Oifig An Chigire Príosún
Office of the Inspector of Prisons

INVESTIGATION REPORT

INTO THE CIRCUMSTANCES SURROUNDING THE

DEATH OF

Mr B

AGED 43

IN MIDLANDS PRISON

ON 5 FEBRUARY 2019

[Date final report submitted to the Minister for publication: 9 August 2022]

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GLOSSARY

ACO	Assistant Chief Officer
Act	Prisons Act 2007
CCTV	Close Circuit Television
CNO	Chief Nurse Officer
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
CSC	Close Supervision Cell
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 a prisoner is subject to disciplinary proceedings
PHMS	Prisoner Health Management System
PIMS	Prisoner Information Management System
SOP	Standard Operating Procedure
SSO	Staff Support Officer

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). The Inspector 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;
- 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; and
- Identify areas that may be pivotal in achieving or obstructing progress of the Department of Justice 2021 to 2023 Strategy to create a 'Safe, Fair and Inclusive Ireland' (Goals 2 and 3).

Methodology

Our standard investigation methodology aims to thoroughly explore and analyse all aspects of each case. It comprises of 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 B's NoK provided consent to the Inspector to access his medical records for the purposes of this investigation.

This report is structured to detail the events leading up to, and the response after Mr B passed.

Administration of the Investigation

The OIP was notified of Mr B's passing on 5 February 2019. At the time of his death Mr B was 43 years old. An OIP representative visited Midlands Prison the next day. Prison management provided a briefing to the OIP and confirmed that CCTV footage for relevant areas of the prison had been saved. Mr B's cell was viewed and information requirements for the investigation were agreed.

Representatives from the OIP met with Mr B's Sister and Partner in May 2019. Based on their understanding of the facts, the family raised several questions. These questions and related findings are set out in more detail in the summary of this report. In broad terms they related to whether procedures had been followed, the circumstances surrounding the death and if Mr B was administered his medication.

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.

Although this report is for the Minister for Justice it will also inform several interested parties. It is written primarily with M B's family in mind. The Office of Inspector of Prisons offer our sincere condolences to the next of kin for their sad loss.

Recommendations

There are eight recommendations for improvement. A copy of the final draft of the report, including the recommendations was provided to the Director General of the Irish Prison Service on 29 December 2021 for review, comments and an action plan. A response was received on 26 May 2022.

The IPS stated that five recommendations are already in place, two recommendations were partially accepted and one recommendation was not accepted. The IPS provided an Action Plan on 26 May 2022 outlining how each recommendation is being/will be addressed. Further details are provided in the section entitled 'Recommendations' on page 7.

Summary

Mr B was committed to Cloverhill Prison on 2 November 2018 and transferred to Midlands Prison on 3 December 2018. He had a release date with remission of 14 March 2019. Mr B had been in continuous custody for three months at the time of his death.

Mr B was placed on protection on 20 January 2019, at his own request, under Rule 63 of the Prison Rules, as amended[1]. Mr B had requested a transfer to a different prison and he was advised that his request would be considered further following completion of pending court appearances.

On 4 February 2019, Chaplain A listened to a voice message from Mr B's partner who was concerned as she had not heard from him for some time. Chaplain A went to A1 landing where Mr B was accommodated but prisoners were locked back at that time and the chaplain communicated with Mr B through the cell door. The Chaplain had concerns for Mr B's wellbeing following that engagement and alerted the Tea Guard[2], Officer A and Assistant Chief Officer (ACO) A, who was in charge of the A Division, to his concerns for Mr B's wellbeing. The Chaplain also spoke with Doctor A and following that conversation the Chaplain A sent an email at 16:50 to: (i) the Chief Nurse Officer (CNO) A, (ii) Operational Chief Officers and (iii) Chaplains informing them about the conversation with Mr B and the Doctor's recommendation that Mr B be placed on special observation. Records examined showed that Mr B was placed on the Special Observation list by the Chief Nurse Officer at 19:00.

The Special Observation List is printed down by the ACO before commencing Night Duty and a copy of the list provided to the Night Guard on each landing. There were conflicting reports as to whether or not the hard copy Special Observation list was provided to the Night Guard[3] on A1 landing on the 4-5 February 2019.

ACO B, on taking up duty at 19:30 on 4 February 2019, generated the Special Observation List and recalled that Mr B's name was on the list. ACO B reported that the list was provided to the Night Guard, Officer B. Officer B denied receiving the Special Observation List and informed the OIP they were not aware that Mr B was on Special Observation. However, Officer B recorded in the Night Guard Journal that they 'checked *on all inmates paying particular attention to those on the special observation list.'* The OIP viewed the Special Observation List and can confirm that Mr B's name was the only prisoner on A1 landing on that list.

ACO A commenced duty at 08:00 on 5 February 2019 and reported that the Special Observation List was in the A1 Class Office on the morning of 5 February 2019.

Officer C was the Class Officer on A1 landing on 5 February 2019, Officer D was the Assistant Class Officer and Officer E who was Dinner Guard[4] all reported that they did not see a Special Observation list on A 1 landing.

Following the death of Mr B, Chief Officer (CO) A, instructed ACO C to locate the Special Observation List. In an effort to locate the list, ACO C made enquiries with Officer F, who was Breakfast Guard[5] on

[1] Rule 63 of the Prison Rules 2007-2017 states a prisoner may, either at his or her own request or when the Governor considers it necessary, in so far as is practical and subject to the maintenance of good order and safe and secure custody, be kept separate from other prisoners who are reasonably likely to cause significant harm to him or her.
[2] An Officer patrolling the landings during tea break (normally from 16:30 to 17:15)
[3] An Officer working from 20:00 to 08:00
[4] An Officer patrolling the landings during dinner period (normally from 13:00 to 14:00)
[5] Officer patrolling the landings during breakfast [normally from 08:45 to 09:15]

A Division and with Officer G who was Assistant Class Officer on A2 landing. ACO C reported that Officer G located the list on A2 landing.

