



Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. C
Wheatfield Prison
11 March 2020

Submission Date to Minister: 23 February 2024

CONTENTS

GLOSSARY	3
INTRODUCTION	4
1. Preface	4
2. Objectives	4
3. Methodology	4
4. Administration of Investigation	5
5. Family Liaison	5
INVESTIGATION	6
6. Wheatfield Prison	6
7. Family Concerns	6
8. Background	6
9. Engagement with Medical/Healthcare personnel	7
10. Events 11 March 2020	8
11. Next of Kin Contact	10
12. Critical Incident Review	10
13. Recommendations	11
14. Support Organisations	11

GLOSSARY

ACO	Assistant Chief Officer
CNO	Chief Nurse Officer
CPR	Cardiopulmonary Resuscitation
DFB	Dublin Fire Brigade
DSH	Deliberate Self-Harm
IPS	Irish Prison Service
NAS	National Ambulance Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PICLS	Prison in-reach Court Liaison Service
WTO	Work Training Officer

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 Chief Inspector of Prisons has been obliged to investigate all deaths in prison custody. This includes the death of any person which occurs within one month of their temporary release from prison custody. The OIP also carries out regular inspections of prisons. The Office is independent of the Irish Prison Service (IPS). The Chief Inspector of Prisons and the staff of the OIP are independent of the Department of Justice in the performance of their statutory functions.
- 1.2 The OIP can make recommendations for improvement where appropriate. Our investigation reports are published by the Minister for Justice, subject to the provisions of the Act, in order that investigation findings and recommendations can be disseminated in the interest of public transparency, to promote best practice in the care of prisoners.

2. Objectives

- 2.1 The objectives for investigations of deaths in custody are to:
 - Establish the circumstances and events surrounding the death, including the care provided by the Irish Prison Service (IPS);
 - Examine whether any changes in IPS operational methods, policy, practice or management arrangements could help prevent a similar death in the 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; and
 - 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.

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 (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 paying particular attention to the care that was afforded to Mr. C during his time in prison.

4. Administration of Investigation

- 4.1 The OIP was notified of Mr. C's death on 11 March 2020.
- 4.2 Prison Management provided the OIP with all relevant information in accordance with the standardised checklist of information required.
- 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 contacted Mr. C's sister on 18 August 2020 and spoke with her over the phone. Covid-19 restrictions came into force during the week following Mr. C's death, and consequently, an in person meeting was not possible at that time.
- 5.3 Although this report is for the Minister for Justice, it will also inform several interested parties. It is written primarily with Mr. C's family in mind.
- 5.4 The OIP is grateful to Mr. C's family for their contributions to this investigation and we offer our sincere condolences on their loss.

INVESTIGATION

6. Wheatfield Prison

- 6.1 Wheatfield Prison is a closed, medium security prison for adult males. It is the committal prison for Counties Louth, Meath, Monaghan, Wexford and Wicklow. It has an occupational capacity of 610 beds.
- 6.2 Mr. C was the first death of a prisoner in the custody of Wheatfield Prison in 2020 and the third in IPS custody which met the criteria for investigation by the OIP.

7. Family Concerns

- 7.1 On 18 August 2020, the OIP contacted Mr. C's sister in relation to any family concerns or question regarding Mr. C's time in custody. The OIP were informed that Mr. C had suffered from a mental health illness for many years and was a patient of a community psychiatrist.
- 7.2 Mr. C's sister asked the OIP to ascertain if Mr. C received psychiatric care while in prison. The family had no other questions or concerns.
- 7.3 It was recorded on the prison medical records examined by the OIP that Mr. C had bipolar disorder and also suffered from depression. The healthcare provided to Mr. C while in custody is outlined in **section 9**.

8. Background

- 8.1 Mr. C was 52 years old when he passed away in Wheatfield Prison.
- 8.2 Mr. C was committed on remand to Cloverhill Prison on 29 January 2020 on foot of a remand warrant from Dublin District Court. Mr. C appeared before the court on 26 February 2020 and was sentenced to serve six months. He was committed to Mountjoy Prison following his court appearance and transferred to Wheatfield Prison on 6 March 2020. Mr. C had a remission date of 19 June 2020.
- 8.3 Mr. C was accommodated in Cell 8 in F Block on committal to Wheatfield Prison. On 7 March 2020 Mr. C underwent a Governor's committal interview with Assistant Governor A and no concerns were recorded regarding Mr. C's safety or welfare.
- 8.4 During the morning of 7 March 2020, Chaplain A met with Mr. C who provided the Chaplain with a phone number for his sister. Mr. C asked the Chaplain to ring his sister and let her know that he had been transferred to Wheatfield Prison. Chaplain A rang Mr. C's sister and reported that he was advised that the Chaplain at Mountjoy Prison had already been in contact with the family.
- 8.5 Mr. C was accommodated with the general prisoner population during his time in custody.

