INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF

Mr A 2019

AGED 22

IN MIDLANDS PRISON ON 27 JANUARY 2019

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INSPECTOR OF PRISONS INVESTIGATION REPORT

MR A 2019

CONTENTS	**PAGE**
GLOSSARY	03
PREFACE	04
SUMMARY	07
RECOMMENDATIONS	10
MIDLANDS PRISON	10
FINDINGS	
Chapter 1: BACKGROUND	11
Chapter 2: TIME IN CUSTODY	11
Chapter 3: SEQUENCE OF EVENTS on 26 AND 27 JANUARY 2019	12
Chapter 4: NOTIFICATION OF NEXT OF KIN	13
Chapter 5: CRITICAL INCIDENT REVIEW	14

GLOSSARY

Act	Prisons Act 2007
ACO	Assistant Chief Officer
AGS	An Garda Síochána
CCTV	Close Circuit Television
CPR	Cardiopulmonary Resuscitation
GP	General Practitioner
Inspector	Inspector of Prisons
ISM	Integrated Sentence Management
IoP	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
P19	Form that is completed when prisoners are disciplined
PAMS	Prisoner Account Management System
PGH	Portlaoise General Hospital
PHMS	Prisoner Health Management System
PIMS	Prisoner Information Management System
SOP	Standard Operating Procedure
SSO	Staff Support Officer

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR A 2019

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 (IoP) 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 Prisons Act 2007 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. Mr A’s NoK provided consent to the Inspector to access his healthcare/medical records for the purposes of this investigation.

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR A 2019

This report is structured to detail the events leading up to, and the response after Mr A's death

Administration of the Investigation

The OIP was notified of Mr A's passing on the 27 January 2019. Staff of the OIP visited Midlands Prison on 28 January 2019. Prison management provided a briefing and confirmed that CCTV footage of the prison had been saved. Mr A's cell was viewed and information requirements for the investigation were agreed. Operational reports were sought from relevant staff outlining what had occurred and their respective responses. Statements were taken from relevant staff and prisoners.

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.

Mr A's family were contacted by letter and subsequently by telephone. A meeting was held on 16 May 2019 with Mr A's grandparents who informed us that his mother was too upset to attend. We explained our role and the objectives of the investigation. Mr A's grandparents brought with them beautiful gifts that their grandson had crafted from matchsticks during his time in prison.

Mr A's grandparents informed us that they were unhappy in how their daughter, Mr A's mother, was notified of the death of her son. We were informed that she received a phone call in or around 04:00hrs and at the time she was on her own with her five children. We were also informed that Mr A's father had died suddenly the previous year and Mr A found it difficult to cope following the death.

Mr A's grandfather stated that during the time Mr A was in prison they found it very difficult to book a visit. He stated that the staff were very pleasant when they did attend the prison and also praised the prison chaplains who they often contacted.

Mr A's grandparents were upset the day they collected their grandson's personal belongings and they felt their upset was compounded by the requirement to go through the search area, with drug dogs present. They suggested that the Prison Service should have an area before the search area where personal belongings could be received by the family.

The requirement to obtain NoK consent to view Mr A's medical records was explained. As Mr A's mother was not present they took the form to speak with her and undertook to revert. A signed form of consent for the release of medical records held by the IPS was subsequently received. The concerns that the family raised are addressed throughout the report.

Although this report is for the Minister for Justice it will also inform several interested parties. It is written primarily with Mr A's family in mind. My colleagues and I offer our sincere condolences to them for their sad loss.

There are two recommendation for improvement. A copy of the final draft of the report, including the recommendations was provided to the Irish Prison Service on 23 March 2021 for review, comments and an Action Plan. A response was received on 29 April 2021. The IPS part-accepted recommendation one and accepted recommendation two.

An Action Plan was provided for the recommendation accepted and areas of responsibility and timelines were included. Implementation of the Action Plan will be monitored in future inspections and or investigations into deaths in custody.

The recommendations and reason for the part-acceptance of recommendation one by the IPS are provided in the following Summary section of the Report.

PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)
1 July 2021

SUMMARY

Mr A was 22 years of age when he died in custody at the Midlands Prison. He had a good disciplinary record. It is reported that he got on well with staff and fellow prisoners. He worked in the kitchen and was described as an excellent worker.

Mr A had been committed to Midlands Prison on 27 June 2018 and had a date of release with remission of 26 December 2019. Mr A's Court Order included an order that whilst in custody he was to receive psychiatric support. Mr A had a history of serious self-harm and was referred to the in - reach psychiatric team following his medical committal interview. The IPS records demonstrated that Mr A received psychiatric support while in custody.

