Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr C
Cork Prison
15 January 2022
Aged 24

[SUBMISSION DATE (to Minister)] 24 May 2023

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GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External defibrillator
AGS	An Garda Síochána
BVM	Bag Valve Mask
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
DiC	Death in Custody
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PAMS	Prisoner Account Management System
VPU	Vulnerable Person Unit

INTRODUCTION

1. Preface

1.1 The Office of the Inspector of Prisons (OIP) was established under the Prisons Act 2007 (the Act). Since 2012, the Minister for Justice has requested the Chief 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 Chief 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 Inspectorate 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 investigation and help to fulfil the obligations of the State 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 includes interviews with staff, prisoners, next of kin (NoK); 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.

3.2 This report is structured to detail the events leading up to Mr C's death in prison on 15 January 2022 and management of the events associated to his death.

4. Administration of Investigation

4.1 The OIP was notified of Mr. C's death via telephone call from Governor A on 15 January 2022. Inspectors from the OIP attended the prison later that day.

4.2 Assistant Governor A provided the OIP with all relevant information in accordance with the Inspectorate's standardised checklist of required information.

4.3 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 The OIP met with Mr C's NoK, his mother, who was accompanied by her son, daughter and daughter-in-law. This meeting took place on 18 January 2022 just three days following the passing of her son. The meeting was arranged very shortly following Mr C's death as Mr C's mother was returning to Poland with her son's remains and was not planning on returning to Ireland.

5.3 Mr. C's mother had very little English but family members who accompanied her had good English and acted as interpreters. The role of the OIP in relation to an investigation into her son's death was explained and an information leaflet provided.

5.4 Mr. C's mother and brother raised a number of concerns which are outlined in section 7.

5.5 Although this report is to the Minister for Justice it will also inform several interested parties. It is written primarily with Mr. C's family in mind. The Office of Inspector of Prisons offers its sincere condolences to the family for their sad loss.

5.6 I am grateful to Mr. C's mother and family for their contributions to this investigation.

INVESTIGATION

6. Cork Prison

6.1 Cork Prison is a closed, medium security prison for adult males with an occupational capacity of 296 beds. It is the committal prison for counties Cork, Kerry and Waterford.

6.2 Mr C was the first death of a Cork prisoner in 2022; and the third death in IPS custody that year.

7. Family Concern

7.1 The family informed the OIP that Mr. C arrived in Ireland during 2017 to join his brother who had moved to Ireland a few years earlier.

7.2 Mr. C's mother could not understand why Mr. C would self-harm stating he had no history of self-harm.

7.3 Mr. C's mother also stated that her son was never in trouble in Poland. To the best of her knowledge, he had no mental health issues and enjoyed physical activity. She described her son as a compassionate person who loved his family and was always trying to help others.

7.4 The family advised the OIP that Mr. C and his girlfriend had been seriously assaulted by their neighbours a few months prior to his imprisonment. The stated that Mr. C had received serious injuries during the assault, the wounds required over 100 stitches. They stated that he was trying to protect his girlfriend and himself from the assailants and that he had used 'pepper spray' on them. He was arrested and charged with obstruction.

7.5 In the opinion of the family Mr. C should not have been in placed in custody. They were annoyed that those who inflicted such serious injuries to Mr. C retained their freedom. The OIP were advised by the family that bail was refused by the Court. The family felt that Mr. C may have been treated more harshly by the Court as he was not Irish.

7.6 Mr. C's mother stated that her son told her that he was afraid in prison as he had never before been imprisoned.

7.7 The questions and concerns raised by the NoK are responded to in section 14.

8. Background

8.1 On 6 December 2021 Mr. C was remanded to Cork Prison to appear before the District Court again on 7 January 2022. This was Mr. C's first time in prison. On 7 January 2022 Mr. C was sentenced to 4 months imprisonment which was backdated to 6 December 2021. Mr. C had additional charges pending, including Possession of a Firearm (Pepper spray), which were listed for hearing on 20 January 2022.

8.2 He was 24 years of age when he died in the custody of Cork Prison on 15 January 2022.

8.3 Mr. C was on the standard level of the Incentivised Regime[1]. On 15 January 2021 Mr. C was on protection and at the time of the incident he was a single occupant of a double cell, cell 29 on A1 landing. Mr C did not make any complaints whilst in the custody of Cork Prison.

