

## **The Death in Custody of Roseanne Irvine<sup>1</sup>**

The NIPS [Northern Ireland Prison Service] wishes to express its sympathy to the friends and relatives of Roseanne Irvine, a 34 year old female remand prisoner who was found dead in her cell at around 22.15hrs last night (3 March 2004) in Mourne House, Maghaberry. Her next of kin and the Coroner have been informed. (Northern Ireland Prison Service press release, 4 March 2004)

On 13 February 2007 following a week-long inquest into Roseanne's death, the jury returned a damning narrative verdict. She had taken her own life while the 'balance of her mind was disturbed'. The jury noted the significance of 'the events leading up to her death, ie long history of mental health difficulties specifically the incidents that occurred from 1-3 March' 2004. The narrative stated: 'The prison system failed Roseanne'. The 'defects' in the system were: 'Severe lack of communication and inadequate recording'; 'The management of the IMR21 (failure to act)'; 'Lack of healthcare and resources for women prisoners'. These contributed to Roseanne's death as follows: 'All staff were not aware of Roseanne's circumstances and could not act accordingly'; 'Priority should have been made to see a doctor'; 'Hospital wing was inadequate for female prisoners'. Asked if 'any reasonable precautions could have been taken' the jury listed four: 'Could have been taken to an outside hospital/ out of [hours] call doctor'; 'Full briefing during handovers'; 'Decisions to be moved from C1 to C2 should not have been made by a non-medically trained qualified staff member'; 'To be paired up with friend in cell – more checks'. Under 'other factors' the jury entered: 'Prison is not a suitable environment for someone with a personality/ mental health disorder. Under Northern Ireland's Mental Health legislation there is no other alternative'; 'more ongoing training on suicide awareness for prison staff'.

The Coroner announced that he would be writing to the Director of the Prison Service and to the Secretary of State for Northern Ireland. As the jury left the court the three rows of family members burst out into spontaneous applause. The verdict reflected the systemic failings in a prison that had been severely criticised by the Prisons Inspectorate in 2003. By the time the research took place early in 2004 the regime had deteriorated further and vulnerable women in particular suffered the consequences (see Scraton and Moore 2004). In 2005 an inquest

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<sup>1</sup> This account is based on research into the imprisonment of women and girls in Northern Ireland carried out on behalf of the Northern Ireland Human Rights Commission in 2004 and published as Scraton, P and Moore, L *The Hurt Inside: The Imprisonment of Women and Girls in Northern Ireland* Belfast, NIHRC, 2005. Roseanne Irvine died in prison while the research was being undertaken and both authors gave evidence at her inquest 6-13 February 2007.

jury heavily criticised the Prison Service for its contribution to the death of Annie Kelly (see Scraton 2007). The Human Rights Commission reiterated its call for a public inquiry into the circumstances surrounding both deaths encompassing the broader issues of institutional failings, managerial incompetence and regime breakdown.

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Born October 1969 in Belfast Roseanne Irvine was the youngest in a family of seven children. According to her pre-sentence report she witnessed and was subjected to violence within the family although one of her sisters recalls a happy childhood. She enjoyed school, left at 16 to enrol at a youth training scheme and then worked in a local factory. In 1991 she became pregnant. Soon after, she began to suffer from depression followed by alcohol dependency. From early 1994 until September 2001 she was treated on 38 separate occasions for anxiety, depression, alcohol intoxication, overdosing, self harm and attempted suicide. This included numerous admissions to hospital, mental health and psychiatric units. In 2001 a consultant psychiatrist diagnosed 'chronic psychosocial maladjustment' exacerbated by alcohol abuse. This was interpreted as 'borderline personality disorder'.

She was considered a loving and caring mother but because of 'repetitive episodes' of self harm and alcoholism her daughter was placed on the Child Protection Register and placed with her older brother and his family. In February 2002 another of Roseanne's brothers died in a hostel fire and the incident had a deep impact on her mental health. She attempted suicide and was admitted to hospital. The day after her release she drank heavily and set fire to her home. With no previous record of offending behaviour she was charged with arson. On the day she was admitted to prison on remand, 22 March 2002, an IMR21 (prisoner at risk of suicide) was opened. This was followed by a second six days later.

