest infection. Later in the consultation John complained about being troubled by flashbacks from activities that he was involved with in his past. He also stated that he had had thoughts of self-harm and ending his life but he was determined to stay strong on account of his children.

The prison doctor reported that John’s main purpose for attending him was because he thought he might have a chest infection. He stated that it was only when he asked John at the end of the consultation “*how are things?*” that John spoke about flashbacks and thoughts of self-harm.

The prison doctor also said that it was his opinion that the flashbacks and thoughts of self-harm were not current and at no time did he consider that John’s demeanour or behaviour indicated the need to initiate a PAR 1. The doctor did not access John’s medical records.

As a result of the consultation, the prison doctor made a referral for John to attend a Consultant Psychiatrist consultation. He

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stated that this was initiated because of a concern that John might be suffering from Post Traumatic Stress Disorder.

Prescribed Medication

Examination of John's medicine records shows that John was prescribed:

- Venlafaxine XL 75mg twice a day. This was started on 5 February 2007 and this continued up to the time of his death. Venlafaxine is an anti-depressant medication.
- Arthrotec 75mg twice a day. This was commenced on 26 February 2007 and continued up to the time of his death. This is a non-steroidal anti-inflammatory drug.
- Diazepam; he received this at a dose of five days at 5mg and five days at 2mg, between the 5 and 14 of February 2007 ie. none was being prescribed at or around the time of his death.
- Phenergan; he received this on 16 February 2007 for seven nights and on 20 April 2007 for seven nights. This is a sedative anti-histamine. This was given to help him sleep.
- Zopiclone; on 12 April 2007 he received 7.5mg of this for three nights. This is a sleeping tablet.

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The only prescribed medications that John was taking at the time of his death were, therefore, Venlafaxine and Arthrotec.

Clinical Reviews

An assessment of John's healthcare including the consultation with the prison doctor on 7 June 2007 were considered as part of the expert clinical reviews. Both clinical reviewers were provided with copies of all records, statements and correspondence. In May 2009, the clinical reviewers were provided with additional information not made available to them at the time of their commission briefing and asked to amend their reports to take account of the new information. They were, in particular, provided with full details of the content of John's telephone calls. This included new information about John accessing and taking non-prescribed, illicit drugs. The reports are attached as Appendices to this report. A summary of the Clinical Reviews and the prison doctor's response to them are included in Section 5.

SECTION 2: EVENTS 31 MAY TO 7 JUNE 2007

(Presented Chronologically)

The section that follows presents chronologically information discussed earlier, as it relates to the period 31 May – 7 June 2007, in order to show the sequence of events in the nine days leading up to John's death.

10. Chronology 31 May – 7 June 2007

Thursday 31 May 2007

- John received notification that he was being refused permission to attend the Christening of his grandchild.
- Staff reports show that John showered and used the phone.
- It is recorded on the Maghaberry Prisoner Visits record that John was visited by a close friend and his two adult children on 31 May 2007. He also saw his grandson. The visit took place from 11.05 to 12.39 (1hr 34mins).
- John made one phone call on 31 May 2007 and appeared in good form. During the call he says:
 - That his grandson is gorgeous and he can't get over him.

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- That the two lads in the SSU “*I was yarning away with*” are to leave the SSU and go back to the houses. John says this is “*just to get at me like. They were glad to see the boys going*”.
- Says he’s been in there 120 days and that they’re trying to break him but he says “*they can try*”. Later he says “*they are trying to break me. Not a f**king chance*”.
- Discusses getting presents to his younger children and chats about his grandchildren.

Friday 1 June 2007

- Staff reports state “*as yesterday, no problems from this prisoner*”. Records show that John attempted to make one phone call but was unsuccessful. (This is likely to mean that the person called did not answer)

Saturday 2 June 2007

- Staff reports state “*spent most of the day in bed, said he had not slept well last night, we asked the medic to have a talk with him as he was acting out of character. Said he was fine*”.
- There are no healthcare notes for the nurse’s visit on 2 June 2007.

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- Asked about the above report at interview a prison officer said that John's "*temperament changed to a state where you had to drag a conversation out of him. The staff asked a medic to have a look at him and assess him due to his unusual demeanour/withdrawnness*".
- A second officer said "*a few days prior to his death John Kenneway did complain to staff about not getting sleep and that he wasn't feeling great. This was not usual form for John. He was normally a prisoner who never complained and got on with his daily routine. He was always up and dressed before we came to his door with breakfast*".
- John made one short phone call.

Sunday 3 June 2007

- Staff reports say that John "*spent today in bed again, requested the medical officer. Still ok according to the medic*".
- There are no healthcare notes for the visit of the nurse on 3 June 2007.
- John made three telephone calls. During the calls he:
 - Is told by someone he "*sounds a lot better today*". He then asks what he sounded like the previous day and she replies "*doped*".

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- Says that he was “*out of my head*” for two days. He says that he woke up and found breakfast, lunch, dinner, everything at his door. He says that the reason was that “*we had a party sure I was f**ked out of my head here for two days*”.
- Says he is “*fing stoned*” and hasn’t got out of bed yet (2.48pm). He explains that they had a party for one of the lads getting out this morning – “*been at it since yesterday*”.
- The caller says “*stoned to the eyeballs are ya?*” John replies “*stoned to fing eyeballs ... still walloped so I am.*” “*I’m only after pulling a splif out before those bastards came to the door*”.
- Says that following the move of the two other prisoners, “*that’s me f**ked now so it is. They moved my big mate away from me*”.
- He also says “*I’m by myself again*” but explains that the person who appears to provide cannabis for him has told him that if he ever needs anything “*just to give her a ring*” and “*I’ll always get a wee bit extra*”.

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Monday 4 June 2007

- There is no entry on the staff reports for 4 June.
- The Prisoner Visits Log shows that John attended a legal visit. This is recorded as taking place at 14.10-15.07pm but this time appears to be incorrect because John is on the phone at this time.
- John made three phone calls on 4 June 2007. During the calls he:
 - Says (at 14.21) that he is “*hoping to get a legal visit today*”. He appears to still think there is a chance he may get out for his grandchild’s Christening.
 - Talks about the arrangements for getting presents to his daughter for her 4th birthday on 6 June 2007.
 - Says in a call at 15.05 that he has seen his solicitor and has seen or received a copy of a letter from Teach na Failte. He says that “*the reals and contos say that I’m under no threat by anyone and I should be moved straight to the Republican Wings*”. Later in the conversation, John says the letter “*is a joint statement from three organisations*” and “*they reckon I’ll be moved within the next week or so*”.
 - Says “*see what they’re doing with me, see the last person they done it with was a German prisoner, one*

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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".

- *The friend spoken to comments that "isolation, that would do your f'ing box away" and says "they are trying to break ya". John replies "that's what he said to me last week, he says I can see it in your eyes John you're breaking and you know what I did I looked at him so I did, I looked at him and says you'll take a heart attack before I'll break".*
- *John then rings a family member to share his "good news" saying "I should be getting moved in the next couple of days" "Get a bit of fresh air about me". He also talks again about his "two mates" being "moved away from me".*
- *John also explains that he has found a "big bag, a massive bag of tablets" in the visits room and has told Prison Officers because he was the last one in the visits room and they "had to be f'ing found and I'm the last one in it, who would have got the blame of it".*

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Tuesday 5 June 2007

- The staff reports for 5 June 2007 record that “*Kenneway is not well; he has requested the doctor twice. Still not seen one. Used shower and phone. Given TV for one night as a reward for finding 250 pills in visits area*”.

- It is unclear whether John saw a nurse or doctor and there is no entry in the medical records.