In November 2018 and January 2019 Mr A applied for a transfer to Shelton Abbey Open Centre, both requests were refused. Assistant Chief Officer (ACO) A reported speaking to Mr A before Christmas 2018 in relation to the refusal of his request for a transfer to an open centre and he discussed a progression plan with Mr A. ACO A stated that Mr A understood why his request was refused and he seemed willing to engage with services. ACO A reported being surprised to hear that Mr A had put in another request for a transfer to Shelton Abbey in January 2019.

On 22 January 2019 Mr A's grandmother contacted prison Chaplin A as Mr A had informed his grandfather that he did not want them to visit him the following day. Mr A's grandmother considered that this request was out of character and, as Mr A had in the past self-harmed and had attempted suicide, she alerted the Chaplain to her concerns. Chaplain A went to Mr A's cell to meet him. However, he was not there as he was in the gym. The Chaplain brought the family concern to the attention of ACO B and the Class Officer on B landing where Mr A was accommodated and also notified the Officer who took up night duty on B landing on 22 January 2019.

On 23 January 2019 Mr A's grandfather visited Mr A in Midlands Prison. Chaplain A attended the visiting area and met with them during the visit.

On 24 January 2019 Mr A did not attend work. He told Officer A that he was not in good form. Officer A made arrangements for Mr A to take the weekend off work and he contacted Chaplain A to request the Chaplain to have a chat with Mr A. On 25 and 26 January 2019 Chaplain A visited Mr A on his landing and reported finding him relaxed and in good form.

Prisoner A a Red Cross Listener, reported speaking to Mr A on several occasions during the week prior to Mr A's death. Prisoner A stated that Mr A was "down in himself" early in the week. Prisoner A stated that he met with Mr A again on Friday 26 January 2019 and Saturday 27 January 2019 and he felt that Mr A appeared in better form.

On the morning of the 26 January 2019 Mr A had a long visit with his uncle and a friend. According to prison records Mr A made two phone calls on the 26 January 2019. The first call was at 19:03 and lasted 6 minutes 14 seconds and the second call followed immediately at 19:09 and it lasted 2 minutes 43 seconds. Both calls were to a female friend. Following the calls he went to his cell and closed out the door which was subsequently master-locked for the night.

The Night Guard, Officer B on B3 landing, took up duty at 19:30 on 26 January 2019 and checked Mr A in his cell. Mr A was checked again at 20:00 and every hour thereafter which was in accordance with IPS policy at the time. The Night Guard recalled that Mr A was not in bed at 01:00 or 02:00 when he checked the cell. When he checked him at 03:00 he saw Mr A "*suspended by a ligature*..." and immediately sought assistance.

Nurse Officer A attended Mr A and received no response to verbal stimuli and Mr A was cold to touch. CPR was not commenced as there were no obvious signs of life. Dr A was called and he pronounced the death of Mr A at 03:3O.

There is no evidence that Mr A expressed any intention to self-harm on the days prior to his death.

The cause of death is a matter for the Coroner.

Mr A's NoK raised the following queries and issues they wished to have clarified:

Mr A's mother was alone with her five children when she received the call in the early hours of the morning notifying her of the death of her son. Why was Mr A's mother notified by phone and not contacted by An Garda Síochána or local Priest?

The IPS Protocol in relation to the notification of the NoK titled 'Chaplaincy and Next of Kin Notification' states that "*the Chaplain as one of two people … will travel to the home of the next of kin to inform them immediately of the death of the prisoner*" but If this is not possible due to distance the chaplain will endeavour to make contact with the family by telephone. As the home of Mr A was circa 50 km from the prison and to ensure that the family were notified as soon as possible a decision was made by prison management to notify the NoK by telephone and Chaplin B telephoned Mr A's mother.

Were details of his required medication sent to the prison by the Courts Service and was Mr A receiving his prescribed medication?

There was no letter from the Courts Service regarding Mr A's medication. Mr A's medication was prescribed by the prison doctor following confirmation from his community GP on 28 June 2019. The Court Order dated 27 June 2018 stated that whilst in custody Mr A should receive psychiatric support and attend any courses available in relation to carpentry. The medical records showed that Mr A was referred to and did engage with the Psychiatric Services while in prison and was administered his psychiatric medication on a daily basis by the Nursing staff throughout his time in Midlands Prison.

Mr A was very disappointed that he was not approved for a transfer to Shelton Abbey open prison and he was agitated about this. Why was his request for a transfer to Shelton Abbey refused?