CCTV footage viewed showed that on 5 February 2019, Mr B collected methadone shortly after 09:00, he went to the server for lunch just before noon and returned to his cell with his meal. An Officer checked Mr B's cell on three occasions between noon and 13:22 and a nurse and an officer were outside his cell at 15:35.

Mr B was found with a ligature around his neck at 16:00 by Officer D who was the Assistant Class Officer on A 1 landing. Mr B was in a single cell.

Emergency medical attention, including CPR, was applied within minutes of Mr B being found at 16:00. Ambulance paramedics arrived at 16:15 and took over care. Mr B's death was pronounced at 16:25 by the prison Doctor.

The cause of death is a matter for the Coroner**.**

RECOMMENDATIONS

The OIP makes its recommendations based on the situation pertaining at the time of the death in custody and having regard to all available evidence gathered during the course of the investigation. As some time can elapse between completing the draft investigation report and obtaining the IPS comments on the report, it can be the case that a Policy, a SOP or new procedure(s) have been implemented by the IPS in respect of some areas on which the OIP recommendations relate to.

Recommendation: 1
The Irish Prison Service should consider availability of chaplaincy services to prisoners during the reserve period from 17:00 to 20:00 (Rostered Hours) when school and workshops are closed and prisoners are unlocked. [Page 14]

IPS Response
Recommendation was accepted. The OIP note that the recommendation is being considered as part of the IPS review of Chaplaincy which is currently underway.

Recommendation: 2
The Officer in charge of the landing should be obliged to record all concerns/incidents brought to his/her attention in the relevant Journal. The note should include the time of the report, who made the report, about whom and the nature of the concern to include action, if any taken. Such entries would ensure that all officers taking up duty on a landing and all supervising officers who check and sign the Journals are fully briefed. [Page 14]

IPS Response
"Already in place. *In 2019 the Irish Prison Service carried out a review of the policy and Standard Operating Procedures with regard to the Monitoring of Prisoners during Periods of Lock Up. The revised documents were published on the IPS Intranet and a comprehensive communications plan was rolled out to raise awareness of same. All staff should be aware of their obligations/requirements to record and note any significant information in relation to the prisoners under their supervision in the appropriate journal.*

SOP 11/21 Close Supervision Cell section 4.1 states "The Governor must ensure information pertaining to all matters relating to a prisoner is recorded in a Close Supervision Log". Further the SOP states "Each observation must be recorded in the log maintained in accordance with the protocol".

The OIP welcomes the IPS commitment to further consider the recommendation in the context of another review of the Policy and SOP in relation to the 'Monitoring of prisoners during periods of lock-up' to take place during 2022. The OIP will continue to monitor the consistent implementation of the policy and SOPs.

Recommendation: 3
A healthcare risk assessment should be completed prior to placing a prisoner on the Special Observation List to (i) determine his/her risk to self or others (ii) if the cell which they occupy is suitable accommodation as regards to potential hazards and (iii) whether any item(s) in the cell or item(s) in their possession create or heighten the risk. [Page 14]

IPS Response
Part accepted by the IPS for the following reasons: "*The requirement for a healthcare risk assessment to (i) determine his/her risk to self or other is set out in SOP 21-059-S-001 Healthcare Special Monitoring, section 3.1.(b) states "Use of this intervention is only initiated based on a thorough clinical assessment which is conducted face to face with the person in custody, by a Registered Medical Practitioner or Nurse."*

The OIP welcomes the introduction and implementation of the Healthcare Special Monitoring Standard Operating Procedure which came into effect two months after the death of Mr B.

Recommendation: 4
A Doctor or a Nurse should review a prisoner on the Special Observation List on the morning following a prisoner being placed on the list to determine if s/he requires continued special observation. [Page 15]

IPS Response
"*Already in place. The requirement to provide a clinical care plan and the recommended level of monitoring is set out in SOP 21-059-S-001 Healthcare Special Monitoring, Section 3.1.(e) states "If Healthcare Special Monitoring is required, there is a duty of care on Healthcare staff to provide an appropriate Clinical Care Plan to manage the clinical presentation in a safe and responsive manner. The formulation of the Care Plan will be undertaken in consultation with operational staff, to ensure that all relevant information is included in the Care Plan". Section 3.1.(d) states "The recommended level of monitoring must be complied with until the prisoner is removed from Healthcare Special Monitoring by the Multidisciplinary Team." Further as per Section 4.2 (h) "Continuation/deselection of inclusion on the Healthcare Special Monitoring list must be discussed and agreed at weekly MDT meeting*."

The OIP welcomes the introduction and implementation of the Healthcare Special Monitoring Standard Operating Procedure which came into effect two months following the death of Mr B.

Recommendation: 5
A Chief Officer and/or a Governor grade should visit prisoners on the Special Observation List during Governor's Parade and record the visit to include the demeanour of the prisoner in the Special Observation Book. [Page 15]

IPS Response
"Already in place. *The requirement by Governors to visit prisoners on special observation on a daily basis is set out in SOP 11/21 Close Supervision Cell section 3.3.5 states "The Prison Governor must visit each prisoner accommodated in a Close Supervision Cell on at least a daily basis". SOP 01/xx Safety Observation Cell section 4.4. h(i) states "The Governor or designate should visit a prisoner in a Safety Observation Cell at least daily*"."