- John made one phone call on 5 June 2007. During the call he is upbeat and he:
 - Asks the person called if they have heard the “*good news*” and says he is “*waiting on word*” of when he will move. He mentions that he has been talking to a governor.

 - Is looking forward to his visit on Friday 8 June 2007 at 10.00.

 - Explains that he found the tablets, “*diazis*”, in the Visits Room and says that he thinks “*they were trying to set him up*”. He says that “*things are looking a wee bit brighter anyway*”. He explains later in the conversation that he got “*as many (of the tablets) between my cheeks as possible and then called the screws*”. He also says he is going back to bed and says “*I haven’t been awake since Friday*” and laughs.

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- Apparently referring to being moved, says *“the good thing is I got it at the beginning of the week so it’ll give me all week to look f**king forward to it”*.
- Asks for arrangements to be made for a bouquet of flowers to be delivered to his daughter’s school the next day and *“to make sure that’s in the morning love”*. He also discusses plans for taking a bike from him to his daughter but pretending that it is from other family members so that she is allowed to have it. John’s daughter is not permitted to receive gifts from him.

Wednesday 6 June 2007

- The staff reports for 6 June 2007 record that *“prisoner is being more like himself today. Spent the morning in the videolink, went to yard pm and used the phone. Was interviewed by the Governor this afternoon”*.
- John made one phone call on 6 June 2007. During the call he:
 - Jokes that he has (at the videolink court appearance) got the *“bail”* to attend his grandchild’s Christening. He then admits that it was refused.
 - Says that he needs the person he is calling to get on to his solicitor *“to get a letter from the peelers to say*

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*that John Kenneway senior is not under threat from any Republican organisation". He adds "and I need that done today. If I get that done today they're going to move me in the morning". He explains "the point is I was talking to the security Governor and he filled me in on a lot of s**t and the problem is that the peelers is saying I'm under attack". He repeats how important this is at the end of the call.*

- Checks that his visitors will have cannabis (canaries) for him. He says *"I'm on a buzz here now if you can get that sorted for me"*.
- Checks whether the flowers were sent to his daughter's school and is told that they weren't because the school would have to phone the child's parents before the child could get them.
- Arranges for £50 to be put in a birthday card for his daughter.
- Says that he has been for a walk in the yard and found *"two big bars of chocolate"*. He laughs and says *"I swear to f**k this is unbelievable"*.
- Asks when the person he is speaking to visits his daughter she whispers in her ear *"your daddy really loves ya and misses ya"* and asks her to *"see if you can get a bouquet of flowers anyway"*.

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Thursday 7 June 2007

- The staff report on 7 June 2007 records “*still not well! Seen doctor PM, used phone otherwise ok*”.
- On 7 June 2007, John had a consultation with the prison doctor. This consultation was initiated because John thought he might have a chest infection. When, during the consultation, the doctor asked “*how are you doing generally*”, a conversation followed as a result of which the doctor recorded “*has had thoughts of deliberate self-harm/ending his life but is determined to stay strong on account of his children*”. The doctor did not access John’s medical notes to check his medical history but did make a referral to a psychiatrist because he thought that there was a possibility that John was suffering from Post Traumatic Stress Disorder. The doctor said that he did not assess John’s thoughts of self harm to be current and said that John did not display any signs of anxiety and low mood.
- At interview a prison officer said:

“On 7 June John spent about 45 minutes with the doctor and when he came out he appeared to be in reasonably good form. He actually joked with me about being in the army and told me he had brothers in the Irish army. At no time did staff receive any communication from the doctor or healthcare staff that supervision should be increased or that John had discussed/given ideas of self-harm. Also at

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no time did John ever discuss thoughts of self-harm. He never expressed any suicidal tendencies, he just appeared a bit under the weather, e.g. how you would expect to see someone who had not slept well, a bit groggy and puffy around the face.”

- Another officer said, in connection with the doctor’s consultation:

“On 7 June John went to the prison hospital to see a doctor. Three officers escorted him over and waited – he was in with the doctor for a good hour but at no time was anything communicated back to staff in the SSU about what he was in about. If the doctor had of known anything he should have fed back to staff in the SSU to allow for supervision to be stepped up. When staff escorted John Kenneway back to the SSU he made no comment about his meeting with the doctor however he offered us mint sweets. He was ‘dead on’ the rest of that day”.

- In a letter the prison doctor who saw John on 7 June 2007 said that *“from the flow of conversation he (John) appeared to be accepting of the fact that it was unavoidable due to threats he was placed in the SSU”.*
- John made two calls on 7 June 2007. These appear to have been made after his consultation with the prison doctor. The first was to a close friend at 15.37 and lasted 9 minutes 13 seconds. The other was to a family member at 15.48 and lasted 4 minutes 13 seconds. The

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recordings of these phone calls and three other calls made during the month of May are not available from the Prison Service.

Missing Phone Calls

I have seen no evidence that would suggest that the reason that phone calls are missing 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 this report.

The family member who received a call on 7 June 2007 could not remember in detail the content of the call because of the passage of time. He said, however, that John was very low, "*the worst I have heard him*" and said that "*they had broken him*". The family member could not recall whether John had asked him whether John's solicitor had been contacted and asked to approach the PSNI for a letter to confirm that he was not under any threat from Republicans. 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 that John's situation was also very difficult for his family and that his kids were worried about him. He said that he pointed out to John that one family member in particular was having to talk to people she would not have had any dealings with previously, in order to try and help to get John moved.

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Another family member said that she had tried to contact John's solicitor on 6 June 2007, as John asked, but had been unable to speak with the solicitor until 7 June 2007. 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 2007 said that he was not aware of the action that had been taken to contact John's solicitor and would not, therefore, have passed this information to John.

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SECTION 3: EVENTS ON 8 JUNE 2007

11. John's Last Day

CCTV footage shows that John's last day in the SSU was as follows:

Time	Check
08.14	Officer checks through the door
08.36	Breakfast passed through chained door.
09.35	Slop out. John is passed brush and mop to clean cell and then stands in corridor while officer checks cell.
09.59	Medical Officer at door, Door on chain.
10.39	Flask collected, through chained door.
10.40	Flask returned, through chained door.
10.42	Officer speaks to John through chained door.
11.44	Meal offered through chained door but does not take.
11.52	Officer checks through door.
13.52	Officer checks through door.
14.26	Officer checks through door.
14.39	John out of cell to telephone.
14.56	John returned to cell.
14.57	A Governor speaks to John through open door.
15.50	Offered meal, through chained door. John not seen in door but item passed in and taken.
16.00	Officer checks through door.
17.15	Officer checks through door, looks again and kicks door.

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The checks carried out on John were over and above that required under Prison Service policy. Governor's Order 7.19 describes that Prisoner Safety checks, where the officer must either elicit a verbal response from a prisoner or observe movement, must be carried out on the dayshift at 08.00, 12.30, 14.00, 16.30, 17.30 and 20.30. However, throughout the day, there was only one occasion when an officer entered John's cell (to check the cell after cleaning) and his total time out of cell was less than 20 minutes.

11a. On 8 June 2007 the officers in the SSU carried out prisoner safety checks over and above the requirements of Prison Service policy.

11b. On 8 June 2007, whilst Prison Policy was followed, there was only one occasion when an officer entered John's cell and John's total time out of cell was less than 20 minutes.

Breakfast 08.36

John was expecting a visit at 10.00 on 8 June 2007.

At interview a Prison Officer said that before the few days prior to his death, John "*was always up and dressed before we came to his door with breakfast*".

