

**A report by the Office of the Inspector of
Prisons into the circumstances surrounding
the death of Mr G
on 6 May 2017 in Limerick Prison**

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

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Foreword

Enclosed is a report of an investigation conducted by the Office of Inspector of Prisons into the death of Mr G who died in custody in Limerick Prison on 6 May 2017. The investigation commenced on 6 May 2017.

The Inspector of Prisons has been investigating deaths in custody since 2012. Over the past six years reports on deaths in custody have identified incidences of failure to complete 'special observations'. In accordance with the Irish Prison Service (IPS) policies and procedures a prisoner who is subject to 'special observations' is required to be checked every fifteen minutes. The investigation into the death of Mr G identified that 'special observations' were not implemented on the night he died, despite the controls that the IPS had put in place to mitigate the risk of such occurrence. It is clear that the controls in place were inadequate. It is noted that similar recommendations have been made in Death in Custody Reports over and over again and therefore it leads me to conclude that they have not been receiving sufficient attention.

Prisons are required to provide safe and secure custody. When a prisoner is identified as requiring 'special observations' there should be zero tolerance in instances where there is failure to carry out the required observations and appropriate disciplinary action taken.

Another matter of concern previously identified and is also a feature of this report, is the failure of the Irish Prison Service (IPS) to record and/or retain relevant Closed Circuit Television (CCTV) footage. The unavailability of such footage should be considered a very serious matter and the IPS should address it accordingly. The investigation of the death of Mr G would have been severely hampered but for the diligence of a Chief Officer in Limerick Prison.

This report also identifies noncompliance with statutory rules number 8(1) and 35(3) of the Prisons Rules 2007-2017. Failure to adhere to the law is of particular concern. This report identifies a number of system failure issues that require to be addressed.

One of the objectives of an investigation into a death in custody is to examine whether any changes in operational methods, policy and practice, or management arrangements would help to prevent recurrence of a similar death or serious event. It is of serious concern that this Office is repeating recommendations over and over again and the opportunity to prevent recurrence of similar deaths does not appear to be sufficiently addressed.

The Draft report of this investigation was provided to the Director General of the IPS in December 2018 for review and comments. Changes to the draft report were made

in circumstances where evidence to support the change request was made available to the investigation team.

I welcome the response from the Director General of the IPS. In December 2018 the Director General accepted all of the recommendations in the report and set out the steps or actions the IPS would be taking to ensure their full implementation and a further update was provided on 13 March 2019 and 25 April 2019. I am aware that in relation to 'special observation' specifically, a range of measures have commenced and are being communicated across the prison estate.

Patricia Gilheaney
Inspector of Prisons
25 April 2019

**A report by the Office of the Inspector of Prisons into the
circumstances surrounding the death of Prisoner G
on 6 May 2017 in Limerick Prison**

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

This investigation was conducted and the Report prepared by
the undersigned.

Helen Casey
Office of the Inspector of Prisons

25 April 2019

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Preface

The aims of this investigation are to:

- Establish the circumstances surrounding the death;
- Examine whether any changes in operational methods, policy and practice or management arrangements would help to prevent recurrence of a similar death or serious event; and
- Address any concerns of the family.

Prisoner G was a 31 year old man who died on 6 May 2017 while in the custody of Limerick Prison.

We offer our sincere condolences to the family and friends of Prisoner G.

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

Helen Casey
Office of the Inspector of Prisons

25 April 2019

Investigation Report

1.0 **General Information**

- 1.1 Prisoner G was a 31 year old single man who came from the Midwest Region.
- 1.2 He is survived by his father, extended family and friends.
- 1.3 Prisoner G was remanded in custody to Limerick Prison on 29 April 2017 to appear at Limerick District Court on 5 May 2017 where he was further remanded to appear again at Limerick District Court on 9 May 2017.
- 1.4 This was Prisoner G's first time in prison. He had no prior convictions.
- 1.5 Prisoner G was on the 'Standard Level' of the Incentivised Regime¹.
- 1.6 On committal to prison, Prisoner G was placed on his own in a double cell – Cell 4 on D4 landing. He was placed on the Special Observation² list.
- 1.7 At 05:07 on 6 May 2017, Prisoner G was found unresponsive in his cell with a ligature around his neck.
- 1.8 Efforts by prison staff and ambulance paramedics to resuscitate Prisoner G were unsuccessful. He was pronounced dead by a Registered Medical Practitioner at 07:00 on 6 May 2017.
- 1.9 Prisoner G had nominated a female friend, Ms A, as his next of kin. The Prison Chaplain visited Ms A on 6 May 2017 to inform her of his death.
- 1.10 As part of our investigation into the circumstances surrounding a death in custody we, inter alia, view relevant Close Circuit Television (CCTV) footage. On requesting the CCTV footage, we were informed by Mr. A an official at Irish

¹ The Incentivised Regime has three levels of privilege – Basic, Standard and Enhanced. Basic level provides the least amount of privileges (number of phone calls permitted, amount of daily gratuity paid etc) while the Enhanced level offers the best privileges. All committals are placed on the Standard level of the Incentivised Regime.

