Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. G
Cork Prison
2 October 2021
Aged 54

Submission Date: 29 August 2023

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GLOSSARY

ACO	Assistant Chief Officer
CBU	Challenging behaviour unit
CIRM	Critical Incident Review Meeting
CISM	Critical incident Stress Management
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
IPS	Irish Prison Service
MHA 2001	Mental Health Act 2001
MQI	Merchants Quay Ireland
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Health Management Service
PICLS	Prison In-reach and Court Liaison Service
SOP	Standard Operating Procedure
VPU	Vulnerable Persons 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 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 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. G's death in prison and the response after Mr. G was found unresponsive in his cell on 2 October 2021.

4. Administration of Investigation

4.1 The OIP was notified of Mr. G's death via telephone call from Governor A on 2 October 2021. Inspectors from the OIP attended the prison later that day.

4.2 Cork Prison Senior Management 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 in-person meeting with Mr. G's family was delayed due to Covid-19 restrictions.

5.3 The OIP met with Mr. G's NoK, his sister, in January 2022. The role of the OIP in relation to the investigation of the circumstances surrounding a death in prison custody was explained.

5.4 Mr. G's sister provided Inspectors with background information on her brother. She outlined the family's concerns and raised a number of questions which are outlined and replied to in Section 14.

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

5.6 The OIP is grateful to Mr. G's sister for her contribution to this 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. G was the second death of a Cork prisoner in 2021, and the seventh death in IPS custody that year.

7. Family Concerns

7.1 Mr. G's sister made a number of observations in relation to persons suffering from a mental health illness and raised concerns regarding the level of support provided by the State for people facing challenges with their mental health. She informed the OIP that her brother was vulnerable as he suffered from bi-polar disorder. She stated that medication helped his condition but only to an extent. However, if he failed to take his medication he could become unstable.

7.2 Mr. G's sister advised the OIP that her brother informed her that he was locked in his cell, on his own, for extended periods. She did not provide any time period for the alleged prolonged periods of lock-back. However, Mr. G's sister expressed the view that she was very unhappy that her brother was locked in a cell for extended periods, which she stated were up to 23 hours based on information from her brother. The NoK went on to express the view that 23 hour lock-back was, in her view, unnecessary during COVID. Furthermore, the NoK considered these actions by the IPS to be what she termed an '*opt-out*' that were not good for her brother's mental health.

7.3 Mr. G's sister stated that her brother engaged with services available to him in Cork Prison and spoke positively about his engagement with a Counsellor from Merchants Quay Ireland.

7.4 However, she expressed the view that "*all arms of the State had left her brother down*" and stated that the family had spent years unsuccessfully seeking mental health and housing support for her brother. Mr. G's sister expressed the strong belief that Prison is not the answer for people suffering from a mental illness.

7.5 When the NoK was notified of the death of her brother, she stated she was not given any "*practical information*" on what to do next. For example, the NoK did not know who was responsible for the removal of the remains from the prison; had NoK to contact an Undertaker or was that the responsibility of the prison; could the NoK view her brother's remains; where the remains were then located. The NoK stated that her brother died on a Saturday and she was not at home when she got a call notifying her of her brother's death but rang the prison when she got home and was told that the Governor would not be in the prison until Monday. The NoK told the OIP that she had to wait until Monday to speak to the Governor "*in order to get practical information*". When contact was made with the Governor on Monday, the NoK stated that, in her opinion, the information provided was what she termed "*piecemeal*" and that there was no formal process to explain what was to happen next.

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

8. Background

8.1 Mr. G was 54 years of age when he died in Cork Prison on 2 October 2021.

8.2 Mr. G was committed to Cloverhill Prison on remand on 6 September 2020. As Mr. G was diagnosed with bipolar disorder he was placed on D2 landing which accommodates people facing challenges with their mental health.

8.3 People accommodated on D2 landing in Cloverhill Prison are assessed and monitored by the Prison In-Reach and Court Liaison Service (PICLS)[1]. Nurse A Forensic Community Mental Health Nurse attached to the PICLS team assessed Mr. G on 14 September 2020. In a letter to the Psychiatrist in Cork Prison Nurse A advised that Mr. G was assessed and he "*did not meet the criteria for mental disorder as outlined in the MHA 2001*" (Mental Health Act).