At a Police interview another Officer said "*as Kenneway's cell door was opened for him to receive his breakfast I could see that he was still lying in bed. This meant that Kenneway was not able to make what we call requests i.e. asking to go to exercise*

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yard, see the Governor, make a phone call, see the doctor etc... Kenneway had his breakfast placed on the floor. I had escorted him to the medics room on Thursday but still thought it strange that he didn't want to wash before his visitors got here".

A review of staff reports for the days that John was visited by family and friends shows that John almost always took a shower on the days of visits.

Slopping Out (Cleaning) 09.35

An officer said at a Police interview that after not getting up for breakfast "*he then didn't do a full slopping of his cell, he partially cleaned it*".

Governor Speaking to John 14.56

A governor spoke to John at 14.56. This was a routine governor check.

At interview the governor stated that he asked John if everything was alright. He said that John "*indicated that everything was ok and asked the officers for some tobacco*".

11c. Unusually, John was still in bed when breakfast was brought to his room on 8 June 2007. He was not up and dressed in order that he could request a shower before his visit.

11d. When a governor spoke to John at 14.56, John said that everything was ok.

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Telephone Calls on 8 June 2007

John had a family visit arranged for the morning of 8 June 2007. In the event, the visit did not take place. It appears that a family member phoned the prison explaining that there had been a problem with the car. A prison officer said at interview that *“visits said that Kenneway’s visitors rang to say they’d be late but visits said they’d still be allowed in”*. He also said that *“shortly after 2pm I asked one of the other officers to ring visits again to see about Kenneway’s visits and became aware that Kenneway’s visitors had had, or had claimed to have had two punctures”*.

John made three phone calls on 8 June 2007. The first was to a family member at 14.42 to discuss the missed visit. The second was to a close friend who knew about the missed visit at 14.49. The third was to the same family member at 14.56.

It was evident from the conversations that there were some confusion/difficulties around the arrangements the family had made for attending the scheduled visit that day.

There is much evidence in phone calls of John being very close to family members and of how much he cares for them.

During the telephone conversations on 8 June 2007, however, John was 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*

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anybody” and that it is *“driving me crazy”*. He also says *“anything I ask my family to do is not done”*.

John does not believe the explanation given by the family for missing his visit that day and talks to his friend about how badly let down he feels. 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 that I could honestly f**ing say that I had to look forward to, and I’m not talking about you, was my two babies and then, see when they take them away from me, I’ve nothing left”*.

On the phone John also talked about the *“smokes”* (cannabis) he was meant to get at the visit. He asked his friend to tell the person who supplies the cannabis that he’ll still get it picked up the next day or some day the next week. At the end of his last call, he repeats *“I’m stuck in f**king hell”*.

Evening Meal 15.50

At interview, a prison officer said that when John was offered his evening meal at 3.30pm he just took his biscuits and not the main meal, saying he was not hungry.

Professor McClelland states in his clinical review that:

“Mr Kenneway appeared to be at his most distressed state on the 8 June. The direct cause for his distress appears to have been a failed visit on that day. He described a sense of isolation, feeling “I might as well be dead” and “in the lowest point of my life”. I

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understand that after the last of the three afternoon telephone calls on 8 June he refused his late afternoon meal. While I have noted a number of vulnerabilities with Mr Kenneway and within his situation it is my impression that a likely trigger for his suicidal action was the distress arising from this failed visit".

Final Checks

At 16.00, an officer checked John through his cell door. At 17.15, an officer checked John's cell and saw him hanging.

12. Response on finding John

CCTV footage provides the following record of events.

At 17.15, an officer was carrying out a prisoner body check in the SSU. On checking Cell 6, Landing 3 he discovered that John was hanging by a black coloured lace. The Officer tried to attract John's attention from outside the cell door, but received no response. He immediately alerted another officer the Landing Class Office before activating the alarm and drawing the cell keys. He also opened the front grille in the SSU to allow access to those responding from elsewhere in the prison.

Another officer ran to John's cell and also tried to get a response. He immediately ran to the Class Office to get the 'Hoffman Knife'⁸ but discovered this was not in place. The officer prepared his own personal pen knife (of a specification permitted by Prison Service policy) in readiness to cut the ligature. When the cell door was opened, the officer ran in and cut the lace that was round John's neck. John was then laid on the floor of his cell. One officer checked for a pulse, whilst another officer applied CPR⁹ until a further officer took over.

At 17.19, healthcare staff arrived in the SSU and entered John's cell. The nurses immediately took charge. They carried out basic checks for signs of life, though John at this point

⁸ Hoffman Knife –a knife that is provided to be used to cut / release ligatures.

⁹ 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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appeared cyanosed¹⁰. A defibrillator machine was placed on John and the CPR procedure was followed. During this procedure, one nurse requested prison staff to call for a cardiac ambulance. CPR continued for approximately 16-18 minutes before the ambulance crew paramedics arrived and took over. An Emergency Medical Technician/Paramedic arrived on the scene at 17.26. On entering the cell and observing John's appearance he believed immediately that life was extinct. A defibrillator was, however, attached which indicated a flat line.

A local doctor arrived at 18.50 and carried out an examination. At 18.55 the doctor pronounced life extinct.

It is Prison Service policy that nursing and healthcare officers, based on their training, expertise and experience, are responsible for any decision taken with regard to resuscitation. The guidance / procedures that were followed are as issued by the Resuscitation Council (UK)¹¹.

12a. When John was found, the correct procedures were followed in respect of attempts to perform resuscitation.

¹⁰ Cyanosed - A bluish discoloration of the skin and mucous membranes resulting from inadequate oxygenation of the blood.

¹¹ Resuscitation Council (UK) Guidelines 2005

13. Unlocking of John's Cell after the alarm was raised

From the CCTV footage of events following the discovery of John and from the entries in the 'Summary of Events' and the 'Serious Incident Log,' it is evident that it took one minute from the alarm being raised until John's cell door was opened.

The procedures in place at Maghaberry Prison and in particular the SSU, for accessing cells in the event of emergency or medical incidents were reviewed as part of the investigation.

John was discovered during the tea time lock up.

The Prison Service has an obligation to balance the security of staff, prisoners and the general prison establishment with the requirement to be able to react to and deal with serious incidents and emergencies in the quickest time possible. SOP 26 - 'Incident Management of SSU' states that in life-threatening situations, staff must act with control, security and staff safety in mind. There have been cases where prisoners have engineered a perceived emergency situation to obtain keys from officers.

In relation to this particular incident the officers on duty in the SSU acted appropriately in responding to the incident. However, because officers do not have immediate access to cell keys in an emergency, it took one minute from the alarm being raised to John's cell door being opened.

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The HM Chief Inspector of Prisons and Chief Inspector of Criminal Justice Northern Ireland, after an announced inspection of Maghaberry Prison¹², recommended that emergency procedures for entering cells at night should be improved. It was reported that *'Night Custody Officers did not have immediate access to cell keys in an emergency. A Senior Officer would have to be called in order to access the cell. It was pointed out that, potentially, this could mean fatal delays.'*

13a. Staff acted in line with existing Prison Service policy when responding to the alarm being raised after John was discovered.

13b. It took one minute from the alarm being raised by the officer who discovered John hanging to his cell door being opened.

¹² Report on an announced inspection of Maghaberry Prison by HM Chief Inspector of Prisons and Chief Inspector of Criminal Justice in Northern Ireland 10-14 October 2005.

14. Availability of a Hoffman Knife

Statements taken from staff who responded to the emergency incident confirmed that a 'Hoffman Knife' was not available in the Class Office.

The Prison Service has confirmed that there was no Hoffman knife in the Class Office on Landings 3 and 4. There were two available in the class office on the ground floor (one on the night guard belt and one in a break glass). Under current arrangements, an officer finding a prisoner hanging on Landings 3 and 4 during a period of lock up would have to go downstairs to the Landings 1 and 2 Class Office to draw the cell keys to unlock the cell and could access the Hoffman Knife at the same time. On the night that John was found, the officer who fetched the key did not lift the knife.