- 8.6 On 10 March 2020, Mr. C was moved to an enhanced level of Incentivised Regime¹ and relocated to the East 2 Wing, Cell 23. Class Officer A reported that he was in charge of East 2 and was contacted by the Officer in charge of 8F landing who informed him that Mr. C had been considered suitable for a move to East Division. This account was corroborated by Officer A in his report. Officer A reported that he was in charge of 8F landing on 9 March 2020 when Chief Officer A decided to place Mr. C on the enhanced level of the Incentivised Regime and move him to East 2. Officer A stated that Mr. C “*seemed content with that decision.*” Class Officer A allocated Mr. C cell 23 on East 2. Mr. C was the sole occupant of cell 23 which was a double cell.
- 8.7 Class Officer A reported that on arrival to East 2 Mr. C was shown the location of the gym, library and servery. Prisoner 1 who was accommodated in the cell next to Mr. C on East 2 informed the OIP that Mr. C was introduced to him by the Class Officer on the evening of 10 March 2020. Mr. C asked Prisoner 1 to fix the TV in his cell and was grateful when the TV worked.
- 8.8 Records confirmed that Mr. C was dispensed his night medication by a Nurse Officer (NO).

9. Engagement with Medical/Healthcare personnel

- 9.1 The records examined by the OIP showed that Mr. C had previous terms of imprisonment, he had a history of alcohol and substance misuse. Mr. C had been diagnosed with “*Bipolar Affective Disorder and Depression*” and was prescribed medication for same. It is also documented that Mr. C had a dependency on alcohol up to his committal.
- 9.2 A nurse’s committal interview was completed on Mr. C’s committal to Cloverhill Prison on 29 January at which his psychiatric history was noted. It is recorded that Mr. C denied any thoughts of deliberate self-harm or suicide and guaranteed his own safety.
- 9.3 On 30 January 2020, Mr. C’s community based doctor’s surgery provided the prison surgery with a list of his eight prescribed medications. It was noted that Mr. C was attending a psychiatrist in the community. On 30 January 2020, Nurse A recorded on the Prisoner Healthcare Management System (PHMS) that Mr. C presented as “*pleasant and cooperative, not withdrawn/hostile, mood euthymic.*”
- 9.4 On 5 February 2020, Psychiatrist A recorded on the PHMS that Mr. C “*declined to attend for review.*” It was also noted that no concerns had been raised regarding Mr. C’s mental state since his committal. Mr. C remained on the list to be seen by the Prison in-reach Court Liaison Service (PICLS) team. The PICLS team assist the Courts in identifying defendants with major mental illness and tries to provide practical solutions to accessing appropriate mental health care through liaison with community services.
- 9.5 On 6 February 2020, Psychiatric Nurse A attached to the PICLS team recorded that an attempt was made to review Mr. C but he again declined to attend.

