



OIFIG AN CHIGIRE PRÍÓSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF
Mr N
AGED 24
ON REVIEWABLE TEMPORARY RELEASE FROM
MIDLANDS PRISON

ON 7 August 2019

Date draft report submitted to the Irish Prison Service: 16 March 2021

Date final report submitted to the Minister for publication: 23 March 2021

[Date published: 22 April 2021]

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GLOSSARY

| | |
|------------|------------------------------------|
| Act | Prisons Act 2007 |
| CAP | Care After Prison |
| CRS | Community Return Scheme |
| CSS | Community Support Scheme |
| IOP | Inspector of Prisons |
| IPS | Irish Prison Service |
| NoK | Next of Kin |
| OIP | Office of the Inspector of Prisons |
| RTR | Reviewable Temporary Release |

PREFACE

The Office of Inspector of Prisons (OIP) was established by the Department of Justice under the Prisons Act 2007 (the Act). Since 2012, the Minister has requested the Inspector of Prisons to investigate deaths in prison custody. In 2018, clarification was received that the Inspector is also requested to investigate the death of any person which occurs within one month of their temporary release from prison custody. The Office is completely independent of the Irish Prison Service (IPS). The Inspector of Prisons and staff of the OIP are civil servants, however, they are independent of the Department of Justice in the performance of statutory functions.

We make recommendations for improvement where appropriate; and our investigation reports are published by the Minister for Justice, subject to the provisions of the Act, in order that investigation findings and recommendations are disseminated in the interest of transparency, and in order to promote best practice in the care of prisoners.

Objectives

The objectives for Inspector of Prisons investigations of deaths in custody are to:

- Establish the circumstances and events surrounding the death, including the care provided by the IPS;
- Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in future;
- Ensure that the prisoner's family have an opportunity to raise any concerns they may have, and take these into account in the investigation; and
- Assist the Coroner's investigative obligation under Article 2 of the European Convention on Human Rights, by ensuring as far as possible that the full facts are brought to light and any relevant failing is exposed, any commendable practice is identified, and any lessons from the death are learned.

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises interviews with staff, prisoners, family and friends; analysis of prison records in relation to the deceased's life while in custody; and examination of evidence such as CCTV footage and phone calls. The Office of the Attorney General has informed the IPS and Inspector that the provisions of the Act in relation to accessing healthcare/medical records of deceased prisoners in relation to investigations of deaths in custody cannot be relied upon. As an interim arrangement pending legislative amendment, the IPS has agreed to release such records with consent from Next of Kin (NoK). This inevitably leads in some instances to a failure to review healthcare/medical records

where NoK is unknown, cannot be located, or refuses to provide consent. It was not deemed necessary to access the healthcare/medical records for the purposes of this investigation.

This report is structured to detail the events leading up to Mr N's Reviewable Temporary Release (RTR) on 4 June 2019 and events following receipt of RTR.

A standardised checklist of information requirements from the IPS to assist an investigation into deaths in custody (while on Temporary Release) is in place. On 09 August 2019 the IPS Operations directorate provided the OIP with a completed checklist, all relevant information requested was attached.

Family Liaison

Liaison with the deceased's family is a very important aspect of the Inspector of Prisons role when investigating a death in custody.

The OIP contacted Mr N's NoK, his mother, by letter on in August 2019 and by telephone in June 2020. The role of the OIP in relation to an investigation her son's death was explained. Mr N's mother did not wish to meet with the OIP and said she had no concerns she wished to raise. Mr. N's mother confirmed she had been contacted prior to the release of Mr N from custody. Mr N's mother stated that she confirmed her willingness to have Mr N reside with her following his release.

Although this report will inform the Minister for Justice and several interested parties, it is written primarily with Mr N's family in mind. I offer my sincere condolences to them for their sad loss.



PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)
23 March 2021

SUMMARY

Mr N was aged 24 years when he was committed to Midlands Prison on 1 April 2019. He had a remission date of 29 June 2019 which was extended to the 21 November 2019 following a Court appearance on 16 May 2019.

At a Community Support Scheme (CSS)¹ review meeting on the 24 July 2019 Mr N was recommended for reviewable temporary release (RTR) to the CSS to commence on 1 August 2019.

In sanctioning Mr N's temporary release the necessary arrangements were made in advance for Mr N to reside with his mother and receive addiction support.

