Oifig An Chigire Príosún
Office of the Inspector of Prisons

Prison Act 2007 Section 31(2) Investigation Report

Death of Ms. X

Following transfer from Mountjoy Women's Prison (Dóchas Centre) to Hospital

14 October 2019

Submission Date to Minister:

CONTENTS

GLOSSARY & ACRONYMS

OIP	Office of the Inspector of Prisons
IPS	Irish Prison Service
DiC	Death in Custody
IPS	Irish Prison Service
ACO	Assistant Chief Officer
PO	Prison Officer
NoK	Next of Kin
CCTV	Closed Circuit Television
The Dóchas Centre	Mountjoy Women's Prison
PIMS	Prisoner Information Management System
PHMS	Prisoner Health Management System
Inspector	Inspector of the Office of the Inspector of Prisons: (includes senior inspector)
CPR	Cardiopulmonary Resuscitation
The Mater Hospital	The Mater Misericordiae University Hospital
Class Office	General Office for administration on a prison landing
DFB	Dublin Fire Brigade
The Act	Prison Act 2007
Rules	Prison Rules 2007
ECHR	European Convention of Human Rights
Red Bag	Emergency First Aid Equipment

INTRODUCTION

1. Preface

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

1.2 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.

2. Objectives

2.1 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).

3. Methodology

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

3.2 This report is structured to detail the period Ms. X spent in prison and the actions of the Irish Prison Service from the time of her detention to the time of her death in the Mater Misericordiae University Hospital (The Mater Hospital).

4. Administration of Investigation

4.1 The OIP was notified Ms. X had been removed from prison to hospital on 4 October 2019 and of her death on 14 October 2019. A standardised checklist of information requirements from the IPS to assist an investigation into deaths in custody was requested. This investigation was initiated by the Inspector of Prisons under Section 31(2) Prison Act 2007.

4.2 The cause of death is a matter for the coroner.

5. Family Liaison

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

5.2 Ms. X was being supported by her local Family Resource Centre who were recorded as Next of Kin on the Prisoner Information Management System (PIMS). She had also been supported for over 4 years by her Family Law Solicitor who acted in her interests when she was in hospital and following her death.

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

OVERVIEW

6. Summary

6.1 Ms. X was originally from Poland and 33 years of age when she was committed to Mountjoy Women's Prison, Dóchas Centre (the Dóchas Centre) as a remand prisoner on 3 October 2019. She had been granted bail at Trim District Court with a condition that she lodged €100 with the court as a security for her re-attendance on 8 October 2019. Unable to pay the €100 she was committed in custody to the Dóchas Centre.

6.2 The offences she was alleged to have committed occurred on 27 September 2018 and were public order related.

6.3 Prior to being detained in the Dóchas Centre Ms. X was held in cells at Trim District Court. During her detention at court she self-harmed by scratching her arms and neck. Gardaí called an ambulance to the court and she was taken to Mullingar Regional Hospital. Following treatment in hospital Ms. X was discharged and escorted by An Garda Síochána (Garda A & Garda B) to the Dóchas Centre.

6.4 On arrival at the Dóchas Centre at 19:49hrs Garda A and B escorted Ms. X into the Main Gate Lobby where ACO A commenced the booking in committal procedure. Garda A states following an explanation to ACO A that their late arrival was due to attendance at hospital for injuries to Ms. X, ACO A responded 'Another one.' ACO A denies saying these words.

6.5 At 19:51hrs ACO B arrived for work and informed ACO A that he would escort Ms. X through security into the Reception Area. Garda A states at this point Ms. X said that she would 'kill herself.' ACO B states he did not hear these comments but did have a conversation with the guards about Ms. X injuries and they confirmed that these were self-inflicted earlier that day whilst in detention at court.

6.6 Ms. X was booked into the prison by Prison Officers A and B who completed the committal procedures and recorded details on the Prisoner Information Management System (PIMS). This was the first time Ms. X had been detained in prison. When asked to provide Next of Kin details Ms. X was initially reluctant to provide one but when Prison Officers A and B explained the importance of having a contact she provided her Family Resource Centre. Prison Officers A and B obtained the Resource Centres' telephone number from Ms. X's mobile phone and the address from the internet.

6.7 At 20:52hrs Ms. X was examined by Nurse Officer A who conducted a questionnaire for risk of self-harm. Nurse Officer A was satisfied that Ms. X was not at risk of immediate self-harm and decided to assign her to a 'shared vulnerable cell.' Ms X was placed in a three person detention room, room 2, with Prisoners A and B in the Committal/Healthcare Unit where she remained for the rest of the night.

6.8 At 08:09 hrs on 4 October 2019 the Dóchas Centre Governor conducted the Governors Committal Interview. The Dóchas Centre Governor was not aware of any of the history of self-harm or circumstances of Ms. X attending hospital on 3 October 2019. The Dóchas Centre Governor did note Ms. X had not been issued with information material on arrival to prison and provided this during the committal interview.

6.9 At 08:44hrs on 4 October 2019 the Prison Chaplain visited Ms. X in detention room 2 in the presence of Prisoners A and B. The Chaplain made arrangements for her Next of Kin to be contacted.

6.10 Ms. X was examined by the Prison Doctor at 10:10hrs on 4 October 2019. The doctor observed that Ms. X presented as cooperative but somewhat anxious noting she suffered from a long history of psychiatric ill health, chronic schizophrenia and substance abuse (cannabis). Ms. X informed the doctor she would be leaving the Dóchas Centre later that day once bail was arranged. Ms. X was prescribed medication and she denied any suicidal ideation. The doctor did not view Ms. X as presenting with any particular risks of self-harm. (See para 16.6, 16.7 for details of doctors assessment).

6.11 At that time (pre-COVID) the Committal/Healthcare Unit allowed prisoners some interaction with staff and other detainees in the communal landing area. By 14:50hrs detainees A and B were moved from the Committal/Healthcare Unit to the general prison population. Detention Room 2 was secured (locked back) at 19:16hrs. This was the first time Ms. X had been detained alone at the Dóchas Centre.

6.12 On 4 October 2019 prison officers conducted routine checks of Ms. X as required by policy. CCTV shows between 19:16hrs to 23:31hrs a total of 19 checks were made including dispensing of medication by Nurse Officer B.

6.13 At 23:31:11hrs on 4 October 2019 Prison Officer A conducted a routine check of detention room 2 and saw Ms. X suspended by a ligature. Assistance was summoned and the detention room was unlocked at 23:32:01hrs and first aid CPR was immediately administered.