² Special Observation Prisoners must be checked every 15 minutes

Prison Service Headquarters that the footage had initially been saved by management in Limerick prison but may have been “*accidentally deleted..... and therefore did not make it to backup*” on the server. Therefore as no footage was available for our investigation we were unable to independently view CCTV footage in relation to the death of Prisoner G.

2.0 **Meeting with family and friend of Prisoner G**

- 2.1 At an early stage in the investigation we met with Ms A, nominated next of kin. Separately, we met with Prisoner G’s Father and Aunt. We explained our role and provided them with an opportunity to raise any concerns they wished to have examined during the course of our investigation.
- 2.2 Prisoner G’s father informed us that his son was ‘a loner’, played music and was very interested in computers. Prisoner G’s father stated that he was not aware that his son had any mental health issues. The father said he had no contact with his son for five months prior to his death which he stated was out of character. During that five month period, prior to committal to prison, we were told that Prisoner G sold personal items and went abroad.
- 2.3 Ms A informed us that Prisoner G had been in the Psychiatric Unit in University Hospital Limerick for five weeks immediately prior to his committal to prison. Ms. A stated that he had been showing “*suicidal ideation*” and was on prescribed medication for his medical condition.
- 2.4 Ms A stated that Prisoner G told her during their telephone conversations that he did not get his medication. Ms A stated that the administration of Prisoner G’s medication was vital to ensure his good mental health. Ms A informed us that she made a number of telephone calls to both the prison and the hospital ward, where Prisoner G had been an inpatient just prior to his committal to prison, regarding the whereabouts of his medication. Ms. A stated that she was informed by a Nurse in the hospital that the Limerick Prison Nurses had been advised regarding Prisoner G’s medication in prison.

2.5 Ms A also informed us that she experienced considerable difficulty in trying to book a visit with Prisoner G. She stated that the first available appointment offered to her was 8 May 2017, more than one week after Prisoner G was committed to prison.

2.6 Ms A stated that she was contacted by prison management following her friend's death and during that engagement she was told that on the night Prisoner G died he had a conversation with an officer about the 'Darkness into Light' walk, which took place on the morning of his death.

2.7 Ms A, Prisoner G's Father and Aunt raised the following concerns:-

- (i) *“Does the prison have a protocol in place regarding the release of a suicide note to a next of kin?”*
- (ii) *Can a suicide note only be given to blood relatives?*
- (iii) *Where is the necklace that Prisoner G had in his possession?*
- (iv) *Why were Prisoner G's belongings not given to Ms A as the stated next of kin?*
- (v) *Please check if Prisoner G spoke to officers on the night of his death regarding the 'Darkness into Light' event?*
- (vi) *Was Prisoner G properly supervised while in prison?”*

3.0 **Recording of property on Committal**

3.1 On examination of prison committal records we found that Prisoner G was committed to Limerick Prison at 17:25 on Saturday 29 April 2017.

3.2 Officer A completed the 'Committal Details Form' which is a list of all property in possession of a prisoner on committal to prison. The following six items were recorded in Prisoner G's possession i.e. mobile phone, wallet, social welfare envelope, passport, key and social welfare cheque.

3.3 Our investigation found that Prisoner G had additional items in his possession on committal to Limerick Prison. He had (i) medication, (ii) prescription and (iii) an appointment letter to see a specialist on 4 May 2017. However, these

items were not recorded on the 'Committal Details Form' as having been in the possession of Prisoner G on committal.

- 3.4 We queried with the Governor the reason for the non-recording of medication, prescription and medical appointment letter on the 'Committal Details Form', Governor A advised that:-

"At the main gate warrants are verified and usually any medication is taken off committals and put in an envelope for the medics.

Personal valuables are handed over in the general office on the security interview, medication might come to light here, this is put into an envelope and put in the drop safe with his/her valuables."