8.4 Mr. C had regular phone contact with his family and a friend from 13 December 2021.

8.5 The cell call alarm was last activated by Mr. C at 14:53:23 on 14 January 2022 which was answered in 18 seconds.

8.6 On 15 January 2022 at 00:02:34 Mr. C made a call to a friend which lasted 4 minutes 36 seconds.

9. Incident while in the custody of An Garda Síochána

9.1 On 6 December 2021 Mr. C was escorted by members of An Garda Síochána (AGS) from Court to the Bandon Garda Station pending his transfer to Cork Prison. We were advised by Garda 1 that Mr. C was somewhat erratic when he arrived at the Garda Station.

9.2 The Garda informed the OIP that on arrival at the Garda Station Mr C had cuts to his left wrist around the area where the handcuffs were secured.

9.3 Mr. C informed AGS that he was recovering from a broken hand and had 130 stitches to wounds around his body. Due to the behaviour of Mr. C when he arrived at the Garda Station and the cuts to his wrist AGS called a number of local doctors to examine Mr. C but there were none available at the time. They also contacted Ambulance Control requesting an ambulance but Ambulance Control was unable to give an estimated time of arrival. The OIP were advised by AGS that Mr C asked for a cigarette but his request was refused as he was awaiting medical attention. AGS reported that Mr. C then produced a small screw which he placed in his mouth and made repeated demands to be taken outside for a cigarette. We were advised that Mr. C subsequently removed the screw from his mouth.

[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.

9.4 Garda 1 stated that AGS rang Cork Prison to inform them of Mr. C's actions while in the custody of AGS. The OIP were informed that the prison personnel advised AGS to bring Mr. C to the prison where he would be assessed on arrival. In the critical incident review meeting following the death of Mr. C, Doctor A reported that a call had been received from AGS prior to Mr C's committal notifying the healthcare personnel that Mr C had self- harmed and Doctor A remained in the prison until Mr. C arrived to assess his condition.

10. Engagement with Healthcare

10.1 On arrival at the prison on the 6 December 2021 Mr C was seen by Nurse A. The Nurse noted on PHMS that '*on arrival self-inflicted superficial laceration to left wrist using a 'rusty screw states 'he did not want to kill himself he was sad that he was arrested.''* The Nurse recorded that Mr. C guaranteed his own safety but placed him on Special Observation[2] '*due to nature of incident and first time in prison*'. Nurse A made a note on PHMS that she cleared his wound with saline and dressed it. Mr C was placed in cell 29 on A1 landing.

10.2 Doctor A reviewed Mr. C on 7 December 2021 and removed him from special observation. Doctor A made a note that Mr. C inflicted a superficial cut to his left wrist as he stated that he was frustrated in relation to the court outcome the day before. The doctor recorded that Mr C denied any further plans of self-harm or suicide. Mr. C advised the doctor that he injured himself out of frustration and not to kill himself.

10.3 Mr. C reported throwing up and there was blood in the vomit. Nurse B placed Mr. C on the list to be seen by the doctor. Mr. C was seen by Doctor A on the 11 December 2021. The Doctor advised Mr. C if there was a recurrent episode of blood in vomit request to see the Nurse. Doctor A informed the nursing team to send Mr. C to the emergency department if melena[3] was present. The following day Doctor A again met Mr C who advised that symptoms were settling.

10.4 On 22 December 2021 Mr. C advised Nurse B that he had hernia pain and had similar symptoms approximately 10 years previously. Mr. C was again placed on special observation and he was referred to the Mercy University Hospital by Doctor B. On the afternoon of 22 December 2021 at 17:58 Mr. C was escorted to the Mercy Hospital Emergency Department. Mr. C was diagnosed with a reducible hernia and returned to Cork Prison at 00:56 on 23 December 2022. A follow up ultrasound appointment was made.

10.5 On his return to Cork Prison Nurse C submitted a request for the GP to prescribe the medication listed in the letter from the hospital. The medication was prescribed by Doctor B on 23 December 2021.

