



OIFIG AN CHIGIRE PRÍOSÚN
OFFICE OF THE INSPECTOR OF PRISONS

INVESTIGATION REPORT
INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF
Mr D /2019
AGED 33 years

In Wheatfield Prison on 23 March 2019.

[Date finalised: 14 June 2021]

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GLOSSARY

Act	Prisons Act 2007
AGS	An Garda Síochána
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CSC	Close Supervision Cell
DG	Director-General
DiC	Death in Custody
GP	General Practitioner
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
P19	Form that is completed when prisoners are disciplined
PHMS	Prisoner Health Management System
PIMS	Prisoner Information Management System
SOP	Standard Operating Procedure

PREFACE

The Office of the Inspector of Prisons (OIP) was established 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). My colleagues and I in the OIP are civil servants, however, we are independent of the Department of Justice in the performance of our 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 other evidence such as CCTV footage.

The Office of the Attorney General has informed the IPS and Inspector that the provisions of the Prisons Act 2007 regarding 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. Mr D / 2019 NoK provided consent to me to access his healthcare/medical records for the purposes of this investigation.

This report is structured to detail the events leading up to, and the response after Mr D /2019 was found unresponsive in his cell while in the custody of the Irish Prison Service at Wheatfield prison.

Administration of the Investigation

The OIP was notified by phone of Mr D's passing on the morning of 23 March 2019. The Inspectorate visited Wheatfield Prison at approximately 12 noon on the same day. Prison management provided a briefing and confirmed that CCTV footage for relevant areas of the prison had been saved. Mr D's cell was viewed and information requirements for the investigation were agreed. Subsequently on 27 March 2019 the Inspectorate returned to Wheatfield Prison to interview and take statements from relevant Officers. On 3 July 2019 the Inspectorate reviewed Mr D's healthcare records maintained on the Prisoner Health Management System (PHMS).

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.

On 9 April 2019 a meeting was held with Mr D's mother and a friend at which the Inspectorate explained and outlined the independent investigation that it was undertaking under section 31 of the Prisons Act 2007 into the death of Mr D while in the custody of the IPS. Mr D's NoK expressed their concerns and the questions in their own words that they wished to have answered were as follows:

1. What were the definitive procedures to be followed by Irish Prison Service (IPS) staff who were responsible for the care of Mr D on the night and morning of his death?
2. Is there a log of checks undertaken by staff during the night of his death?
3. Can the log be filled in after an occurrence/incident?
4. What is the officer checking for when they check the cell?
5. Do they record what they see, i.e. whether the prisoner is awake or asleep when checked?
6. Do they make a written record of what they see in those checks?
7. What time was Mr D found?
8. Gardaí said Mr D was pronounced dead at 9:30am is that correct?
9. What was the definitive time of death?
10. What happened between the time Mr D was found and when contact was made with the family?
11. What happened between the time Mr D was found in the cell and pronounced dead?
12. What time was the cell door opened?
13. Was Mr D in a "strip cell" on his own?
14. Is it normal procedure to place someone in a "strip cell on" committal?
15. Was Mr D in that cell since the Thursday prior to his death?
16. Had Mr D his own clothes on? Family were told by Gardaí his clothes were outside the cell.
17. What clothes had Mr D on – was he naked?
18. Was there a toilet in the cell?
19. If so, did Mr D have control over the flushing of the toilet?

20. Why did it take so long for the IPS to contact the family?
21. Why did it take so long to arrange for someone to accompany the Chaplain to go to the house?
22. What efforts were made to contact the NoK on their mobile phone?
23. When did the IPS last update Mr D's next of kin details?
24. Is there an IPS protocol to contain an incident, i.e. to inhibit information from leaking and spreading until the family are notified?
25. If Mr D was in an area where prisoners are restricted i.e. 'strip cell', how did prisoner(s) in another area of the prison hear about Mr D's death and contact people outside of the prison?
26. Gardaí stated that a bag with brown substance was found in his cell, is that correct?
27. Where did the substance come from?
28. Was the cell cleaned before Mr D was placed in it?
29. Gardaí said Mr D had drugs internally, is that correct?
30. When Mr D came back into prison did the IPS take a urine sample from him to see if he had drugs in his body?
31. If the IPS thought Mr D had drugs internally – it's a ticking bomb. Mr D was in their care, did they carry out a comprehensive medical check on him?
32. Is there an x-ray machine similar to what is in an airport which would show if there is anything internally?
33. How long before we get the Coroner's Report?
34. Can we get a copy of the toxicology report before the Inquest?
35. Will the IPS have the toxicology report before the Inquest?
36. Why did the prison management not know where Mr D's body was when the NoK attended the prison?
37. Are there GSM jammers to stop illegal use of mobile phones by prisoners?
38. Why was Mr D's prison account closed so promptly after his death?