- 3.5 On our examination of the prison records we could find no evidence that the Nursing staff were informed by the Main Gate Officer or by the Reception staff that Prisoner G had medication, a prescription and a letter for a medical appointment in his possession on committal. We found no evidence that the Nursing staff were informed that medication had been placed in the General Office.
- 3.6 Prisoner G was committed on the Saturday of a Bank Holiday weekend. The General Office in a prison operates from Monday to Friday and is closed over a Bank Holiday weekend.
- 3.7 Nurse Officer A who conducted the committal medical interview with Prisoner G on 29 April 2017 made no reference in that report to the fact that Prisoner G had medication in his possession on committal. However, it is recorded that Prisoner G did give the nurse details of his prescribed medication.
- 3.8 On Sunday 30 April 2017 Assistant Governor A accompanied by Chief Officer A and ACO A, conducted a Committal Interview with Prisoner G. Assistant Governor A records showed that she directed that Prisoner G be placed on the

Special Observation list. Assistant Governor A recorded that Prisoner G “ ... *informed me he was on other medications and I informed the surgery of same.*”

4.0 Interaction with prison Medical Services

4.1 On committal Prisoner G was seen by Nurse Officer A on 29 April 2017. Nurse Officer A recorded that Prisoner G said that he had been discharged from an acute psychiatric unit the previous day. Nurse Officer A also recorded on the Prison Health Management System (PHMS) that prisoner G denied any thought of “*SI or SH*” (referring to self-injury or self-harm); noted that it was his first time in prison; referred him to GP and recorded details of the medication Prisoner G stated he was taking.

4.2 Later on the 29 April 2017 Prisoner G was seen by Nurse Officer B who recorded “*requesting his meds, advised [Prisoner G] his medication did not arrive with him and he will have to see a gp* “(sic).

4.3 On 30 April 2017 Nurse Officer A recorded on the PHMS that Prisoner G was placed on “*special obs*” and contact was made with the University Limerick Hospital regarding Prisoner G’s medication prescription.

4.4 On 1 May 2017 Nurse Officer B recorded in the medical notes that Prisoner G was to see GP the following morning. Chief Nurse Officer A’s notes of 2 May 2017 stated that Prisoner G declined to attend the Prison Doctor.

4.5 On 1 May 2017 the Prison Doctor prescribed medication for Prisoner G. On 1 May 2017 medication was also administered twice - late afternoon and night. The records show that the nursing staff administered the prescribed medications to Prisoner G twice daily (morning and night) from 2 May 2017 to 5 May 2017.

4.6 On Tuesday 2 May 2017 at 12:22 Chief Nurse Officer A recorded on the PHMS notes “*Picked medication up from G.O. this am and appointment for 4th May with (Dr A)*”.

4.7 On 5 May 2017, Nurse Officer C, who was on night duty, administered prescribed medication to the deceased in his cell at 20:09. His cell was then closed and locked for the night.

5.0 **Other relevant facts**

5.1 At 11:55 on 4 May 2017 Prisoner G was taken from Limerick Prison by Gardaí on foot of a warrant, for further questioning. He was returned to the prison at 20:10 that evening and placed back in Cell 4 on D4 landing.

5.2 On 5 May 2017 Prisoner G was escorted to Limerick District Court at 09:45 where he was further remanded in custody to Limerick District Court on 9 May 2017. According to the prison records he was returned to Limerick Prison at 11:50 that day.

5.3 Officer B reported that on the 6 May 2017, in the course of checking cells on D4 landing Prisoner G was discovered in his cell at approximately 05:00 with a ligature around his neck. He was unresponsive. Officer B stated that ACO A and Nurse Officer C were alerted by radio.

5.4 Nurse Officer C stated that “*shortly after 05:00*” a radio call was received to attend Prisoner G’s cell Nurse Officer C responded arriving “*.... at the cell at approximately 05:05.*” Following an examination Nurse Officer C reported that ACO A was asked “*.. to call for an ambulance.....*” It is reported that the “*defibrillator was attached and CPR commenced immediately.*” Nurse Officer C was assisted by Officer C and they continued CPR until the arrival of the paramedics at 05:25.

6.0 **Telephone calls made by Prisoner G**

6.1 We requested the transcript of the telephone calls made by Prisoner G. The records show that Prisoner G telephoned Ms A on 30 April 2017, 1 May 2017, 2 May 2017 and 3 May 2017. In the telephone call on 30 April 2017 at 14:42 Prisoner G stated that he had not been given his medication.