¹ A prisoner is moved to enhanced level when of good behaviour – 9.10

- 9.6 On committal to Mountjoy Prison on 26 February 2020, a nurse's committal interview was conducted by Nurse B. It was recorded that Mr. C denied any thoughts of deliberate self-harm (DSH). Doctor A conducted a Doctor's Committal interview on 27 February 2020 and also recorded that Mr. C "*denies any thoughts of DSH*". Doctor A noted that Mr. C had no history of attempted suicide.
- 9.7 On 28 February 2020, Psychiatric Nurse A referred Mr. C to the Psychiatric team in Mountjoy Prison. Psychiatric Nurse A requested that Mr. C be added to their waiting list for psychiatric assessment as he had failed to attend two interviews while in Cloverhill Prison.
- 9.8 On 5 March 2022, the Psychiatric in-reach team in Mountjoy Prison assessed Mr. C and it was recorded that Mr. C informed Nurse C that he was thinking a lot about things which resulted in his committal to prison and his mood was low. Mr. C denied any thoughts of self-harm or suicidal ideation. The Clinical Impression recorded was "*nil psychotic/hypomanic symptoms elicited.*"
- 9.9 On transfer to Wheatfield Prison, Mr. C was assessed on 6 March 2020 by Nurse D. On 7 March 2020, Doctor B conducted a Doctor's Committal Interview; both the nurse and the doctor recorded that Mr. C reported "*No thoughts of self-harm suicide.*"
- 9.10 On 9 March 2020, following Mr. C's transfer to Wheatfield Prison an in-reach Mountjoy psychiatric nurse referred Mr. C to the psychiatric in-reach team in Wheatfield Prison recommending follow-up care for "*depression and anxiety*".
- 9.11 Mr. C was seen by Psychiatrist B in Wheatfield Prison on 11 March 2020 at 11:20. During the interview Mr. C reported that he was "*a bit low at the moment*" and was finding custody difficult. Psychiatrist B recorded that Mr. C reported *ruminations about suicide. However, denied current plan or intent.*" Psychiatrist B also recorded that Mr. C presented with "*current mild depressive symptoms. No evidence of psychosis.*" The dosage of a medication prescribed to Mr. C was increased and he was advised to engage with the general nursing staff and to seek a further appointment with psychiatry if he had any concerns about his mental state.
- 9.12 At 17:15 on 11 March 2020 nursing staff responded to a radio call for emergency medical assistance on East 2 where Mr. C had been found unresponsive in his cell.

10. Events 11 March 2020

- 10.1 Prison records showed that at approximately 08:16 Mr. C was administered his morning medication. The CCTV footage viewed showed that at 08:15 Mr. C's cell was unlocked for breakfast and at 08:17 Mr. C exited the cell to collect his breakfast, returned at 08:30 and closed the cell door. Mr. C was a sole occupant of a double cell (Cell 23, East 2 Landing).
- 10.2 At 10:45 a prison officer unlocked Mr. C's cell door, entered the cell, exited moments later and entered the adjoining cell. At 11:13 a prison officer stood in the doorway of Mr. C's cell and appeared to be in conversation with him. Mr. C exited the cell and walked off the landing, escorted by the officer. The medical records showed that Mr. C attended the surgery returning at 11:47.
- 10.3 On return to the landing Mr. C collected his lunchtime meal before returning to his cell and closing the door, at 11:54 and the cell door was locked.

- 10.4 CCTV footage showed that three checks were carried out on Mr. C's cell at 12:14, 12:36 and 13:50. At 14:14, Work Training Officer (WTO) A unlocked Mr. C's cell, pushing the cell door open. He reported speaking to Mr. C, who then exited the cell to make a phone call, after which he returned to his cell and pulled the door closed at 14:23.
- 10.5 Between 16:00 and 16:13 prisoners on the landing collected their evening meals and returned to their cells. Mr. C did not leave his cell which was unlocked but the door remained closed.
- 10.6 At 16:15 Officer B checked Mr. C's cell and found him with a ligature around his neck. Officer B immediately called for assistance and issued a Code Red² over the radio. Officer B entered the cell with WTO B, followed immediately by WTO A. Officer C and Officer D. WTO B reported lifting Mr. C assisted by Officer C and Officer D. The officers managed to loosen the ligature while Officer B was retrieving a Hoffman knife³ from the Class Office on the landing. Mr. C was placed on the floor and Cardio Pulmonary Resuscitation (CPR) immediately commenced. Officers present reported that there was no pulse detected.
- 10.7 Nurse E arrived at 16:16, placed a breathing mask on Mr. C and continued CPR while issuing a request to call an ambulance. The nurse was assisted by the Chief Nurse Officer (CNO), Nurse G and Nurse H arrived at the cell at 16:18. Nurse F arrived with the emergency red bag. Chest compressions continued rotating between the nurses. The CNO contacted the surgery over radio and again asked for an ambulance and also requested a doctor to attend the cell but there was no GP on site.
- 10.8 ACO A arrived at the cell and instructed staff not directly involved to leave the cell area. CCTV showed 10 staff in the vicinity. At 16:31 Chief Officer B and Governor A arrived outside the cell followed by Chaplain A and Chaplain B, none of whom entered the cell.
- 10.9 At 16:41, four Dublin Fire Brigade (DFB) paramedics arrived to the cell and took over CPR from prison nursing staff. At 16:46 two National Ambulance Service (NAS) personnel arrived and assisted with CPR alongside the DFB paramedics. At 16:48, Governor A requested that Chaplain A contact the NoK.
- 10.10 Mr. C's vital signs indicated he was deceased at 16:53 and CPR was ceased. Governor A and Chief Officer B were informed. At 16:57 and 16:59 respectively, the DFB and NAS personnel departed the landing.
- 10.11 At 16:59 Chaplain B entered the cell to anoint Mr. C and say some prayers. At 17:03 Chaplain B and the CNO exited the cell, which was then master locked⁴.
- 10.12 The scene was secured and an officer was assigned to log all movements into and out of the cell following it being master locked. At 17:30 and 17:45 members of An Garda Síochána arrived at the prison and at 18:02 the cell was unlocked for the forensic examination by An Garda Síochána Scenes of Crime Officer.
- 10.13 At 18:25 a doctor arrived and pronounced the death of Mr. C. At 20:16 the Funeral Directors arrived and removed Mr. C's remains from the prison at 20:23.