The NoK was informed that our investigation would endeavour to answer their questions and they are addressed throughout the body of this report. It was pointed out that some of their questions related to matters for the Coroner to determine and therefore fell outside of the scope of our investigation. Q 37 is not answered as its disclosure may be prejudicial to the security of the prison. In addition to the questions answered throughout this report we can confirm that in relation to Q 38 it is usual IPS procedure that such accounts are closed as soon as possible following a death..

Although this report is prepared at the request of the Minister for Justice it is written primarily with Mr D's family in mind. My colleagues and I offer our sincere condolences to them for their sad loss.

The draft report contained seven recommendations. This report was sent to the Director General of the Irish Prison Service on 15 March 2021 for review, comment and an Action Plan to address the recommendations. The Director General accepted all seven recommendations. An Action Plan for Implementation of the recommendations was received on 11 June 2021.

PATRICIA GILHEANEY
Inspector of Prisons
14 June 2021

RECOMMENDATIONS

Recommendation 1: IPS should put in place appropriate controls to ensure adherence to the provisions of Rule 11 of the Prison Rules 2007-2017. (see page 10)

Recommendation 2: The admission to prison of a person subject to Rule 11, should be automatically notified to healthcare by triggering a notification on PIMS to the PHMS. This timely notification would alert healthcare so that the provisions of the Rule will be addressed within the required timeframes. (see page 10)

Recommendation 3: Medical and Nursing personnel should contemporaneously record medical and nursing interventions on the PHMS. (see page 10)

Recommendation 4: IPS should ensure compliance with its own SOP regarding observation of prisoners detained in CSC's. (see page 12)

Recommendation 5: All persons who are to be subject to 'Special Observation' should be clearly identified on the 'Special Observation List', irrespective of where in the prison they are being accommodated. (see page 12)

Recommendation 6: When the IPS is checking random samples of CCTV footage it should ensure that written records are accurate as evidenced by CCTV footage. (see page 12)

Recommendation 7: The IPS should ensure that accurate records are maintained and any failure to do so should be appropriately addressed. (see page 13)

The IPS accepted the seven recommendations. An Action Plan, outlining how the recommendations would be addressed that is Specific, Measurable, Achievable, Realistic and Time-bound (SMART) was requested and provided.

WHEATFIELD PRISON

Wheatfield Prison is a closed, medium security prison for adult males. It has an operational capacity of 600 prisoners¹.

Mr D's was the first death of a prisoner in Wheatfield Prison in 2019; and at the time of his death he was the fourth person to die in IPS custody in 2019.

FINDINGS

CHAPTER 1: Background.

Mr D was committed to prison on 6 May 2010. He served his time in a number of prisons including Mountjoy, Castlerea, Midlands, Wheatfield and Shelton Abbey. As part of his preparation for release he transferred from Wheatfield Prison to Shelton Abbey Open Prison on 5 November 2018. At that time he had a release date with remission, of 10 October 2019.

It was reported on the Prisoner Information Management System (PIMS) that on 9 March 2019 Mr D was to be subject to a prison disciplinary process (a P19 hearing) in relation to reports number 48 and 49, for 'prohibited article' (not specified in the documentation received) and 'positive urine sample for opiates'. The following day, 10 March 2019 at 11:30 to 12:30 he received a visit from three males. Also on 10 March 2019 he absconded from Shelton Abbey Open Prison and was categorised as Unlawfully At Large (UAL).

Eight days later on 18 March 2019, Mr D contacted the prison (Shelton Abbey) to inform them he would return the following day. He was requested to present himself at Wheatfield Prison as that was the last closed prison he had been in prior to his transfer to the open prison.

On 18 March 2019 Chief Officer A in Shelton Abbey sent an email to Wheatfield Prison to inform the Governor that Mr D was going to return to custody voluntarily and he was going to report to Wheatfield Prison on the 19 March 2019. Mr D also contacted Wheatfield Prison on 18 March 2019 and informed them he would return to custody the following day.

¹ www.ips.ie

CHAPTER 2: Committal and time in Custody prior to Mr D being found unresponsive.