- 6.2 On 1 May 2017 at 09:43 Ms A received a phone call from Prisoner G during which she told him that she had contacted the hospital and was advised that the prison medical staff had been provided with details of his medication. Ms A enquired if he felt better after receiving his medication. Prisoner G told Ms A that he had not yet received medication.
- 6.3 On 2 May 2017, during another telephone conversation with Ms A Prisoner G stated that he was given some of his medication the previous night but he didn't think it was his normal dose as this medication "*was on its own*".
- 6.4 In the course of this five minute telephone call which commenced at 15:26:30, Prisoner G also voiced distress about being on his own in the cell. He was recorded as stating "*It's too hard, I'm not able for the isolation, the isolation is too hard on me*".
- 7.0 **CCTV Footage**
- 7.1 Chief Officer B was responsible for the prison internal investigation of this death which included collating the material required by the office of Inspector of Prisons for the investigation. Chief Officer B saved and viewed the CCTV footage in relation to the activities in the vicinity of Cell 4 on D4 landing. While viewing the footage Chief Officer B prepared a written chronological timeline of events as observed on the CCTV footage commencing at 19:07 on 5 May 2017 and concluding at 06:46 on 6 May 2017. CCTV footage was not made available to the Investigation Team for the reasons outlined in section 1.10. Therefore as no footage was available for our investigation we were unable to independently view CCTV footage in relation to the death of Prisoner G.
- 7.2 Chief Officer B is to be commended for his diligence in making the written record of the CCTV footage. The record provides details of all interactions and checks conducted on Cell 4 on D4 landing from the time it was originally master locked at 19:07 on 5 May 2017 to 05:02 on 6 May 2017 when Prisoner G was discovered unresponsive in his cell with a ligature around his neck. According to the record made by Chief Officer B a total of five Prison Officers checked

Prisoner G on nine separate occasions during this period, namely Officer B, Officer C, Officer D, Officer E and Officer F.

The variation between times the deceased was checked are as follows:

- **34 minutes** between 19:07 and 19:41
- **28 minutes** between 19:41 and 20:09
- **2 hours 54 minutes** between 20:09 and 23:03
- **56 minutes** between 23:03 and 23:59
- **49 minutes** between 23:59 and 00:48
- **1 hour 9 minutes** between 00:48 and 01:57
- **57 minutes** between 01:57 and 02:54
- **1 hour 14 minutes** between 02:54 and 04:08
- **54 minutes** between 04:08 and 05:02

7.3 There was no explanation provided by the five officers as to why the cell checks were not every 15 minutes.

7.4 When provided an opportunity to review and comment on the draft report the Governor of the Prison informed the Investigation Team that staff in the area were also dealing with an incident in D2 for over two hours and details were provided. The Governor further advised that on night of 5/6 May 2017 *“there were 10 prisoners on the Spl Obs list and 9 further committals. This resulted in 768 checks on Spl obs and 2520 general checks; total of 3288. This number of spl obs and general checks is physically impossible to complete while dealing with an incident for over two hours on D2.”* The Governor also stated that the special observation protocol in Limerick *“...has since been comprehensively reviewed”*.

8.0 **Incomplete Reports**

8.1 When a prisoner dies while in the custody of the Irish Prison Service it is standard practice for a representative of the Office of the Inspector of Prisons to visit the prison where the death occurred. This initial meeting took place at Limerick Prison at 12:30 on 6 May 2017. At that initial meeting with prison

management, the records required for examination were identified and Operational Reports sought from officers who had contact with Prisoner G for a 72 hour period prior to his death.

- 8.2 There was one officer detailed in-charge of D4 Landing on the night of 5/6 May 2017 namely Officer C. However, our investigation found that five officers conducted the cell checks during the night of 5 and morning of 6 May 2017 on D4 landing. Despite several requests made by this Office (nine in total) no explanation was provided by the officer detailed in-charge of D4 landing or by the other four officers who assisted in checking Prisoner G's cell as to why five officers conducted these checks on D4 landing on the night in question. Please see explanation provided at section 7.4 above.
- 8.3 The short reports received from Officer B, Officer C, Officer D and Officer E lacked specific information regarding their full tour of duty on the night of 5 May 2017 and morning of 6 May 2017. Officer B reported finding Prisoner G at "around 0500" on 6 May 2017, Officers C, D and E's respective reports relate to their response to the call for assistance. None of the officers provided particulars of their detailed post/duty on the night in question and no officer mentioned how frequently they checked the cell of the deceased.
- 8.4 The local Chairperson of the Prison Officer Association Officer G responded on behalf of the officers to our requests for additional information. The response from the POA Official is dated 27 April 2018 as follows: *"In response to requests for further statements from the relevant officers you will be aware that we have sought to review the CCTV footage for the night in question in order to enable all officers to give a full, comprehensive and accurate account of all their interactions with [Prisoner G] in the period immediately before his death....."* The POA representative further stated that; *"All officers are eager to submit their reports and bring this matter to a close but have been hampered in that they have not been allowed to review the CCTV footage to refresh their memories given that the incident occurred nearly 12 months ago"*.
- 8.5 The POA representative may not have been made aware when replying on behalf of these officers, that this office requested additional details prior to