The Irish Prison Service response does not address the OIP recommendation. It is noted that the IPS response refers to SOP's where a prisoner is placed in a Safety Observation or Close Supervision Cell however, in the case in question whilst the prisoner was on a Safety Observation List he was not in a designated cell falling within the terms of the SOP's quoted. The OIP would encourage the IPS to have specific regard to the oversight arrangements needed for all prisoners on the Special Observation List no matter where they are accommodated.

Recommendation: 6
The Irish Prison Service should replace the Breakfast, Dinner Guard and Tea Guard Journals with one Class Journal in which all officers assigned to the landing make daily entries including to whom they hand over responsibility for the landing. [Page 17]

IPS Response
IPS accepted the Recommendation. The OIP welcome the commitment by the IPS to consider this recommendation during their 2022 review of all Policies and SOP in relation to the monitoring of prisoners during periods of "lock up".

Recommendation: 7
When a Supervising Officer on 'handover' provides the Special Observation List to the Class Officer, Dinner Guard or Tea Guard (Receiving Officer) the names of those on special observation should be recorded in the relevant Class Journal signed and dated by both the Officer handing over the list and the Officer receiving the list to ensure there is no doubt as who is subject to checks at 15 minute intervals. [Page 17]

IPS Response
The IPS did not accept this recommendation for the following reasons:
"*This recommendation would result in duplication of effort and as such is not accepted. The observation list is readily and easily available in real time on PIMS which staff have access to. Prisoners name, wing, cell, frequency and type of monitoring is available to view on one screen. As part of the circulars referenced above, Operations will remind Governors of the importance of the special observation list and how they can easily access the list."*

As staff have access to an up-to-date Special Observation List on PIMS, the OIP would question the need for the ACO to provide the Class Officers with a hard copy list which has the potential to be mislaid.

Recommendation: 8
When a prisoner is placed on the Special Observation List, whether in his/her own cell or in the Safety Observation Cell, the Safety Observation Book should be completed and healthcare staff should conduct two hourly checks as is required when a prisoner is placed in a Special Observation Cell. [Page 17]

IPS Response

The IPS part accept this recommendation for the following reason: "*The process for placing a prisoner on special observation list for Healthcare Special Monitoring is set out in SOP 21-059-S-001 Healthcare Special Monitoring, section 4.2.(c) and 4.2.(d) state "If a decision is made by health care staff to place the person in custody on Healthcare Special Monitoring, he/she must update PHMS accordingly, inform the Governor and Chief Officer, who must in turn inform relevant operational staff. All persons placed on the Healthcare Special Monitoring List are included on The Special Observation/Monitoring List, in real time, on the Prisoner Information Management System (PIMS). The recommended level of monitoring is set out in SOP 21-059-S-001 Healthcare Special Monitoring, section 3.1.(d) states "The recommended level of monitoring must be complied with until the prisoner is removed from Healthcare Special Monitoring by the Multidisciplinary Team*."

The OIP welcomes the introduction of SOP 21-059-S-001 and will monitor its consistent implementation.

Family Questions

In relation to the queries raised by Mr B's family our findings are as follows:

What is the procedure to notify a death? Would a Garda not call to the house?

The IPS Protocol in relation to the notification of the NoK titled 'Chaplaincy and Next of Kin Notification' provides that the Chaplain as one of two people will travel to the home of the NoK 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 Mr B's family resided over 50 km from the prison, Chaplain B contacted Mr B's NoK a by telephone and also provided Garda A with Mr B's mothers' contact details.

Why was Mr B in possession of items of personal clothing if there were concerns regarding his wellbeing? Was procedure followed?

Mr B was in his own cell and was in possession of his personal belongings. He was not in a safety observation cell. If he was placed in a safety observation cell articles of clothing should only be removed if there was a risk of self-harm. As Mr B was placed on the Safety Observation List there was a requirement on officers to check him every 15 minutes. As you see from this report, the 15 minute checks were not conducted as there was conflicting reports between middle management and Officers on the landing as to whether or not the Special Observation List was provided the Officer in charge of the landing (the Class Officer).

How long was there between checks?

Details of the cell checks is as set out at Appendix A.

Was Mr B availing of recreation?

Mr B had informed prison management that his life was under threat and requested to be placed on protection. He was accommodated on A1 and informed the ACO that he was unable to mix with anyone on the landing. On 4 and 5 February 2019, CCTV footage viewed showed Mr B had limited time out of cell which was to collect meals, clean cell and collect methadone. Local prison

management informed the OIP that there were prisoners, including Mr B, who were subjected to the restricted unlock protocol as they could not mix with each other.

When was Mr B placed on Special Observation?

Mr B was placed on the Special Observation List on the 4 February 2019 at 19:00. He was not placed in a Safety Observation Cell. This is explained in more detail in the section entitled 'Special Observation List' on page 17.

Did he come out of his cell on the day he died, for breakfast, recreation, etc? Who spoke to Mr B on the day of his death? How long was he in the cell without communication?

CCTV footage showed that breakfast was delivered to Mr B's cell at 08:25 by two officers on the morning of the 5 February 2019. Mr B left his cell at 09:03 to collect his methadone and went to the Class Office to collect an electric kettle. The CCTV footage showed Mr B leaving his cell again at 11:57 to collect dinner. On his way to collect dinner Mr B could be seen looking up and he appeared to be speaking to a person on the above landing who was off camera. At 14:50 a prisoner who was cleaning the A1 landing stopped outside Mr B's cell and appeared to interact with Mr B through the cell door.

At 15:35 a nurse and an officer can be seen on CCTV footage outside Mr B's cell. The officer appeared to communicate through door.

Was Mr B told the Chaplain was not calling to see him?