6.14 Nurse Officer B entered detention room 2 at 23:32:14hrs with the 'Red Bag' (emergency first aid kit) and directed an ambulance be called.

6.15 Dublin Fire Brigade (DFB) paramedics arrived at 23:43:49hrs and took over emergency first aid assisted by National Ambulance Service paramedics who arrived 2 minutes after DFB. At 00:04:51hrs on 5 October 2019 Ms. X was removed by ambulance to the Mater Misericordiae University Hospital (the Mater Hospital).

6.16 On 10 October 2019 due to serious health concerns for Ms. X, Trim District Court struck out proceedings against her in response to an application by her Family Law Solicitor. Ms. X was then no longer subject of a warrant of committal and was released from the custody of the Irish Prison Service. The rostered 2 prison officers assigned 24/7 to the hospital since the time of Ms. X's admission were withdrawn.

6.17 On 14 October 2019 at 11:11hrs Ms. X died in the Mater Hospital.

7. Recommendations

1. Vulnerability: Where a 'shared vulnerable cell' is recommended this should be made known to all prison staff with a responsibility and duty of care for the detained person and recorded in relevant journals.
2. If it is decided a 'shared vulnerable cell' is no longer required a risk assessment should be conducted to justify de-escalation. This should be recorded on the detained persons PIMS record.
3. The IPS should review self-harm policies at the Dóchas Centre considering SADA Reports and the National Strategy for Prevention of Suicide (See section 23).
4. As required under Prison Rule 13, the IPS should ensure that all prisoners 'shall upon admission to prison' be provided with a leaflet of their rights and entitlements. To achieve this the IPS should conduct a review of all committal areas and prisons for the availability of these information leaflets in English, Irish and other languages. Prison Governors should check compliance with this Prison Rule during their regular inspections of a prison.
5. A Person Escort Record should be introduced and completed for every movement of a prisoner into or out of a prison whether by Irish Prison Service staff or Gardaí. This should include details

of risks of self-harm and vulnerability in addition to security considerations and include any comments or threats made by a detained person[1]. (Example of HMPPS provided at footnote).

6. All journals should be corporate, serial numbered, and completed in a policy led manner that is accurate, detailed and consistent across the IPS. This policy should include instructions for prison officers of information that should be recorded.
7. In the event of a death in custody the governor of the prison should seize and securely store all relevant original journals and issue new books.
8. IPS policy should mandate all complainants be formally informed of progress of their complaint, including a decision not to investigate an allegation and the rationale to justify discontinuance. (Compliant with Section 57B Prison Rules (Amendment) 2013).
9. The IPS should conduct a critical incident review following any death subject to investigation by the OIP[2].

8. Mountjoy Women's Prison & Women's Prison Population in Ireland

8.1 The Dóchas Centre is a closed, medium security prison for women aged 18 years and over. It is the committal prison for women committed on remand or sentenced from all Courts outside the Munster area. On 3 October 2019 it had an operational capacity of 105, while occupancy was recorded as 132 (126% of bed capacity). On 4 October 2019 occupancy was recorded as 138 (131% of bed capacity).

8.2 On 3 October 2019 Limerick Women's Prison had an operational capacity of 28, while occupancy was 35 (146%). On 4 October 2019 Limerick Women's Prison occupancy was recorded as 33 (138%).

8.3 On 4 October 2019 occupancy of the two Women's Prisons in Ireland was 34% over capacity.

8.4 Ms. X was the first death of a person detained in the Dóchas Centre in 2019 and the 15 death in IPS custody that year meeting the criteria for investigation by the OIP.

[1] Person Escort Policy 2019 HMPPS - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/988643/per-paper-detailed-guidance-hmpps.pdf

[2] The Prison Governor did speak with different people following the death but no formal Critical Incident Review took place.

FINDINGS

9. Family, Next of Kin Concerns

9.1 Ms X had two young sons and was estranged from their father with whom they reside. She had access allowing regular contact with her sons. Since 15 March 2019 Ms. X had received support in the community from her local Family Resource Centre.

9.2 During committal Prison Officers A and B requested Ms. X provide Next of Kin (NoK) details. She was initially reluctant to provide a Next of Kin but when officers explained the importance of providing a contact Ms. X suggested her Family Resource Centre. Prison Officers A and B found the centre's address on the internet and the telephone number from contacts on Ms. X's mobile phone.

9.3 Whilst the Family Resource Centre was nominated as Next of Kin, Ms. X's Family Law Solicitor had represented her throughout the four years before she died and acted in her interests while she was being treated in the Mater Hospital and following her death on 14 October 2019.

9.4 On 18 October 2019 the Family Law Solicitor made a complaint to the Irish Prison Service and has also raised a number of questions with the Office of the Inspector of Prisons.

9.5 These questions are as follows:

1. Were the handover procedures between An Garda Síochána and the Irish Prison Service conducted properly and was information exchanged including explanations of self-harm whilst in the detention at Trim District Court. (Section 12, 13, 16.4 & Recommendation 5).
2. Did the Irish Prison Service know and record Ms. X had stated she would kill herself when handed over from An Garda Síochána to the Irish Prison Service. (Section 13)
3. Was the hospital letter and medication prescribed at hospital recorded by the Irish Prison Service. (Para 14.2).
4. When the Family Solicitor met the Dóchas Centre Governor at the Mater Hospital the Governor was unaware that Ms. X had been treated in hospital for self-harm prior to arrival at the Dóchas Centre indicating the prison did not have background information. (Para 16.2, 16.3, 16.3, 16.6).
5. Why was Ms. X alone in a cell when she had already self-harmed. (14.6 & Recommendation 2, 3).
6. Were the conditions in which Ms. X was accommodated appropriate to her vulnerability? (Recommendation 3 & 5).

9.6 Responses to these questions are contained throughout the body of this report and focus points are detailed above for ease of reference.

9.7 The Family Law Solicitor made a complaint to the IPS on 16 October 2019. The Dóchas Centre Governor informed IPS Headquarters and the Director General on 23 October 2019 that this was a category A complaint. The IPS Director General appointed an independent investigator to the case on 4 November 2019[3]

[3] Prison Rules (amendment) 2013 57B(5)(a) Subject to subparagraphs (b) and (c), the Director General shall appoint an investigation team comprising one or more persons to investigate the complaint. The person or persons appointed shall not be members of staff serving at the prison to which the complaint relates or have had a recent association with that prison through having worked there or otherwise, and may be persons from outside the Irish Prison Service. The Governor and Inspector of Prisons shall be notified of the appointment of the person or persons.