8.4 Subsequently at Waterford Circuit Court on 15 September 2020 Mr. G received two 10 month consecutive sentences, he received further sentences at Waterford District Court on 4 February 2021 and 13 April 2021, resulting in a total sentence of two years and three months. Mr. G's release date with remission would have been 16 May 2022.

8.5 Mr. G was committed to Cork Prison following sentencing on 15 September 2020. On committal he was accommodated in a single cell in the Challenging Behaviour Unit (CBU) Cell 2 which was located on B1 landing. Governor B advised that his placement in the CBU was due to cell availability at the time.

8.6 We requested detailed information on the cell movement and enquired whether he was accommodated in shared or single occupancy cells. The examination of the records found that Mr. G was a single occupant of a cell for the following periods:

- 15 September 2020 to 18 September 2020
- 28 October 2020 to 20 November 2020
- 22 January 2021 to 31 January 2021
- 16 February 2021 to 20 February 2021
- 19 March 2021 to 30 March 2021
- 9 May 2021 to 19 May 2021
- 22 May 2021 to 27 May 2021
- 7 July 2021 to 08 July 2021
- 28 August 2021 to 2 October 2021

8.7 On 31 October 2020 Mr. G was moved to the cell 6 in the Vulnerable Persons Unit (VPU) and placed under the Psychiatric team as he was reported as behaving erratically on the landing. Further details in relation to the healthcare provided to Mr. G are detailed in Section 9.

8.8 On 24 May 2021 Mr. G was moved to cell 5 wing B1 CBU. It is recorded that he admitted to the Governor that he was under the '*influence of a substance he took/inhaled'.* Mr. G returned to his own cell later on the same date.

[1] The main objective of the PICLS is to improve the identification of people suffering from mental health issues when they are remanded to prison. The scheme aims to assist patients, the criminal justice system and local psychiatric services by ensuring a rapid response and by systematically identifying prisoners with a primary diagnosis of psychotic illness.

8.9 Mr. G was a close contact of a suspected Covid-19 case and was placed in quarantine with another prisoner on 19 July 2021. Mr. G was swabbed and when negative results were received on 23 July 2021 quarantine was lifted and Mr. G returned to the general population.

8.10 The records examined confirmed that Mr. G was seen regularly by the psychiatry team and engaged well with the Addiction Counsellor from Merchants Quay Ireland (MQI)[2].

8.11 The phone records viewed by the OIP showed that Mr. G had almost daily phone contact with either his sister or a friend.

8.12 All staff and service providers with whom the OIP met confirmed that Mr. G interacted well with them and other prisoners.

8.13 Mr. G was on the standard level of the Incentivised Regime[3] at the time of his passing.

9. Engagement with Healthcare

9.1 At the time of his prior committal to Cloverhill Prison, Mr. G was referred to the PICLS team. Psychiatric Nurse A wrote to the Psychiatrist in Cork Prison on 16 September 2020 advising that Mr. G was assessed on 14 September 2020 by Doctor A and Nurse A. They recorded that Mr. G was pleasant and cooperative on review. The Nurse further advised that Mr. G had a background of bi-polar disorder that was complicated by alcohol and polysubstance abuse. As noted in Section 8 Nurse A stated that at the time of the assessment the opinion was formed that Mr. G did not meet the criteria for a mental health disorder as outlined in the Mental Health Act (MHA) 2001[4].

9.2 Mr. G was seen by Doctor B the Psychiatrist in Cork Prison on 17 September 2020 and he recorded on the Prisoner Health Management System (PHMS) that Mr. G '*was relatively calm, not suicidal and no elation.'* He was seen again by Doctor B on 8 and 20 October 2020 where Doctor B noted he '*Cannot see himself, negative view, wants to see Psychologist.'* The Psychiatric Nurse A sent a referral to the Psychology Service on 20 October 2020.

9.3 On 3 February 2021 Mr. G completed a psychology consent form and he was seen by Senior Clinic Psychologist on 5 March 2021 who provided Mr. G with reading material in relation to bipolar disorder.

9.4 The OIP was advised by MQI Addiction Counsellor A that Mr. G had 27 engagements with the addiction service from February 2021 until the time of his death. MQI Addiction Counsellor A last saw Mr. G on 29 September 2021. He stated that Mr. G was in good form and there were no '*red flags*'. MQI Addiction Counsellor A also stated that Mr. G attended yoga sessions

[2] Merchants Quay Ireland (MQI) provided a range of counselling interventions and release planning strategies to those in custody in Cork Prison, which included motivational interviewing, relapse prevention strategies, cognitive–behavioural therapy, development of alternative coping strategies and harm reduction approaches. MQI addiction counselling is provided by accredited Counsellors who participated in the multi-disciplinary meetings.