Mr D did not present himself at Wheatfield Prison on 19 March 2019.

On 21 March 2019 at 12:10, he presented himself at the gate of Wheatfield Prison and was admitted in to custody. He was taken to reception at 12:15 and was processed in reception as a new committal by the Reception Officer which included updating the IPS records to show that he was back in custody. As he had absconded for 11 days, his date of release with remission was re-calculated and his new date for release with remission was 19 October 2019 with his sentence expiration date being 10 December 2023.

As Mr D had been returning to prison from a period of being unlawfully at large, he was not allowed to mix with the general prison population. At 14:00 Mr D was taken to West 2 landing where he was placed in cell 17 while awaiting the searching and cleaning of Cell 11 to be completed. Cell 11 on West 2 landing is a designated Close Supervision Cell (CSC). The furnishings are minimal, however, there is in-cell sanitation and the occupant has control over the toilet flushing mechanism. The use of a CSC is governed by the IPS policy on the use of such cells. As the name suggests, persons placed in CSC's are subject to close supervision i.e. checks at 15 minute intervals. Mr D was brought to cell 11. He was searched and provided with refractory clothing.

As a new committal, Rule 11 of the Prison Rules² 2007-2017, relating to medical examination was applicable to Mr D. Rule 11 provides as follows:

"11. (1) Subject to paragraphs (2) and (6), each prisoner shall be examined separately by a doctor on the day of his or her admission to a prison for the purpose of-

- (a) the diagnosis of any physical or mental illness and the taking of such measures as are necessary to ensure that any such illness is treated,*
- (b) the isolation of, on medical grounds, a prisoner suspected of having a contagious condition or any condition that might threaten the health or wellbeing of others if they were to come into contact with him or her,*
- (c) the determination of the prisoner's fitness for work,*
- (d) the noting of any physical or mental conditions that might impede the prisoner's integration into the prison regime or into society upon his or her release,*
- (e) the noting of any indication of recent injuries, and*
- (f) the recording of any medication prescribed for the prisoner.*

(2) Save in the most exceptional circumstances, a prisoner admitted to prison on the day of his or her committal, at a time when a doctor is not available, shall, immediately following his or her committal, be given a preliminary medical screening by a nurse officer, or any other person duly authorised in that behalf, and

² S.I No. 252 of 2007

shall then be examined by the prison doctor on the first scheduled visit of the prison doctor to the prison following his or her committal.

(3) Each prisoner on transfer to another prison shall be examined by the prison doctor on the first scheduled visit of the prison doctor to the prison after the transfer.

(4) The prison doctor shall determine what use shall be made of medicines brought into the prison by a prisoner.

(5) A prisoner who attends court and returns to the prison within 24 hours of leaving it shall not be required to be examined by the prison doctor unless particular circumstances exist that require his or her medical examination.

(6) The prison doctor may, as he or she considers appropriate, examine separately a prisoner prior to his or her final discharge from prison.

(7) All medical examinations by a prison doctor shall, except where the prison doctor, on grounds stated and recorded, requests otherwise, take place out of sight and hearing of persons other than healthcare professionals.”

On the day of committal, unless in the most exceptional circumstances, (none of which were identified during the investigation), Mr D should have been examined by a doctor, or if a doctor was not available immediately following his committal, a preliminary medical screening should have been carried out by a nurse officer. This did not happen. It is recorded in the minutes of the Critical Incident Review Meeting that convened on 25 March 2019 that Chief Nurse Officer A (CNO) stated that there was “No record of Nursing Committal Interview or GP interview – only recorded interaction was the Code Red Call on Saturday.” “No baseline Nurse assessment – appears the Surgery were not informed of the Committal.”

The IPS Standard Operating Procedure (SOP) OP 11-002, Administration of processing a prisoner at Reception, with an effective date of 01/08/18 (updated 20/08/19) was provided to the OIP on request. *It is noted that at section 4.1.2 “The ACO must notify the Administration Staff (if their prison Administration Staff carry out this function), and the Nurse Officer that the prisoner is committed.”* Whilst this is welcome, it remains open to human error and an automatic notification at the point of committal should be considered.

Recommendation 1: IPS should put in place appropriate controls to ensure adherence to the provisions of Rule 11 of the Prison Rules 2007-2017.

Recommendation 2: The admission to prison of a person subject to Rule 11, should be automatically notified to healthcare by triggering a notification on PIMS to the PHMS. This timely notification would alert healthcare so that the provisions of the Rule will be addressed within the required timeframes.