9.8 The instructing email sent to the investigator on 4 November 2019 by the IPS states: 'I wish to confirm that you have been assigned to investigate a serious complaint made by (*The Family Law Solicitor*) on behalf of prisoner (*Ms. X*) who died while in the custody of the Irish Prison Service.' The email provides a timeline of 3 months for completion of the investigation which it states could be extended but this would require the submission of an interim report.

9.9 On 9 July 2021 the OIP emailed IPS Headquarters requesting an update of the status of the complaint. On 12 July 2021 a response was received from IPS Complaints Unit confirming an investigator had been assigned but no interim report was available due to this being a death in custody. This was the first notification to the Inspector of Prisons that an investigator had been assigned, contrary to requirements under Prison Rule 57B(5)(a).

9.10 On 14 October 2021 IPS Complaints Unit emailed the OIP stating 'Dear Inspector of Prisons, please see attached decision on Complaint D445 by (Ms. X). Complaint has been deemed outside of the scope of rule 57b of the Prison Rules by the Director General. The Governor of Mountjoy Female/Dóchas Centre has also been informed of this decision.'

9.11 Prison Rules Section 57B(1)(a) (amendment) 2013 states[4]:

This Rule shall apply to any complaint made after the Rule comes into operation by any person alleging—

(i) assault or use of excessive force against a prisoner, or

(ii) ill treatment, racial abuse, discrimination, intimidation, threats or any other conduct against a prisoner of a nature and gravity likely to bring discredit on the Irish Prison Service, whether or not the incident occurred before this Rule comes into operation and shall apply notwithstanding Rule 57A.

Section 57B(5)(b) states:

The Director General may decide not to appoint an investigation team if he or she is satisfied that the complaint is vexatious, without foundation or falls outside the scope of this Rule. If such a decision is made the Director General shall document the reasons for the decision and arrange for the complainant, the Governor and the Inspector of Prisons to be advised of the decision and the reasons for the decision.

9.12 At the time of writing this report the complainant has not been informed of the discontinuance of the investigation and the Inspector of Prisons has not been provided with the reasons for the decision.

9.13 A copy of the complaint will be attached to this report for the Minister, but will not be included in the text of the report for confidentiality reasons.

10. Background

10.1 The Family Resource Centre support worker and Family Law Solicitor provided inspectors with background information of how Ms. X had suffered from depression, mental health illness and self-harm since childhood.

10.2 The Family Resource Centre Co-Ordinator informed inspectors that on 28 June 2019 Ms. X attempted to take her own life and was only prevented from doing so by a passing member of the public who pulled her from the sea. This resulted with Ms. X being admitted as an inpatient

[4] https://www.irishstatutebook.ie/eli/2013/si/11/made/en/print

to a psychiatric unit. On 14 August 2019 Ms. X again attended a psychiatric unit for mental illness, this time as a day patient.

10.3 The charges Ms. X faced were of a public order nature alleged to have been committed on 27 September 2018[5]. Ms. X failed to appear at court and a warrant was issued for her arrest. On 3 October 2019 Ms. X was arrested on the foot of the warrant and taken to Trim District Court. The court granted bail with a condition that €100 be lodged as security for her re-attendance on 8 October 2019.

10.4 The Family Resource Centre Co-Ordinator, who has over 13 years in social care including at managerial level, stated the alleged offences of 27 September 2018 were a symptom of Ms. X's mental illness requiring treatment and support and not criminal justice intervention. Her Family Law Solicitor, who also practices in criminal matters, concurred with this opinion as did An Garda Síochána members and staff of the Irish Prison Service.

11. Court Detention and Escort to the Dóchas

11.1 Ms. X did not have funds to pay €100 for her bail and was detained in the cells at Trim District Court. While in custody she pulled out some of her head hair and scratched herself with her nails. An ambulance was called and Ms. X was taken to the Regional Hospital Mullingar Emergency Department accompanied by members of An Garda Síochána, (Garda A & Garda B).

11.2 Following treatment Ms. X was discharged and provided with medication and a letter for the prison authorities. She was driven to the Dóchas Centre by An Garda Síochána who reported that Ms. X was calm and quiet on the journey.

12. Arrival and Committal - The Dóchas Centre

12.1 Ms. X arrived to the Dóchas Centre at 19:48hrs coinciding with shift changeover in the prison. An Garda Síochána apologised for their lateness and explained it was due to attending hospital with Ms. X. It is claimed by Garda A that the Assistant Chief Officer at the Main Gate Reception, ACO A, responded saying 'Another One.' ACO A, denies he said this.

12.2 ACO B arrived for duty at 19:50hrs and indicated to ACO A that he would escort Ms. X into the prison. Garda A stated that ACO B inquired of Gardaí how Ms. X had received her injuries and it was explained they were self-inflicted while in court custody. Garda A states that as Ms X was taken to the prison security screening area she said that she would kill herself.

12.3 Gardaí left the prison and returned to their station where Garda A reported the handover to a supervising officer. Garda A completed a note of events in the Dóchas Centre before finishing the tour of duty. A copy of this note has been provided to the Office of the Inspector of Prisons[6] and will be provided to the Minister but not included in the report due to confidentiality reasons.

13. Self-Harm Knowledge

13.1 When interviewed by inspectors both ACO A and ACO B stated they did not hear Ms. X state that she would kill herself.

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[5] Offence 1: Section 4(2) Penalty - A person who is guilty of an offence under this section shall be liable on summary conviction to a fine not exceeding £100. Offence 2: Section 6(2) Penalty - A person who is guilty of an offence under this section shall be liable on summary conviction to a fine not exceeding £500 or to imprisonment for a term not exceeding 3 months or to both. (The financial penalty of the legislation is still show in Irish punts).

[6] GSOC were involved in a separate investigation that is now complete.

13.2 ACO A stated the committal warrant was presented by Garda A who kept answering on behalf of Ms. X so he advised the Garda member that she needed to answer for herself to confirm she understood the process.

13.3 ACO A explained that Ms X. confirmed her name, date of birth and address. ACO A explained that conversations in the front gate reception area can only be heard behind the screen when the two way audio system is activated by an intercom switch from inside the office. ACO A states that the conversations that took place between Ms. X and Gardaí or ACO B could not be heard as the intercom would have been muted. ACO A categorically denied making the comment 'Another one.'

13.4 ACO B did not hear Ms. X say she would kill herself and stated if these comments had been overheard the duty nurse officer would have been informed.

