Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr M
Aged 24

Tallaght Hospital
In the Custody of Wheatfield Prison
1st August 2019

Office of the Inspector of Prisons
24 Cecil Walk
Kenyon Street
Nenagh
Co. Tipperary
Tel: + 353 67 42210
www.oip.ie

Contents

GLOSSARY

ACO	Assistant Chief Officer
Act	Prisons Act 2007
AED	Automated external defibrillator
AGS	An Garda Síochána
CCTV	Closed Circuit Television
CO	Chief Officer
CNO	Chief Nurse Officer
CPR	Cardio Pulmonary Resuscitation
CSC	Close Supervision Cell
CT Scan	Computed Tomography Scan
DG	Director-General
DiC	Death in Custody
DSH	Deliberate self-harm
ED	Emergency Department
GP	General Practitioner
Inspector	Inspector of Prisons
IPS	Irish Prison Service
NoK	Next of Kin
Office	Office of the Inspector of Prisons
OIP	Office of the Inspector of Prisons
P19	Prisoner Disciplinary Form alleging breach of discipline
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). 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 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 M's NoK provided consent to the Inspector 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 M passed.

Administration of the Investigation

The OIP was notified of Mr M's passing on the morning of 1 August 2019. An OIP representative visited Wheatfield Prison the next day. Prison management provided a briefing and confirmed that CCTV footage for relevant areas of the prison had been saved. Mr M's cell was viewed and information requirements for the investigation were agreed.

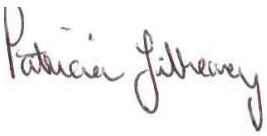
All information that was requested was provided promptly and fully by the IPS.

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.

A colleague and I met with Mr M's mother and father on 26 September 2019. Based on their understanding of the facts, the family raised several questions. These questions and related findings are set out in this report. In broad terms they related to Mr M's medication, healthcare and the timeline of his death.

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



PATRICIA GILHEANEY
Inspector of Prisons (Chief Inspector)

Summary

Mr M was aged 24 when he was found unresponsive in his cell at 08:30 on 1 August 2019. He was accommodated on unit 8G in cell 5 which was a double cell and the alarm was raised by his cellmate.

Mr M was committed to Mountjoy Prison on 15 May 2019. He was moved to Wheatfield Prison on 21 May 2019. His release date with remission would have been 7 December 2019. This was Mr M's first time in Prison.

Nursing staff contacted Mr M's pharmacy on 16 May 2019 to ascertain the usual prescription for Mr M and he was prescribed the medication advised by the pharmacy, i.e. Effexor. On transfer to Wheatfield Prison on 21 May Mr M told the nurse he was on the wrong medication and the nurse rang the GP who advised that Mr M's prescription was Lexapro. Mr M was on Effexor from 16 May 2019 until his prescription was changed on 21 May 2019 when he was prescribed Lexapro. Both medications, although different, are used to treat depression and general anxiety disorders.

The cell call alert system in Mr M's cell was activated at 08:27 on 1 August 2019 and emergency medical attention, including CPR, was applied to Mr M within minutes of the alarm being raised. Staff were alerted to the urgency of the situation and confirmation was given that an ambulance had been summoned.

CPR was administered by the Nurse Officers until the emergency ambulance paramedics arrived at the cell at 08:50 with the fire brigade paramedic arrived shortly after, they took over care.

Mr M was taken by ambulance from the prison with the escort detail at 09:15. Four paramedics administered medical treatment to Mr M on the way to the Emergency Department (ED) at Tallaght Hospital.

On arrival at Tallaght Hospital Emergency Department Mr M continued to receive medical treatment until his death was pronounced at 09:38 by the Consultant in Emergency Medicine, Doctor A.

Inspectors received uncorroborated information from Prisoner 1 suggesting that Mr M may have taken heroin the day before his passing. The investigation was unable to confirm if Mr M had taken an illicit substance.