[3] 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.

[4] Section 4 of the MHA 2001 notes *'in making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made*.' The involuntary admission of persons to approved centres is cover in Part 2 of the MHA 2001

regularly in Cork Prison school and he was very interested in mindfulness. Mr. G practiced the exercises shown and provided to him. Mr. G's last engagement with MQI was a phone call two days before he passed, 30 September 2021, during which Mr. D asked for more reading material in relation to positive thinking and self-care. MQI Addiction Counsellor A stated that Mr. G '*left an impression on people*' and sent his condolences to Mr. G's family.

9.5 Mr. G was seen by nursing staff, the prison doctors and the psychiatrist on a regular basis during his time in prison. From the date of his committal to Cloverhill Prison on 6 September 2020 to the time of his passing there were 198 engagements recorded with healthcare professionals including one to one addiction counselling, attendance at the Nurse's clinic, examination/consultation with the prison doctors, appointments with psychology and psychiatry. Records examined confirmed that Mr. G received his depot injection every three weeks, as prescribed. Mr. G regularly attended the Doctor's clinic in relation to shoulder pain and for the tremor in his hands for which he was prescribed kemadrin[5].

9.6 The OIP was provided with a Record of 'dates of medication '*not taken or awaiting supply*'. There were 58 occasions between 16 September 2020 and 2 October 2021 when Mr. G was not administered medication at the specified dispensing time. Where a medication is not dispensed the Nurse had one of three options to tick on the medications administration chart for non-administration. The reasons for non-dispense of medication were (i) did not attend (ii) not signed (iii) awaiting supply. The Chief Nurse Officer (CNO) A informed the OIP that nursing staff follow up with prisoners who do not collect medication. Occasionally prescribed medication would not be available, particularly at the early morning medication round. If medication was '*awaiting supply*' the CNO informed the OIP that the medication would be obtained and administered during the course of the same day.

9.7 Mr. G was placed on special observation on two occasions whilst in custody. On 31 October 2020 Mr. G was moved to B1 VPU 6 due to possible holding of medication and his general behaviour being of concern. Mr. G suffered delusions. Nurse B spoke to Mr. G about his medication and he initially told the nurse that he '*don't need it*' but following the conversation with Nurse B Mr. G agreed to take his medication and did so in her presence. Nurse B made a note on PHMS that having regard to Mr. G's presentation at the time the decision was made to place Mr. G on special observation and move him to the VPU.

9.8 Nurse B visited Mr. G again later on 31 October 2020 and recorded that he was '*settled for the afternoon, medication compliant.'* He was checked again by nursing staff at 20:00. At 21:30 Mr. G was administered analgesia for muscle ache, there is a record that at this time Mr. G was '*Elated, pressure of speech, listing multinational companies he is 'the boss' of. No obvious distress.'* Mr. G's medical file recorded four checks by Nursing staff on the 1 November 2020 and two on 2 November 2020. PHMS records showed that Nurse B requested that psychiatry schedule an appointment for Mr. G at the 3 November 2020 clinic.

[5] Kemadrin is used to treat and relieve the symptoms of Parkinson's disease. Kemadrin is also used to manage the side effects of neuroleptic medicines (used to treat serious mental illnesses). These side effects are quite similar to the symptoms of Parkinson's disease.

9.9 On 3 November 2020 Mr. G was seen by Doctor B Psychiatrist who recorded that Mr. G had no visual or auditory hallucinations, was mildly elated, taking his medication and was cleared to return to the landing. Chief Nurse Officer A also recorded that Mr. G was discussed at the special observation meeting on 3 November 2020 and it was agreed that he could return to the general population.

9.10 Mr. G was again placed on special observation by Doctor C on 23 May 2021 as it was believed he was under the influence of an unknown substance. On 24 May 2021 the Doctor recorded that Mr. G was well, he had no suicidal thoughts, guaranteed his own safety and could be taken off special observation.