14a. No Hoffman Knife was located in the Class Office Landings 3 and 4 in the SSU.

The availability of a Hoffman Knife has been discussed in connection with other death in custody investigations carried out by my predecessor. One option identified was a specially designed officer belt containing a Hoffman ligature knife and a short range radio to allow for immediate contact with the ECR and Control Room. This might be particularly appropriate for officers supervising accommodation housing more vulnerable prisoners.

15. Ambulance Access to the SSU

An ambulance was requested at 17.20. An ambulance crew was dispatched from Lagan Valley Ambulance Station at 17.23.

The ambulance crew arrived at Maghaberry Prison at 17.41 and received clear access to the prison, arriving on the scene at 17.42. The paramedics took over from prison staff and healthcare staff who had already commenced and continued with CPR for approximately 16-18 minutes.

A Doctor arrived and pronounced life extinct at 18.55.

15a. The ambulance that arrived at Maghaberry was able to proceed immediately through the Prison to the SSU.

16. Death in Custody Contingency

The document 'Contingency Plan 45 – Death of a Prisoner' provides guidance to the Emergency Control Room on the actions to take immediately following a death in custody between the hours of 17.00-08.00 and clearly details the roles and responsibilities of all members of staff upon notification of a possible death.

It is evident that the Governor and all staff fully adhered to all the requirements of the Plan in dealing with the incident.

16a. All staff carried out their roles and responsibilities in line with Prison Service policy in responding to John's death.

17. Preservation of Evidence

When any prisoner dies it is important that the Prison Service takes all necessary steps to ensure the preservation of a scene and evidence.

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

Governors Order 3-12 sets out what procedures should be followed in the event of such an emergency.

17a. Prison procedures for managing the scene of an incident were not fully adhered to. Personnel were at the scene who were not required to be there.

18. De-briefs

The Prison Service's Revised Self Harm and Suicide Prevention Policy revised September 2006, states:

“A hot de-brief meeting is vital following the death of a prisoner as it enables all who took part to comment, while it is fresh in their minds, in respect of what went right or what could have been done better. Hot de-brief meetings make a positive contribution to the implementation of better practice locally, and sometimes, across the Prison Service. It also gives staff the opportunity to discuss their feeling and reactions and calm down or seek help before going home.”

A 'hot de-brief' enables all who took part in the incident to comment, while it is fresh in their minds, in respect of what went right or what could have been done differently. The de-brief also permits management to assess any support required by staff. The Governing Governor carried out a hot de-brief by personally meeting and speaking with all staff who were involved in the incident immediately after the event.

In line with Prison Service Policy at the time of John's death, the hot debrief was not recorded. A revised Policy, now requires that a written record of hot de-briefs is produced.

18a. A hot de-brief was carried out, in line with Prisoner Service policy, by the Governing Governor.

SECTION 4: MATTERS RELATED TO JOHN'S DEATH

19. Initiation of a Prisoner at Risk (PAR 1) Booklet

The Prison Service's Revised Self Harm and Suicide Prevention Policy revised September 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. The Service recognises that this is an important priority and one that demands a holistic approach".

The Policy states that *"all staff carry an equal and continuing responsibility for the management of prisoners considered to be at risk of committing suicide or other acts of self-harm".*

In the event that a prisoner is deemed at risk of self-harm, any member of prison or healthcare staff may trigger the opening of a PAR 1 booklet. This action will trigger a response of increased observation of the prisoner on a needs assessed basis and healthcare input.

The notes on the PAR 1 Booklet describe *"distress signals"*, detailing behaviours, thoughts, feelings, physical changes and situations/triggers that would alert staff to a problem. The Booklet advises *"be aware that some people may conceal their intent. Consider what the person says and does"*.

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The list includes:

- ♦ Showing signs of distress at being alone
- ♦ Disturbed sleep
- ♦ Change/loss of appetite
- ♦ Lack of physical energy for no apparent reason
- ♦ Feeling powerless
- ♦ Feeling lonely
- ♦ Feeling hopeless
- ♦ Feels desperate
- ♦ Home leave refusal or other knock back
- ♦ Has not been receiving visits, has had an unhappy visit or received bad news.

Staff Response to Possible Distress Signals

A number of possible “distress signals” applied to John in the days leading up to his death. Staff did not, however, consider the need to open a PAR 1 Booklet.

Whilst staff were not aware of all distress signals evident in John’s last week, they were aware that:-

- Prisoners in the SSU are vulnerable
- John complained of having trouble sleeping
- John had been refused compassionate leave
- John had missed a visit on 8 June, the day he died, and was noticed to be angry and upset when using the phone
- John had exhibited mood changes and had been staying in bed.

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Staff appear not to have known that John was taking drugs and they would have been unaware of the distress he expressed in phone calls.

It is also the case that:

- staff did not appear to know that John was using drugs
- there is no evidence that staff had any knowledge of John's medical history
- they were unaware that the behaviours they were observing and instances of self harm had featured in John's medical notes in connection with mental health problems many times before
- staff were sensitive to changes in John during the week before his death and did seek medical input and were twice reassured that John was fine
- John had made no previous attempt at self-harm during his time in the SSU
- at times during his last week John's demeanour was upbeat
- the prison doctor who saw John on 7 June 2007 did not open a PAR 1 or alert staff to any need for increased supervision.

Staff training is discussed in the next section.

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- 19a. A number of the possible “distress signals” listed on the PAR1 Booklet applied to John in the days leading up to his death.**
- 19b. Staff did not open a PAR1 Booklet.**
- 19c. Staff did ask a nurse to check John and were told that he was okay.**
- 19d. Staff were unaware of John’s medical history; unaware that he was using drugs and unaware of the distress he expressed in phone calls.**

Prison Doctor Response to Possible Distress Signals

At a consultation with a prison doctor on 7 June 2007, the day before his death, John showed evidence of having psychological symptoms including flashbacks, which it was noted he appeared to be quite troubled by, and thoughts of self-harm and suicide.

As recorded earlier, John did have a psychiatric history of repeated episodes of anxiety, insomnia, periodic depression and acts of deliberate self-harm/suicide attempts.

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 his General Practitioner had prescribed an antidepressant. Appropriate medication was prescribed at the committal

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assessment. No psychological assessment was planned or took place between the committal interview and John's death.

On 2 April 2007, John was seen by a nurse when he was having difficulty sleeping. On 20 April 2007, he was seen by a nurse who noted in his records that he was having a tension headache, complaining of not sleeping and having panic symptoms. This did not lead to subsequent concern or monitoring of mental health issues. The only other medical entries, in May, refer to treatment for ear wax.

At the consultation on 7 June 2007, the prison doctor did not ask for John's medical notes held in the filing room in the medical centre and did not, therefore, access the information relating to John's medical history and his committal record.

The doctor would have been aware of the symptoms noted by a nurse on 20 April 2007 because it is recorded that the nurse spoke to the same doctor at the time to ask for a prescription of Phenergan to assist John's insomnia. A note in connection with this was also recorded on the new electronic medical record system which the doctor had immediate access to.

It is noted that the doctor:

- Would not have been aware, in the absence of any notes on John's medical records, that he had been seen by a nurse on 2 June, 3 June and possibly 5 June 2007.

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- Would not have been aware, in the absence of staff opening a PAR 1 Booklet, of the changes in John's demeanour and behaviour noted by staff and the fact that he had been spending days in bed. The PAR 1 Booklet always moves with a prisoner and is an important channel of communication.
- Would not have been aware of the content of John's phone calls.
- Appears to have had no knowledge or suspicions about illicit and non prescription drugs being taken by John and, in particular, the drugs he found in the visits room on 4 June 2007.