When the Chaplain went to see Mr B on the evening of 4 February 2019 he told Mr B that he would call to him again the following morning. The Chaplain was unable to attend work on the 5 February 2019 but contacted a chaplaincy colleague to inform them of their concerns. The Chaplain on duty intended to call to Mr B but due to other chaplaincy commitments had not visited Mr B prior to his death.

Did he get methadone on the day?

Mr B received methadone at approximately 09:07.

Mr B was on Valium. Was he given something else?

Mr B was prescribed Valium/Diazepam. Mr B's family will be informed privately of the other medication he was prescribed and administered.

Was the call bell activated?

The cell call bell was not activated on 5 February 2019. The call bell was last activated on 4 February 2019. The officer who responded was told by Mr B that it was an accidental activation and he did not require anything.

How many Nurses were on duty?

While the total number of nurses on duty is not known, a total of four nurses immediately responded to the request for assistance.

Who found Mr B? Was Mr B found at 16:05 approximately?

Officer D who was the Assistant Class Officer on A1 landing found Mr B at 16:00.

Was he under threat? Who did he tell? Can we have details?

Mr B requested to be placed on protection having informed an ACO that he was under threat from prisoners on A2, B and D Divisions. He did not name the source of the threats. Mr B requested to be moved to a different prison. Mr B was informed by an ACO on 29 January 2019 that efforts had been made to secure a transfer but due to pending court appearances it was proving difficult and his request for a transfer would be considered again following completion of his upcoming court appearances.

Why was Mr B not moved from a cell with a broken window? Did the Governor write to headquarters re broken windows regarding the associated risk?

A broken window in the cell occupied by Mr B provided an opportunity for Mr B to secure a ligature and inflict self-harm. The Governor confirmed that IPS HQ had been made aware that a number of the windows in the Midlands Prison were in a state of disrepair at the time. In the IPS 2016-2018 Strategic Plan there was a commitment "*to replace the bulk of windows in the Midlands prison*". This project was completed in mid-2020 and all broken cell windows have now been replaced.

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 875 beds. On the 5 February 2019 Midlands Prison held 823 prisoners.

Mr B was the second death of a Midlands prisoner in 2019; and the second death in IPS custody that year which met the criteria for investigation by the OIP.

FINDING

Chapter 1 - Background

Mr B was committed to Cloverhill Prison on 2 November 2018 and transferred to Midlands Prison on 3 December 2018. He had a release date with remission of 14 March 2019. He was accommodated in a single cell on the A1 landing when he was found unresponsive with a ligature around his neck on 5 February 2019. A broken window was used by Mr B to secure a ligature and inflict self-harm. Mr B had been in continuous custody for three months at the time of his death.

Mr B also had outstanding charges and was scheduled to appear before Kilkenny Circuit Court on 20 February 2019.

Doctor A reported that Mr B had a history of polysubstance abuse, had a hearing deficit in one ear, suffered from depression and had previously attended community psychiatric services. Doctor A also reported that Mr B had been on methadone on account of opiate addiction and was attending addiction services in prison. Doctor A stated that Mr B had multiple bereavements in his family and was referred to in-reach psychiatric services in the Midlands Prison. The Psychiatric team discharged Mr B back to the care of the prison GP on 6 December 2018.

Chief Nurse Officer A reported that Mr B was on methadone and had a history of Deliberate Self-Harm that he was seen by the GP on 6 December 2018 and was discussed at the multi-disciplinary meeting. Nurse A met with Mr B on 30 January 2019 at the request of an officer on A1 landing. The identity of the officer was not recorded in the report of Nurse A. The Officer reported that Mr B was behaving strangely and had concerns for his well-being. Nurse A recorded on the Prison Health Management System (PHMS) that Mr B was on anti-depressants, he made good eye contact, and seemed to have no major issues. Mr B was placed on the list to see the GP the following day. The OIP were advised by Doctor A that Mr B was not seen on 31 January 2019 due to time constraints. Mr B was not seen by the prison Doctor between 31 January 2019 and the date of his passing.

Chapter 2 – Time in Custody

ACO D emailed CO B stating that Mr B claimed he could not mix with anyone on A2, B or D Divisions. Mr B informed the ACO that he was under threat because he refused to bring contraband into the prison for un-named persons when he returned to prison custody. Mr B told ACO D that he would not require protection if relocated to a different prison.

CO B emailed his counterparts in three prisons on 19 January 2019 with the request to secure a transfer for Mr B. One Chief Officer undertook to consider the request when Mr B had no further court appearances pending. ACO D told Mr B on 29 January 2019 that efforts had been made to secure a transfer to another prison but due to pending court appearances it was proving difficult but at least one prison had committed to consider the request when his court appearances were completed.

On 20 January 2019 Mr B was placed on protection under Rule 63 of the Prison Rules at his own request.

Mr B was on a methadone maintenance programme and received methadone on the morning of 5 February 2019. His anti-depressant medication was administered once daily. As per medical records

examined, this medication was administered on 4 February 2019 but had not been administered prior to his death on 5 February 2019.

Mr B had no P19 disciplinary reports throughout this period in custody. Mr B had no visits while he was in Midlands Prison but made 22 phone calls during this period. His last recorded phone call was on the 22 January 2019 to a family member. He received six letters throughout this period in custody, five from his solicitor and one from a family member. Mr B was on basic level of the IPS Incentivised Regime.[6]

Chapter 3: Events of 4 and 5 February 2019

Chaplaincy

On Monday 4 February 2019, Chaplain A listened to a voicemail message on the Chaplains office telephone. The message had been left by Mr B's partner on the 3 February 2019, who was concerned about Mr B as she had not heard from him for some time. Chaplain A visited Mr B at approximately 16:20 and informed him of his partners concern. Mr B wanted to talk to the Chaplain face-to-face but as prisoners were locked back for tea, the Chaplain stated that he could not gain access to the cell at that time. The Chaplain offered to talk to Mr B through the cell door and did so. It was reported by the Chaplain that Mr B asserted that he (the Chaplain) didn't care about life. The Chaplain explained to Mr B that the door could not be opened as it was lock-back and that he would speak to him in person the following morning. Mr B agreed to talk to the Chaplain on the following morning. Mr B asked the Chaplain to pass a message to his mother saying he loved her and he would come to see her soon.