9.11 Mr. G had regular interaction with healthcare personnel up until the time of his death. He was last seen by the Psychiatrist Doctor B on 14 September 2021 and Psychiatrist A on 20 September 2021 in relation to his prescription. He was last seen by Doctor D on 22 September 2021 in relation to a prescription. Nurse C administered his depot injection on 25 September 2021 and recorded that he was approached by Mr. G on Friday 1 October 2021 requesting to see a Doctor. Nurse C stated Mr. G didn't give a reason but this wasn't an unusual request as Mr. G often requested/had appointments with the doctor to review his medication. Nurse C could not recall anything unusual or of concern when speaking to Mr. G. Mr. G's name was placed on the list to be seen by the Doctor on Monday 4 October 2021 which was the first appointment following his Friday request. The Prison Doctor does not convene regular clinics over the weekend, the Doctor meets with committals, transfer prisoners and deals with emergencies. Mr. G's request for a doctor's appointment was routine and not an emergency. The Nurse described Mr. G as being very pleasant, engaging and said he had settled well into this sentence and was in the general population. Nurse C stated that Mr. G was well able to engage and vocalise any issue he had and nursing staff had no concerns regarding his wellbeing.

10. Events of 2 October 2021

10.1 Officer A, the Night Guard, on 1 October 2021 reported he checked the cell on seven occasions during his tour of duty and had no interaction with nor had he concern about Mr. G. Officer A handed over to Officer B.

10.2 Officer B reported that he was the early start officer on 2 October 2021. He was detailed to A3 landing. The Officer checked all prisoners and recalled that Mr. G was sitting up watching television when he checked his cell. He stated that Mr. G did not bring any concerns to his attention during his tour of duty. CCTV footage confirmed that Officer B lifted the hatch of Mr. G's cell at 07:17.

10.3 Officer C was Breakfast Guard on 2 October 2021. On examination of the Breakfast Guard Journal Officer C had entered that he '*patrolled the landings for the duration of duty checking all offenders at irregular intervals finding all correct*.' The review of the CCTV footage conducted by the OIP does not corroborate this entry as checks were not conducted. In his statement Officer C stated that "*I wrote my report and before I could carry out my check a medical emergency occurred to me*."

10.4 Officer D was assigned Class Officer on A3 landing. Officer D stated that he checked and counted the prisoners on the landing, this was at approximately 09:02. This report is corroborated by CCTV footage Officer D recalled Mr. G was sitting on a chair watching television when he checked his cell.

10.5 Officer D informed the OIP that after checking on the prisoners he asked the Assistant Chief Officer (ACO) A if he could unlock the prisoners for breakfast. He was instructed to wait as there was insufficient staff to unlock and a decision had been made for a staggered[6] unlock.

10.6 Officer D was seen on the CCTV footage at 09:04 walking back down the landing to unlock the gate at the opposite end of the landing to the Class Office, this was in preparation for breakfast unlock to allow prisoners to exit the landing from one end and return through the stairwell at the opposite end of the landing. Having unlocked the gate to the stairwell, Officer D walked back towards the Class Office, as he walked he was looking up at the overhead landing/skylight. Mr. G's cell was on the opposite side of the landing to where Officer D was walking. When Officer D was almost adjacent to Mr. G's cell his Cell Call Alarm light activated outside the cell door. As Officer D was looking upward he did not see the flashing light, which is located just above waist height.

10.7 Officer D continued walking towards the Class Office where he reported being joined by Officer E, Officer F and Officer G. He stated they were waiting for more staff to become available in order to start unlock. Officer D stated that approximately 30-35 minutes later the ACO instructed them over the radio to unlock A3 for breakfast.

10.8 Officer D's account of events was corroborated by Officer E. Officer E reported while waiting for the ACO's instructions to unlock he spent time at the railing on the landing and in the Class Office with Officer D and Officer F. Officer F reported standing close to the Class Office while awaiting for the instruction to commence unlock.

11. Cell Call Activation

11.1 On the morning of 2 October 2021 the cell call activation records showed that Mr. G pressed the regular cell call alarm at 09:04:37 and he pressed the emergency cell call alarm at 09:04:40.

11.2 Officer D commenced unlock for breakfast at approximately 09:35, unlocking cell 1 first, the closest cell to the Class Office. Mr. G was in cell 8. Having unlocked a few cells Officer D stated that he then noticed a light flashing outside cell 8 and immediately went to the cell and unlocked it. CCTV footage showed Officer D unlocking the door of Mr. G's cell at 9:36.