The events of 8 June 2007 would, of course, be unknown at the time of the doctor's consultation which took place on June 7.

On 7 June 2007, the doctor did initiate a psychiatric referral. He did not, however, based on John's demeanour at the consultation, John's behaviour and their discussion, feel that John's thoughts of self harm were current or that he was at risk or that there were any indicators to suggest the need for the opening of a PAR 1 to trigger increased supervision of John.

Both Clinical Reviewers felt that consideration should have been given to the introduction of the PAR 1 process as a safety net. The assessment by the Clinical Reviewers of John's consultation with the prison doctor on 7 June 2007 is included in Section 5 "The Expert Clinical Reports".

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- 19e. In the week before his death, John was subject to/showed signs of a number of the possible “distress signals” detailed in the PAR 1 Booklet. Staff noted some of these and requested medical input but they were not alerted to any need to open a PAR 1 Booklet.**
- 19f. The prison doctor who saw John on 7 June 2007 did not ask for John’s medical notes and was not aware of his medical history.**
- 19g. The doctor had not been made aware of the other changes in John’s demeanour, sleeping habits and other “distress signals” known to staff.**
- 19h. The doctor was unaware that John was accessing and taking illicit and unprescribed drugs.**
- 19i. The doctor did not believe that there was any indication that a PAR 1 Booklet should be opened.**

20. SSU – Staff Training

The investigation was advised that staff working in the SSU, at the time of John's death, had received training in suicide awareness 3-5 years before John's death. However, no arrangements for refreshing and updating training were in place.

It was noted earlier that staff in the SSU did not initiate the opening of a PAR 1 Booklet for John even though there was evidence of a number of "danger signs" as detailed in the PAR 1 Booklet.

In his Clinical Review report, Professor McClelland states:

"The guidance for all staff on the use of the PAR 1 arrangement should make explicit the threshold criteria for its introduction. For example: where there is an alteration of the usual pattern of behaviour or mood, where known risk factors are present. Such arrangements should prevail until an appropriate professional assessment of suicidal risk has been completed."

Staff in the SSU themselves suggested, in the aftermath of John's death, that they should receive further training in dealing with and managing vulnerable prisoners.

I have been informed that arrangements are now in place to provide staff who work in the SSU with additional relevant training.

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20a. Training in suicide awareness had been provided for the staff in the SSU 3-5 years before John's death.

20b. Training has now been put in place for staff working in the SSU. This is designed to help them support and manage vulnerable prisoners.

21. Notification to John's Family

A Priest notified a local priest from Turf Lodge at 19.03 on 8 June 2007 of John's death. The local priest in turn notified John's family of his death.

John's family confirmed that they had received notification from the local priest. However, John's family did highlight a concern relating to information being leaked to the media before they had an opportunity to inform all family members.

As part of any investigation into the death of a prisoner, notices are issued to staff to inform them of the investigation. Staff are invited, if they have information which may assist the investigation, to contact the Investigation Team. One staff member at Maghaberry Prison contacted the office to discuss information relating to John's death being passed to him from another member of staff.

The officer advised that on 8 June 2007 at 18.07 he received a text message from another member of staff who was not on duty advising him that John had been found dead his cell. (It should be noted that John was not pronounced dead until 18.55.) The officer who met with my Investigation Team had reported this incident to the Security Department at Maghaberry Prison.

At the request of the Prisoner Ombudsman, the Prison Service carried out an investigation into this matter. In March 2008, the investigation concluded that the action of the member of staff who sent the text message was immature and

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unprofessional, but that no further action was deemed necessary.

21a. The actions of an officer who sent a text to an off duty colleague telling him of John's death, 48 minutes before John was pronounced dead, was inappropriate and deeply regrettable.

22. Prisoner Response to Notices

The Notice to Prisoners issued by the Prisoner Ombudsman's Office invited prisoners to come forward with any information relevant to my investigation. In response to the Notice one prisoner, John's nephew, contacted the Investigation Team and requested a meeting. An investigator met with this prisoner who provided a statement. In his statement he alleged that John had not committed suicide and that he had heard a Governor in the prison making inappropriate remarks related to this after John's death.

An investigation was carried out into these allegations and the appropriate governor was interviewed and denied making the alleged remarks. From the limited information provided by the prisoner it was not possible to prove or disprove whether the alleged, inappropriate remarks were made.

SECTION 5: THE EXPERT CLINICAL REVIEWS

23. Conclusions of the Clinical Reviews

Two medical experts were engaged to carry out comprehensive Clinical Reviews of John's healthcare whilst in prison, up to the time of his death. Professor Roy McClelland has extensive experience of researching non natural deaths in NI Prisons. Dr Neil Lloyd Jones was able to provide a peer on peer review. The reviews are attached as Appendices to this report.

Following the preparation of the initial reports, Professor McClelland and Dr Lloyd Jones were presented with new evidence, particular relating to John taking drugs and to other matters raised in telephone conversations and asked to amend their reports as they deemed appropriate.

The following are key points from the Expert Clinical Reviews.

Dr Neil Lloyd Jones

Includes in his assessment the following points:

1. Mr Kenneway had a repeated psychiatric history of anxiety, insomnia, periodic depression and acts of deliberate self-harm.
2. Mr Kenneway re-entered prison in February 2007. Whilst the initial medical assessment and management was common and acceptable medical practice, at some stage

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over the following months a clinical review should have taken place to ascertain “the current state of play” as to further clinical management. This did not occur. Therefore it is my opinion that here the standard of medical care fell below common and acceptable medical practice.

3. I feel it would have been good and acceptable practice for one of the medical officers to have:-
 - reviewed any previous prison medical records;
 - to have spoken to, or requested in writing, a resume of his previous/ongoing medical problems from his previous general practitioner;
 - in the light of the above information to have consulted with John Kenneway to form a new clinical benchmark of his current mental state;
 - formed a management plan with a review date etc.

4. In relation to John’s consultation with the prison doctor on 7 June 2007, there were two components to the consultation. The first involved a possible chest infection where I conclude the standard of medical care was common and acceptable medical practice.

5. The second component involved a psychiatric component where John reported symptoms of deliberate self-harm and ending his life. It is my opinion that the prison doctor did not take a sufficiently objective clinical psychiatric history to determine whether or not increased supervision was needed. A more comprehensive examination was needed to determine further management.

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6. Given that the prison doctor did not carry out a more comprehensive psychiatric assessment, he should have, given the presenting history, requested an increase in supervision until an appropriate comprehensive mental state examination had taken place.

Professor Roy McClelland

Includes in his assessment the following points:

1. It was noted in the committal assessment in February 2007 that Mr Kenneway had a history of depression, had had a psychiatric referral with complaints of poor sleep and had been prescribed an antidepressant by his doctor.
2. Mr Kenneway was a vulnerable man, vulnerable to psychological distress. On a number of occasions he manifested such distress and either sought referral to prison medical services or the help of his General Practitioner. On several occasions during adult life he made attempts at deliberate self-harm and expressed feelings of wanting to die. Also, Mr Kenneway's prison health records contain substantial evidence of mental health vulnerability, including previous episodes of low mood, mental distress and several documented instances of deliberate self-harm. All of these are risk factors which would need to be considered in the context of mental health and behavioural problems arising in the course of the present committal.