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

Family Questions

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

1. **How long did it take for someone to arrive at the cell after the alarm was raised?**
   CCTV footage showed the cell call alarm light activated at 08:26. Officer A arrived at the door at 08:28 looked in briefly and then ran up the landing to get assistance. At 08:29 Nurse Officer A and Officer A entered the cell. Between 08:31 and 08:33 Nurse Officers B, C and D entered the cell. The paramedics arrived at 08:50 and the Fire Brigade paramedic arrived at 08:52. At 09:07 Mr M was removed from the cell on a trolley and taken to the ambulance. The ambulance left the prison at 09:15

2. **What time was he pronounced dead in hospital or did he die in prison?**
   Mr M's death was pronounced at Tallaght hospital at 09:38. Officer B who travelled in the ambulance with Mr M reported that he continued to receive treatment on the way to the hospital and also on his admittance to the ED in Tallaght Hospital.

3. **Why was his medication increased, how and when was he medically assessed?**
Mr M's medical assessments throughout his time in custody are detailed in Chapter 2. There is no evidence in the Prison medical records examined that Mr M's medication was increased while in custody. He was given an alternative medication on 21 May 2019 to that prescribed on 16 May 2019. Both medications treat depression and general anxiety disorders. Mr M's medication was administered daily by nursing staff. While in custody Mr M was seen by Nurses, Doctors and a Dentist.

4. **Did he take something, if so how did he get it?**
Mr M's cellmate suggested that Mr M may have taken heroin the day before he was found unresponsive in his cell. This investigation was unable to determine if this suggestion by Mr M's cellmate was accurate. It is a matter for the Coroner to establish the cause of death.

Recommendations

There are five recommendations for improvement. A copy of the final draft of the report, including the recommendations was provided to the Director General (DG) of the Irish Prison Service on 30 December 2021 for review, comments and an Action Plan. A response was received on 26 May 2022. The IPS accepted two recommendation, two recommendations were in place already and the IPS wish to meet the OIP in relation to one recommendation. Implementation of the action plan will be monitored in future inspections and or investigations into deaths in custody.

1. **IPS Management must ensure that all sections of Official Journals are fully and comprehensively completed in legible handwriting and all signatures are supported by block capitals. Furthermore, that regular audits of all records is carried out to ensure compliance. [Page 10]**

   Recommendation accepted by the IPS

2. **The issuing of Official Journals should be recorded in a master file showing date of issue, by who, date received and by who, location and date of completion. Only officers of ACO or above should sign for these books. [Page 10]**

   Recommendation accepted by the IPS

3. **Officers on supervisory duty in charge of the exercise yard should respond when prohibited article(s) are thrown onto the netting and make every effort to ensure that contraband is not secured by prisoners. [Page 11]**

   Meeting to be arranged between IPS and OIP

4. **Prisoners sharing a cell where a serious incident occurs should not be placed with other prisoners when removed from that cell as vital evidence could be contaminated or lost. [Page 12]**

IPS stated that the Recommendation is in place and confirmed that:

"The requirement to remove and isolate other prisoners from the cell is set out in Appendix 2 – Death in Custody – Action Checklist which forms part of SOP 11/019 Death in Custody.

The requirement to remove and isolate other prisoners from the cell is set out in Appendix 2 – Death in Custody – Action Checklist which forms part of SOP 11/019 Death in Custody.

Where a serious incident occurs, prisoners are searched, clothes removed for evidence and prisoners are placed in a free cell. This would be standard practice."

The OIP has reviewed the Death in Custody SOP (Standard Operating Procedure) 11/019. The section of the SOP referred to by the IPS in their Action Plan is a questionnaire as opposed to an instruction. It allows for the response to be yes or no, indicating this is optional. In addition, there two actions in one column 1) Remove any other prisoners from cell 2) Isolate from other prisoners. This is generic and does not instruct what action should be taken or mention where necessary, provide a change of clothing. There is also no mention of searching any prisoners sharing a cell and when or how this should be conducted. In order to meet the recommendation of the OIP an SOP should give specific instructions of actions to follow. SOP 11/019 does not meet that requirement.

5. **The recommendation in relation to cell searches in our death in custody investigation report Mr K 2018 is also applicable as a recommendation in this report i.e. that the IPS should conduct regular routine and unannounced cell searches for illicit material. The results should be made available to the Inspector of Prisons for the purposes of Death in Custody investigations. [Page 13].**

"Recommendation in place:

Insofar as resources allow, targeted (cell specific) and general area searches of prisons occur on a regular basis with the aim of retrieving contraband.