11.3 Officer D informed the OIP that when he unlocked the cell door Mr. G was in a seated position on the floor, slumped with his back against the lower bunk bed. Officer D stated that he immediately called for medical assistance over the radio and got an immediate response from Officers and Nurses. Officer D informed the OIP that Officers placed Mr. G in a prone position on the cell floor before nursing staff took charge.

11.4 Officer D stated that he did not hear an alarm activation, nor did he see any light flashing outside Mr. G's cell on the landing until he commenced unlocking the cell doors for breakfast.

11.5 Officer E stated that at approximately 09:30/09:35 they received their instruction to unlock for breakfast. Officer E had the Assistant Class Officer keys and was unlocking the right hand side of the landing which was the opposite side to Mr. G's cell. Officer E recalled that he was about half way down the landing when he heard Officer D call for assistance and he ran over to Mr.

[6] Unlock landing by landing

G's cell and saw him slumped over with his back against the bunk bed. He recalled that other officers were present so he secured the area to keep the landing clear for the arrival of healthcare personnel.

11.6 Officer E stated that he did not hear any cell call alarm or see any cell call light activation while waiting for the instruction to unlock. If he heard an alarm he stated that he would have responded.

11.7 Officer F stated that after unlocking about five cells he heard a call on the radio from Officer D for immediate medical assistance on A3. Officer F went straight to Mr. G's cell and informed the OIP that Officer D was opening the door as he arrived. He saw Mr. G at the very back of the bunk, slumped on the floor with his back against the bunk. Officer F stated that Mr. G was white/pale and he didn't respond to his name being called. He recalled the medics arriving very quickly. Officer F informed the OIP that he did not notice any cell call light activate nor did he hear any cell call bell while he waited for the instruction to unlock.

11.8 Trades Officer A took up the post in the Control Room as Breakfast Guard at 09:00 he was not accompanied in the Control Room. Trades Officer A confirmed that an emergency alarm, if activated, should ring in the Control Room and should continue ringing until answered. He stated that on the morning of the 2 October 2021 the emergency alarm did not activate in the Control Room.

11.9 The Inspectors who visited the Control Room on 2 October 2021 found the emergency alarm phone situated on a desk behind where Trades Officer A was seated. Trades Officer A stated that if it rang he would have heard it but he could not see the handset from where he was seated. Trades Officer A stated that he became aware of a medical emergency at 09:35 approximately following a radio call for assistance. He stated that numerous instructions followed from the ACO to phone for an ambulance and ensure the ambulance had immediate entry when it arrived. Trades Officer A confirmed that he did not leave the Control Room from the time he took up Breakfast Guard duty at 09:00 until he left at 10:00 to preserve the scene on A3 landing.

11.10 The OIP Inspectors checked the cell call bell and emergency bell in cell 8 on A3 landing when they attended Cork Prison on the afternoon of 2 October 2021. When pressed inside the cell, the cell call alarm light activated outside the cell door. However, on checking the handset in the Class Office - which should have rung when the cell call button was pressed - the Inspectors found that the volume had been reduced to the minimum level possible and only a faint buzz could be heard when standing close to the handset. The volume on the emergency device in the Control Room was also placed at minimum and could not be heard.

11.11 In addition, the OIP found that notices attached to the glass panel of the Class Office obstructed the Class Officer's view of the landing when seated. The cell alarm light is positioned in line with the key hole on the cell door. When seated in the Class Office the Inspectors found that it was not possible to see the cell call light of some cells as the railing around the landing obstructed the view only the cells close to the Class Office could be seen.

11.12 The Cell Call System standard operating procedure (SOP) in operation in Cork Prison on 2 October 2021 stated that the:

'Normal cell call should ring in the Class Office for 60 seconds before defaulting to the control room. Emergency call shall ring parallel in the local Class Office and the Control Room.'

11.13 The cell call activation records for Mr. G's cell showed that Mr. G pressed the cell call activation button at 09:04:37 and the emergency call activation button at 09:04:43. Neither alarm was responded to as the volume was lowered to minimum on both handsets.

11.14 Mr. G was found unresponsive at 09:34:29 which was 30 minutes after he first activated the cell call emergency alarms.

11.15 We were advised by Governor A that there was a verbal agreement between the Prison Officers Association and the Chief Officers that the volume on the handsets in the Class Office and in the Control Room would be set at an agreed audible level. Governor A was not aware that the volume on the phone could manually be adjusted to minimum.