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3. While it would appear that a nurse in April 2007 had some concern regarding Mr Kenneway's mental wellbeing, including the raising of a prescription for Phenergan to assist his sleeping, there is no documented monitoring of these issues. Prison staff had concerns in early June 2007 and requested a "medic" opinion on two occasions. Documentation of such considerations, opinions and actions are an important part of professional practice and risk management. Earlier documented evidence of poor sleep and admission evidence of a history of depression and antidepressant medication should have been available to healthcare staff.
4. There appears to have been concern among prison staff that Mr Kenneway's behaviour was altered in the early part of June 2007. What is unclear is whether or not staff were considering a psychological basis to such altered behaviour but the reassurances from the medic on those occasions was a sufficient override. It is also unclear whether the medic assessments in early June 2007 gave serious consideration to suicidal risk.
5. It is ultimately the responsibility of a mental health professional to carry out specialist psychiatric assessment, taking full account of all available information, from all available sources, and within a multi-disciplinary context. Nevertheless it is the responsibility of all staff to consider the possibility of suicidal risk in at-risk prisoners. As a General Practitioner, the prison doctor would not have been

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responsible for a detailed mental health assessment risk on Mr Kenneway. He did make a psychiatric referral. However in the absence of a specialist assessment of suicidal risk all staff, including healthcare staff, must consider the introduction of the PAR 1 process as a safety net.

6. Professional risk assessment of suicide must include a consideration of the recognised risk factors. It is not clear whether all of the foregoing facts were available to the prison doctor at the time of assessment.
7. If the information at committal and the further information on Mr Kenneway's health was available at the time of assessment this should have provided sufficient information, in addition to the findings at interview with Mr Kenneway on 7 June 2007, to have triggered the introduction of the PAR 1 process.
8. Analysis of telephone calls made by Mr Kenneway provides some additional information on his mental health over this period. From my analysis of this information two main issues emerge. The first is that Mr Kenneway was using illicit and non-prescribed drugs. However, the most objective evidence for this is in the forensic analysis of urine and blood. From this it can be concluded that he had consumed Cannabis and the Benzodiazepine drug, Diazepam.
9. Scrutiny of the telephone conversations also gives some insights into Mr Kenneway's general mood state over this

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period. He made several telephone calls on most days and appeared to engage readily with the various callers – family and friends. On occasions, he did refer to his sense of boredom and, particularly in late May and early June 2007, his increasing sense of isolation.

10. It would also appear that, in addition to Mr Kenneway's situation of relative isolation and boredom, problems in relation to visits greatly amplified his level of distress. On two separate occasions he described himself as being depressed or low – 29 May, 8 June 2007. On the former this appeared to be in the context of difficulties surrounding a planned visit.
11. Mr Kenneway appeared to be at his most distressed state on the 8 June 2007. The direct cause for his distress appears to have been a failed visit on that day. He described a sense of isolation, feeling "*I might as well be dead*" and "*in the lowest point of my life*". I understand that after the last of the three afternoon telephone calls on 8 June 2007 he refused his late afternoon meal. While I have noted a number of vulnerabilities with Mr Kenneway and within his situation it is my impression that a likely trigger for his suicidal action was the distress arising from this failed visit.
12. Possible contribution of drug use is raised. It is possible that ongoing use of Diazepam from 4 June 2007, may have contributed. Recent use was confirmed by the forensic test findings. While the amount detected was within the

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therapeutic range, assuming he took the substance during the night of 7 June 2007, the actual levels at that time could have been rather higher.

13. Cannabis. Taking all of the information, the various observations of Mr Kenneway, including his telephone conversations, and the medical literature, it is unlikely that Cannabis use per se on 2 and 3 June contributed significantly to alteration in behaviour on 8 June 2007.

Prison Doctor Response to Expert Clinical Reviews

The Prison Doctor

In responding to the findings of the Clinical Reviews, the prison doctor made the following points.

- He was not provided with copies of the staff reports on John from staff in the SSU.
- John presented on 7 June 2007 solely because of a physical problem – a chest problem.
- There was no other background information given to him to suggest that John had any mental instability at that time and that John did not voluntarily say anything else was wrong.
- It was only when John was asked, as he was about to leave, “*how are you doing generally?*” that a new conversation was triggered.
- John did not display any signs of anxiety or low mood and was totally composed. He was relaxed and had good eye contact. He was positive about his wife and children and his current thinking was about keeping strong for his children.
- He did not miss anything or any signs, would not miss signals easily and that there was no reason due to John’s

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demeanour, to open a PAR 1. Even looking back in retrospect, he believes this to be the case.

- He did not consider John's thoughts of self harm to be current based on the consultation.
- He made a referral to a psychiatrist because he thought there was a possibility that John was suffering from Post Traumatic Stress Disorder. He did not record his thoughts re post traumatic stress disorder because he wanted to leave the diagnosis to the psychiatrist.
- At the conclusion of the consultation, John offered his hand in a handshake which does not happen frequently in prison and so is all the more significant. The doctor interpreted the handshake as a signal that John was happy that he was showing interest in him and John was showing appreciation of that.
- Staff reports for 6 June 2007 (supplied after John's death) point out that "*John is more like himself today*" and that this would suggest that there was nothing untoward about John when he presented at the consultation.
- He did not notify discipline staff of any concern as he was not at a high level of alert due to the flow of conversation.
- At no time did anyone (general residential or healthcare staff) indicate to him any other concerns prior to John coming to him.

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- He did not write exhaustively about the consultation because he did not feel the need to.
- A clinical reviewer does not have the benefit of the personal observation of clinical signs which were evidence in the consultation.

South Eastern Health and Social Care Trust's Response to the Clinical Review's

In respect of the clinical care provided by the Prison Doctor on 7 June 2007, the South Eastern Health and Social Care Trust said:

"The trust has considered the independent report regarding the clinical care of the prison doctor). We note that he saw and assessed Mr Kenneway for a range of complaints. In relation to Mr Kenneway's mental health, he identified what could be interpreted as not current thoughts of self harm and imagery (flashbacks). It appears that he had considered these flashbacks to have been more significant and referred for a more in depth assessment from a psychiatrist, which in the circumstances is appropriate. This would seem to be what many GP's would do in practice but is at variance with the clinical opinion of your Independent GP. A clinical judgement is made at the time with the information presented. The prison doctor conducted an assessment. Had the prison doctor considered Mr Kenneway to be a prisoner at risk, he would have placed him on observations."

The Prison Service strongly supported this view.

24. CONCLUSIONS OF THE EXPERT FORENSIC REPORT

It was evident from the Autopsy Forensic Science Report that John had cannabis and non-prescribed diazepam in his blood at the time of his death. It was also clear from John's phone calls during May and June 2007 that he was accessing and taking non-prescribed, illicit drugs.

In the light of this evidence, I commissioned an expert review by an experienced Forensic Toxicology Scientist, Pauline Lax.

The Forensic Scientist obtained and analysed a blood sample stored after John's death and was provided with all of the relevant evidence from this investigation. She was asked to undertake a comprehensive interpretation of the information provided. She was asked to say whether or not the findings would have affected John's behaviour. She was also asked to address the following questions:

1. Given the fact that diazepam was reported in the Forensic Science Report as being at a therapeutic level, how does this relate to Mr Kenneway's prescribed medication and his apparent taking of blue tablets found on 4 June? What is the half life¹³ of diazepam?

¹³ Half life - The duration of action of a drug is known as its half life. This is the period of time required for the concentration or amount of drug in the body to be reduced by one-half.