[2] Checked by operational staff every 15 minutes
[3] Melena refers to Black colored stools that occur as a result of gastrointestinal bleeding. This bleeding usually comes from the upper gastrointestinal (GI) tract, which includes the mouth, esophagus, stomach, and the first part of the small

10.6 Psychiatry had a scheduled clinic on 29 December 2021. Nurse D on 25 December 2021, referred Mr. C to the psychiatrist clinic on 29 December 2021. Mr. C did not attend the clinic on 29 December 2021 as the Healthcare records examined by the OIP recorded the clinic as 'cancelled'. Nurse D made another referral on 29 December 2021 for Mr. C to be assessed by psychiatry on 30 December 2021 again the records showed that this clinic was also 'cancelled'. Mr. C did not attend the psychiatry clinic on either date.

10.7 The OIP made further enquiries from Doctor C, Psychiatrist. Doctor C, informed the OIP that members of the psychiatry team were available to provide in-reach mental health services on both 29 and 30 December 2021 but patients *'could not be facilitated due to no collectors being available on the mentioned dates.'* Doctor C reported that he had highlighted to IPS management and to the Psychiatry Executive Clinical Director of the risks associated with failing to escort patients to psychiatry clinics.

10.8 On 11 January 2022 a request was made by psychiatric Nurse A for Mr. C to attend the psychiatric clinic on 17 January 2022. Doctor C explained that this request was made on his direction as they were reviewing their referrals. Doctor C reported a back log of patients to be reviewed due to Christmas break and absence of officers to escort the patients to clinics which created a backlog. Doctor C reported reviewing the PHMS notes on Mr. C with his team and there were no '*red flag'* issues highlighted nor was there any urgent concern(s) brought to his attention by prison staff. Doctor C stated that in-reach psychiatric service '*..did not ever see this man...'*

10.9 Mr. C's last interaction with the healthcare team was on the morning of 14 January 2022 when Nurse E attended Mr. C's cell to administer medication. The Nurse reported that Mr. C did not voice any concerns and did not display any signs or symptoms of mental health difficulties.

10.10 Mr. C had daily interaction with healthcare personnel while in the custody of Cork Prison.

11. Phone Activity and Tuck Shop Account

11.1 A remand prisoner, has a right to make not less than five telephone phone calls a week to named family and/or friend(s) (Rule 46 [4] (a) of the Prison Rules 2007-2020). The contact numbers of the family member/friend must be provided to prison staff, an officer will then contact the person(s) named to ensure they will accept a phone call from the person in custody. As those nominated agree to accept a call their number is added to the 'phone card' and activated. Examination of the documentation showed that setting up of Mr. C's phone card commenced on 6 December 2021. He had five people named on the card.

11.2 Records showed that Mr. C attempted to ring his mother from 14:39 on 7 December 2021 but all attempts to connect were unsuccessful until his 72nd time he rang his mother, this was at 14:26 on 13 December 2021. This was Mr. C's first contact with his family since he was committal on 6 December 2021. During the period 7 to 13 December 2021 Mr. C also tried to contact his sister without success. The status of the failed connections were recorded on the 'Phone Report as 'No Ring'. On further investigation by the OIP it was noted that the phone numbers recorded for Mr. C's mother and sister were incorrect. There was an additional digit in his mother's mobile number and a digit missing in his sister's number.

11.3 Mr. C rang his solicitor's number on 12 occasions starting on 5 January 2022 before he had a successful connection on 10 January 2022 at 10:45:31. The number recorded for the solicitor was correct.

11.4 Mr. C was committed to prison with no money. A standard regime prisoner received a weekly gratuity of €11.90 per week. Mr. C Prisoner Account Management System (PAMS) showed that he received gratuity of €11.90 on 12 December 2021 and on 19 December 2021 a second amount of €11.90 was also lodged into the account.

11:5 On 20 December 2021 Mr. C had sufficient funds to make his first Tuck Shop purchase which cost €17.63.

11:6 On 26 December 2021 a further €11.90 gratuity was lodged to his account. Mr. C purchased item(s) in the Tuck shop on 27 December 2021 which cost €17.16, leaving him with a balance of 41 cent in his account.