Prison Service records showed that Mr A's application for a transfer to Shelton Abbey Open Centre was discussed at a Prisoner Review Meeting at the Midlands Prison. The Prisoner Information Management System (PIMS) showed that the transfer request was refused. There was no reason recorded on PIMS documentation received as part of this investigation, however on enquiry, the IPS informed the Inspectorate that the decision was made having regard to matters such as; regime level, work in the prison, disciplinary record, the nature and gravity of the offence, engagement with addiction services, length of sentence, term of the sentence completed and the views of An Garda Síochána. In making the decision the group noted that Mr A was on the enhanced level of the incentivised regime, he was working in the kitchen and had an excellent disciplinary record. ACO A stated that as Mr A was not long into his sentence a transfer to Shelton Abbey was unlikely. Those at the Prisoner Review Meeting discussed strategies, including engagement with support services, which would help Mr A progress to securing a transfer to Shelton Abbey.

How could Mr A have died in his cell?

Mr A was checked hourly in accordance with the IPS policy at the time. The Officer on duty reported that Mr A was awake at the 01:00 and 02:00 cell checks. At the 03:00 check the officer noted Mr A was suspended by a ligature. The cause of Mr A's death is a matter for the coroner.

Why were Mr A's grandparents security screened when entering the prison to collect their grandson's personal belongings?

Security screening for all persons entering prisons was introduced by Ministerial Order in 2008. As a result all persons (staff, prisoners and visitors) must submit to screening on entering a prison.

RECOMMENDATION

Recommendation 1

IPS management should ensure that there is clear communication in advance to the family of a deceased person as regards the security requirements placed on them when entering a prison to collect person belongings; consideration should be given to all such meetings taking place in an area (such as the Visitors waiting area) where security screening is not required.

The IPS response:

Operations management shall issue a circular regarding the importance of clear communication with the family of a deceased person regarding security requirements.

Consideration will be given to the availability of areas where security screening is not required however it is important to note that this is not always an option depending on the location of the DIC.

Recommendation 2

The IPS should give consideration to reviewing the Protocol on 'Chaplaincy and Notification of Next of Kin' to provide for the assistance of An Garda Síochána in a situation where contact with the NoK cannot be made in person in a timely manner. [Page 14]

The IPS response:

The Notification of Next of Kin protocol is to be reviewed when the arrangements for out of hours services by Chaplains is agreed with staff representatives.

MIDLANDS PRISON

Midlands Prison is a closed, medium security prison for adult males, located at Dublin Road, Portlaoise, Co. Laois. It is the committal prison for Counties Carlow, Kildare, Kilkenny, Offaly and Westmeath. It has an operational capacity of 845 beds. On 27 January 2019 it accommodated 824 prisoners.

Midlands prison has a Visiting Committee whose role is to frequently visit the prison; meet with prisoners and hear their complaints; and report to the Minister on matters of concern.

Mr A was the first death of a prisoner in Midlands Prison in 2019 and the first death in IPS custody that year that met the criteria for an investigation by the OIP.

INSPECTOR OF PRISONS INVESTIGATION REPORT

MR A 2019

FINDINGS

CHAPTER 1: BACKGROUND

Mr A was committed to Midlands Prison on 27 June 2018. Mr A had a date of release with remission of 26 December 2019.

Mr A's Court Order included a provision that he receive psychiatric support in custody and attend any courses available in relation to carpentry. IPS records showed that Mr A was referred to and engaged with the psychiatric services and was employed in the carpentry workshop for a period before moving to a full time a position in the kitchen.

CHAPTER 2: TIME IN CUSTODY

Mr A was in a single cell, cell 35 on B3 landing at the time of his death.

He had no disciplinary breaches recorded against him. ACO B noted that Mr A's behaviour was exemplary, he worked well in the kitchen and he attended the gym regularly.

Mr A was on the enhanced level of the Incentivised Regime[1]. He was in receipt of a gratuity of €18.90 per week. There was nothing unusual regarding Mr A's spending pattern in the prison tuck shop and he had a balance of €74.85 in his account at the time of his passing.

Mr A freely associated with all other prisoners on B3 landing, interacting well with staff and other prisoners.

Mr A had regular visits and phone calls with his family and friends.

Medical History

A medical committal interview and assessment was undertaken by the prison GP on the 28 June 2018 during which Mr A's medical history was explored. It was recorded that Mr A had a history of depression prior to his committal to prison. He availed of mental health services having had two serious incidents of deliberate self-harm, one four years and the second eighteen months prior to his committal. He was on prescribed psychiatric medication at the time of his committal to prison. The GP referred Mr A to the In-reach Psychiatric Team, he attended his first appointment on 6 July 2018.