11.16 A Governor's Order was put in place by Governor A following the passing of Mr. G which:

(a) Removed the options to turn down or mute the volume on Cell Call handsets;
(b) Required the ACO to check the cell call system daily on each landing and record same in their daily reports, which are to be reviewed by the Chief Officer;
(c) ACO must check the cell call system in the Control Room and record the check in their daily reports, which are to be reviewed by the Chief Officer;
(d) To fit monitoring devices to cell call systems[7] in order to generate email alerts to management in the event of any cell call device being unplugged in the Class Offices and/or Control Room.

11.17 The OIP was provided with a copy of the revised Cell Call System SOP which now states that:

'*At no stage are the volume sound levels on the cell call phone in the Class Offices/Control room to be muted or turned down below audible levels.'*

11.18 There was no evidence in the documentation examined or from the statements and reports obtained that prison officers on taking up their posts complied with Rule 87.(b) which requires a prison officer "*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*."

11.19 The OIP took the opportunity of its full unannounced inspection of Cork Prison in March/April 2023 to verify the operation in practice of these new procedures.

It found that, while the call volume issue had been resolved, the location of the call lights outside the cells was unchanged; it remained the case that only those lights closest to the Class Office could be seen.

Moreover, the Inspectorate's team identified a further issue with the operation in practice of the call system at Cork Prison, leading the Chief Inspector to raise the following Immediate Action Notification (IAN):

[7] Cell call systems refers to the phones which ring in the Class Office and Control room when a prisoner presses the cell call activation button.

"At present, if any prisoner in Cork Prison presses the ordinary call button in their cell, it is not possible for prison staff to cancel that intercom/priority call from the Class Office or the Control Centre without answering it. Moreover, for so long as prison staff do not answer that call, all other intercom/priority calls from every other cell in their accommodation Division (A or B) will remain stacked in a queue. This means that the current call bell system enables the refractory actions of a single prisoner to prevent prison staff in the Class Office and in the Control Centre from answering any other intercom or priority call from a prisoner living in the same Division until the first call in the queue has been answered.

For emergency calls, although these go directly to the Control Centre as well as to Class Offices, the first emergency call made will remain at the top of the queue until the cell from which it was made has been physically visited to carry out a reset. In the meantime, no other emergency call in the queue can be answered until the first emergency call in the queue has been answered.

The dangers of this situation are obvious: it could easily be the case that a genuine emergency call goes unremarked and unanswered for a critical period of time, leading to a variety of avoidable harms, up to and including the death of a person living in the prison.

The Inspectorate of Prisons considers that the likely impact of this concern is **critical** and that the probability of this impact occurring is **likely**. Consequently, the Inspectorate deems the risk involved to be **very high**.

Given the gravity of this concern, I have decided to raise the following Immediate Action Notification:

*Having become aware of a serious concern regarding the call bell system at Cork Prison which is **likely** to have a **critical adverse impact** on people living in Cork Prison, the Chief Inspector of Prisons:*

- *Formally notifies the Director General of the Irish Prison Service and the Acting Governor II of Cork Prison that this concern has been deemed by the Inspectorate of Prisons to involve a **very high risk**;*

- *Requests the Director General of the Irish Prison Service and the Acting Governor II of Cork Prison to **intervene immediately** to mitigate the very high risk identified in this Immediate Action Notification;*

- *Requests the Director General of the Irish Prison Service and the Acting Governor II of Cork Prison to inform him, at the latest by 5pm on 17 April 2023, of the steps that they propose to take to **mitigate** the very high risk identified in this Immediate Action Notification.*

11.20 The Director General of the Irish Prison Service immediately responded to this IAN, including by sending a technical team to Cork Prison on the following day. A further meeting took place between the Inspectorate's team and a technical team from the IPS on 14 April 2023, during which the following mitigation measures were proposed:

- Installation of new high visibility call light boards in class offices;
- Re-calibration of the cell call telephone system to resolve the issue of one unanswered call blocking all others;
- Enhanced monitoring of cell call response times.

11.21 The OIP welcomes the prompt action taken by the Director General in response to the Chief Inspector's Immediate Action Notification and will closely monitor the efficacy in practice of the mitigation measures that the IPS introduces.

