Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. T
Limerick Prison
25 December 2022

[Submitted to Minister: 30 July 2024]

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
AG	Assistant Governor
AGS	An Garda Síochána
CCTV	Closed Circuit Television
CNO	Chief Nurse Officer
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
CSC	Close Supervision Cell
EAP	Employee Assistance Programme
DiC	Death in Custody
GP	General Practitioner
HQ	Headquarters
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PO	Prison Officer
PHMS	Prisoner Healthcare Management System
UHL	University Hospital Limerick

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 of 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 the future;
- Ensure that the prisoner's family has an opportunity to raise any concerns they may have and take these into account in the investigation; and
- Assist the Coroner's investigation and contribute to meeting the State's obligations 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 of 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. T during his time in prison and examining the events leading up to Mr. T's passing on 25 December 2022.

4. Administration of Investigation

4.1 As agreed with the IPS, the OIP is notified of a death in custody by telephone followed by an email providing additional information. On this occasion no phone call was made; however, Assistant Governor A (AG) notified the OIP of Mr. T's death by email on 25 December 2022. Inspectors attended the prison on 28 December 2022.

4.2 Chief Officer A (CO) provided the OIP with all relevant information in accordance with the standardised checklist of documents 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 OIP role when investigating a death in custody.

5.2 The OIP contacted the NoK by letter on 18 January 2023. On 8 February 2023, the investigation team met with Mr. T's NoK; his mother, who was accompanied by her daughters, as well as a cousin and uncle of the deceased. The role of the OIP in relation to an investigation into her son's death was explained and an information leaflet provided.

5.3 The NoK stated that Mr. T had been accommodated on A Wing until it was closed a few weeks prior to his passing. On the closure of A Wing Mr. T, along with a number of other prisoners, was moved to D Wing.

5.4 The NoK stated that Mr. T was involved in a number of initiatives while in custody. He was a Listener[1] and had participated in a CPR[2] course.

5.5 The OIP was informed by family members that Mr. T had been complaining of headaches for 14 months and stated he was only ever given paracetamol while in prison. They stated that his father had died of an aneurysm[3] at the age of 54.

5.6 A third-party had informed the NoK on Christmas morning that Mr. T had collapsed but the family stated that they were not informed by the prison. The NoK stated that the only call received by the family was from the Chaplain at around lunchtime on 25 December 2022 to let them know that Mr. T had died.

5.7 Mr. T's NoK raised a number of concerns which are outlined in section 7 and responded to in section 13.

5.8 The NoK expressed disappointment that a Governor did not contact them following Mr. T's death. Mr. T's sister informed the investigation team that she rang the prison about ten days after her brother's death and asked to speak to the Governor but was told that the Governor was not available. Mr. T's sister also stated that she attended the prison to collect her brother's personal belongings the morning after she rang seeking to speak to the Governor and Mr. T's personal effects were handed to her in a brown box. Mr. T's sister stated that she never saw the

[1] A Listener is a peer supported scheme within prisons which sees prisoners trained to give emotional support to other prisoners.
[2] Cardiopulmonary Resuscitation – lifesaving technique that is applied to a person experiencing cardiac arrest.
[3] An aneurysm is an abnormal swelling in the wall of a blood vessel.

Governor and that no one in the prison expressed their condolences to her when she collected these personal effects.

5.9 Although this report is for the Minister for Justice, it may also inform several interested parties. It is written primarily with Mr. T's NoK in mind.

5.10 The OIP is grateful to Mr. T's mother and family for their contributions to this investigation.

INVESTIGATION

6. Limerick Prison

6.1 Limerick Prison is a closed, medium security prison for adult males and females. It is the committal prison for males for counties in Clare, Limerick and Tipperary and for females for all six Munster counties. In December 2022, it had an operational capacity of 210 beds for male prisoners and 28 for female prisoners.

6.2 Mr. T was the second death of a prisoner in the custody of Limerick Prison in 2022 and the twentieth death in IPS custody that year.

7. Family Concerns

7.1 The NoK raised the following questions:

Q.1 The family stated that the Chaplain initially told them that Mr. T had taken a heroin overdose but rang back later to tell them that the information conveyed during the initial phone call was incorrect and apologised for the error. Why were we informed that the cause of death was a heroin overdose?