A Prison Officers' Association (POA) representative informed the Governor that Roseanne had attempted suicide during the previous night guard period (Letter, 9 April 2002). He stated that on arrival she was considered at risk but was not seen by the prison doctor. She was located on the C2 committals landing where a nurse officer carried out an initial check. Again an IMR21 form was raised confirming she was a 'potential suicide risk' but the doctor did not visit her. At 10.05pm there was an emergency unlock. Roseanne had attempted to kill herself using a ligature 'lying face down'.

The Night Guard stayed with her until a hospital officer arrived from the male prison hospital. This took 35 minutes. Soon after midnight she was examined by a doctor who recommended her transfer to the

male prison hospital for 'special care' (the purpose-built women's hospital had been mothballed). The transfer did not happen and Roseanne was taken to the 'Prison Support Unit', known as the punishment block, dressed in an anti-suicide gown and placed on 15 minute observation in a strip cell. Referring to criticisms of prison management following a previous death in custody, the POA letter asked:

Why does the management of the Prison Hospital continue to ignore the contents of the Suicide Awareness Manual?

Why are the hospital management so reluctant to accept female prisoners and why are those prisoners who are admitted to the Prison Hospital returned to Mourne House after the briefest possible stay?

Why are IMR21's raised by Mourne Wing staff constantly brushed aside after a token examination by a Hospital Officer?

Why did it take approximately thirty-five minutes for the Night Guard Hospital Officer to reach C2 on the night of the incident in question?

Why was Irvine not admitted to the Prison Hospital immediately after attempting to take her own life?

Why was [she] placed in a Segregation cell in Mourne PSU [prison support unit]?

In a subsequent letter to the Governor, the POA stated that Roseanne again had attempt to take her own life: 'To our dismay once again the regulations laid down in the Suicide Awareness Manual were ignored' leaving her 'in her own cell and placed on fifteen minutes observation by the night guard' (Undated correspondence). Previously it had been agreed that prisoners on 'special watch' would not be accommodated on residential landings. Yet the healthcare Governor and the prison doctor were 'of the opinion that prisoners who are not in clinical need should be kept in a Residential House'. The POA, however, considered that 'prisoners deemed to be at risk of self harm' should be 'placed in the Health Care Centre and treated by Nursing Officers'. Soon after the POA registered a 'failure to agree' with the Governor stating:

Hospital management are continuing to ignore the regulations governing the treatment of prisoners who are attempting self-harm. This is placing an intolerable burden on discipline staff by placing these prisoners in residential units instead of the healthcare centre. Prisoners deemed to be at risk of self-harm by medical staff should be placed in the prison hospital. (19 April 2002)

In May 2002 the POA Chairman advised a health care meeting that it was 'necessary to have a Health Care Officer in Mourne House during association and at night and requested the matter be looked into'

(Meeting minutes). This was a consequence of Roseanne's self harming and attempted suicide. Subsequently he stated:

There are only two health care officers at night on the male side. If you have two medical emergencies you've had it. You must have a health care officer available for Mourne House at all times. (Interview, March 2004)

Following a further meeting in June 2002 the POA noted that the Governor had accepted the 'manual' might not be used appropriately in responding to self harming prisoners. The Governor had stated that admission to the prison hospital was based on a medical assessment of clinical need and self harm was 'not necessarily a medical problem' but a 'multi-disciplinary problem'. Further, a working party on the implementation of the new suicide awareness arrangements was in process and a recent healthcare review recommended handling 'at risk prisoners ... on normal location'. The POA requested 'a review into the possibility of re-opening Mourne [women's] healthcare centre' (Interview, March 2004).

In September 2002 a further incident involving Roseanne occurred and again the POA sent a memorandum headed: 'Treatment of Prisoners deemed to be at risk of Self-Harm' (16 September 2002). It noted that Roseanne had 'committed an act of self harm on C2 landing' and 'As usual the regulations contained in the Inmate Suicide Awareness Manual ... were ignored by Prison Management'. The Duty Governor had 'left instructions that Irvine should be placed on fifteen minutes observation and remain in her cell on C2'. The POA commented 'Once again Night Guard Staff untrained in medical procedures are being placed in an intolerable situation'. He was unequivocal that prisoners 'on special watch cannot remain on a residential unit'.