12. Medical Intervention

12.1 Nurse B stated at approximately 09:30 on 2 October 2021 there was a call over the radio for medical assistance on A3. Nurse C stated that Nurse B responded immediately and he secured the medication and then went to A3 landing where he saw Mr. G lying on his back on the cell floor with Nurse B checking his vitals and they immediately started Cardiopulmonary Resuscitation (CPR), working in rotation until paramedics arrived.

12.2 Nurse B corroborated Nurse C account and further stated that on arrival at the cell she saw Mr. G slumped in a seated position facing the cell door with his back against the end of the bottom bunk. Nurse B stated that Mr. G was clammy, warm to touch, unresponsive and no palpable pulse was located. Nurse B stated Nurse D, Nurse C and Nurse E rotated CPR until the arrival of the paramedic team who took over care of Mr. G.

12.3 The paramedics arrived at 09:50 followed by Doctor E at 10:15.

12.4 Doctor E on arrival at Mr. G's cell was briefed by the senior paramedic who advised that CPR had been ongoing for 45 minutes. Doctor E observed the resuscitation for a number of minutes but there were no signs of life. Doctor E pronounced the death of Mr. G at 10.26.

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

13. Critical Incident Review Meeting (CIRM)

13.1 A critical incident review meeting took place on 3 October 2021.

13.2 The meeting was attended by five staff, one of whom was directly involved in the incident.

13.3 Chief Officer A gave an outline of the incident.

13.4 The Chaplain agreed to act as family liaison and stated that he had already spoken to Mr. G's NoK.

13.5 The Staff Support Officer informed the meeting that he had held a critical incident stress management (CISM) meeting with staff and remained in contact with the first responders to the incident.

13.6 Assistant Governor A praised the efforts of all staff who responded to the call for assistance.

13.7 The purpose of the Critical Incident Review meeting (CIRM) 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. There is no reference in the CIRM minutes in relation to activation of the emergency and cell call alarms by Mr. G nor was there any reference to the failure by staff to respond to these activations.

13.8 The IPS SOP entitled 'Critical Incident Reporting and Debriefing Procedures' which came into effect on 1 July 2020 provides for the holding of both a hot and cold debrief following a critical incident such as a death in custody and 'should include, to the greatest possible extent, all the staff involved in the incident.' A cold debrief was not held and only one staff member involved in the incident attended the hot debrief.

14. Questions and concerns raised by Mr. G's NoK

- **NoK could not get through to her brother when she rang him. Mr. G told his sister that he reported a fault with the phone in his cell but the fault was not repaired**

  Telephone handsets had been installed in some cells in Cork Prison which permitted a family member or friend, who had been approved by the IPS, to ring the person in custody directly in their cell. That system was a pilot, on trial for one month from 31 May 2021 to 25 June 2021 at which time it ceased operation for further analysis and consideration by IPS management.

- **Mr. G informed his sister that he had been placed in a cell with a prisoner who, he alleged to his sister stole from him and whom he feared, He asked to be moved, is this correct?**

  There was no record of any complaint having been made by Mr. G about another prisoner nor a record of a request to be moved in the documentation examined by the OIP. Further enquiries were made with Cork Prison management, the OIP were informed that there was no record of Mr. G reporting missing/stolen personal items from his cell. They did not receive a complaint or a request by Mr. G to move cell and/or not to be accommodated with any particular prisoner(s). The Governor stated that staff on the landings did not report any concerns in that regard.

- **When there was an outbreak of Covid-19 in Cork Prison Mr. G was locked back without being tested, why?**

  The Irish Prison Service algorithm "IPS Risk Assessment for People Presenting to and in Prisons - Clinical Criteria for Prisoner(s) to be Tested" outlined the criteria to be followed in certain circumstances during Covid-19. Where a prisoner identified as a close contact of a confirmed case they were immediately placed in isolation and testing was arranged by the healthcare team. If a prisoner received a negative result from the swab test, isolation was stopped once a prisoner had been asymptomatic for 48 hours.

- **Why was there a delay in prisoners getting the Covid-19 vaccination? Mr. G's sister stated that if he was in the community he would have been vaccinated at an earlier date.**

  The OIP can confirm that the IPS lobbied the National Public Health Emergency Team (NPHET) for the prioritisation of COVID-19 vaccinations for people living and working in prisons. However, despite the IPS efforts to acquire vaccinations prisoners did not receive the Covid-19 vaccinations in line with the eligibility criteria in the general community.