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2. The day before he died a prison doctor who saw Mr Kenneway said that he considered him to be in reasonably good form. On the morning of his death there is evidence that Mr Kenneway may have been very down. There have been reports of 'UDA blues' being linked to suicides/attempted suicides. There are also reports of the drugs producing a 'high' followed the next day by feeling very bad. Might Mr Kenneway, as a result of taking the blue tablets, have experienced a high, followed by a severe low on the day of his death?
3. Mr Kenneway was looking forward to a visit on the morning of his death which the visitors were unable to make. He appeared to expect that his visitors would be bringing drugs for him. If he had been continually using drugs over the previous week(s), as his calls suggest, what might be the effect of his supply of drugs being halted?

A Summary of the Key Findings from the Expert Forensic Toxicology Science Report is as follows:

1. Cannabinoids

THC is the major active constituent of cannabis and cannabis resin, and is largely responsible for the effects experienced by users. THC is broken down in the body firstly to hydroxy-THC, which is also pharmacologically active. This is then further converted to carboxy-THC, which is not pharmacologically active and is eliminated from the body primarily in the form of a glucuronic acid

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conjugate (that is, with the addition of a sugar-derived molecule which renders it water soluble). Carboxy-THC was detected in Mr Kenneway's blood at a low concentration and no THC or hydroxy-THC was detected. Due to the absence of THC and hydroxy-THC, these results would usually be consistent with the non-recent use of cannabis/cannabis resin. This use would be likely to be either very light use within a few hours of death or heavier use many hours or even days before death. In either of these circumstances it would be unlikely that he would have been under the influence of cannabis at the time of his death.

The original analysis did not test for THC or hydroxyl – THC and, because of the passage of time, it cannot be concluded that THC or hydroxyl – THC would not have been present at the time of death.

Cannabis and cannabis resin are normally abused by mixing the drug with tobacco, preparing a hand-rolled cigarette (usually called a “reefer”, “joint” or “spliff”), and smoking the mixture. The effects of cannabis are reported to vary with the amount used, the setting, and the experience and expectation of the user. These effects may include euphoria and relaxation, distortion in the perception of space and time, disturbance of memory and judgement, irritability, and deterioration in co-ordination. The onset of these effects follows quickly after smoking the drug, the effects reach a peak in about 20 to 30 minutes, and then gradually dissipate over the following 3

to 4 hours. Cannabis is normally a relaxing, sociable drug, which is unlikely to cause hyperactivity however anxiety or panic reactions may occur, particularly in inexperienced users and psychoses have been reported as an adverse effect in some individuals.

2. Benzodiazepines

Diazepam is a benzodiazepine drug used in the treatment of anxiety and in acute alcohol withdrawal. It is also commonly taken by drug users to alleviate dysphoria when regular drugs of abuse are not available. The recorded side effects of diazepam therapy include dizziness, drowsiness, lack of co-ordination, disorientation, reduced alertness and slowed reactions, but someone who is receiving low regular doses may experience few, if any, of these.

The levels of diazepam and its breakdown products found in the forensic analysis after Mr Kenneway's death are typical of the levels reported in individuals who are taking therapeutic doses of diazepam on a regular basis. It appears from Mr Kenneway's list of prescribed medication that he was not being prescribed diazepam at the time of his death.

Diazepam is broken down in the body to desmethyldiazepam and as the desmethyldiazepam is slightly higher than the diazepam it is likely to indicate that Mr Kenneway had not taken a very recent dose of

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diazepam and it may have been some hours since he took his last dose. However as the levels are relatively high, it is consistent with him having taken diazepam on a regular basis and having taken his last dose relatively recently and possibly within the last day or two preceding his death.

3. The Blue Tablets found in the Visits Area

It is noted that the blue tablets found by John on 4 June 2007 and according to phone conversations taken by John, were not analysed and the content is, therefore, unknown.

Drugs referred to as 'blues' are often diazepam 10 milligram tablets which are blue in colour. I have, however, seen reference to tablets called 'loyalist blues' which are said to contain 'ecstasy' and ketamine. With reference to the analyses carried out by the Northern Ireland Forensic Laboratory, it seems likely that Mr Kenneway had not taken ketamine and 'ecstasy' in the hours leading up to his death, as these drugs were not detected in the blood or urine samples. However if he had taken them a number of days before his death, then they may well have been eliminated from his body by the time of death.

As diazepam was detected in Mr Kenneway's blood, it seems most likely that the tablets referred to were diazepam tablets. The development of dependence is

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common after regular use of benzodiazepine drugs such as diazepam, even in therapeutic doses for short periods, and is particularly likely in patients with a history of drug or alcohol abuse and in those with marked personality disorders. Symptoms of benzodiazepine withdrawal may include anxiety, depression, headache and irritability. Rarely more serious symptoms such as psychosis, convulsions and hallucinations may occur. However, benzodiazepines do not produce the acute withdrawal symptoms which are associated with drugs such as heroin. Symptoms typical of withdrawal have occurred despite continued use of benzodiazepines and may be due to the development of tolerance. 'Pseudowithdrawal' has also been reported in patients who believed incorrectly that their dose of benzodiazepines was being reduced.

4. **MDMA**

MDMA, which is commonly known as "Ecstasy", is widely abused, and has been a popular recreational drug on the dance and club scene for many years. It is a stimulant and mildly hallucinogenic drug, which is chemically related to amphetamine. MDMA is reported to produce feelings of euphoria and benevolence to others, with a blunting of inhibitions, a heightened awareness of sensory stimuli such as sight and touch, and an altered perception of time. As with other stimulants, the stimulant effects may be followed by fatigue, depression and reduced physical performance, which can result in impaired judgement. If the blue tablets contained MDMA

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and Mr Kenneway had taken them 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 after effects at the time of his death.

5. **Ketamine**

Adverse effects associated with ketamine may include delirium, irrational behaviour, blurred vision, slurred speech, tachycardia, palpitations and depressed respiration. Ketamine is now commonly abused for its hallucigenic effects, which include floating sensations, perceived dissociation of the body from the mind and feelings of arousal and euphoria. Ketamine is eliminated from the body relatively quickly and, as none was detected in Mr Kenneway's blood, it is unlikely to have had any adverse effects at the time of his death.

6. **Effects of Supply of Drugs being Halted**

If Mr Kenneway had been expecting his visitors to bring him diazepam, I cannot exclude the possibility that he may have suffered some sort of 'pseudowithdrawal' if he thought that he would no longer have access to this drug.

[Note: Another prisoner, who John indicated in phone calls was supplying drugs to him, appears to have been moved out of the SSU in the days before John's death.]

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Conclusion

From the findings and information included in the Expert Forensic Toxicology 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.

SECTION 6: OTHER ISSUES

25. Cell windows in the SSU

As part of a previous review of multiple complaints from prisoners, a review was carried out into various aspects of the workings of the SSU. As part of the review, it was noted that the cell windows opened at each side but that there was a metal grille at the openings which it was explained provided security and a deterrent for passing unauthorised items. At that time investigators asked the Prison Service about the possible replacement of windows by those similar to windows in use in Scottish Prisons, i.e. anti-ligature windows with air grilles rather than windows that actually open. However, the Prisons Service advised that this was neither cost effective nor an urgent requirement at that time.

John hanged himself using a ligature, a black lace, which was attached to the upper part of the cell window frame. During this investigation staff in the SSU advised that, prior to John's death, written correspondence had been passed from staff to Prison Service management detailing concerns about ligature points within the SSU. Suggestions were also made by staff about the provision of anti-ligature windows.

The correspondence was from a senior officer to a governor on 14 August 2006 and included the following:

“RE: Fitting of anti ligature vents to SSU cell windows I recently visited Hydebank YOC where safer cells have been constructed,

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on viewing the cells I realised that the anti ligature vents would be ideal for the SSU if fitted to all cell windows.

In the SSU we have three dry cells ... all other cells have window grilles which enable prisoners to pass items from one cell to another by the use of swings which are made from prison bedding and towels.