² Urgent medical assistance required

³ A knife designed to safely cut ligatures without injuring a person. [911 Hoffman Knife / Rescue Tool - YouTube](#)

⁴ Locked with a key retained by supervisors.

11. Next of Kin Contact

- 11.1 A working contact number for the NoK was not available on the Prisoner Information Management System (PIMS) as the number listed was no longer in service.
- 11.2 As the Chaplains had no telephone number for the family, two Chaplains, Chaplain A and Chaplain B, travelled to Mr. C's home address to relay the sad news of Mr. C's passing. On arrival, they met with Mr. C's father who contacted his daughter (Mr. C's sister). Mr. C's sister arrived to her father's home to meet the Chaplains.
- 11.3 The Chaplains reported that Mr. C's father spoke about his son with respect and sadness at how his life had gone, and showed the Chaplains a kitchen which had been fitted by Mr. C. The Chaplains were informed that Mr. C was well liked by their neighbours.
- 11.4 Assistant Governor B rang the NoK the following morning to offer condolences on behalf of Wheatfield Prison staff and arranged to meet with the family later that day.

12. Critical Incident Review

- 12.1 A Critical Incident Review meeting⁵ and debrief took place on 12 March 2020. Nine of the personnel involved in the incident attended the meeting along with Governor B and an administrative staff member who recorded the minutes. Governors A and C acknowledged the efforts of the nursing and operational staff, expressing appreciation for their efforts.
- 12.2 Governor A noted the concern raised regarding the non-availability of an on-site doctor at the time of the incident.
- 12.3 Governor B acknowledged the response of staff and asked that all be informed of the availability of support services.
- 12.4 ACO A reported that the Samaritans⁶ had been made aware of the passing of Mr. C and support was offered to prisoners who required same. ACO A suggested that more posters be displayed around the prison so prisoners would be more aware of supports available to them.
- 12.5 The OIP were pleased to learn that the vacant doctor post in Wheatfield Prison at the time of Mr. C's passing has since been filled by the appointment of a full-time general practitioner.

⁵ This meeting is between prison management and all prison staff who were involved in the incident of who may have relevant information. These are conducted to identify good practice, potential shortcomings and to address any welfare needs. In this case no issues of concern were raised or identified.

⁶ The Irish Prison Service in co-operation with Samaritans provide confidential emotional support to people who are experiencing feelings of distress or despair

13. Recommendations

The Office of the Inspector of Prisons has made three recommendations:

- 13.1 Posters displaying information about the support services/programmes available to prisoners experiencing mental health issues should be rolled-out across the Irish Prison Service estate. Governor grade staff should regularly verify that such posters remain in place.
- 13.2 The Irish Prison Service should ensure that all staff who are not directly involved in operational or first aid efforts during a medical or other emergency return to their own posts as soon as it is practical. **[Repeated Recommendation – see Mr. N 2012]**.
- 13.3 Incorrect NoK contact details can cause delays in establishing contact with the families in the case of emergencies. It is recommended that IPS staff verify the nominated NoK at committal by ringing the phone number provided.

14. Support Organisations

- 14.1 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.