Recommendation: 1

The Irish Prison Service should consider availability of chaplaincy services to prisoners during the reserve period from 17:00 to 20:00 (Rostered Hours) when school and workshops are closed and prisoners are unlocked.

Chaplain A went to the Class Office and informed the Tea Guard, Officer A of his concerns regarding Mr B's continued wellbeing. Chaplain A also went to the surgery but the CNO was unavailable. Chaplain A then spoke to ACO A who was in charge of A Division and relayed the concerns to the ACO. Chaplain A also spoke to Doctor A. Doctor A informed the Chaplain that Mr B should be placed on special observation. Following the conversation with the doctor, Chaplain A, at 16:50 sent an email to the CNO, to all Chief Officers and to Chaplains informing them about the conversation with Mr B and the doctor's recommendation that Mr B should be put on the Special Observation List. Mr B was placed on the Special Observation List by the CNO at 19:00 on 4 February 2019.

The OIP was advised by Governor B that the Healthcare clinician placing a prisoner on Special Observations Monitoring should also place that prisoner on the list for review by the GP the following morning. It is noted by the OIP that Mr B was already on the waiting list to see the doctor and had been on the list since 30 January 2019.

[2] 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.

Recommendation: 2

The Officer in charge of the landing should be obliged to record all concerns/incidents brought to his/her attention in the relevant Journal. The note should include the time of the report, who made the report, about whom and the nature of the concern to include action, if any taken. Such entries would ensure that all officers taking up duty on a landing and all supervising officers who check and sign the Journals are fully briefed.

Recommendation: 3

A healthcare risk assessment should be completed prior to placing a prisoner on the Special Observation List to (i) determine his/her risk to self or others (ii) if the cell which they occupy is suitable accommodation as regards to potential hazards and (iii) whether any item(s) in the cell or item(s) in their possession create or heighten the risk.

Chaplain A phoned Mr B's mother and passed on her son's message. Mr B's mother asked the Chaplain to tell Mr B that all was well with her, she loved him and to give her a call. The Chaplain returned to Mr B's cell at approximately 17:00, relayed the message from his mother and confirmed that he would see him the following morning. The Chaplain on leaving Mr B's cell reported that Mr B seemed content. The following morning Chaplain A was unable to attend work due to an unforeseen personal matter. Chaplain A phoned the Chaplains office and spoke to Chaplain B regarding Mr B. Chaplain B informed the OIP that they had to meet new committals and two prisoners who suffered recent family bereavements on the 5 February 2019. Chaplain B intended to also meet with Mr B but had not met with him prior to his passing.

Close Supervision Cell

On 4 February 2019 at 17:49 a prisoner was placed in a close supervision cell (CSC) at the opposite end of the landing to where the cell of Mr B was situated.

On 5 February 2019 at 09:54 a nurse and two officers were seen on CCTV footage entering the CSC. At 11:10 Doctor A accompanied by two staff enter the CSC for 2 minutes. At 11:20 Assistant Governor A accompanied by a Chief Officer and two officers enter the CSC cell for three minutes. Neither the Doctor, the Nurse, the Chief Officer nor Assistant Governor went to the cell of Mr B, who was on the Special Observation List, even though all were on the landing that morning reviewing the prisoner in the CSC.

Recommendation: 4

A Doctor or a Nurse should review a prisoner on the Special Observation List on the morning following a prisoner being placed on the list to determine if s/he requires continued special observation.

Recommendation: 5

A Chief Officer and/or a Governor grade should visit prisoners on the Special Observation List during Governor's Parade and record the visit to include the demeanour of the prisoner in the Special Observation Book.

Special Observation List

There was a Governor's Order on Special Observation in place in the Midlands Prison dated 31 January 2019. The Order required all prisoners on special observation to be checked every 15 minutes by the officer in charge of the landing on which the prisoner is accommodated. The Order required the ACO

in charge of each Division to ensure that all Class Officers are in possession of the current Special Observation List each morning. The ACO in charge of the Prison, the Night Guards, Breakfast Guards, Dinner Guards and/or Tea Guards should ensure that all officers in charge of landings are in possession of the Special Observation List. It is the responsibility of the Assistant Chief Officer in charge of each area to ensure that, at the commencement of each tour of duty, they refer to the latest copy of the Special Observation List.

There is conflicting reports between the ACO's and Prison Officers as to whether the Special Observation List was provided to the Officers on A1 landing on the night of 4 February 2019 and available to officers in charge of A1 on 5 February 2019.

ACO B took over duty at 19:30 on 4 February 2019. The ACO reported generating the Special Observation Prisoner List. ACO B recalled seeing Mr B's name on the list. ACO B stated that while escorting the nurse on the medications rounds they gave the list to Night Guard on A 1 landing Officer B.

Night Guard, Officer B, commenced duty at 19:30 on 4 February 2019. Officer B stated they were not aware that Mr B was a special observation prisoner as they did not received a Special Observation List while on duty that night. However, Officer B recorded in the Night Guard journal that they 'checked *on all inmates paying particular attention to those on the special observation list.'* The OIP viewed the Special Observation List and Mr B was the only prisoner on A1 landing named on the list.