Q.2 Was there a doctor on call? If not, why not?

Q.3 Why was there a delay in contacting the family?

Q.4 Mr. T had been saying he was unwell for a long time, why was he not sent to the hospital?

Q.5 How did the media get information about Mr. T's brother who had been in an accident? Was it from the IPS or Gardaí?

Q.6 Why did the Governor not contact the family?

Q.7 Why did it take the paramedics 30 minutes to get to the prison and how was Mr. T removed from the prison?

Q.8 Why is there not a defibrillator in the prison?

7.2 The questions and concerns raised by the NoK are responded to in section 13 of this report.

8. Background

8.1 Mr. T was 34 years of age when he passed away on 25 December 2022.

8.2 On 25 June 2020, Mr. T was committed on remand to Limerick Prison from Limerick District Court where he appeared on a number of charges including attempted robbery. Mr. T appeared at Limerick District Court on 30 June 2020 and on 1 December 2020 he was sent forward for trial in the Circuit Court. He was further remanded nineteen times before going to trial. On 30 April 2021 at Limerick Circuit Court Mr. T received a five year sentence backdated to 25 June 2020 for the charge of attempted robbery; all remaining charges were withdrawn. Mr. T had a remission date of 23 March 2024.

8.3 Mr. T was a protection[4] prisoner because of conflict with a number of other prisoners. Mr. T was on the standard level of the Incentivised Regime[5]. On the closure of A Wing he was moved to D Wing on 16 December 2022 and accommodated in Cell 4.

8.4 On 25 December 2022, Mr. T was sharing a three person cell with two other prisoners: Prisoner 1 and Prisoner 2.

8.5 The OIP review of the prisoner phone and visitors logs showed that Mr. T had regular contact with his family and a friend.

9. Event of 25 December 2022

9.1 Prison Officer (PO) A was detailed as the Night Guard[6] on D4 landing for the period 20:00 on 24 December 2022 to 08:00 on 25 December 2022. On reviewing CCTV footage for the period 23:59 on 24 December 2022 to 08:00 on 25 December 2022 a total of six checks were conducted by officers on cell 4, which was in accordance with the IPS policy in place at the time.

9.2 On the morning of 25 December 2022, PO B was Class Officer in charge of D4 landing. At 08:12 PO B unlocked cell 4 and offered all three occupants breakfast. Prisoner 1 and Prisoner 2 stated that they all declined breakfast.

9.3 PO C was detailed as the Breakfast Guard[7] from 09:00 to 10:00 on 25 December 2022. At 09.13 hours PO C checked all prisoners and cells on the landing.

9.4 From 09:46 to 09:51 Nurse Officer (NO) A and NO B entered D4 landing to dispense medication, they were accompanied by PO C. The occupants of cell 4 were not listed for morning medication and CCTV footage showed the nurses pass by cell 4.

9.5 At 10:06, PO B returned to D4 landing and he checked all the cells.

[4] Out of cell time would be restricted as he could only mix with certain prisoners.
[5] 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.
[6] A prison officer detailed on night duty.
[7] A prison officer who takes charge of a landing while the Class Officer avails of a breakfast break.

9.6 PO B reported that at 10:22 he unlocked cell 4 offering the occupants exercise and almost immediately locked the cell to facilitate the locking back of another prisoner. When the other prisoner was securely locked in his cell PO B returned and unlocked the door of cell 4. This account is corroborated by CCTV footage.

9.7 At 10:25:25 Mr. T emerged from cell 4. As he stepped onto the landing he waved to another prisoner and appeared to be rubbing his head. Mr. T re-entered his cell almost immediately and had his hand on his head. At 10:25:38 Prisoner 3 entered cell 4 and left the cell again at 10:27:00.