11:7 A gratuity of €11.90 was lodged to Mr. C's account on 2 January 2022. On 6 January 2022 Mr. C had a recorded balance of €83 following a lodgment to his account. Mr. C made purchases totaling just over €37. A gratuity was again lodged on 9 January 2022 in the sum of €11.90 and on 10 January 2022 Mr. C made a large purchase totaling €66, this was the last Tuck Shop purchase made by Mr. C. The balance in Mr. C's account when he passed was €8.85.

12. Events on 14 and 15 January 2022

12.1 On Friday evening 14 January 2022 Officer A was in charge of A1 landing. The Officer reported carrying out checks at approximately 19:20, 21:00 and again at 23:05. The Officer reported that on each occasion there was nothing unusual to report regarding Mr. C. Officer A stated that he observed Mr. C watching television when he checked his cell at 23:05.

12.2 Mr. C had access to an in-cell telephone from which he was able to make outgoing calls to family/friends for whom he had permission to ring. Mr. C made a phone call on 15 January 2022 at 00:02:34, this phone call was to his girlfriend of and lasted 4 minutes 36 seconds. The OIP listened to the recording of this phone call, during which Mr. C stated that he had suicidal thoughts and was anxious about upcoming court case.

12.3 Officer B discovered Mr. C unresponsive in his cell at 01:04:50 on 15 January 2022. Officer B stated that on checking the cell they observed Mr. C suspended from a ligature. The Officer called for assistance from Officer C who was on the landing. Officer B used the tetra radio to seek assistance from Assistant Chief Officer (ACO) A and Nurse C who responded immediately.

12.4 Officer C, who was Night Guard on A2 and A3 landings, retrieved the master key to unlock the cell. ACO A opened the cell door and entered the cell along with Nurse C, Officer C, Officers D, Officer E who was Night Guard on B1 landing, this was 01:06:36. Officers C and D reported holding the prisoner while Officer E removed the ligature. Mr. C was removed from the cell and placed on the A1 landing where CPR [4] was commenced.

12.5 At approximately 01:06 ACO A instructed Officer F, who was in the Control Room, to call for an ambulance. Officer B was instructed to take charge of the main gate to facilitate the entry of the paramedics.

12.6 Nurse C stated that Mr. C was removed to the landing for ease of access for medical intervention including the provision of oxygen. Chest compressions were rotated between Nurse C and Officer E. This account of events is corroborated by CCTV footage viewed by the OIP which showed Mr. C being placed on the landing at 01:06:33 and being attended to by the Nurse assisted by other staff.

12.7 Nurse C reported that Mr. C was not breathing and had no pulse detected, oxygen was administered via Bag Valve Mask (BVM). Compressions were commenced and Automated External Defibrillator (AED) was applied. Nurse C reported that a faint/irregular pulse was detected and 'Nil shocks' were advised by the AED. CPR continued until the Fire Brigade personnel arrived and took over CPR and care of Mr. C. The First Brigade Responders and HSE Ambulance personnel arrived shortly after the Fire Brigade personnel and they provided advanced care. At approx. 01:45 Nurse C recorded that a faint pulse was detected but Mr. C was not breathing independently.

12.8 The CCTV viewed showed that at 01:17 three Paramedics from Cork Fire Brigade arrived and took over charge followed by two ambulance personnel at 01:23 and another two ambulance personnel at 01:39. All were involved in the provision of healthcare assistance to Mr. C.

12.9 A trolley was brought to the landing at 01:59 and Mr C was lifted onto the trolley and removed from the landing by Ambulance personnel. The ambulance left the prison at 02:02 transferring Mr. C to the Mercy Hospital, accompanied by Officer G and C who remained with Mr. C until his death was pronounced at the hospital at 02:34. Chaplain A was also in attendance at the Hospital.

[4] Cardiopulmonary resuscitation is an emergency procedure consisting of chest compressions

13. Critical Incident Review and Debriefing meeting

13.1 A critical incident review and debriefing meeting took place on 17 January 2022. The purpose of this meeting is to establish the facts, to provide an opportunity to share views in relation to how the situation was managed and identify any additional support or learning.