In the past prisoners attempting self-harm in the SSU have used the window grilles to affix ligatures and only the quick action of staff has prevented injury or death. The installation of the safer cell anti ligature window vents would not only enhance the safety of the unit for prisoners but would also greatly curtail the ability of prisoners to pass or receive prohibited items”.

The windows in the SSU remained unchanged up to John's death on 8 June 2007.

Professor McClelland, in his Review of Non-natural deaths in Northern Ireland Prison establishments, found that suicide deaths are almost universally by hanging. He stated:

“Therefore, as in NHS mental health inpatient units, attention needs to be given to removing all potential ligature points within areas of the prison where prisoners at high risk of suicide are placed”.

Following John's death, a governor confirmed in June 2008, that all windows in the SSU would be replaced with anti-ligature windows and that this action be treated as 'high priority'.

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In January 2009, the windows had still not been replaced.

A letter to my office from the Director of the Prison Service in February 2009 indicates that, further to the confirmation provided by the governor in June 2008, it was decided that locating two safer cells in the SSU was a “*more appropriate way forward given funding constraints*”.

It should be noted that, in the absence of the identification of the need to open a PAR 1 Booklet, John would not have been located in a safer cell, even if one had been available.

25a. The window grilles in most of the cells in the SSU in Maghaberry Prison can still be used to anchor a ligature.

26. Availability of Shoe Laces

John's family were concerned that John was allowed shoe laces.

As part of the investigation into John's death, some comparative research with prison establishments throughout the UK was carried out to establish in what circumstances prisoners have shoe laces removed. I also noted the findings of past investigation into the death of a prisoner in the SSU at Magilligan Prison who died by hanging, using shoe laces as a ligature.

From this research, it would appear that the general practice is to only remove shoe laces from prisoners where it is deemed really necessary because a risk of serious self-harm or suicide has been identified. This would seem to be a proportionate approach.

In January 2009, I visited Holloway Prison where staff spoke of the de-humanising effect of removing normal clothing and emphasised the need to provide normal, purposeful regime and regular, interactive checks on vulnerable prisoners.

The normal practice at Maghaberry Prison for prisoners with an open PAR 1 Booklet would not be to remove shoe laces. Where a prisoner deemed at serious risk of self-harm or suicide is located in a special observation cell, the Prison Service may take the precaution of removing shoe laces and authorising the use of anti-ligature clothing, in line with its Self Harm and Suicide Prevention Policy.

27. The Billy Wright Enquiry – John Kenneway’s Involvement

There is well publicised evidence of John’s involvement in the death of Billy Wright. The Inquiry Chairman, Lord McClean, was contacted on 29 February 2008 to establish the following:

- Had Mr Kenneway provided a statement to the Inquiry;
- Whether or not it had been planned to call Mr Kenneway as a witness to the Inquiry; and
- If Mr Kenneway was to be called as a witness had he been notified of a possible timescale for this?

A response was received from the Billy Wright Inquiry on 8 May 2008. It confirms that:

- John had not provided a statement to the enquiry, though a statement had been requested.
- John had been advised, via his solicitors, on 20 June 2005, that the inquiry wished to interview him. On 3 October 2006 John advised the Inquiry that he was prepared to be interviewed but on 12 February advised that this was no longer the case.
- On 7 June 2007, the Inquiry wrote to John’s solicitor to ask whether his position remained the same.
- No decision had been taken by the Inquiry as to whether John was to be called to give oral evidence. This decision

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could only have been taken once a statement had been obtained or, using appropriate legislation, after he had failed to provide a statement when required to do so.

John's solicitor confirmed that as the letter of 7 June 2007 was only received by his office on 8 June 2007, John was never made aware of the contents.

John's family also confirmed that John was not concerned that he might be required to give evidence to the Billy Wright Inquiry.

27a. There is no evidence to suggest that concerns about having to give evidence to the Billy Wright enquiry, played any part in John's death.

28. SSU Developments

It is widely accepted that the priority should be to relocate prisoners being held in Special Supervision Unit for their own protection to a more suitable environment, wherever possible. This is particularly the case where a prisoner is held for an extended period.

Where this is not possible, best practice in England and Scotland suggests that the emphasis in the SSU should be on securing an ethos of supervision rather than punishment. This includes: reducing the time spent in cell by prisoners, increasing the opportunities for purposeful activity and, in the absence of association with other prisoners, increased opportunities for positive association/interaction with staff. This has implications for the selection and training of staff.

At the time of John's death, the Prison Service, recognising the need for improved facilities and increased opportunities for out of cell time were implementing an improvement project.

This has resulted in the following facilities that were not available during the period of John's stay in the SSU:

- A recreation room
- A small gymnasium
- A dedicated visits area
- A visiting library trolley

28a. At the time of John's death a Prison Service project was underway to improve the facilities and out of cell opportunities for prisoners held in the SSU under Prison Rule 32 for their own protection.

This is further addressed in the Recommendations at the end of this report.

Revised Management of Special Supervision Unit Procedures

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

The new Procedures require prison staff to *"understand and comply with all processes and procedures necessary to ensure that prisoners accommodated in the SSU are properly cared for, in accordance with Prison Rules and Governor's Orders specific to the Management of the SSU"*.

The new Procedures recognise that prisoners held in the SSU may be especially vulnerable. Its many provisions include requirements that:

- Each prisoner in the SSU is treated with humanity and as an individual.
- SSU managers draw up a positive regime which goes beyond the minimum of one hour's exercise for prisoners held in the SSU for more than 72 hours.

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- All staff in the SSU have specific training that includes an awareness of mental health and personality disorder issues.
- Every prisoner, as a minimum, has access to a daily newspaper, books and magazines and each prisoner serving over three days has, where possible, access to gym equipment and television out of cell. It is stated that *“it is no longer acceptable to keep prisoners in isolation without providing some stimulus and distraction to minimise the potential disadvantage of isolation and boredom”*.
- Prisoners accommodated for more than 14 days in the SSU to be permitted a TV notwithstanding their regime level unless there are exceptional reason for refusing access.
- Prisoners on Rule 32 for their own safety are considered for association with other prisoners accommodated in the SSU, both in the exercise yards and in communal areas, subject of course to full risk assessments.
- Prisoner requests not made at first unlock are considered as they arise.
- Where circumstances permit, prisoners are to be encouraged to participate in education.
- The Drugs Awareness Team and Healthcare are permitted access to prisoners in need of counselling services.

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The new SSU Procedures Document also encourages staff to engage with prisoners in a positive and constructive manner; provides advice on staff recruitment and addresses staff responsibilities in the care of prisoners who are vulnerable or not coping.

28b. Revised Management of SSU Procedures were issued in August 2007. These address many of the issues which impacted on John's experience in the SSU.

One of the recommendations that follow makes reference to the Revised SSU Procedures.

29. REPORT ON MINIMISING THE SUPPLY OF DRUGS IN NORTHERN IRELAND PRISONS

As a response to concern about the increase in drug related incidents and evidence of increased misuse of drugs in each of the prisons, the Northern Ireland Prison Service published in July 2008, 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 produced. These included recommendations relating to:

- Staff Training
- Entry and Exit Points
- Visits
- Searches
- Passive Drugs Dogs
- Use of Intelligence
- Drug Testing
- Search Facilities
- Detection Equipment.

An Action Plan was produced by the Prison Service in respect of the recommendations made but an audit of the implementation of the plan has not yet taken place.

Reference to this Action Plan is included in Recommendations that follow.

RECOMMENDATIONS TO THE PRISON SERVICE

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

Recommendation 1

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

RECOMMENDATIONS RELATED TO HEALTHCARE

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

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(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.

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.

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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.