9.8 At 10:26:50 PO B passed cell 4, gestured to the occupants of this cell and continued to walk along the landing.

9.9 Prisoner 1 reported that he thought Mr. T was "*having a fit, his face was stiff".* Prisoner 1 stated that he "*screamed for help"*. PO B reported that he unlocked the cell door at 10:30 and found Mr. T on a mattress in the recovery position on the cell floor. However, the CCTV footage viewed does not fully corroborate PO B's recollection of events. The footage showed:

- 10:24:13 PO B unlocking cell 4
- 10:24:26 Prisoner 1 exited and immediately re-entered cell 4
- 10:25:25 Mr. T exited the cell and waved to another prisoner, he was rubbing his
- head and immediately re-entered the cell with his hand on his head
- 10:25:38 Prisoner 3 entered cell 4
- 10:26:50 PO B walked past cell 4, gestured to the occupants and appeared to have been speaking to them
- 10:27:00 Prisoner 2 exited cell 4
- 10:27:33 PO B walked back down the landing passing cell 4
- 10:27:36 Prisoner 1 exited cell 4 and appeared to be calling PO B who returned and stood outside cell 4 on his radio, this was at 10:27:46. PO B in his report stated that he put out a radio call "*for medic*s"
- 10:27:54 PO B entered cell 4 along with another Officer who arrived at the cell.

9.10 Prisoner 2 stated that he commenced CPR on Mr. T, which he continued until the nurse arrived. Footage showed Prisoner 1 and Prisoner 3 leave the cell at 10:32 just as NO A entered the cell. NO A recorded on the Prisoner Healthcare Management System (PHMS) that Mr. T was "*unresponsive, not breathing, no pulse*" and CPR was commenced and continued until care was handed over to the paramedics at approximately 10:50. It was also recorded on PHMS that the Auto Defibrillator advised a no shock message. A no shock message from the AED can mean that the person has a pulse, regained a pulse, or the victim is pulseless but is not in a shockable rhythm. The Lucas Automated Chest Compressor[8] was applied by the Ambulance Tactical Support Officer and Mr. T was transferred to hospital at 11.25.

9.11 NO B attended the cell immediately following the radio call for assistance and reported assisting in the attempted resuscitation of Mr. T until the arrival of ambulance personnel.

9.12 The CCTV footage showed ambulance staff enter cell 4 at 10:51:26 and at 11.25.21 Mr. T was removed from the cell on a stretcher. Assistant Chief Officer A (ACO) reported that Mr. T was transferred to University Hospital Limerick (UHL). PO D who was one of the escort officers

[8] Mechanical chest compression device

reported that hospital staff continued resuscitation attempts for approximately 20 minutes following arrival at the hospital. The death of Mr. T was pronounced at UHL at 12:19. PO D notified prison management of Mr. T's death at approximately 12:30.

10. Health and Medical Care

10.1 On 26 June 2020, NO C conducted a Nurses Committal Interview with Mr. T. It is recorded on PHMS that Mr. T informed the nurse that he had, "*no medical concerns or circulatory conditions*". No other medical conditions were recorded during this interview. Doctor A completed a report on Mr. T on his committal and recorded "*known to service, had alcohol two days ago but at present has not any clinical features of withdrawal from same".*

10.2 On 2 June 2022, NO D recorded on PHMS that Mr. T declined to meet the GP. On 24 June 2022 NO A noted that Mr. T reported having "*aches around his chest and stabbing pains with a long history of same"*. NO A recorded Mr. T's blood pressure as 127/83. NO A placed Mr. T on the list to see the doctor the following day.

10.3 On 25 June 2022, Doctor B recorded that Mr. T had complained of *"a tight chest, and panic attacks*" and noted that Mr. T was to start Trazadone[9] 50mg at night and recommended that Mr. T be seen in three days in the clinic. There is no record in the documentation reviewed by the investigation team that Mr. T attended the clinic on 28 June 2022. Doctor A examined Mr T on 5 July 2022 and recorded that he had, *"both chest and shoulder blades pain on and off for a few weeks",* which according to the records got worse when doing physical work but without the presence of palpitations or nausea. Doctor A further recorded that Mr. T had commenced Trazadone 50mg and he was to continue on this medication.