  The delay in the vaccination of the prisoner population was of great concern to the OIP given that prisoners live in congregated settings, where the opportunity for spreading of disease was greater. The OIP strongly supported Covid-19 vaccination of all prisoners in accordance with the eligibility criteria. This position was highlighted in the OIP Covid-19 Inspection Thematic reports which were presented to the Minister for Justice during 2021 and are published on the OIP website at www.oip.ie

- **Mr. G told his sister that he was unable to get confirmation on the duration of his sentence, he had also asked his Solicitor but had not received confirmation.**

  Mr. G had a number of court appearances and received concurrent and consecutive sentences. The duration of his sentence was calculated and recorded on the PIMS. The OIP was unable to establish if Mr. G requested details on the duration of his sentence as it was not contained in the documentation reviewed. Further enquiries were made with Governor B who informed the

OIP that this information would have been provided to Mr. G if requested by him as it was readily available on PIMS. The engagement between Mr. G and his solicitor is legally privileged.

- **Mr. G's sister stated that her brother was *"haunted by derogatory comments made by some Prison Officers*" these comments related to the manner in which his depot medication was administered. The NoK suggested continuous training on treating people with dignity should be provided to staff**

  The management in Cork Prison said that they were not aware of any such incident and that any such behaviour would not be tolerated. The OIP made enquires with Irish Prison Service College to ascertain if new and established Officers are provided with training in working with people who suffer from a mental illness and/or dignity and respect generally. It was confirmed by the IPS that Mental Health Awareness training was provided to all serving staff in 2015 and since then Mental Health Awareness training is delivered to all Recruit Prison Officers.

- **Mr. G's sister stated that her brother was becoming hypomanic or manic the day before he died and she was worried about him and questioned if he was he taking his medication?**

  The nursing staff reported that there was nothing unusual or of concern regarding Mr. G's behaviour on 1 October 2021. It is recorded on the Medications Chart that Mr. G took all prescribed medication on 1 October 2021.

- **I received notification of my brother's death at 11:15, why were we not informed earlier?**

  Mr. G's death was pronounced at the prison by the Doctor at 10:26, the NoK was notified 49 minutes after death was pronounced. We were advised by the Chaplain that the NoK were not contacted earlier as the contact number for the NoK was not readily available. The Chaplain rang the priest and Garda Station in the parish where the NoK resided in their effort to make contact.

- **Mr. G was buried and the family did not know how he died, why were we not told?**

  Prison management stated that they were not aware of the full circumstances of the death when contact was made with the NoK and would not wish to provide any information which may not be accurate.

15. Recommendations

The OIP makes eight recommendations to the Irish Prison Service in response to the death of Mr. G:

1. The Irish Prison Service should ensure that the 'volume control' on all emergency activation devices in the Class Office and Control Room across the prison estate be locked to an audible volume which cannot be lowered or deactivated.

2. A Class Officer and an Assistant Class Officer should continuously observe the landing to which they are detailed to, inter alia, ensure prisoners are adequately supervised to ensure they do not require urgent attention.

3. Class Officers and management grades should ensure that the visibility of a landing is not obstructed by posters and/or notices displaced on the glass panel of a Class Office. It is recommended that Irish Prison Service HQ issue an instruction to this effect to all Prison Governors who should ensure implementation and compliance.

4. The Irish Prison Service consider the relocation of the Cell Call Activation light from its current position and place it towards the top of the cell door thereby eliminating any possible obstruction of a flashing light.

5. Consideration should be given to a review of the 'Chaplaincy and Next of Kin Notification' document to include guidance on the provision of general practical information to the NoK following a death in custody.

6. It is recommended that that an Office Notice be issued to all Prison Governors to remind them of the importance of adherence to the terms of the IPS 'Critical Incident Reporting and Debriefing Procedures' which provides for the holding of both a hot and cold debrief following a death in custody and for all staff involved in the incident to be encouraged/facilitated to attend briefing.

7. The Irish Prison Service should ensure that staff understand the importance of accurate records and the consequences of creating an inaccurate record/report of their duty. Regular audits should be carried out by line management to ensure compliance. A Similar recommendation has been made in the past in Mr. A 2012, Mr. H 2014 and Mr. I 2018.

8. It is recommended that Prison Officers be reminded of their obligation under Prison Rule 87(1)(b) which requires them to examine equipment in their area of responsibility and report any defects which could compromise good order, safe or secure custody or health and safety.

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 OIP 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