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In November 2002, still on remand, Roseanne was bailed to Bridge House into the custody of her mental health worker. Although a successful placement, she failed to comply with her conditions by breaking the no alcohol regulation and was recommitted to prison. In October 2002 she was discharged at court on two years probation. Roseanne was returned to prison in August 2003 for breaching her probation order and again was placed on an IMR21. In November 2003 she had served her time and was discharged from prison. On release she lived in a hostel but her problems with alcohol, glue, gas and drugs continued. She transferred to another hostel where she was very unhappy because of intimidation by men living there. She moved to a flat but her habit impelled her back to the hostel. According to a nun with whom she had regular contact, 'her mood became very low and she said she wanted psychiatric help' (Interview and

Correspondence, 2004). One night she was expelled from the hostel and left on the streets. The hostel social worker considered Roseanne required appropriate psychiatric care. She was given an appointment for early February 2004. On 21 January while out with others from the hostel she was attacked by one of the group. She was frightened and asked to be taken to prison for safety.

Within two weeks, following a suicide attempt, Roseanne was admitted to hospital. The nun visited her and found her 'very withdrawn and depressed'. Yet Roseanne was optimistic she would receive care and treatment at a forthcoming hospital appointment. The following afternoon the nun visited her again:

When I arrived I could see Rosanne was very depressed and did not know what was happening to her. She had seen [the consultant] in a room with many other people, which she found very distressing, and was unable to communicate. I went to see the ward sister who came with me to Roseanne's bedside and told her that she was being discharged under the care of the community health team. Roseanne was very distressed.

Roseanne was discharged from the hospital without medication. The hospital had no information on her whereabouts. She was taken to the Homeless Advice Centre and allocated a place in a house occupied by men who suffered multiple problems, mainly alcohol and drugs related. She was 'very frightened' living at the house. The caretaker was on duty only from 7pm until 7am. Roseanne kept her February appointment with the consultant who told her that she should be in hospital. An appointment was made for her to attend the day hospital for medication. The nun continued to visit Roseanne:

I went to [the house]. I could not get in several times. Then on one occasion a drunk man answered the door and he told me Roseanne was out. I left a message for Roseanne to phone me. I eventually got to see Roseanne. I brought another sister with me as I was afraid to go into this house by myself. Roseanne was in a terrible state of depression, confusion. She said she was frightened 'out of her mind', had taken drugs, drink and glue and no medication.

The nun was concerned that Roseanne had not been visited at the house to assess the appropriateness of the conditions under which she was living. She telephoned Roseanne's care manager to report that she 'was depressed, suicidal and unable to stand, her eyes rolling'. The care manager arranged for Roseanne to attend the day hospital. That evening she telephoned 'quite drunk and suicidal'. Within a week she was in police custody and 'appeared in court in her pyjamas'. She had set fire to her room at the hostel and was charged with arson. On 20 February Roseanne was remanded in custody.

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When Roseanne arrived at Mourne House she was 'health screened' by a Nursing Officer. While her 'risk classification' was assessed as 'No risk indicated at present' an entry stated that she had attempted hanging only six days before she was imprisoned. It was also noted that she had self harmed to her face and arms three days earlier. The form requested information regarding mental or physical health concerns expressed by the police or any other agency. There was no entry. Yet a PACE form from the Police Service of Northern Ireland accompanied Roseanne to prison. The section on potential exceptional risk under 'May have suicidal tendencies' had three ticks and two handwritten asterisks. Under 'Physical illness or mental disturbance' it had one tick. In the section 'Supporting Notes' the words SELF HARM were written in capitals, underlined, with two asterisks. There followed, also underlined with accompanying asterisks, the handwritten comment, 'Informed C.P.N that she would cut herself if the opportunity arose'. The asterisks and underlining were in red ink. The PACE form had been ignored.

On 1 March Roseanne told a prison officer that she intended to hang herself. The officer opened an IMR21 and Roseanne was put in an anti-suicide gown, supplied with an anti-suicide blanket, potty and a container of water and transferred to C1, the close supervision unit, known as the punishment block. Women who repeatedly self harmed or were considered a suicide risk were 'managed' in Mourne House by being put in a strip cell, locked up in isolation for 23 hours a day. They had no contact with other prisoners and minimal contact with staff. During the following morning there was some discussion between two Governors and the Senior Officer but she was left on C1. She was scheduled to attend 'sick parade' in line with the IMR21 requirements. It was cancelled and the duty doctor was not made aware of her condition. The healthcare section of the IMR21 remained blank. During the day an officer recorded that she was distressed in the strip cell and had been pulling hair out of her scalp. Despite this on the evening of 2 March she was returned C2.