13.5 ACO B recalled asking Gardaí if Ms. X's injures were self-inflicted, which was confirmed. ACO B ('believed' this information was shared with Prison Officers A and B who booked Ms. X into the prison and completed the Prisoner Information Management System (PIMS).

13.6 Prison Officer A or B did not recall ACO B informing them that the injuries were self-inflicted, but stated Ms. X herself disclosed how these were caused.

14. Medical Screening

14.1 Under the Prison Rules 2007 there is a requirement for every person committed to a prison to be medically examined under Rule 11(2) which states:

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

14.2 Nurse Officer A conducted the preliminary medical screening at 20:52hrs on 3 October 2019 which included a mental health assessment and risk of potential to self-harm. The details and responses by Ms. X were recorded on the Prisoner Healthcare Management System (PHMS). Nurse Officer A read the letter from Mullingar Hospital and noted the medication prescribed. It was explained to Ms. X medication could not be dispensed until after the prison doctor's examination on 4 October 2019.

14.3 Nurse Officer A confirmed that no information was provided by any prison officer of any comments relating to self-harming. However, Nurse Officer A remarked even if such information had been disclosed it would not have changed decisions as the examination was of how Ms. X presented as many inmates at the Dóchas Centre make threats to self-harm.

14.4 Nurse Officer A recorded on the PMHS that Ms. X disclosed she had self-harmed on many occasions since the age of 11 years including self-cutting, and deliberate overdoses. Ms. X informed Nurse Officer A that she suffered with schizophrenia, that her last episode of an overdose occurred in January 2019 and that she had self-inflicted scratching on 3 October 2019 in the 'police station' [Court cells].

14.5 Her injuries were recorded on the PHMS as: 'Bilateral wrist and right side of neck covered with fresh dressings, because of scratch wounds she did to herself in the police station 3/10/19.'

14.6 Ms. X had slightly high blood pressure which was attributed to the stress and fear of admission to prison. Nurse Officer A concluded Ms. X was not at risk of self-harming and decided allocation to a 'vulnerable shared cell' would be sufficient to mitigate any potential risk.

15. First Night in Detention at the Dóchas Centre

15.1 Ms. X spent her first night in the Dóchas in a 3 person detention room, room 2, with two other detainees. Prison Officer A reported that Ms. X and the other two detainees were in conversation during the night.

16. Friday 4 October 2019

16.1 On 4 October 2019 the Dóchas Centre Governor conducted the Committal Interview[7] in the company of a prison officer between 8.10hrs and 8.17hrs in the Class Office of the Committal/Healthcare Unit.

16.2 When conducting the committal interview the Dóchas Centre Governor was unaware of the history of self-harm and self-inflicted injuries. The Governor explained the PHMS record is not shared outside of healthcare staff and Ms. X did not disclose her self-harm to him nor was she asked the cause of her injuries. The Prison Governor stated that had information been made available to him regarding recent and past history of self-harm additional measures for her safety would have been considered.

16.3 The Dóchas Centre Governor recalled that the PIMS record showed that Ms. X had not been provided with information documentation on her arrival into the prison and so this was provided to her during the Committal Interview. Under the Prison Rules these documents should be provided on arrival to the prison[8]. The Dóchas Centre Governor explained Ms. X did not appear to be stressed during the interview and that arrangements were made for telephone calls to be made to assist her in securing bail. The Dóchas Centre Governor explained that information on PHMS is not shared due to data protection and confidentiality but acknowledged this could frustrate prison staff in making informed decisions for prisoner safety.

16.4 The Dóchas Centre Governor was of the view that a handover report should be introduced for every prisoner entering a prison detailing any risks and medication in their possession. The Governor has proposed this idea to senior management at IPS Headquarters post the death of Ms. X and it is under consideration. A similar policy exists in UK Prisons following recommendations by HM Inspectorate of Prisons, the Prisons and Probation Ombudsman and Coroners[9].

16.5 The Prison Chaplain visited Ms. X in detention room 2 between 08:44hrs and 08:53hrs noting Ms. X was vulnerable but nothing out of the ordinary for women detained in the Dóchas Centre. The Chaplain was confident Ms. X would be leaving prison that day once €100 was lodged to secure bail. The Chaplain spoke with the Family Resource Centre during the day and thought matters were in hand for them to assist Ms. X and secure her bail.

16.6 Between 10:10hrs and 10:30hrs the Prison Doctor examined Ms. X and recalled she did not present differently from many women who are committed to the Dóchas Centre. The doctor observed that Ms. X presented as cooperative but somewhat anxious noting she suffered from

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[7] Prison Rule 14: The Governor shall, as soon as may be after the admission of a prisoner on committal to the prison concerned, meet that prisoner, and satisfy himself or herself that the prisoner has been informed of, and understands, his or her obligations, entitlements and privileges under these Rules, and shall further ensure that details of any matters of significance to which the prisoner may draw his or her attention are recorded.

[8] Prison Rule 13(1) Each prisoner shall, upon admission to prison, be given an explanatory booklet outlining his or her entitlements, obligations, and privileges under these Rules.

[9] Person Escort Policy 2019 HMPPS - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/988643/per-paper-detailed-guidance-hmpps.pdf

a long history of psychiatric ill health, chronic schizophrenia and substance abuse (cannabis). The doctor noted Ms. X was seen on a regular basis by her community psychiatric service. At the time of examination Ms. X denied being unwell but was concerned to get her 'Seroquel' medication as she said without it she would hear disturbing voices. The discharge notes of Mullingar Hospital were examined by the doctor but did not indicate any grave concern over Ms. X's mental status. The doctor stated Ms. X presented as being alert and rational but a little agitated. The wounds on her forearms were mild abrasions consistent with the scratching injury described by Ms. X and she denied any further impulse to self-harm. The doctor's assessment was that Ms. X suffered chronic schizophrenia and substance abuse and was well known to her local services and recommended that she be referred for routine review by the Dóchas Centre psychiatric service the following Monday, 7 October 2019. The doctor explained a high number of women in the Dóchas Centre have a history of self-harm, addiction or chaotic lifestyles not seen so frequently in male prisons.

16.7 The Prison Doctor was of the opinion that even if it was reported that Ms. X had stated she would harm herself when she arrived at the Dóchas Centre it would not have altered the healthcare decisions as threats like this are frequent in the women's prison.