Officer B was viewed on CCTV footage outside Mr B's cell at 22:35 for one minute and again at 22:37 for 40 seconds. As per CCTV footage Officer B checked Mr B at regular intervals (see Appendix A) throughout the night but not at 15 minute intervals. Officer B reported that Mr B was awake in his cell up until 07:00. Officer B stated that he asked Mr B if he was ok and Mr B replied 'I *am fine I just cannot sleep*'. Officer B informed the OIP that Mr B was not in poor form or agitated in anyway.

ACO A was in charge of A Division from 08:00 to 20:00 on 4 February 2019 and 5 February 2019. The ACO recalled speaking to Chaplain A before finishing duty and was informed that he had concerns for Mr B's wellbeing.

On commencement of duty on 5 February 2019 ACO A checked the Night Guard Journal and the Special Observation List. The ACO reported that the Special Observation List was in A1 Class office on morning of 5 February 2019.

ACO E was in charge of the Breakfast Guards on 5 February 2019. ACO E stated that part of their duty was to check with all Breakfast Guards to ensure they had Breakfast Guard Journals and the Special Observation List. ACO E stated that ACO B had printed a hard copy of the List the night before and that as far as they were concerned everything was in order on each Division.

Nurse B recorded in the 'nurse notes' on PHMS that CNO A asked to be reviewed during their tour of duty on the night of 4 and morning of 5 February 2019 as he had been placed on the Special Observation List. Nurse B reported that the night round commenced at 22:15 and on checking Mr B through the viewing panel on the cell door he appeared to be asleep so the Nurse left him resting.

Officer C commenced duty at 07:30 on 5 February 2019. At about 09:15 Officer D was redeployed to be Class Officer on A1 landing. Officer C was *'… aware that there was one prisoner accommodated in the Close Supervision cell' This* was not Mr B. Officer C stated that he *'was not aware of any other prisoner being on special observation on the landing.* Officer C stated that he *'was not given a list and did not see a list of special observation prisoners.'* Officer C recalled checking cell 20 (Mr B's cell) when

conducting the medical rounds but could not recall doing any other check on the cell that day. CCTV footage showed a nurse and officer on medication rounds stop at Mr B's cell at 09:50. Mr B was not administered medication at this time. See Appendix A for details of CCTV footage viewing log of cell 20 on 4 and 5 February 2019.

ACO F who was in charge during the Dinner Guard[7] on 5 February 2019 from 12:45 until 14:00 - reported attending all Divisions to confirm prisoner numbers and to ensure they were in possession of the Dinner Guard Journals and Special Observation List. When informed by the Dinner Guards that they were all in possession of the Special Observation List no further action was taken.

Officer E took up duty as Dinner Guard on the A Division at 12:30. Officer E reported conducting a full check of A1 landing at 13:25 including Mr B's cell. This check was corroborated by CCTV footage. Officer E stated that they "*didn't see any special observation list and no one brought such a list to my attention."* They stated that they were aware of one special observation prisoner but not Mr B. In the Dinner Guard journal Officer E recorded the following; "*patrolled landings throughout the break, checking all prisoners paying special attention to special obs."* There was only one prisoner, Mr B, on the Special Observation List provided to the OIP by local prison management.

Officer D was the Assistant Class Officer on A1 landing on 5 February 2019. Officer D reported that they were not aware of any prisoner on the landing being on the Special Observation List. Officer D stated that at about 15:30 when passing cell 20 they glanced into the cell as the viewing flap on the cell was up and noticed Mr B sitting on his bed watching TV. On checking CCTV footage an officer can be seen passing Mr B's cell at the 15:30, however the camera which recorded the footage was located at the opposite end of the landing and the footage was of very poor quality. The OIP was unable to determine whether or not the flap on the viewing pane was up.

Officer H who was Assistant Class Officer on A1 reported not being aware that Mr B was on a Special Observation List. Officer H stated that they did not see a Special Observation List in the Class Office and did not recall any specific interactions with Mr B.

Following the death of Mr B, Chief Officer A instructed ACO C to locate the Special Observation List. ACO C requested Officer F and Officer G who was Assistant Class Officer on A2 landing, to locate and secure the Special Observation List. Officer C and Officer D reported locating the Special Observation List in the A2 Class Office and bringing it to the A1 Class Office where ACO C reported retrieving the List and handing it to Chief Officer A in the Chiefs Office.

Recommendation: 6

The Irish Prison Service should replace the Breakfast, Dinner Guard and Tea Guard Journals with one Class Journal in which all officers assigned to the landing make daily entries including to whom they hand over responsibility for the landing.

Recommendation: 7

When a Supervising Officer on 'handover' provides the Special Observation List to the Class Officer, Dinner Guard or Tea Guard (Receiving Officer) the names of those on special observation should be recorded in the relevant Class Journal signed and dated by both the Officer handing over the list and the Officer receiving the list to ensure there is no doubt as who is subject to checks at 15 minute intervals.

[7] An Officer who takes over responsibility for a landing while the Officer in Charge (Class Officer) avails a meal break from x to y

Recommendation: 8

When a prisoner is placed on the Special Observation List, whether in his/her own cell or in the Safety Observation Cell, the Safety Observation Log Book should be completed and healthcare staff should conduct two hourly checks as is required when a prisoner is placed in a Special Observation Cell.

Chapter 4: Incident on 5 February 2019

At 16:00 Officer D went to the door of cell 20 and observed Mr B with a ligature around his neck. Officer D shouted for assistance. Officer C who was a few feet away responded and was present with Officer D while the cell door was being opened.