10.4 On 4 July 2022, NO D recorded reviewing Mr. T and found him "*very excited and anxious*". Mr. T described his symptoms as *"jaw tightness, headaches, pins and needles across his neck today and tightness in his chest."* Mr. T informed the nurse that he was "*anxious and prone to panic attacks*." Mr. T stated that he was not sleeping and did not go to the yard as he felt "*dizzy most of the time."* It is also recorded that Mr. T stated that he had experienced these symptoms "*over the last year*". NO D noted Mr. T's blood pressure at 160/110, his breathing was normal but would ask the doctor to review. On 5 July 2022, NO D referred Mr. T to psychology due to "*panic attacks, anxiety and difficulty sleeping"*. The records showed that Mr. T had previously engaged with the psychology service.

10.5 It was recorded that Mr. T had been offered a psychology appointment in early June 2022 which he declined to attend. On 28 June 2022, Mr. T attended an appointment with the Psychology Service and it is documented by the psychologist that Mr. T "*did not need Psychology".* In July 2022, Senior Clinical Psychologist A recorded that Mr. T was again referred to the Psychology Service by nursing staff who *"were concerned about his health, but felt that his concerns were psychological in nature"*. Mr. T's psychology referral was re-opened but Mr. T had not met with the psychologist before he passed.

[9] Trazodone is an anti-depressant medication used to treat depressive and anxiety disorder and difficulties with sleep.

10.6 Doctor C noted on the 13 July 2022 that Mr. T had a right ear infection, he was given advice about ear cleaning.

10.7 On 9 August 2022, Doctor A examined Mr. T and noted he suffered from "*headache on and off".* Doctor A recorded a normal temperature and blood pressure at 130/80. It is recorded that Brufen[10] and Circadin[11] were prescribed.

10.8 On 3 September 2022, NO D recorded on PHMS that Mr. T got sick after taking Imigran.[12] Medical records examined showed that Mr. T had been prescribed Imigran for a short period from 29 August 2022 to 4 September 2022.

10.9 Chief Nurse Officer A (CNO) recorded on PHMS that Mr. T declined an appointment with an optician on 22 September 2022.

10.10 Entries by both nurses and doctors on 4 October 2022 recorded that Mr. T had been placed in a Close Supervision Cell (CSC)[13] for disruptive behaviour and that he would be seen by a GP the following day. On 5 October 2022, Doctor A recorded that Mr. T was, "*in CSC and declined to see me".* On 1 November 2022, Doctor A met with Mr. T and recorded that he *"refers to musculoskeletal pain, will C/O Brufen and observe".*

10.11 On 17 November 2022, NO D recorded Mr. T's "*urine positive for Benzos[14] and Cannabis*". On the same date, Doctor A further recorded that Mr. T had "*generalised body aches/pains*" was very vague and also mentioned poor sleep. Doctor A recorded blood pressure of 140/105 with a regular heart rate. Doctor A prescribed Circadin for 28 days, which was administered to Mr. T until 14 December 2022.

10.12 On 21 November 2022, Doctor A noted that Mr T declined to attend the surgery and on 6 December 2022 CNO A recorded that Mr. T had declined to attend the GP.

10.13 Addiction Counsellor A recorded on 26 August 2022 that Mr. T had "*anxiety and panic attacks"* and that his medications were not working. Mr. T had another session with the Counsellor on 16 September 2022. During consultations on 7 October 2022 and 9 November 2022 Mr. T again spoke about anxiety and coping with anxiety. The connection with trauma and addiction were also recorded as discussed. An entry by the Counsellor on 21 December 2022 recorded that Mr. T declined to meet.

10.14 CNO B at Limerick Prison confirmed to the investigation team that Mr. T had no hospital appointments during his sentence, which had commenced in June 2020.

[10] Brufen (Ibuprofen) is an anti-inflammatory drug that is used to relieve pain.
[11] Circadin is a medication used to treat insomnia.
[12] Imigran is a medication used to treat migraine.
[13] Close Supervision Cells may be used when alternative and less restrictive methods of control are considered by the Governor as inadequate, in circumstances which include protection of the prisoner or others, preservation of good order and/or reasons of security and safety.
[14] (Benzos) Benzodiazepines are a class of depressant drugs used to treat anxiety and depression.