She remained on the IMR21 and although at risk was put back in an ordinary cell that had multiple ligature points. She had access to a range of ligatures. Once again sick parade was cancelled and she was not seen by a doctor. Officers reported her as being 'calm' and 'in good form'. In the afternoon she was visited by the prison probation officer who informed her that negotiations were going on with Roseanne's social worker for a meeting just over a week later at which a visit from her daughter would be arranged. The probation officer stated that she gave Roseanne a handwritten note to that effect. The note was never found. After the visit from the probation officer Roseanne became

upset and told officers that she might not be able to see her daughter again.

During a short evening unlock Roseanne stated that she had taken '5 Blues', tablets that she had been given by another prisoner. This information was given to the Governor who was in another part of the male prison. He stated that he ordered an immediate cell search. This was not carried out and the women were locked up in their cells for the night. The Night Guard with responsibility for C2 stated that she did not know that Roseanne was on an IMR21, nor did she know that she had taken a drugs overdose. At approximately 9-15pm she was seen sitting on her bed writing a note. She asked for the light to be turned out. Just over an hour later she was checked. She was hanging by the neck from the ornate bars of the window. She had made a noose from a draw cord in her pyjama bottoms and attached it to a sheet through the bars. Her feet were on the ground.

An officer who entered the cell stated:

Although RI was 'on' an IMR21 [prisoner 'at risk' of suicide] and we were aware that there was a strong possibility that she was liable to attempt suicide, we were unable to avert this suicide, as it was impossible to observe her continually throughout our shift ... Not only was it a very stressful and traumatic experience having to deal with this unfortunate death, it has been made worse by the fact that although we were aware of the situation, we were helpless to prevent it. (Interview, March 2004)

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The death of Roseanne Irvine is particularly shocking by its apparent inevitability. As an officer put it: 'We have our own list, our own worries as to specific women who might have died ... she displayed the symptoms, the prior attempts. The warning bells were there' (Interview, March 2004). A professional worker stated that 'everyone realised that Roseanne had great needs but it [the provision] fell short because no-one put their hand up for overall responsibility (Interview, March 2004). Given Roseanne's personal history of self harm and attempted suicide, the lack of an effective care plan for such a vulnerable young woman raises serious concerns about the circumstances in which she died. She had arrived in prison in a deeply distressed state and was very worried she might lose access to her daughter. Another prisoner recalled:

She was always talking about her wee daughter. She loved her so much she talked about [her] every day. She hadn't seen her daughter for three weeks and she really missed her. She said to me that she did not think she would see her again because what

her social worker told the prison officer to tell her. She told Roseanne that [her daughter] was happy and it would not be right to bring her up to the prison to see her. That really hurt Roseanne. You could see it in her face when she was telling me. It was Roseanne's child and she had every right to see her. (Interview, March 2004)

A prison officer stated that Roseanne 'was not getting to see her daughter' but did not know why. She continued: 'In a letter a week ago she told her daughter that she was not well, but that she really missed her and wanted to see her. She loved her daughter but she was ill and it [the illness] was no fault of her own' (Interview, March 2004).

From the accounts of other women prisoners on C2 Roseanne had suffered in the punishment block. One woman stated that 'she had had to lie on wood' and another commented that she 'was sore on her back after the punishment block' (Interviews, March 2004). In fact she had lain on a concrete plinth without a mattress or a pillow. Still considered at risk, her return to C2 gave her access to several ligatures in a cell with multiple ligature points, not least the patterned metal-work of the cell window bars. She received no counselling, had little meaningful contact with staff and was locked up, unobserved, for extended periods.

A woman prisoner stated that earlier in the evening of her death 'Roseanne told me not long before we got locked up that the staff did not check on the women every hour and she said to me that one of these nights they will find someone hanging and they will be dead. That very night Roseanne was found dead' (Interview, March 2004). She continued:

If the staff had checked on Roseanne more often that night she might be alive today. They knew she was down ... The girl needed help which she did not get. She was so down. This place is like hell on earth.