Officer C ran to the Class Office to get the Hoffman knife to cut the ligature and returned to the cell accompanied by Officer H Officer I and Officer J. Officer C cut the ligature and Officers H, I and J placed Mr B on the bed. The ligature was removed from around the neck of Mr B. Officer H called a Code Red (call for assistance) over the radio. Officer C reported that Nurse C responded immediately followed by Nurse E. Officer C stated that both Nurses commenced CPR. Officer C's report is corroborated by the statements of Officer H, Officer I, and Officer J.

Nurse E reported that at approximately 16:00 they responded to a call for assistance on A1 landing. On reaching cell 20 they observed Mr B with a ligature around his neck and immediately ran to the surgery, calling on the radio for the emergency bag. Nurse C along with Nurse E collected the emergency bag from Nurse D and returned promptly to cell 20. Nurse E reported requesting staff to call an ambulance. CCTV footage corroborated the report of the Nurses as the footage showed two nurses run to Mr B's cell at 16:01:40 then immediately leave the cell returning at 16:02:49 with the emergency response equipment.

On returning to the cell, Nurse E stated that Mr B was not breathing, he had no pulse, pallor face, his eyes were open, his pupils were fixed and dilated, his body was cool to touch and he had ligature marks around his neck. Nurse E placed AED pads on his chest and commenced CPR which continued until Nurse C took over.

At 16:05:00 Nurse A and Nurse F arrived and assisted Nurse E and Nurse C with resuscitation attempts. Doctor A arrived moments later and witnessed that nurses were performing CPR. When Doctor A arrived he reported that a number of Prison Officers and Management were outside the cell. The CPR was alternated between nurse colleagues and Doctor A until the ambulance crew arrived and took over his care, using a mechanical chest compression device.

CCTV footage showed 24 officers on the A1 landing having responded to the call for assistance, a number of the officers were in the vicinity of the cell door. CCTV footage showed two paramedics from the ambulance service attend the cell at 16:15 and another two paramedics attend at 16:20. The four paramedics are observed leaving the landing at 16:29. Doctor A stated that CPR was discontinued after 25 minutes as there was no response and Mr B's death was pronounced at 16:25. Doctor A is observed on CCTV footage entering the cell at 16:05 and leaving the cell at 16:28.

ACO A reported being in the A2 Governor's office on hearing a call for assistance on A1. ACO A immediately went to cell 20 and on entering the cell saw Mr B being held up by officers as another officer was trying to remove the ligature. ACO A stated Nurse E asked if an ambulance had been called and ACO A then radioed control and asked for an ambulance to be contacted. ACO A reported moving out of the cell and taking control of the personnel who had arrived to lend assistance. CO C reported that Assistant Governor A and Assistant Governor B attended A1 landing to provide assistance. When

Mr B was pronounced dead, CO C contacted Portlaoise Garda Station and requested they contact the Coroner's Office.

Chaplain B contacted Mr B's family ringing his partner at 16:45. Chaplain B then rang Mr B's brother who informed the Chaplain that he would like to be with his mother when she was being notified of her sons passing. The Chaplain rang Mr B's mother while she was in the company of her son, Mr B's brother. The Chaplain also reported saying prayers in Mr B's cell following his death.

At 17:34 CCTV footage showed members of An Garda Síochána visit the cell including the Crime Scene Examiner.

Chapter 5: Critical Incident Review

A critical incident review meeting was held on the 6 February 2019. The purpose of the critical incident meeting is to establish the facts and provide an opportunity to share views in relation to how the situation was managed, and identify any additional support or learning that could have assisted.

It was attended by 11 staff members, six of whom were involved in the incident. The meeting was chaired by Governor A.

CO C reported that some staff were in shock and had to be removed from the landing and the Staff Support Officer was requested to engage with these staff members.

Chaplain A gave an account of their interactions with Mr B on the 4 February 2019 and referenced the email sent in relation to the placement of Mr B on the Special Observation List. Chaplain A reported that they could not attend the prison on the 5 February 2019 due to an unforeseen personal matter but contacted Chaplain B and informed them of their engagement with and commitment to meet with Mr B on the morning of 5 February, 2019.

Chaplain B stated that when death was pronounced they contacted Mr B's partner, his brother and mother to notify them of the passing of Mr B. The meeting was informed that Mr B's brother was with his mother when she was notified of the death. Mr B's mother asked to see her son and the Chaplain reported explaining that members of An Garda Síochána had taken charge and the Chaplain stated they provided Mr B's mother's contact details to the members that had attended the prison.

There was no evidence that a cold debrief was held. In previous investigation reports, the OIP recommended there should be a hot and cold debrief, for example Mr I 2018 and Mr O 2018.The OIP are pleased to note that since the death of Mr B and prior to the completion of this investigation, the Irish Prison Service has reviewed its Critical Incident Policy. The Irish Prison Service Standard Operating Procedure (SOP) titled '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*."

Chapter 6: Reducing Self-Harm in Prisons

'Connecting for Life' is Ireland's National Strategy to Reduce Suicide initially from 2015 to 2020 and now extended to 2024[8]. This strategy has 7 Goals with 23 targets. Goal 5.3 is to: 'Reduce and prevent suicidal behaviour in the criminal justice system.' It recognises those in prison as vulnerable to self-harm.

The strategy creates a number of objectives and actions applicable to the Irish Prison Service:

Objective 3.1 'Improve the implementation of effective approaches to reducing suicidal behaviour among priority groups.

This gives the action as 'Integrate suicide prevention into the development of relevant national policies, plans and programmes for people who are at risk of suicide or self-harm.'

Key partners to this objective are the Irish Prison Service.

Objective 5.3 'Reduce and prevent suicidal behaviour in the criminal justice system.'