Mr A was assessed and reviewed by the Psychiatric Team three times within a month of his committal and monthly from August 2018 to November 2018. Records showed that at each appointment with the Psychiatric Team Mr A denied any thoughts of self-harm or suicide. On 6 November 2018 Mr A was discharged back to the care of the prison GP and remained on psychiatric medications throughout his imprisonment. His medication was administered on a daily basis by the nursing staff.

[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.

Mr A attended the doctor's surgery on seven occasions during his period of imprisonment in relation to minor physical ailments. He attended Portlaoise General Hospital (PGH) for x-ray on 11 September 2018 for a minor injury.

Senior Probation officer A stated that Mr A was discussed at the Multi Agency meetings held on 12 July 2018, 26 July 2018, 23 August 2018, 30 August 2018 and 4 October 2018. The Multi Agency meetings [for prisoners under the care of the psychiatry team] are attended by a Governor, a Chief Officer, the Chief Nurse Officer, a Chaplain, Psychologist, Integrated Sentence Management Officer and the relevant ACO who has knowledge of the person(s) being discussed. The group noted that he had a history of self-harm, attempted suicide and had contact with his local Mental Health Team in the community prior to committal. Senior Probation Officer A reported that it was noted at the five meetings that Mr A denied any current thoughts of self-harm or suicide during recent assessments. Senior Probation Officer A also reported that they had begun their engagement with Mr A and on 16 January 2019 and that he (Mr A) had been referred to the Psychiatric services in accordance with the Court Order. There is a record of Probation Officer B's request for a referral on the Prison Health Management System (PHMS) to comply with the original Court Order. However, as stated earlier in this report in accordance with the Court Order Mr A had been referred to the Psychiatric Service by the Prison Doctor in July 2018 and had engaged with that Service until his discharge back to the care of the Prison Doctor in November 2019.

CHAPTER 3: SEQUENCE OF EVENTS ON 26 AND 27 JANUARY 2019

On Saturday 26 January 2019 Officer C was in charge of B3 landing and recalled speaking to Mr A on a number of occasions during the day in relation to his phone card. Mr A also enquired about magazines that had been left into the prison for him. Officer C told Mr A that the magazines had to be cleared by the censor's office and he would collect the magazines the following day. Officer C reported giving the list of his active phone card numbers to Mr A at approximately 18.55 on Saturday evening. Officer C reported that there was nothing unusual noted when the prisoners were counted at approximately 19:00.

According to prison records Mr A made two phone calls on the 26 January 2019, the first at 19:03 which lasted 6 minutes 14 seconds and the second at 19:09 which lasted 2 minutes 43 seconds both to a female friend.

CCTV footage showed Mr A returning to his cell at 19:14 and closing the cell door. At 19:18:54 an Officer can be seen going to his cell, lifting the viewing flap looking into the cell and locking the door. The cell is then master locked for the night. Mr A's cell was checked on four occasions from 19:18:54 up to 20:58:55 and hourly checks were carried out throughout the night.

The Night Guard, Officer B, reported taking up night guard duty on B3 landing at about 19:30 on 26 January 2019. Officer B checked all cells on B3 landing and at about 19:45 reported the prisoner numbers to the ACO in charge of the Keys Office. Officer B stated that all prisoners on B3 were checked at 20:00 and every hour thereafter. Officer B recalled checking Mr A's cell at about 01:00 and 02:00 and reported that Mr A was not in bed at those times. The CCTV footage confirmed that Mr A's cell was checked at those times. Officer B stated that on one occasion Mr A was at the toilet and on the other occasion he was sitting at the table in his cell. The Officer stated there was nothing unusual noted and there was no conversation between them. Officer B looked through the viewer of Mr A's

cell again at 03:00 and on this occasion Mr A was suspended by a ligature, assistance was immediately sought.

Supervising Officer A, who was nearby responded, got the master key and unlocked the cell. Officers D, Officer E and Officer F also responded, all four stated they entered the cell, removed the ligature using the Hoffman knife and placed Mr A on the bed.

Nurse Officer A reported receiving a radio call at approximately 03:00 from Supervising Officer A requiring assistance on B3 landing and reported that on arrival to cell 35 was informed that a ligature had been removed and that Mr A had been placed in a supine position on the bed.

Nurse Officer A examined Mr A and reported finding no response to verbal stimuli. Mr A was cold to touch, had no signs of life, no radial or carotid pulses and his pupils were fixed and dilated and had nil reaction to light. The Nurse Officer reported that there was a ligature mark and bruising evident around Mr A's neck, his lips were cyanosed and mottling was evident on his hands. The Nurse Officer recorded that CPR was not commenced as there were no obvious signs of life. Nurse Officer A stated that ACO A called for an ambulance while the Nurse Officer returned to the main surgery to contact Doctor A.