OSG regularly provide Operations and the Statistics Unit with contraband seizure figures. These figures are now available on the Prison Service website."

Wheatfield Prison

Wheatfield Prison is a closed, medium security place of detention for adult males. It has an occupational capacity of 550 beds. On the night of 31 July 2019 there were 510 prisoners in Wheatfield prison.

Mr M was the 2nd death of a Wheatfield prisoner in 2019; and the 13th death in IPS custody that year which met the criteria for investigation by the OIP.

Chapter 1: Background and Time in Custody

Mr M commenced a nine month sentence on 15 May 2019 and was due for release with remission on 7 December 2019. This was his first time in prison. He had been in continuous custody for two and a half months at the time of his death.

Mr M was transferred to Wheatfield Prison on 21 May 2019. He was accommodated on West 2 Cell 7CS, on 30 May 2019 he was relocated to cell 5 on unit 8G where he remained until his removal to hospital on 1 August 2019.

Mr M was on the standard level of the IPS Incentivised Regime[1]. He had a regular spending pattern in the tuck shop and did not make any complaints during his time in custody.

Mr M received three P.19's disciplinary reports whilst in custody; on the 26 May 2019 (abusive to medical officer), 28 May 2019 (fighting with another prisoner in the yard) and 30 May 2019 (prohibited articles). The sanctions he received included prohibition on specific activities/evening recreation, prohibition on using money/credit and a prohibition on personal visits but was allowed one visit per week with family members. The Prison Visitors Record showed Mr M had weekly visits from a family member during this period.

Mr M received continuous support from his family and partner while in custody. IPS records showed that Mr M had regular visits and made regular phone calls to his family and partner.

Chapter 2: Medical Attention Received in Custody

Mountjoy Prison

Nurse Officer E conducted a nursing committal interview with Mr M on 15 May 2019 where he gave details of his mediation and his dispensing pharmacy. Mr M informed Nurse Officer E that he did not have a history of drug or alcohol abuse and did not have any current thoughts of self-harm or suicide.

On 16 May 2019 Mr M attended a committal interview with Doctor B where the Doctor made a note on record that Mr M's antidepressant medication needed to be confirmed by his GP. On the same day Nurse Officer F contacted Mr M's dispensing pharmacy and confirmed Mr M's medication to be Effexor. The healthcare records examined showed that the dispensing pharmacy informed Nurse Officer F that Mr M was on different medication to what he (Mr M) advised Dr B he had been prescribed.

On transfer to Wheatfield Prison on 21 May 2019 Mr M told the nurse he was on the wrong medication and the nurse rang his GP who advised that Mr M's prescription was Lexapro. Mr M was on Effexor from 16 May 2019 until his prescription was changed on 21 May 2019 when he was prescribed Lexapro. Both medications, although different, are used to treat depression and general anxiety disorders.

Wheatfield Prison

Mr M was transferred to Wheatfield Prison on 21 May 2019. He had a nursing committal interview with Nurse Officer H who recorded that he reported being in good form and he was in no danger of self-harming.

Mr M had a Doctor's committal interview with Doctor C on 22 May 2019 where Mr M denied any thoughts of self-harm. Doctor C recorded that Mr M was on the antidepressant medication which had been confirmed by his GP.

[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.

On the 28 May 2019 following a fracas in the exercise yard with another prisoner Mr M was seen by Nurse Officer A. Mr M had no obvious injuries and reported that he was 'grand' and did not require any medical intervention. The following day he was reviewed by Nurse Officer I who recorded that there were '*no injuries noted or reported*'.

Mr M was placed in a Close Supervision Cell (CSC) on 29 May 2019. On examination of the Close Supervision Journal we could not ascertain why Mr M was placed in the close supervision cell as the section of the journal where such details should have been recorded was not completed. However on examination of the healthcare records it was noted that Mr M was placed in the CSC as he was fighting in the exercise yard with another prisoner. In a situation where there is an alleged breach of prison discipline a disciplinary process is commenced by way of issuing of a P.19 form which outlines the nature of the alleged breach and a hearing takes place. Assistant Governor A noted in the CSC record, which was completed at 10:45 on 30 May 2019, that there were *'No issues, p19 dealt with and he was authorised back to wing 07 G.'*

Recommendation 1:

IPS Management must ensure that all sections of Official Journals are fully and comprehensively completed in legible handwriting and all signatures are supported by block capitals. Furthermore, that regular audits of all records is carried out to ensure compliance.