April 2018. The information from all officers who had contact with Prisoner G was initially requested on the date of his death i.e. 6 May 2017 when the Inspectorate attended the prison and agreed with the Chief Officer on duty the information required to complete our investigation. There were at least nine subsequent requests for a detailed account from these officers on the events of the night of 5 May and morning of 6 May 2017.

8.6 One of the five officers failed to provide any report to this office prior to his retirement, eight weeks following the death in custody.

9.0 **Responding to the concerns raised by Prisoner G's friend, father and aunt.**

9.1 In paragraph 2.7, I set out a number of matters the family wished to have addressed. In this paragraph, I endeavour to address these issues:-

(i) *Is there a protocol in place in the prisons regarding the release of a suicide note to a next of kin?*

The Irish Prison Service does not have a protocol for the release of a suicide note to the next of kin. Any note left is taken as evidence by the investigating Gardaí for the attention of the Coroner.

(ii) *Can a suicide note only be given to blood relatives?*

As a suicide note is taken as evidence by the investigating Gardaí, the release or otherwise of such notes is a matter for An Garda Síochána and the Coroner.

(iii) *Where is the necklace that Prisoner G had in his possession?*

We could find no evidence that Prisoner G was in possession of a necklace when he was committed to prison. The inventory of property in the possession of Prisoner G on his committal does not record a necklace.

(iv) *Why were Prisoner G's belongings not given to Ms A as the stated next of kin?*

We were informed that Prisoner G's father called to the prison for his son's belongings and they were released to him.

- (v) *Please check if Prisoner G spoke to officers on the night of his death regarding the 'Darkness into Light' event.*

Our enquiries failed to establish if Prisoner G discussed the 'Darkness into Light' event with officers on duty on the night of his death. In correspondence with the Office of the Inspector of Prisons Governor A stated "[Prisoner G] *did not have a conversation around the Pieta House run with prison staff.*"

- (i) *Was Prisoner G properly supervised while in prison?"*

Prisoner G was placed on the Special Observation list which in accordance with IPS policies and procedures requires a prisoner to be checked every 15 minutes. As Prisoner G was locked back from 19:07 on 5 May 2017 to 05:02 on 6 May 2017 thirty nine (39) checks should have been completed. The CCTV records provided to the Inspectorate indicate nine checks were completed. Therefore Prisoner G was not checked every 15 minutes. The intervals between the checks on his cell varied from 28 minutes to 2 hours 54 minutes.

10.0 **Findings**

- 10.1 Prisoner G was alone in his cell when found unresponsive with a ligature around his neck on 6 May 2018.
- 10.2 Prisoner G had disclosed to Assistant Governor A and Nursing Staff that he had been an inpatient in an Acute Psychiatric Unit just prior to his committal to Limerick Prison and informed them that he should be taking medication.
- 10.3 Prisoner G was placed on the Special Observation list by both Assistant Governor A and Nurse Officer A following their committal interviews with Prisoner G. Nurse Officer A's records note that prisoner G denied any thoughts of suicidal ideation or self-harm.