Mr N was released from Midlands Prison on RTR on 01 August 2019.

Mr N presented at his initial appointment with a Care After Prison (CAP)² support worker on 1 August 2019 in the Portlaoise Office. At the meeting the RTR conditions were explained to Mr N. Mr N was informed he would be required to engage weekly with a support worker in the Dublin Office of CAP, these meeting were arranged on the same day Mr N was to sign-on in Mountjoy Prison.

On the 8 August 2019 Mr N did not present for his appointment with CAP. A support worker made contact with Mr N's mother who reported that Mr N had passed away at home the previous day.

The cause of Mr N's death is a matter for the Coroner.

¹ Structured form of temporary release for those doing a sentences of 3 months to 1 year

² Community Based Project which supports people affected by imprisonment

MIDLANDS PRISON

Midlands Prison is a closed, medium security prison for adult males. It is the committal prison for Counties Carlow, Kildare, Kilkenny, Laois, Offaly and Westmeath. It has an occupational capacity of 845 beds.

Mr N was the 4th death of a prisoner in the custody of Midlands prisoner in 2019. At the time of his death he was on RTR and died in the community. His death was the 14th death in IPS custody that year which met the criteria for investigation by the OIP.

FINDINGS

BACKGROUND AND TIME IN PRISON CUSTODY

Mr N was aged 24 years when he was committed to Midlands Prison on 1 April 2019.

On foot of a Production Order Mr N again appeared in Court on 16 May 2019. He received sentences of 9 month and 3 month on the charges preferred which ran concurrently with his previous sentence. Mr N's release date was subsequently extended from the 29 June until the 21 November 2019.

Mr N was on the enhanced level of the prison incentivised regime³.

On 24 July 2019 Mr N was assessed as suitable for release to the Community Support Scheme (CSS). He was approved Reviewable Temporary Release (RTR) to the scheme from 1 August 2019 with a condition to sign on at Mountjoy Prison on a weekly basis.

The Care After Prison CSS manager confirmed Mr N's address with his mother on 29 July 2019 who confirmed her willingness for Mr N to reside with her with the structured support of the CSS.

Mr N undertook to adhere to the following conditions when he was released on RTR on 1 August 2019:

1. Not to drive any Motorised Propelled Vehicle
2. Be of good behaviour
3. Do not convey messages in/out of prison
4. Keep the Peace
5. Report to [specified] (24hr) Garda Station within 24 hours of release & daily thereafter to get TR form stamped
6. Report to Mountjoy Prison (Male) on date and time listed
7. Shall be of sober habits
8. Shall not enter a pub, club or other licensed premises or off-licence premises
9. Shall reside at [specified address]
10. Agree not to change address [specified] without new TR Form
11. Must link in with and attend all appointments arranged by the community support worker

EVENTS FOLLOWING RECEIPT OF REVIEWABLE TEMPORARY RELEASE (RTR)

On the day of Mr N's release, 1 August 2019, he presented at his initial appointment with a CAP support worker in their Portlaoise office. Mr N's RTR conditions were explained to him. He was informed that he was required to engage weekly with a CAP support worker and on the same day sign on at Mountjoy Prison.

³ The Incentivised Regimes Programme provides for a differentiation of privileges between prisoners according to their level of engagement with services and behaviour. The objective is to provide tangible incentives to prisoners to participate in structured activities and to reinforce good behaviour, leading to a safer and more secure environment. There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level.

Mr N was provided with an appointment card with contact details for the Dublin CAP office. He was asked to provide a mobile number but as he did not have a mobile phone he provided his mother's mobile number for contact purposes.

On 2 August 2019 Mr N's CAP support worker made contact with the community addiction team in Mr N's locality to link him back in with that service. The CAP support worker tried to make contact with Mr N on 2 August 2019 to introduce himself to the community addiction team but was advised by Mr N's mother that Mr N had gone out.

On 6 August 2019 the CAP support worker made contact with Mr N to remind him of his appointment in CAP on 8 August 2019.

On 8 August 2019 Mr N did not present for his appointment with CAP. A support worker made contact with Mr N's mother. The support worker was informed that Mr N had passed away at home the previous day.

Recommendations

There are no recommendations in this report. Mr N was assessed as suitable for RTR and all appropriate arrangements in terms of securing accommodation and a CSS place were put in place.

The OiP expresses its condolences to the family of Mr N.