Recommendation 3: Medical and Nursing personnel should contemporaneously record medical and nursing interventions on the PHMS.

Mr D was not on any medication during his time in Wheatfield Prison. Nurse Officer A informed the Inspector of Prisons that in normal course nursing staff are informed when a prisoner is placed in a CSC for management reasons.

Chief Officer B visited Mr D in the CSC at 18:40 on 21 March 2019 and he reported that he spoke to him and asked why he had absconded from Shelton Abbey.

He also reported that he asked Mr D if he had *“brought any contraband back into Wheatfield, to which he stated that he did not bring anything back with him”*. The Chief Officer reported that he explained to Mr D that he would have to remain in the CSC overnight for observation as he had returned from being Unlawfully At Large. He signed his name in the CSC log book and in the observation column he wrote *“from UAL. remain in CSC”*. That is the only record in the log book showing the reason for Mr D being held in the CSC.

The dedicated log book for the CSC for 22 March 2019 records that Mr D was given his breakfast at 08:00, dinner at 12:00 and that he declined his teatime meal but accepted a carton of milk. It records the officers who were the Breakfast, Dinner, Tea and Night Guards. The log also records that at 09:30 Mr D was seen in the cell by Dr A with the recorded entry *“No medical issue”*.

Mr D was visited in his cell at 10:23 on 22 March 2019 by Governor A accompanied by Chief Officer C with a recorded entry in the log book of *“No issues raised”*. At the same recorded time, Chief Officer C who accompanied the Governor signed the log book.

The minutes of the Critical Incident Review meeting that convened on 25 March 2019 records Governor A's recollection as follows:

“Met [Mr D] at approx. 10:23 on Friday 22nd, along with CO C. There was a Nurse in the vicinity, along with Officer A. [Mr D] was calm and in good form. He said his details were all the same. That he had messed up in Shelton and gone UAL from there. Asked if he was seen by a Doctor, and he said yes, and everything was OK. It is confirmed by the report book that he was seen by Dr A with Nurse Officer B present at 9:30 am. (Should be a record of this on PHMS).”

A dedicated log book is kept to record all periods a prisoner is held in a CSC. The record maintained shows that Mr D was placed in Cell 11 at 14:30 on 21 March 2019. Not all of the required fields in the log book were completed, such as, the reason for and background to placement in a CSC.

The log book is signed by the ACOs in charge of the landing during the day and night of 21/22 March 2019 and by Tea Guard and Night Guard. It is signed by the Assistant Chief Officer (ACO) in charge during the day on 22 March 2019 and by the Breakfast, Dinner, Tea and Night Guards on 22/23 March 2019.

The log book also records that Mr D received breakfast at 08:00 and dinner at 12:00 on 22 March 2019 and declined his teatime meal.

At 18:41 Chief Officer C visits Mr D briefly in the CSC and then visited other cells. The Chief Officer initialed the log book and recorded the time of the visit.

Night Guard Officer E signed the log book in the designated section for the Night Guard. In his statement, given to the OIP on 27 March 2019, he acknowledged that he took up duty at 19:30 on 22 March 2019 on West 2 and West 3 landings and he was told there were no issues when taking up duty on the landings.

Officer E stated that at about 8:15pm he reported the number of prisoners on the landings to Supervising Officer A who gave him a copy of the special observation list of prisoners. These are prisoners who must, as dictated by IPS Policy, be checked every fifteen minutes. He noted that Mr D's name was not on the list.

Officer E stated that he commenced his watch tours at 21:00 and he noted that Mr D was lying on his right side. He checked at 22:00 and observed Mr D lying on his left side and that "*...he jumped in the bed with the noise of me lifting the flap to check on him.*" He stated that at 23:00 Mr D was in the same position in the bed. When he checked Mr D at 24:00 midnight he had moved "*to lie on his back in the bed.*" He stated he checked Mr D every subsequent hour up to 07:00 and on each occasion Mr D was in "*the same position in the bed.*"

The log book recorded that officers observed Mr D in his cell every fifteen minutes from 08:00 on 22 March 2019 until 07:45 on the morning of 23 March 2019 as is the IPS Policy in respect of prisoners who are held in a CSC. These observations were recorded by means of placing a tick in the column for the time and indicating whether the prisoner was awake or asleep, agitated or passive and signed by inserting the writers' initials. All entries show that Mr D was either asleep or awake at the time of the checks.