- 10.4 There is nothing in the records reviewed to suggest the Nursing staff were informed by the Operation staff that Prisoner G had medication in his possession on committal.
- 10.5 There is no evidence in the records examined that the Nursing staff were informed that Prisoner G's medication and prescription had been placed in the General Office. An office which closed over the Bank Holiday weekend.
- 10.6 The Prison Nursing staff made contact with the Nursing staff in the University Limerick Hospital to ascertain what medication had been prescribed to Prisoner G prior to his discharge from hospital.
- 10.7 The records show that Prisoner G declined to be examined by a Prison Doctor following committal to Limerick Prison.
- 10.8 Prison medical records show that the Prison Doctor prescribed medication following the Nurses contact with the hospital. According to the records the prescribed medication was administered to Prisoner G by the Nursing staff from late afternoon 1 May 2017 until 5 May 2018.
- 10.9 As Prisoner G was on the Special Observation list he should have been checked every 15 minutes. It is clear from the chronological timeline of events, as recorded by Chief Officer B that these checks were not carried out every 15 minutes.
- 10.10 The five Prison Officers who performed checks of cells on D4 landing on the night of Prisoner G's death failed to provide comprehensive statements despite numerous requests from this office.
- 10.11 CCTV footage was initially saved by the prison but subsequently could not be located by the I.T. staff at Irish Prison Service Headquarters.
- 10.12 Prisoner G made phone calls to Ms A, on 30 April, 1, 2 and 3 May, 2017.

- 10.13 The ‘Committal Details Form’ of property in possession of Prisoner G on committal did not record details of medication, prescription or the medical appointment letter which were in his possession on committal. This is not in compliance with Rule 8(1) of the Prison Rules 2007-2017 which provides as follows: *“The Governor shall maintain an inventory of all articles including money brought into the prison by each prisoner, or handed in or sent to the prisoner for his or her use, and every such article shall be placed in the custody of the Governor who shall make a record thereof in that inventory.”*
- 10.14 Prisoner G was removed from the prison by Gardaí at 11:59 on 4 May 2017 for questioning and was returned to the prison at 20:10 on 4 May 2017.
- 10.15 Prisoner G was removed on escort from the prison at 10:20 on 5 May 2017 to attend Limerick District Court. He was returned to the prison at 11:50 on 5 May 2017 on further remand to appear at Limerick District Court on 9 May 2017.
- 10.16 Prisoner G had no visits during the period he was detained on remand in Limerick prison. Prisoner G’s friend stated they found it extremely difficult to make an appointment. There was no available visit slot provided from the date of his committal on 29 April 2018 until 8 May 2017 – nine days following his committal. This is not in compliance with Rule 35(3) of the Prison Rules 2007-2017 which states that: *“Subject to the provision of these Rules, an unconvicted prisoner shall be entitled to receive one visit per day from relatives or friends of not less than 15 minutes in duration on each of six days of the week, where practicable, but in any event, on not less than on each of three days of the week.”* Ms A had booked a visit, which was scheduled for 8 May 2017.

11.0 **Recommendations**

Special Observations

- 11.1 It is noted in the circumstance of this case the Governor has stated that staff were unable to conduct 15 minute special observation checks due to other operational demands on the night – see paragraph 7.4. In such circumstance the Officer in charge of the division/landing should document the reason for non-

compliance with Irish Prison Service policy and procedure at the first opportunity following his/her return to their post. All such entries should be counter-signed by the Supervising Officer (Assistant Chief Officer / Chief Officer, as appropriate or in their absence the person designated with that responsibility) when conducting his/her checks.

Property

- 11.2 All property in the possession of a prisoner who is committed to prison should be fully recorded and a detailed description entered in the prison records. Irish Prison Service Management must ensure that there is a section in the Property Journal to record details of all personal property in the possession of a prisoner on committal. Prison management must ensure that immediate steps are taken to ensure that the Prison Information Management System (PIMS) is fully and accurately completed ensuring that the 'Property Description' is correctly completed and should include a record of medication (in general terms) in a prisoner's possession on committal. This recommendation was also made in previous reports including H/2014, A/2017 and B/2017.

Visiting

- 11.3 Irish Prison Service should review its visitor booking system to ensure that visitors of unconvicted prisoners are facilitated with visits in accordance with Rule 35(3) of the Prison Rules 2007-2017.

CCTV

- 11.4 All CCTV must be saved as soon as possible following a serious incident and/or death in custody and it should be 'locked-down/ secured' electronically to avoid deletion.

Policy and Procedures

- 11.5 A centralised Policy and Standard Operating Procedures should be developed to ensure the Nurse in-change is notified immediately when a new committal has in his/her possession medication and/or medical related material.

- 11.6 A centralised Policy and Standard Operating Procedures should be developed to provide clarity in relation to the return of personal items following a death in custody.

Access

- 11.7 No medical items should be placed in an area to which Nurses do not have 24 hour access, 365 days of the year.

Reports

- 11.8 To ensure full and accurate recall on the sequence of events a detailed operational report should be obtained from all staff who had a duty in the supervision of the prisoner and/ or a role in a critical incident such as a death in custody, before they report off duty on the date of the incident.