In Mr Q 2019, the OIP recommended that all prison staff should be required to insert their name in block capitals beside their signature when completing all written records including prison journals. The Director General committed to making a determination by the end of September 2021. When submitting this report to the D.G. we still awaited an update on whether or not the recommendation in Mr Q 2019 has been accepted.

Recommendation 2:

The issuing of Official Journals should be recorded in a master file showing date of issue, by who, date received and by who, location and date of completion. Only officers of ACO or above should sign for these books.

On the 2 June 2019, Mr M was seen by Nurse Officer A following an email from the chaplain that his 'family was anxious about treatment for his depression while in prison.' Nurse Officer A recorded that Mr M said he was 'grand' and guaranteed his own safety. Nurse Officer A further recorded that Mr M was informed that the therapeutic level of his medication would usually be reached in 4-6 weeks. He understood that he would feel much better when this level was achieved. It was noted in PHMS he was '*for ongoing review*.'

On 14 June 2019 Mr M was seen by Nurse Officer A for a soft tissue infection on the sole of his left foot. Mr M was subsequently prescribed antibiotics for one week to clear the infection.

Mr M was seen by Dentist A on 24 June 2019 and Dental Nurse A on 27 June 2019.

Chapter 3: CCTV Footage of Mr M's Movements on 31 July 2019.

At 09:51 Mr M left his cell (cell 5). He could be seen walking up and down the Unit (8G) and interacting with a number of other prisoners. At 10:09 Mr M left his Unit and headed towards the exercise yard where he spoke to other inmates. At 10:20 Mr M entered exercise yard 2A, walked across the yard and then began to walk laps and lengths of the yard with various prisoners for the next hour. At 11:34

prohibited articles hit the yard netting and prisoners were seen throwing their runners at the net to dislodge the prohibited articles. Mr M did not get involved. At 11:34 Mr M left the yard and headed towards his Unit, he could be seen on the Unit walking up and down with various prisoners and then left his Unit at 12:12 to collect lunch at the servery. At 12:13 Mr M returned to his Unit and entered his cell, his cell was locked secure at 12:22.

At 14:14 Mr M exited his cell and entered cell 8 and subsequently could be seen walking up and down the Unit with a number of prisoners. At 14:29 Mr M left the Unit and entered the exercise yard. At 14:32 prisoners began throwing runners at the net and picking up articles that fell, Mr M was not involved. At 14:36 Mr M sat down in the yard in the company of other prisoners and the view was obscured. At 14:39 Mr M began to walk around the yard again.

Mr M returned to 8 G at 15:38. At 16:07 Mr M's cellmate went to the servery and collected tea for himself and Mr M. The cell and Unit was locked secure at 16:14.

At 17:37 the cells and Unit were unlocked. Mr M did not appear on camera until 18:33 but there was a lot of activity around his cell with other inmates coming and going to the cell. Mr M's cellmate left the cell on a few occasions during this period. At 18:33 Mr M walked around the Unit alone and with other inmates until 19:08 when the Nurse Officer administered his medication from a central point on the landing and he returned to his cell. This is the last sighting of Mr M outside his cell. At 19:17 the cells and Unit were locked secure.

Recommendation 3:

Officers on supervisory duty in charge of the exercise yard should respond when prohibited article(s) are thrown onto the netting and make every effort to ensure that contraband is not secured by prisoners.

Chapter 4: Events Surrounding Mr M Being Found Unresponsive.

Prisoner 2, who was accommodated a few cells away from Mr M in cell 8 informed the OIP that he was woken to the sound of Mr M's cellmate complaining about Mr M snoring. He stated that this was around 04:00/04:30. Prisoner 2 advised that Mr M was known to be a heavy snorer.