13.2 The meeting was attended by seven staff, none of whom were directly involved in the incident. The Irish Prison Service Standard Operating Procedure (SOP) titled 'Critical Incident Reporting and Debriefing Procedures' which came into effect on 1 July 2020 provides that '*an operational hot debrief should take place at the end of a Critical Incident at the earliest opportunity, and where possible before staff finish their shift*'.

13.3 There is no evidence that a cold debrief was held. The SOP mentioned above states that '*an operational cold debrief should be arranged at the earliest opportunity, but no later than 14 days post incident and should include, to the greatest possible extent all the staff involved in the incident*'.In previous investigation reports, the OIP has recommended there should be a hot and cold debrief (see, for example, Mr. I 2018 and Mr. O 2018) and these recommendations led to the development of this IPS policy, which was not adhered to following this death.

13.4 At the meeting Governor A gave an outline of the incident stating that Mr. C was found to be unresponsive in his cell at approximately 01:04. He stated that staff and paramedics arrived very quickly and Mr. C was removed to the Mercy Hospital.

13.5 Chief Nurse Officer (CNO) A informed the meeting that Mr. C had been placed on special observation and accommodated on the vulnerable persons unit (VPU) on committal. He was seen by Doctor A on 7 December 2021 and removed from special observation. He was placed on special observation again on 22 December by Nurse F and following a consultation with Doctor B he was conveyed to hospital in relation to abdominal pain. During his time in Cork Prison Mr. C was seen by a Nurse every day, he had been referred for an ultrasound but no appointment had become available prior to his death.

13.6 CNO A also reported that Mr. C had been referred to the psychiatry service on 29 December and 30 December 2021 and an appointment had been scheduled for 17 January 2022.

13.7 Assistant Governor A informed the meeting that he had received an email from the ACO B in his capacity as Staff Support Officer confirming that he was engaging with the staff involved in the incident and would continue to engage with them. A CISM (Critical Incident Stress Management) meeting had been held a CISM and ACO B remained in contact with the first responders to the incident.

13.8 Governor A praised the staff for their professionalism and commitment throughout this incident commending them on their efforts to have the life of Mr. C in performing CPR.

14. Family Questions and Answers

14.1 **Why was my son in prison?**

Mr. C was remanded to the custody of Cork Prison from the District Court on 6 December 2021, having been charged with obstruction. The Presiding Judge did not award bail and consequently your son was placed in prison custody. Your son had a further Court appearance scheduled for 7 January 2022 and on that date he was sentenced to four months imprisonment on the charge of obstruction and further remanded to appear in Court on 20 January 2021 for face further criminal charges, as outlined earlier in the report.

14.2 **Mr C asked for bail in Court and it was refused, why?**

The decision as to whether or not bail is granted is a matter exclusively for the presiding Judge.

14.3 **Mr. C told his mother he was asking for help while in custody and didn't get any, he was also afraid. Did he get any help and why was he afraid?**

On 16 December 2021 Mr. C was moved to A1 cell 29 on protection as a member of the family with whom he had difficulties in the community was also in custody. The other person remained on a different landing. As Mr. C was on protection, it restricted his out of cell time and his interactions would have been with a small group of people on his landing.

Mr. C's engagement with and sought assistance from the Healthcare services is outlined in section 10 of this report. His scheduled appointments with the psychiatrist were cancelled because prison officers did not escort him to those appointments.

14.4 **What was said in the last phone call he made to his girlfriend.**

Mr C made a phone call to his girlfriend on 15 January 2021 at 00:00:54. They had a conversation about personal matters including their unborn baby.

Mr. C also told his girlfriend that he had suicidal thoughts and he was only alive because she would waiting for him. He went on to state that the thoughts of those who assaulted them being on the outside and free was driving him "*crazy*"; he said that he expected to get a few years for the charges against him.

His girlfriend told him that "*there was no point in suicidal thoughts*" and encouraged Mr. C to contact the solicitor who could advise him about bail etc. Mr. C agreed but again stated that the charge of '*section four*' could be five to 10 years. His girlfriend again advised Mr. C that they always "*say the worst case scenario firs*t". The call ended suddenly at 00:04:00.

14.5 **We were told that there were two notes found in the cell – one was in English and the other in Polish, where are these?**

Notes were left and taken possession of by An Garda Síochána. The OIP has not had access to these notes.