Action: Through the Death in Custody/Suicide Prevention Group in each prison identify lessons learned, oversee the implementation of a corrective action plan and carry out periodic audits and the IPS should ensure compliance with relevant policies through regular audit and implementation of audit recommendations.

Key partner is the IPS and to be chaired by a Senior Governor in each prison.

Commitment 6.2.3: The IPS will ensure that access to ligature points in cells is minimised and that this issue is given ongoing attention, particularly in the planning of all new prisons.

As outlined in page 12 of this report, the IPS 2016-2018 Strategic Plan committed "*to replace the bulk of windows in the Midlands prison*". This project was completed in mid-2020 and all broken cell windows in the prison have now been replaced which is in keeping with objectives of the strategy to reduce self-harm in prisons and minimise access to ligature points.

Chapter 7: Support Organisations

Those who are affected by a death in custody can obtain assistance or advice from a number of charities and support groups. The Office of the Inspector of Prisons has an information pamphlet for relatives and friends of someone who dies in the custody of a prison. Further information can be found on the OIP website at www.oip.ie.

[8] Connecting for Life gov.ie website link: https://www.gov.ie/en/publication/7dfe4c-connecting-for-life-irelands-national-strategy-to-reduce-suicide-201/

Appendix A

CCTV Viewing Log

Displayed time (From media Clock)	Narrative
4 February 2019	
16:00:28	Mr B exits his cell (20) and collected his tea.
16:01:23	Mr B returned to cell, cell is locked.
16:21:47	Chaplain entered picture, appeared to make passing comment to officer outside class office before making way to Mr B's cell.
16:25:40	Chaplain leaves doorway of Mr B's cell and entered class office, off picture.
16:27:00	Chaplain exited office and exited picture (leaves wing).
16:55:54	Chaplain Returned to Mr B's cell
16:57:00	Chaplain entered class office. Exited
16:59:00	Chaplain entered class office
17:00:10	Chaplain exited office and wing.
17:35:03	Officer opened Mr B cell door.
17:35:45	Mr B exited cell carrying refuse bag. Appeared to have conversation with an out of view person on A2 wing. Officer B Collected sweeping brush, collected bin bag and returned to Class Office briefly.
17:47:16	Officer goes to cell 20 and locked the cell.
17:49:10	Officer escort arrived on landing with a prisoner who was placed in the Close Supervision Cell close to class office.
17:49:54	Officer arrived to landing and attended the Close Supervision Cell
17:58:50	Officer and nurse at cell 20, medication round.
19:18:25	Officer checked Mr B cell
19:19:54	Cell master locked
19:42:49	Officer checked Mr B cell
21:01:52	Officer checked Mr B cell
22:01:52	Mr B's cell checked Officer remained at cell door until 22:02:50
22:31:40	Nurse appeared to lift flap of Mr B's cell (quality of the footage is poor).
22:31:52	Nurse moved away from cell of Mr B.
22:35:36	Officer checked Mr B cell

22:37:12	Officer checked Mr B cell
22:59:29	Officer checked Mr B cell
5 February 2021	
00:04:42	Mr B's cell checked 35 seconds at door.
01:01:02	Officer checked Mr B's cell
02:01:10	Officer checked Mr B's cell
02:59:57	Officer checked Mr B's cell
04:03:12	Mr B's cell checked - 50 seconds at door.
05:04:06	Officer checked Mr B's cell
06:05:48	Officer checked Mr B's cell
06:57:45	Officer checked Mr B's cell
07:39:31	Officer checked Mr B's cell
08:15:49	Officer checked Mr B's cell
08:25:40	Breakfast trolley at Mr B's cell, two officers were present.
08:43:22	Officer checked Mr B's cell
08:59:39	Officer checked Mr B's cell
09:03:14	Officer opens cell, Mr B exited cell to collect methadone.
09:05:16	Mr B at class office appeared to be in conversation with officer. Mr B Entered class office before appearing back on camera with kettle and proceeded to cell.
09:08:50	Officer locked Mr B's cell
09:28:14	Officer checked Mr B's cell
09:50:47	Medication round - Nurse and officer outside Mr B's cell
09:54:48	Close supervision cell. Nurse and two officers entered cell
11:10:11	Doctor and two officers entered close supervision cell for two minutes
11:21:38	Governor, Chief Officer and two officers entered close supervision cell for three minutes
11:52:25	Officer checked Mr B's cell
11:57:15	Officer unlocked Mr B's cell. Mr B walked towards servery, stopped and appeared to communicate with unidentified person from above landing. Officer moved Mr B on and Mr proceeded to servery.
11:59:38	Mr B returned to cell with meal
12:22:55	Officer checked Mr B's cell
12:25:55	Officer checked Mr B's cell, spent 20 seconds at cell door
13:21:45	Officer checked Mr B's cell
14:22:23	Prisoner escorted from close supervision cell by ACO and two officers.
15:32:33	Nurse on landing with medication trolley
15:35:16	Nurse and officer outside Mr B's cell
16:00:56	Officer at cell 20 raised alarm. Second officer near cell responded. Officers ran to the Class Office

16:01:40	Two nurses ran to Mr B cell, followed by a number of officer's (>20).
16:02:49	Two nurses return to cell with emergency bag
16:05:39	Doctor entered Mr B's cell
16:15:17	Two paramedics from the ambulance service attended Mr B cell.
16:20:10	Two further paramedics from the ambulance service attended the cell
16:28:00	Doctor departed Mr B's cell along with nurses. Doctor briefly stopped to communicate with an officer
16:29:40	Four paramedics from ambulance service departed landing
17:34:20	Members of An Garda Síochána arrived