Mr M's cellmate Prisoner 1 also informed the OIP that he was woken at around 04:00 by Mr M snoring heavily so he leaned over the bunk bed and banged the lower bunkbed and called him. He said the snoring eased off and he put in his ear plugs. Prisoner 1 reported that he got out of bed when the door clicked open in the morning and went down to get cereal for Mr M and himself. When he returned to the cell after collecting breakfast he stated that he made coffee and then called Mr M but got no response. He stated that he leant over to call Mr M and again got no response. Prisoner 1 stated that he started shaking Mr M and when he got no response he activated the cell call alarm. CCTV footage showed the red light activating on the landing at 08:26. Prisoner 1 recalled an officer responded quickly. CCTV footage showed an officer responding at 08:28. Prisoner 1 reported that he told the medics that he had tried to wake Mr M but could not. CCTV footage showed healthcare staff arrive to the cell at 08:29. Prisoner 1 was relocated by staff to cell 1. Cell 1 accommodated two other prisoners at the time.

Recommendation 4

Prisoners sharing a cell where a serious incident occurs should not be placed with other prisoners when removed from that cell as vital evidence could be contaminated or lost.

The OIP made a similar recommendation in Mr I 2019. The Director General part-accepted the recommendation in Mr I 2019 stating **"***there may not be a free cell readily available and while it may be possible on most occasions to relocate prisoners to a single cell, there may be occasions when this is not possible*". **'**The OIP in response highlighted the importance of preserving a scene where a death occurred, which could potentially be a criminal scene and it is critically important pending the arrival of An Garda Síochána. It is the experience of the OIP that there is always a free cell in a prison, such as a Close Supervision Cell, where a vital witness could be accommodated until An Garda Síochána has an opportunity to examine the scene and engage with him/her.'

Officer C who was the Class Officer in charge of 8G on the morning of 01 August 2020 reported entering cell 5 to check on Mr M. Officer C stated "*I got a response so I moved on.*" CCTV footage showed the Officer enter the cell briefly (for 5 seconds) at 08:18.

The Breakfast Guard, Officer A, stated that on taking up duty all prisoners were checked on 7G followed by 8G. Officer A observed that the red light was activated outside cell 5 and on checking the cell the Officer was informed by Mr M's cellmate that he could not wake Mr M. Officer A reported that Nurse Officer A also attended the cell.

Nurse Officer A went to the cell immediately and was informed by Officer A that attempts to wake the prisoner failed. CCTV footage showed Nurse Officer A enter the cell at 08:29. Nurse Officer A's medical notes recorded that Mr M was unresponsive to verbal or tactile stimuli, breathing was inaudible and there was no carotid pulse. Nurse Officer A called a Code Red[2] over the radio. Three Nurse Officer's B, C and D responded and attended the scene followed by Chief Nurse Officer (CNO) A with the emergency bag. Nurse Officer A reported that AED was applied and the airway was managed by Nurse Officer B and CPR was rotated between the nurse officers. Nurse Officer A reported that this continued until the ambulance paramedics arrived and took over care at approximately 08:45.

Nurse Officer B reported hearing a Code Red across the radio and responded immediately. Nurse Officer B stated on arrival Nurse Officer A was already in the cell assessing Mr M. Nurse Officer B reported seeing Mr M lying on the bottom bunk rolled on his left side, and stated he was not breathing and had no pulse. Nurse Officer B stated that Mr M was moved to the floor, they commenced CPR and administered medication as per protocol. Nurse Officer B requested staff on the landing to phone for an ambulance.

The reports of Nurse Officers A and B were corroborated by Nurse Officers C, D and CNO A. CNO A confirmed with Chief Officer (CO) A that an ambulance was required and at the request of the treating staff CNO A went to the surgery to ascertain his medical history. CNO A stated while in the surgery contact was made with the ambulance service to confirm CPR was ongoing with the use of AED. The ambulance service confirmed that a crew had been dispatched to the prison.

Assistant Chief Officer (ACO) A reported responding to a Code Red call at approximately 08:25 and on arrival the Nurse Officers were assessing Mr M. ACO A assisted in removing Mr M from his bed onto the floor and CPR commenced. When the ambulance crew arrived, the ACO along with other officers covered up the viewing panels of the cell doors to ensure privacy while Mr M was being removed from the unit to the ambulance.