ACO A reported receiving a radio call for help on B3 landing. ACO A went to B3 and was informed of the death of Mr A. ACO A immediately initiated the "*Death in Custody*" protocols. ACO A noted that an ambulance, the fire service, An Garda Síochána (AGS), Assistant Governor A, Doctor A and Chaplain B attended the prison.

At 03:20 two paramedics from the National Ambulance Service attended at Mr A's cell.

At 03:30 Doctor A arrived at the cell and examined Mr A. Doctor A recorded that on the basis of a clinical examination the death of Mr A was pronounced at 03:30 on 27 January 2019.

At 03:35 AGS entered the cell and preserved evidence which included notes left by Mr A. When AGS left the cell they informed the Officers that the cell was to remain master locked until the scene of crime officers had attended. AGS stated they would contact the Coroner's office.

CHAPTER 4: NOTIFICATION OF NEXT OF KIN

At 03:15 on 27 January 2019 ACO A contacted Chaplin B by phone and informed him of the death of Mr A. Chaplin B went to the prison at approximately 04:00 "*anointed, said prayers and blessed Mr A*."

Chaplin B was asked by Assistant Governor A to inform the next of kin.

The IPS Protocol in relation to 'Chaplaincy and Next of Kin Notification' states:

"Should the Governor request, the chaplain as one of two people requested ….. will travel to the home of the next of kin to inform them immediately of the death of the prisoner and subsequently meet that

person at the hospital or prison. If this is not possible due to distance or other practical or security reasons, the chaplain will endeavour to make contact with the family by telephone".

The Inspectorate was informed that due to distance and to ensure that the NoK was notified as soon as possible following death being pronounced, Chaplin B telephoned Mr A's mother and informed her of the death of her son. This call was made at approximately 04:30. Later that morning at 05:58, Mr A's grandfather telephoned Chaplin B who confirmed that Mr A had died during the night.

At 14:00 on 27 January 2019 Chaplin B and Assistant Governor B met with Mr A's family at the mortuary at PGH.

RECOMMENDATION 2

The IPS should give consideration to reviewing the Protocol on 'Chaplaincy and Notification of Next of Kin' to provide for the assistance of An Garda Síochána in a situation where contact in person with the NoK cannot be made in a timely manner

CHAPTER 5 – CRITICAL INCIDENT REVIEW

A Critical Incident Review Meeting took place on 28 January 2019 at Midlands Prison. It was attended by nine staff, only two of which were involved in the incident - Doctor A and Assistant Governor A. The meeting was Chaired by Governor A.

Governor A opened the meeting by expressing the great sadness and regret of everyone with the death of Mr A and extended condolences to his family. A detailed account in relation to the sequence of events on the night of 26 January 2019 and early morning of 27 January 2019 as submitted by Supervising Officer A was included in the minutes.

Doctor A outlined some of the medical services Mr A availed of while in prison. Doctor A stated that Mr A had been referred to the In-reach Psychiatric Team on committal and he had eight appointments with the team before he was discharged in November 2018 back to the G.P. Dr A stated that Mr A remained on psychiatric medication throughout his imprisonment which was administered daily by the Nursing staff. Doctor A further reported that Mr A had some interactions with the Prison GPs for minor medical issues.

Assistant Governor A reported on the emergency response and with whom he engaged including members of AGS investigating the incident. Assistant Governor A reported that Chaplin B attended and contacted Mr A's mother by phone to inform her of Mr A's death. He stated that he remained in charge until he handed over at 09:30 to Assistant Governor B.

It was agreed that Assistant Governor B would liaise with the IoP and AGS. It was also agreed that Chaplin B would continue to liaise with the family and would be assisted by Chaplin A in arranging a prayer service on B Division and liaising with the prisoners.

It was further agreed that the Staff Support Officer (SSO) would follow up with staff and arrange a critical incident support meeting (CISM). Chief Officer A confirmed that the staff involved in the incident had been contacted and informed that a debriefing would take place on 30th January at 10am.

There is no evidence that a cold debrief was held. In previous investigation reports we recommended there should be a hot and cold debrief, for example Mr I 2018 and Mr O 2018. We are pleased to note that since the death of Mr A and prior to the completion of this investigation the Irish Prison Service had reviewed its Critical Incident Policy. The Irish Prison Service Standard Operating Procedure (SOP) entitled 'Critical Incident Reporting and Debriefing Procedures' came into effect on 1 July 2020. The new SOP provides for the holding of both a hot and cold debrief following a critical incident such as a death in custody and …"*should include, to the greatest possible extent, all the staff involved in the incident*."