16.7 Prison Officer C escorted Ms. X from the doctors examination back to her detention room and noticed Ms. X appeared more relaxed after her consultation. Prison Officer C was informed by the Chaplain that having spoken with the Family Support Centre it was okay for Ms. X to call them. Prison Officer C arranged for two telephone numbers to be obtained from Ms. X's mobile phone to be entered onto the prison telephone system. One of these was a friend who Ms. X said she would call the following day. The other was for the Family Resource Centre. During the day Ms. X had asked Prison Officer C for a towel and a television remote control which Ms. X collected from the Class Office and returned once she had turned the television set on.

16.8 The Family Resource Centre informed inspectors that on 4 October 2019 the Dóchas Centre Chaplain contacted with them advising Ms. X was in custody. When they asked for the circumstances of her detention they were informed that no information could be shared due to data protection and that they should call the Dóchas Centre switchboard and request to speak with Ms. X.

16.9 At 13:19hrs Ms. X made a telephone call from the prison to the Family Resource Centre Co-Ordinator. This call was recorded on the prison telephone monitoring system[10]. They discussed the €100 required to secure bail and Ms. X explained that she only had €5 on her. When asked how they could help Ms. X she said "I don't know how this is working, I don't know how this is paying. I don't know nothing you know, nothing." When asked can they give you a bus ticket to get home Ms. X said: "Oh I don't know, I don't think so" and then stated "Probably I'm going to be walking home." Ms. X said "They told me they was that maybe some friend is going to be able to help me eh pay that bill for €100 and I'm going home, or I'm going to be sitting here till 8th [October]."

16.10 The call terminated abruptly mid-conversation after 6 minutes, this being the maximum call period permitted by the IPS for a convicted prisoner phone call. The Dóchas Centre Governor advised inspectors that there should not have been a limit on this call period but there is no

[10] Prison Rule 46(7) :The Governor may, for the purposes of maintaining good order and safe and secure custody or ensuring that a prisoner does not make any telephone calls to which paragraph (8) applies, intercept a telephone communications message made during a telephone call, provided that the prisoner or the person with whom he or she proposes to communicate is informed before any communication takes place that any telephone communications message made during the course of the telephone call may be intercepted.

explanation available why a longer call was not facilitated. The Dóchas Centre Governor also explained those who are discharged from prison are given sufficient funds to get home[11].

16.11 The Family Resource Centre were surprised when the call terminated mid-conversation. The Family Resource Centre Support Worker. They decided it was not appropriate to pay the €100 bail for fear Ms. X would be at greater risk if she were released and unable to get home. They were of the opinion that if she remained in the custody of the Dóchas Centre she would be safer and looked after.

16.12 As the call ended the Family Centre Co-Ordinator was explaining that they would await to hear from the prison. There is nothing to suggest Ms. X passed on details of this call to any prison officer or official in the prison.

16.13 By 14:50hrs on 4 October 2019 both detainees sharing with Ms. X were relocated to the general prison population leaving Ms. X as the sole occupant.

16.14 CCTV shows Ms. X spent the remainder of the day mixing with others on the landing or in her cell. She had lunch and her evening meal. At 18:44hrs she can be seen collecting a mop and bucket from a storage room and returning to her detention room. Two minutes later she returns the items to the storage room and goes back to her detention room. The Healthcare/Committal Unit detention rooms were locked at 19:16hrs, and Ms. X was now alone in her prison detention room.

16.15 At 20:44:06hrs Nurse Officer B dispensed medication to Ms. X in her detention room. Nurse Officer B asked if she wanted anything for the pain in her arm and she said she did so was given ibuprofen. Nurse Officer B stated 'the interaction was unremarkable.'

16.16 Chief Officer A reported to the OIP that Ms. X was accommodated in the Committal/Healthcare Unit on her first night as per Standard Operating Procedures (SOP). She spent a second night in the Committal/Healthcare Unit due to the high numbers (see section 8) and that staff believed her bail was going to be paid.

16.17 CCTV shows on 4 October 2019 checks were conducted of Ms. X at regular intervals by prison officers. This is done by opening a flap over a small window in the door and visually observing the occupant. These were conducted from the time of Nurse Office A dispensing medication at:

- 20:44:06hrs
- 21:05:44hrs
- 21:14:35hrs
- 21:32:30hrs
- 21:44:02hrs
- 22:00:41hrs
- 22:09:10hrs
- 22:28:01hrs
- 22:29:34hrs
- 23:01:53hrs
- 23:10:01hrs
- 23:21:25hrs
- 23:23:19hrs
- 23:31:11hrs

These checks fell within the policy for the Dóchas Centre.

[11] Prison Rule 61(1): When a prisoner is discharged from prison whether on temporary release or otherwise, the Governor shall ensure that he or she has sufficient means for travelling to his or her destination within the State.

16.18 At 23:31:11hrs Prison Officer A conducted a check of detention room 2 and saw Ms. X suspended by a ligature from a disused television bracket fixed to the wall. Assistance was immediately summoned and Prison Officer A ran to the Class Office to collect the ligature cutter[12]. At 23:32:01hrs ACO B arrived and opened the detention room and entered with Prison Officer A and Prison Officer D and they released Ms. X from the ligature.

16.19 At 23:32:14hrs Nurse Officer B arrived carrying the 'Red Bag' emergency first aid equipment and immediately commenced first aid. There were no signs of breathing so Nurse Officer B attached a defibrillator to Ms. X which advised no shock but commence CPR (Cardiopulmonary Resuscitation). Nurse Officer B continued CPR until the arrival of paramedics.

16.20 At 23:43:49hrs two Dublin Fire Brigade paramedics arrive followed by 2 National Ambulance Service paramedics at 23:45:40hrs. For the next 19 minutes paramedics continued to administer first aid and CPR.

16.21 At 00:04:51hrs on 5 October 2019 paramedics moved Ms. X by stretcher to an ambulance and transported her to the Mater Hospital.

17. After leaving the Dóchas Centre

17.1 Ms. X was in a gravely serious condition at the Mater Hospital intensive care unit and remained in the custody of the Irish Prison Service under the guard of two prison officers 24/7 until proceedings were struck out on 10 October 2019.

17.2 The Dóchas Centre Governor attended the Mater Hospital on the morning of 5 October 2019 and tried to contact the Family Resource Centre as the listed Next of Kin, but as it was a Saturday the centre was closed.

17.3 The Dóchas Centre Governor accessed Ms. X's mobile telephone to identify recently called numbers or contacts. A male was identified and when called Prison Officer E translated from Polish to English for the Governor. The male identified himself as partner of Ms. X living at her address but that he was not her Next of Kin.

17.4 On Saturday 5 October 2019 the Dóchas Centre Governor advised the Office of the Inspector of Prisons of the incident and Ms. X being admitted to the Mater Hospital.