CO A reported responding to a Code Red at approximately 08:30 and noted surgery staff were carrying out CPR on arrival to the cell. CO A at the request of CNO A arranged for an ambulance to be called. ACO B confirmed that the Control Room was contacted and a request for an ambulance was placed to

[2] Request for an immediate response to a medical emergency.

the emergency services. CO A reported that a log book was opened and an officer was placed at the cell door of Mr M's cell with the instruction that no one was to enter the cell unless sanctioned and all movements to and from the cell were to be recorded in the log book. CO A reported that he and ACO B had spoken with Prisoner 1 who had shared the cell with Mr M. Prisoner 1 suggested to CO A and ACO B that Mr M may have taken heroin the day before.

Recommendation 5

The recommendation in relation to cell searches in our death in custody investigation report Mr K 2018 is also an applicable recommendation in this report i.e. that the IPS should conduct regular routine and unannounced cell searches for illicit material. The results should be made available to the Inspector of Prisons for the purposes of Death in Custody investigations.

ACO B also reported responding to the Code Red. ACO B stated that contact was made with the Detail Office to organise three members of staff to escort Mr M in the ambulance. ACO B met the ambulance crew on arrival and escorted them to the unit. ACO B then contacted Chaplain A over the radio and asked the Chaplain to inform Mr M's NoK that Mr M was about to be moved to Tallaght Hospital. ACO B reported that Chaplain B administered last rights before he was removed to hospital.

Governor A reported going to 8G on receiving a call from CO A at approximately 08:35 in relation to a Code Red. Governor A stated that on arrival the surgery staff were carrying out CPR and the Governor was informed that an ambulance had been called. The Governor stayed on 8G until Mr M was removed from his cell on a stretcher and reported that Mr M's cell was then master locked.

Officer D who accompanied Mr M in the back of the ambulance reported there were four paramedics in the ambulance administrating medical treatment and on arrival at the hospital Mr M was brought straight to the Emergency Department where he continued to receive medical treatment from a team of doctors, nurses and paramedics. Officer D was informed by a Consultant in Emergency Medicine Doctor A at approximately 09:40 that Mr M had passed away at 09:38. Officer D contacted ACO B at 09:40 to advise that Mr M had passed away with the time of death recorded as 09:38.

Mr M's remains were accompanied to the family room by the three escort staff; Officers B, D and E. Officer D reported that Mr M's family were with Chaplin A and Chaplain B, Officer D accompanied them into the family room to view Mr M's remains. Officer D explained to the family that nobody could touch the body until after the post-mortem had been conducted. Officer D reported that Chaplain A prayed with the family.

At approximately 11:15, members of An Garda Síochána (AGS) arrived and asked Mr M's father to identify the body. Gardaí recorded details about Mr M from Officer D, took charge of the body and seized the prison duvet as evidence.

Officer D was provided with a letter from the Consultant, Dr A stating Mr M's time of death and that the remains were now in the custody of AGS.

Officer B and Officer E who were on the hospital escort corroborated Officer D's account of events.

Governor B reported being informed that Mr M had passed away by CO A at approximately 09:40. Governor B notified the Director of Operations, the Inspector of Prisons and An Garda Síochána of the death of Mr M.

Critical Incident Review

A critical incident meeting was held at 14:30 on 01 August 2019. The purpose of a 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 17 members of staff, 11 of whom were involved in the incident. There were other staff who were present at the incident but were not at the debriefing. The meeting was chaired by Governor B. Governor B commended the Surgery staff for their professionalism and tireless work in attempting to save Mr M's life. The Governor noted the professionalism and support shown by the operational staff.

Nurse Officer A reported that there were four nurses administrating CPR and treatment. Nurse Officer A stated that the nurses responded appropriately and no changes were recommended. Chaplain A reported notifying the NoK that Mr M had been removed to hospital and advising them to attend the hospital. The Chaplain reported that as Mr M was being placed into the ambulance he was met by Chaplain B who said prayers. At the hospital prayers were also said with Mr M's parents. Assistant Governor A reported calling all prisoners on 8G to the recreation room at 11:45 to sympathise with them.

The recommendations which were made included:

- Care and Rehabilitation Directorate to consider the provision of ongoing CPD training to the nursing staff;
- Care and Rehabilitation Directorate give serious consideration to developing a protocol around Code Red for pastoral care; and
- Flaps should be fitted to each cell doors, to provide dignity to prisoners in situations such as today.

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 M 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*."