Officer E on duty on the night of 22/23 March 2019, stated that he checked on the cell at hourly intervals throughout the night but completed the record of checks as being every fifteen minutes. The CCTV reviewed as part of this investigation confirmed that hourly checks were conducted. However, it does not support the written record that checks were conducted every fifteen minutes. When shown the log book entries, Officer E acknowledged that he had completed the '15 minute checks' section of the form as having conducted checks every fifteen minutes between 20:00 and 07:30 and initialed same, although he had checked every hour. He stated "*although this form is completed I did not complete 15 minute checks as Prisoner D was not on the Special Obs list.*" Falsification of official records is a serious matter and the IPS and oversight bodies should be in a position to rely on the veracity of such records. This is not the first occasion where this Office has identified confusion in relation to the frequency of observation required for individuals placed in CSC's.

The OIP is aware that in 2019 the IPS introduced the viewing of random samples of CCTV to ensure compliance with its standard operating procedure regarding prisoner observation.

Recommendation 4: IPS should ensure compliance with its own SOP regarding observation of prisoners detained in CSC's.

Recommendation 5: All persons who are to be subject to 'Special Observation' should be clearly identified on the 'Special Observation List', irrespective of where in the prison they are being accommodated.

Recommendation 6: When the IPS is checking random samples of CCTV footage it should ensure that written records are accurate as evidenced by CCTV footage.

Recommendation 7: The IPS should ensure that accurate records are maintained and any failure to do so should be appropriately addressed.

CCTV footage viewed showed that on 22 March 2019 at 18:33 Officer A and Officer B escorted Mr D from his cell and brought him down stairs to a rear doorway for the opportunity to smoke a cigarette. He returned to the CSC at 18:39. Both officers confirmed this in their operational reports. They both stated that at the time they escorted Mr D downstairs they “*conversed with him and his mood was good and did not appear under the influence of anything or in any way inebriated or in ill health.*”

The dedicated CSC log book does not contain a record that Mr D was taken from his cell so that he could smoke a cigarette nor that the Chaplain called to his cell on 21 and 22 March 2019 offering to meet with him, which he declined on both occasions.

Mr D was recorded as being placed on the standard level of the incentivised regime¹ while in custody at Wheatfield Prison.

There is no record of Mr D having made any phone calls or of having any visitors following his committal to Wheatfield Prison on 21 March 2019.

There is a cell call system which facilitates the occupant to seek the assistance of staff by activating a switch which turns on a light outside the door of the cell and also activates a light and buzzer in the Class Office. A review of the cell call system for Cell 11 on West 2 landing, showed that there were no activations of the cell call from Cell 11 from the time Mr D was placed there on the 21 March 2019 to when he was found unresponsive at 08:10 on 23 March 2019.

This indicates that at no time did Mr D activate the call bell to seek assistance.

CHAPTER 3 EVENTS WHEN Mr D WAS FOUND UNRESPONSIVE

On 23 March 2019 Officer B took up duty relieving the Night Guard at 07:35. He commenced checking the prisoners in their cells and at 07:38 he checked Mr D's cell, he lifted the viewing flap and looked in. He saw Mr D in bed and reported that he appeared to be asleep. Having checked all cells he started preparing for the opening of the cells for the delivery of breakfast.

At approximately 08:10 Officer C and Officer D arrived on the landing with breakfast and went to Mr D's cell (Cell 11 CSC). On unlocking the cell Officer C called to Mr D but received no response, and, as the Officers entered the cell they continued to call, without receiving any response. Officer C felt the back of Mr D's hand and he was cold to touch. He told Officer D to call a medic immediately.

At 08:11:09 Officer D went to the class office and called a code red for West 2 landing.

¹ 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.

Nurse Officer C who was in East 2 landing preparing morning medications, responded immediately and went directly to West 2 landing, arriving at Cell 11 at 08:12:29. Within one minute Nurse Officer D arrived, at 08:13:39.

Nurse Officer C reported on 23 March 2019 at 09:12 as follows:

“Responded to code red call to West 2 @ approx. 08:10. Second responder Nurse D followed closely behind.

On arrival to cell [Mr D] was lying on his back. Unresponsive to verbal and painful stimuli. No Carotid, radial or brachial pulse present on palpation. No chest movements. No respirations. Pupils fixed and dilated. Body cold to touch. My assessment found him incompatible with life. Body rigid and fixed. Conclusion rigor mortis. Findings concurred by Nurse D

Rizla paper wraps observed on floor of cell.