17.5 In the evening of 5 October 2019 the Governor obtained the mobile number of the ex-partner and father of Ms. X's children. The Dóchas Centre Governor contacted him to advise that Ms. X was unwell and advised he should attend the hospital.

17.6 On Monday 7 October 2019 the Dóchas Centre Governor contacted Ms. X's Family Law Solicitor who had been acting for her for the previous 4 years.

17.7 The father of Ms. X's children attended the hospital but for unrelated reasons it was agreed by the Dóchas Centre Governor and the hospital that he could not act as Next of Kin and that the Family Law Solicitor would act in her interests.

18. Court Proceedings Struck Out

18.1 Ms. X had been due to appear before the District Court on 8 October 2019. Her case was relisted on 10 October 2019 on an application made by her Family Law Solicitor when the court struck out proceedings against Ms. X. This meant she was no longer in detention of the Irish Prison Service and the charges against her were dropped. The 2 prison officers stationed at the hospital as escort since her admission were immediately withdrawn.

[12] Ligature cutter: A hooked knife or tool specifically designed for use to release a ligature safely.

19. Mater Hospital – 14 October 2019

19.1 On 14 October 2019 at 11:11hrs Ms. X was pronounced deceased at the Mater Hospital with her Family Law Solicitor and the Dóchas Centre Governor in attendance. Her Family Law Solicitor arranged for prayers to be played to Ms. X in her native Polish language during the final moments of her life.

19.2 On 14 October 2019 the Dóchas Centre Governor informed the relevant authorities, including the Office of the Inspector of Prisons, of the death of Ms. X and arranged for material to be provided to inspectors under the Death in Custody Protocol.

20. Prison Act 2007 Section 31(2) Investigation Commenced

20.1 As Ms. X was not in custody or on temporary release at the time of her death this case fell outside of the remit of the Inspector of Prisons instructions from the Minister to investigate a death in the custody of a prison or within a month of temporary release. However, due to the circumstances of this case the Inspector of Prisons decided that an investigation under Section 31(2) of the Prison Act 2007 was required[13].

21. Records and Journals in the Dóchas

21.1 The Dóchas Centre retains numerous records relating to individual prisoners, areas of the prison or for specific roles and responsibilities. This list shows the various journals and documents the Inspector of Prisons was advised were created relevant to Ms. X.

- PIMS – Prisoner Information Management System (electronically inputted)
- PHMS – Prisoner Health Management System (electronically inputted)
- Reception Book
- Gatekeepers Record of Prisoners Committed
- Committal Unit Day Journal
- Night Guard Report Journal for the Committal/Healthcare Unit
- Night Guard Report Journal for the Control Room
- ACO Night Duty Book (Senior officer on duty at night)

21.2 The Night Guard Journal and the Committal Unit Day Journal are used to record details of incidents and information like special monitoring or special observation[14]. Ms X was not on special observations and there is no mention in any journal of any risk to her, including any reference to the recommendation by Nurse Officer A of a 'shared vulnerable cell.' This was accessible by Nurse Officer B on PHMS who did not know of this information when asked by inspectors.

21.3 Each day the Dóchas Centre produces a 'Special Observations/Monitoring List.' Ms. X did not feature on this list on 3 or 4 October 2019. On 3 October 2019 5 detainees in the Dóchas Centre featured on the Special Observation/Monitoring List, two are shown in the Committal/Healthcare Unit. While on 4 October 2019 2 detainees featured on this list, one is shown in the Committal/Healthcare Unit.

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[13] Prison Act 2007 31(2) The Inspector may, and shall if so requested by the Minister, investigate any matter arising out of the management or operation of a prison and shall submit to the Minister a report on any such investigation.

[14] Prison Rule 64(1): Subject to paragraphs (6) and (7) a prisoner shall, where the Governor so directs, be accommodated in a special observation cell designated by the Minister under Rule 18 *(Certification of cells or rooms)* for the purposes of this Rule, for such period, not exceeding 24 hours, as is specified in the direction concerned.

21.4 The Prison Governors Committal Interview section of PIMS is populated with some details from the Healthcare Committal Interview. This includes a section stating 'Healthcare recommendations regarding prisoner accommodation.' In this section of the Governors Committal Interview for Ms. X it states 'Shared vulnerable cell.' There is also a section for the Prison Governor to enter 'Prisoner Risk and Needs Analysis and Governor Recommendations.' No entries are made in this section. A further section allows the Governor to make entries for 'Other Concerns.' There are no entries in this section. A pre-formatted question to be asked by the Governor during Committal Interview is 'Prisoner Information Booklet Given to Prisoner?' This has a tick box response section 'yes or no' for the Governor to complete. The answer shown on the record for Ms. X is 'no.' The Prison Governor informed inspectors he realised the booklet had not been issued during committal on 3 October 2019 so he issued one as part his Committal Interview.

21.5 The senior officer on duty in a prison at night is an Assistant Chief Officer. The ACO Night Duty Journal is the official record for the ACO to record incidents or issues in the prison. The journal is completed each tour of duty and the entries are signed by the ACO. The IPS is unable to locate the original ACO Night Duty Journal for 3 and 4 October 2019, despite the Campus Governor and Assistant Governor, IPS Director of Corporate Services and the current Prison Governor B all attempting to locate it.

21.6 The IPS have produced a copy of the ACO Night Duty Journal page for 4 October 2019 and the front cover of the Journal. The front cover is hand written and says 'ACO Night Duty Report Book' and has dates stating 'From 18.12.12 to 21/2/13[15]. Below these dates it states '14.06.19.' Due to the unreliable information on the front cover it is unknown the correct period this Journal relates to and the extent of the information and data that is lost. This book has no Unique Reference Number or apparent issuing procedure.

21.7 The copy of the ACO Night Duty Journal for 4 October 2019 shows ACO A coming on duty at '11.00pm.' The next entry is shown for '11.30pm' and reports the Ms. X incident and ACO A attending the 'committal unit.' At '11.50pm' it shows an ambulance arrived and at '12.05am' and shows it leaving the Dóchas Centre. It then shows day staff arriving and off duty at '8.00am[16].' A copy of this journal and the front cover will be provided to the Minister but will not be included in the report for confidentiality reasons.

21.8 Prior to ACO A reporting for duty at 23:00hrs a prison officer (PO) grade was in charge of the prison from 20:00hrs.

21.9 The IPS have been unable to provide the original or a copy of the entries of the ACO Night Duty Journal for 3 October 2019. Both 3 October and 4 October 2019 entries would have been in the same journal.