14.6 **Mr. C had good spoken English but was poor at reading. Were things explained to him?**

Mr. C was not processed through Reception, he taken straight to the landing and placed in quarantine (on his own in a cell for x days) as it is recorded that he was symptomatic. Prison management confirmed that Mr C was provided with a 'kit bag' on committal which the prison authorities indicated should have included an information booklet in English. However, as the OIP has no inventory of the materials removed from Mr C's cell by AGS, it has not been possible to verify this.

14.7 **Did someone get into his cell, where did he get the ligature and what was used?**

Mr. C was alone in a double cell. Nobody entered the cell, he was lock in his cell at the relevant time. This was verified by the OIP by viewing the CCTV footage. An Garda Síochána took the ligature as evidence for the Coroner's Inquest.

14.8 **Mr. C had an iphone 11 which was not returned with his property.**

There is no record of Mr. C having an iphone or any mobile phone in his possession on committal to Cork Prison. In an effort to be of assistance, the OIP made enquiries with An Garda Síochána and were advised that custody record at the station where Mr. C was detained pending transfer to Cork Prison did not record Mr. C as having a mobile phone in his possession on committal to the Garda Station.

14.9 **Some of Mr. C's personal possessions were not returned.**

The OIP were advised that the Chaplain returned Mr. C's personal belonging to the family.

The OIP checked the IPS PIMS committal record and the following was recorded:

- No cash
- 1 key

On 18 January 2022 it was recorded that the key and "*all property*" was returned to the family.

Prison management advised the OIP that no record was maintained by the prison service of property removed from the cell by An Garda Síochána (AGS). The OIP does not have access to the AGS inventory of items removed from the cell.

15. Recommendations

The OIP make seven recommendations to the Irish Prison Service in response to the death of Mr. C 2022.

15.1 It is recommended that the Irish Prison Service put in place the necessary staffing arrangements (including, if necessary, revision of Regime Management Plans) to ensure that prisoners' appointments to attend healthcare clinics are not cancelled because prison staff are unavailable to escort them. This is particularly critical in relation to referrals to psychiatric in-reach clinics; the necessary staffing resources to escort prisoners to appointments of this nature should be "ring fenced" in the Regime Management Plans of all prisons in the State.

15.2 If, exceptionally, a person in custody cannot be escorted to an ordinary somatic healthcare appointment due to acute staff shortages or other operational reason(s), a record of any appointments that are cancelled for this reason should be maintained by healthcare personnel and the Governor in charge of the prison notified of these on a weekly basis by the Chief Nurse Officer. Any prisoner whose health care appointment is cancelled for this reason, should be facilitated to attend a replacement appointment as a matter of urgency.

15.3 Prison Governors should be reminded of their obligation to comply with the Irish Prison Service Standard Operating Procedure (SOP) titled 'Critical Incident Reporting and Debriefing Procedures' which came into effect on 1 July 2020.

15.4 It is recommended that the Irish Prison Service ensure compliance with Prison Rule 13(1) and (4) of the Prison Rules 2007 – 2020 which requires the Irish Prison Service to provide each prisoner with an information booklet outlining their entitlements, obligations and privileges; the booklet should, "as far as practicable be provided to a foreign national in a language understood by him or her".

15.5 The Irish Prison Service must ensure that all telephone numbers are accurately recorded on the phone cards of prisoner and that, once activated on the phone card, they are working. It should also ensure that the operation of the system is explained to the person in custody, particularly if it is their first time in custody.

15.6 The Irish Prison Service should, in accordance with Rule 46(4)(a) ensure that a remand prisoner is permitted to make not less than five phone calls per week and if any of these calls fail, the reason should be recorded.

15.7 It is recommended that an inventory of all clothing and other personal items in the possession of a person on committal should be recorded in accordance with Rule 8(1) of the Prison Rules 2007-2020, this inventory should include clothing and its label. In addition, a similar inventory should be made of all items returned to the family/next-of-kin following a death in custody and separately a list should be compiled by prison staff of any item(s) taken into the possession of An Garda Síochána.

16. Support Organisations

16.1 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.