Guards contacted by operational staff. [Medical agency] contacted and Doctor on the way.”

Nurse Officer D reported that she entered the cell and found Mr D lying on the bed and concurred with Nurse Officer C’s assessment that there were no signs of life.

At 08:15 all staff exited the cell and the cell door was closed and locked.

At 08:20 Governor B and Chief Officer C visited the cell.

At 09:05 members of An Garda Síochána visited the cell.

At 09:30 Dr B and Nurse Officer C arrived at the cell and a Garda recorded the doctor’s name prior to his entry into the cell. Dr B noted that Mr D was wearing prison clothes - a pants and a gown. He was fully covered and had ankle length socks on both feet. He was lying on his back. Following clinical assessment Mr D’s death was pronounced at 09:35.

At 09:36 a Garda Scene of Crime Examiner entered the cell. Mr D’s clothing, which was outside his cell, was removed by An Garda Síochána (AGS). AGS took photographs before and after Mr D’s remains were removed from the cell. They removed the following items: blanket; plastic wrappings with brown residue (cell floor); white wrapping under mattress; black under armour runners (outside cell); navy under armour track bottoms (outside cell); navy/blue under armour top (outside cell); white North face t-shirt (outside cell).

At 10:35 the remains of Mr D were removed from the cell by undertakers and taken for post mortem.

At 12:35 the OIP accompanied by Governor A and Chief Officer D entered and viewed the cell.

Contact with Mr D's family after his death

At 09:35 on 23 March 2019 Prison Chaplain A was present at cell 11 on West 2 when the doctor pronounced Mr D's death. Governor A requested Chaplain A to notify the NoK of the death of Mr D.

At 09:45 Chaplain A obtained the NoK details that were on PIMS and accompanied by Chaplain B, left the prison to go to the home address recorded on the PIMS for Mr D's mother, who was listed as his NoK.

On arrival at the address they got no reply so they decided to contact Mr D's mother by phone and at approximately 10:35 it is reported that Chaplain B spoke to the NoK on the phone and told her he was at her address and wished to speak with her. According to the Chaplains report Mr D's mother stated that she no longer lived at that address and that she was already on her way to the prison as she had been informed from someone inside the prison that her son was dead. It is reported that Mr D's mother was in a distressed state and wanted to know why she had not been informed earlier.

The Chaplains returned to Wheatfield Prison. At 11:40 Chaplain A met Mr D's mother and brother and brought them to the conference room to meet with Governor A and Chief Officer D to inform them of what had occurred.

At 11.55 Chaplain A escorted the family members from the prison. They were distressed having learned that Mr D's remains had been removed for post mortem.

On the 25 March 2019 Campus Governor A met Mr D's mother and uncle. Mr D's mother told him of her distress and dissatisfaction of having learned of her son's death in prison from a prisoner in Wheatfield and not from the Management of the prison in a timely fashion. Campus Governor A explained that the Management were required to wait until a doctor had formally pronounced death before they could inform NoK that a death has occurred. He explained that as soon as this had happened at 09:35 on 22 March 2019 the Chaplain was asked to go to the home of the NoK to personally inform them of Mr D's death. The address that was on Mr D's file was a previous address that the deceased had confirmed on his committal to prison and not the current address of the NoK .

On the 9 April 2019 the OIP met with Mr D's mother and a friend and confirmed that an independent investigation was being conducted by the OIP under section 31 of the Prisons Act 2007. The process involved and possible timeframe were outlined.

Critical Incident Review

On 25 March 2019 a critical incident review meeting was held in the boardroom at Wheatfield prison, chaired by Governor A and attended by A/Governor A, Chief Officer D, Chief Officer C, Chief Officer E, Chief Nurse Officer A, ACO A, Officer E, Officer F, Psychologist A and Chaplain A. Minutes were recorded by PCO A.

The meeting was opened by Governor A, who expressed the sympathies and condolences of management and staff of the prison to the family of Mr D on his death.

The meeting reviewed the sentences Mr D had been serving, the fact that he had absconded from Shelton Abbey on 10 March 2019, his subsequent contacts with Shelton Abbey and Wheatfield Prison to arrange to return to custody and his eventual return to Wheatfield Prison on 21 March 2019. Mr D's time in custody since his return to prison was discussed. It was noted in the record of the meeting that a Nurses Station in reception was to be commissioned as a matter of urgency.

The cause of death is a matter for the Coroner.