22. Condition of Detention Room 2: Dóchas Centre

22.1 Detention Room 2 is a three person shared room with its own in cell toilet and shower facilities. Whilst this room is basic it meets standards of size, heating and facilities for prisoner accommodation.

22.2 At that time prisoners would access a kettle from the Class Office and CCTV shows good levels of socialisation on the landing area outside the detention rooms during the day.

22.3 Detention room 2 had a self-standing television set rested on a small shelf area to the left of the door. The room previously had a television that was mounted to a bracket that extended from

[15] Layout copied as on the front cover.
[16] This book appears to be formatted by the user and not professionally printed. It has no URN or alike.

the wall[17]. This bracket was about 4 feet from the floor level and despite being redundant and having no purpose was still in situ. This bracket was obvious and represented a health and safety accident hazard. Inspectors attempted to identify when the television was replaced but the prison were unable to provide records. This wall bracket was used by Ms. X to secure a ligature and inflict self-harm.

22.4 Following this incident on 15 October 2019 the Dóchas Centre Governor instructed the prison be inspected for any similar brackets and they be removed. It is unknown if additional brackets were identified.

22.5 It is the duty of the Governor to conduct daily inspections of a prison including the areas where prisoners are accommodated[18]. No records have been identified to suggest anyone recognised the risk this bracket presented despite this being in the Committal/Healthcare Unit where vulnerable inmates are accommodated.

23. Reducing Self-Harm in Prison

23.1 The Irish Prison Service established a Steering Group for the Prevention of Self-Harm and Death in the Prison Population renamed the National Suicide and Harm Prevention Steering Group (NSHPSG) in 2014. This group meets quarterly to 'promote best practice in preventing and, where necessary, responding to self-harm and death in the prison population.' It considers reports and recommendations by the Inspector of Prisons and from Coroners.

23.2 The NSHPSG membership consists of representatives of Senior Prison Management, IPS Headquarters, Samaritans Ireland, IPS Healthcare Services, IPS Psychology Service, Prison Chaplaincy Service, Prison Policy Division, Prison Officers Association, IPS Probation Service, and the National Forensic Mental Health Services. A representative from the Department of Justice also attends the meetings of the National Steering Group.

23.5 'Connecting for Life' is Ireland's National Strategy to Reduce Suicide initially from 2015 to 2020 and now extended to 2024[19]. 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.

23.7 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 4.1 'Improve psychosocial and psychiatric assessment and care pathways for people vulnerable to suicidal behaviour.'

[17] IPS Operational Support Group have provided photographic imagery of the TV bracket in situ (available to the Coroner).
[18] Prison Rule 77(1): The Governor shall make daily inspections of the prison including those areas of the prison where prisoners are accommodated or congregate or are otherwise held. The times of all such visits shall be at the Governor's discretion and recorded in a manner as prescribed by the Director General. In the event that the Governor is absent from the prison, he or she shall ensure that the responsibilities to carry out the inspections under this Rule shall be delegated to a Deputy Governor or Assistant Governor.
[19] Connecting for Life gov.ie website link: https://www.gov.ie/en/publication/7dfe4c-connecting-for-life-irelands-national-strategy-to-reduce-suicide-201/

The Irish Prison Service is shown as a key partner.

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.

23.8 Appendix 8 of the National Suicide Prevention Strategy provides a number of Government Commitments:

Commitment 5.3.3: Implement the IPS Prisoner Release Policy to ensure care, treatment and information is provided, including identifying the appropriate mental health services in each area for those leaving prison. This will include links with the community mental health services.

Commitment 3.1.1: Integrate suicide prevention into relevant national policies and programmes for those that are at an increased risk of dying by suicide within the justice and prison sectors.

Commitment 5.1.5: Develop and disseminate evidence based shared resources in relation to mental health and suicide prevention across the criminal justice system.

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.

23.9 The Irish Prison Service has introduced research known as SADA (Self-Harm Assessment & Data Analysis). Three annual reports have been published and the last on 21 April 2021 relating to self-harm in prisons during 2019[20], the year Ms. X died.

The Director General of the IPS fully supports SADA stating in the 2021 report[21]:

'In 2015, the IPS committed to the aims of the National Strategy to Reduce Suicide 2015 – 2024 ("Connecting for Life") and sought to improve on both the reporting, review and response to incidents of self-harm and suicide across the service. Since its inception in 2016 the vision for the SADA Project has always been to accrue high quality, reliable and robust data from within the IPS to influence and guide future policy and practice development in achieving a reduction in both self-harm and suicides in the prison environment. A major part of this drive to reduce incidents of self-harm and suicide in the IPS estate was to truly understand the multiple factors that influence these behaviours and develop bespoke responses to meaningfully impact on and prevent future incidents. The research that we now have available to us following the publication of our Third Annual Report provides a quality reference basis and a significant amount of evidence to allow us to move to the next step of developing appropriate and effective interventions for people in distress, enhancing current interventions and supports.'

23.10 Page 21 of the latest SADA annual report provides data for episodes of self-harm in 2019. This reveals in 2019 19.8 female prisons per 100 self-harmed in prison (almost 1 in 5), this being 8 times higher than males.

23.11 Of 203 episodes of self-harm reported in prisons during 2019, 67 involved a female prisoner. Whilst the report and the data it discloses needs to be examined in its entirety, the increased risks to women of self-harming in prison is well established.

[20] SADA Report 2021 for 2019: https://www.nsrf.ie/wp-content/uploads/2021/04/Self-harm-in-Irish-Prisons-2019-Third-report-from-the-SADA-Project-Final-for-Publication.pdf
[21] Ibid: page 2

23.12 The SADA report also highlights in 2019 those on remand in prison were twice as likely to self-harm as those who were sentenced prisoners.

23.12 The previous SADA report published in July 2020[22] provided self-harm data for 2018 and 2017 where it is stated that during 2018 approximately 3% of male and 19% of female prisoners engaged in self-harm, consequently the rate of self-harm among female prisoners was 5.7 times higher than males (19.3 versus 3.4 per 100). The rate of self-harm among female prisoners was 21% higher in 2018 than 2017 (19.3 versus 16.0 per 100). This data reveals that there was a small increase in episodes of self-harm by women prisons in 2019 from 2018. The July 2020 report does highlight that 1 in 8 self-harm episode require emergency hospital treatment.

24. Critical Incident Review

24.1 Following a death in custody a critical incident review should normally take place in a prison involving all parties to the incident. This is to identify issues, areas of good practice or areas that require development. The Dóchas Centre Governor did report speaking with relevant parties but there is no evidence that a critical incident review took place in respect of the death of Ms. X.