A woman in her cell on C2 could hear another woman 'squealing and shouting' to Roseanne but 'no buzzer went off'. She was convinced that the officers had turned off the emergency cell buzzers. Another woman stated:

What happened to Roseanne was frightening. You think you're going to bed safe and you wake up and ask a warder where someone is and they say she hanged herself ... All she wanted was to see her child but they didn't listen to her. Roseanne's death could have been prevented. (Interview, March 2006)

The impact on the other women prisoners was immediate:

The next day I just sat and cried. I then had panic attacks. They didn't get the nurse over. I pushed the [emergency] button and they came to the door. I asked to see the nurse and they just said 'No'. They said, 'You're not allowed to push the button. It's for emergencies only'. I said I was having a panic attack. They said, 'Take deep breaths'. It was early evening. I sat up on the bed with a pillow and cried and cried. (Interview, March 2006)

Roseanne's closest friend on the landing, Jane, was devastated and was transferred to the male prison hospital where she was interviewed several days after Roseanne's death. The interview took place in an office and the level of constant noise outside was intense. It seemed out of place in a healthcare facility accommodating acutely disturbed and distressed patients:

While we were talking the daily routine of the prison hospital was happening beyond the door ... loud male voices shouting and laughing; jokes and banter between staff; the constant rattling of keys; whistling; telephones ringing; people's names being shouted down corridors. All interpersonal communications seemed at full pitch. (Fieldnotes, March 2004).

Throughout the interview Jane was agitated and cried. Initially she had difficulty in focusing and apologised constantly for her emotional and physical 'state'. Although continuing to cry, Jane gathered herself:

The way that girl was treated the system let her down. There should be a hospital for women. It was disgusting, dirty in here ... I always told her not to do anything to herself. I tried to see her that night but we only got 20 minutes out [of the cells]. I started to write things down myself. I wrote there should be more support for women with mental health problems. (Interview, March 2004)

Jane talked about her own mental health problems: 'You get no support, the staff ignore you'. She had twice received visits from a psychiatric nurse 'then it was stopped'; there was 'no support for women with depression'. In the prison hospital 'you're locked up 23 hours a day'. She continued:

If you're sitting there [in the cell] for hours there's stuff that goes through your mind. If I don't get out today I'll plan something. They think there's nothing I can do but I can. They think they know everything but they don't. I've got a plan, I know what I'll do. My first cousin hung himself.

She had not wanted to be transferred to the male prison hospital, 'it's filthy'. Jane held in strip conditions. The bed was bolted to the floor and the metal toilet, with fixed wooden seat, was open to observation. It was described by a senior orderly as a 'basic suite' which the staff tried 'to keep as clean and tidy as possible given the circumstances'.

Jane wanted relocating to Mourne House where she could have contact with other women. She had been under the impression that her move to the prison hospital had been for 'one or two nights'.

The doctor doesn't want me to go back over there but I can talk better over there. Over here they don't even talk to you and it's supposed to be a hospital. Here, if you feel really down they don't care.

The isolation, particularly from other women, was the most difficult aspect of the 23 hour lock up: 'I've never been in prison before. I hate getting locked up ... it brings memories back to me'. She disclosed a history of sexual abuse, 'I'm lying trying to sleep, thinking about these things'. She continued:

In the hospital they [male prisoners] talk filthy and dirt with the other prisoners. A man exposed himself. Said, 'I'll give her one'. He thought 'I'll pull it out 'cos there's a woman there'. We were all outside together. One man is in for sexually abusing a child. We have to have association with them. They are crafty, some of them. I told them [staff] about what the man did but they never did anything about it. I did not feel safe around them.

Her account was deeply disturbing. The senior orderly on duty confirmed that Jane had been on association with male prisoners in the recreation room. He explained:

There are difficulties housing women prisoners in a male ward. These are acutely disturbed prisoners ... Unlock depends if there's sufficient female staff. But they do have association with male prisoners. (Conversation, March 2004)

On hearing Jane's experiences in the recreation room the orderly stated that they always made sure that a female member of staff was with her but he did not contest Jane's version of events. He simply stated that the 'situation' in the prison hospital was 'acute and volatile'. For Jane, grieving the loss of her friend while struggling with her past memories and current fears the experience of incarceration was 'like a nightmare and you think it's never going to end'. She said that if 'they'd doubled me up [shared cell with Roseanne] then I could have saved her life. She was worried about whether she would ever see [her daughter] again'. Jane's concern was that 'there'll be more

deaths in this prison because people don't get the help they need'. She wrote later:

I have four kids and four grandkids and I miss them all so much. I keep thinking to myself I will never see mine again. I love them all so much too. But to me time is running out for me. I can't take much more. Every day is like a nightmare.