25. Closing

25.1 Ms. X had a long history of self-harming and when she arrived in prison her presentation, answers to her assessment and expression that she did not intend to self-harm was accepted as sufficient mitigation of any potential of self-harm. Nurse Officer A did decide that allocation of a shared vulnerable cell was required. Those sharing with Ms. X were moved to the general population of the prison on the afternoon of 4 October 2019. Ms. X was alone in detention room 2 when she self-harmed. Records of occupancy in the Committal/Healthcare Unit for 4 October 2019 shows there was the possibility for Ms. X to remain in shared accommodation.

25.2 The presence of a redundant extending television bracket provided the means to use a ligature. There is a commitment in objective 6.2.3 of the National Strategy to Reduce Suicide (*see para 23.15*) in order to address this type issue. Prison Rules require a Prison Governor to conduct daily checks of the prison. Prison Officers are also duty bound to report any issues that may create a risk to a prisoner under the Prison Rules 2007, Rule 87[23]. Despite these requirements in the Prison Rules and additional Health and Safety regulations[24] no reports or information has been provided to show anyone recognised the hazard or risk the redundant television bracket presented.

25.3 Gardaí state Ms. X said she would 'kill herself' but this was not heard by ACO B. The self-inflicted injuries were known to ACO B who was in charge of the prison on night duty 3 October 2019. ACO B is shown as conducting supervision checks of the Committal/Healthcare Unit on 9 occasions during the night to morning of 3 to 4 October 2019 in line with policy.

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[22] SADA Report 2020 for 2018: https://www.irishprisons.ie/wp-content/uploads/documents_pdf/Press-Release-SADA-2018-Report.pdf

[23] Rule 87: A prison officer shall: (a) forthwith report any defect or insufficiency in the state of a building, structure or equipment which could compromise security, good order and good government of the prison or health and safety; and
(b) In particular, on taking up duty and as frequently as is reasonable thereafter, examine the state of any building, structure, or equipment of such area for which he or she has responsibility, and forthwith report any defect or insufficiency which could compromise good order, safe or secure custody or health and safety

[24] HSA: Identifying Risks and Hazards: https://www.hsa.ie/eng/Topics/Managing_Health_and_Safety/Safety_Statement_and_Risk_Assessment/#Whatisthedifference

25.4 Unfortunately the ACO's Night Duty Book entries for 3 October 2019 cannot be located, yet the IPS have been able to produce a copy of the front page and the record of 4 October 2019 from the same journal.

25.5 Other than the PHMS (unavailable to prison officers) no entry is made in any of the journals that Ms. X was to be allocated to a shared cell. This vital piece of information was unknown to prison staff who had a duty of care to Ms. X.

25.6 The absence of a procedure to share information for Ms. X to be in shared accommodation was detrimental to Ms. X's safety. Record keeping and the exchange of any risk factor should be addressed by the IPS as part of its plans to deliver the National Suicide Prevention Strategy.

25.7 As an example of good practice in record keeping the IPS may wish to review the policy of the Police Service of Northern Ireland[25]. Whilst not all sections of the PSNI policy are relevant to the IPS, it demonstrates the standards necessary of criminal justice actors.

25.8 The OIP has criticised IPS record keeping on several occasions. Accurate record keeping is an important element for prevention of self-harm and compliance with Articles 2 and 3 ECHR. Significant improvements in record keeping should be a priority for the IPS.

25.9 Overcrowding in Women's Prisons in Ireland (Dóchas Centre & Limerick) has been an issue for some time. The new women's facility in Limerick is due to open in the near future which may bring some improvements. However, the vulnerability, short sentencing cycle, use of remand in custody and history of abuse of women who are incarcerated in Ireland needs better understanding and opportunities for diversion from prison. The Joint Probation Service – Irish Prison Service Strategy 2014 – 2016 'An Effective Response to Women Who Offend' previously set out a plan for change and may need to be re-visited[26].

25.9 The management and disposal of the complaint made by the Family Law Solicitor demonstrates serious deficiencies in the current process and the need for greater transparency and accountability. The ongoing review of the Prison Complaints Procedures should consider this case as an example of the frustration experienced by those making complaints against the Irish Prison Service.

26. Support Organisations

26.1 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

[25] PSNI notebook and journals record keeping policy: https://www.psni.police.uk/globalassets/advice--information/our-publications/policies-and-service-procedures/official-issue-notebooks-journals-and-daybooks-140219.pdf

[26] Report by Irish Prison Service and female strategy: http://www.irishprisons.ie/images/pdf/female_strategy.pdf

RECOMMENDATIONS & ACTION PLAN

The Office of the Inspector of Prison has made 9 recommendation in this case.

No.	Recommendation	IPS Response	Action Required	Action Owner	Timeline
1	Vulnerability: Where a 'shared vulnerable cell' is recommended this should be made known to all prison staff with a responsibility and duty of care for the detained person and recorded in relevant journals.				
2	If it is decided a 'shared vulnerable cell' is no longer required a risk assessment should be conducted to justify de-escalation. This should be recorded on the detained persons PIMS record.				
3	The IPS should review self-harm policies at the Dóchas Centre considering SADA Reports and the National Strategy for Prevention of Suicide (See section 23).				
4	As required under Prison Rule 13, the IPS should ensure that all prisoners 'shall upon admission to prison' be provided with a leaflet of their rights and entitlements. To achieve this the IPS should conduct a review of all committal areas and prisons for the availability of these information leaflets in English, Irish and other languages. Prison Governors should check compliance with this Prison Rule during their regular inspections of a prison.				

5	A Person Escort Record should be introduced and completed for every movement of a prisoner into or out of a prison whether by Irish Prison Service staff or Gardaí. This should include details of risks of self-harm and vulnerability in addition to security considerations and include any comments or threats made by a detained person. (Example of HMPPS provided at footnote 7).				
6	All journals should be corporate, serial numbered, and completed in a policy led manner that is accurate, detailed and consistent across the IPS. This policy should include instructions for prison officers of information that should be recorded. .				
7	In the event of a death in custody the governor of the prison should seize and securely store all relevant original journals and issue new books.				
8	IPS policy should mandate all complainants be formally informed of progress of their complaint, including a decision not to investigate an allegation and the reason for discontinuance.				

9	The IPS should conduct a critical incident review following any death that is to be investigated by the OIP. (Agreed by IPS in recommendations in other DiC's).				