11. Critical Incident Review Meeting

11.1 A Critical Incident Review Meeting took place on 28 December 2022. The purpose of this meeting was 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.

11.2 The meeting was attended by AG A, CO A, CO B, NO B, NO A and Chaplain A.

11.3 AG A gave an outline of the incident and stated that CCTV footage had shown Mr. T on the landing two minutes before the incident. AG A acknowledged the quick response of NO A, the healthcare team and the emergency services. AG A expressed sadness at the passing of Mr. T and thanked the medical and operational staff for their professionalism.

11.4 CO A was appointed to investigate this incident on behalf of the IPS and collate documentation for the OIP.

11.5 AG A acknowledged the Prison Chaplain's contact with the NoK and also Mr. T's brother who was at the time in the custody of Limerick Prison.

11.6 Three actions were agreed at the meeting as follows:

- Cellmates of Mr. T to be referred to psychology.
- All staff continue to be offered peer support and EAP[15] referral, as required.
- Telephony enabled radio for Medic 1 to allow for direct contact with Ambulance Dispatch.

11.7 The OIP was informed by prison management that all recommendations were actioned. In relation to bullet point three the investigation team were informed that it was decided, following more detailed examination and consideration by local prison management, that a Medic 1 radio which is used during periods of lock back would not be required as staff carry a radio and they are also in close proximity to a Class Office which has a phone.

12. Engagement with Prisoners

12.1 On 28 December 2022, Prisoner 1, who was a cellmate of Mr. T, met with OIP Inspectors. Prisoner 1 stated that he had a good relationship with Mr. T and the other cellmate Prisoner 2. Prisoner 1 had been accommodated on A Wing with Mr. T prior to its closure around November 2022. Prisoner 1 informed the investigation team that Mr. T regularly complained of painful headaches. He stated that Mr. T would get assessed by healthcare staff but then complain to him that he was only given paracetamol and ibuprofen.

12.2 On the morning of 25 December 2022, Prisoner 1 reported declining breakfast at around 08:00, he further reported that between 09:30 and 10:00 the three occupants of the cell were offered exercise in the yard and he stated that the three of them decided to avail of exercise before

[15] Employee Assistance Programme

dinner which was due to be served at midday. Prisoner 1 stated that when the Class Officer opened the cell, Mr. T exited and could be heard wishing Happy Christmas to Prisoner 3 before he returned to the cell, sat on a chair near the sink and began brushing his teeth.

12.3 Prisoner 1 reported that he was sitting on a lower bunk bed and as he reached below the bed for his shoes he noticed that Mr. T was suddenly "*stiffing out*" and his body appeared to be locked in a straightened position…" Prisoner 1 believed that Mr. T was suffering from a form of physical seizure. Prisoner 1 stated that he physically held Mr. T and called Prisoner 2, who was on the opposite side of the cell, to help. Prisoner 1 informed the OIP that Prisoner 2 had first aid knowledge and he put Mr. T on his side, checked for a pulse and began rubbing Mr. T's chest. Prisoner 1 stated that he was informed by Prisoner 2 that Mr. T's pulse was weakening and they both then called for medical assistance. Prisoner 1 stated that the Class Officer responded immediately and checked Mr. T's vitals before calling for medical assistance over the radio. The CCTV footage showed Prisoner 1 exit the cell and PO B immediately returned to cell 4 and was using his radio. This sequence of events and timeline is outlined in section 9.9.

12.4 The investigation team also met Prisoner 3 on 28 December 2022. Prisoner 3 stated that he was a friend of Mr. T's prior to prison. Prisoner 3 stated he had been on D Wing for 10 days at the time of Mr. T's passing and prior to that they were on A Wing together. Prisoner 3 stated that while on A wing "…*Mr. T had been asking for medication as he complained of pains in his veins shooting up his arms, blurred vision and pains in his head. He couldn't even turn on a light with light sensitivity. This was going on for months. Medics and doctors all just kept giving him paracetamol or Ibuprofen. He honestly was complaining every day. He would regularly bang on his cell door asking for medication. He was so desperate".*

12.5 Prisoner 3 reported that on the morning of 25 December 2022 he made his way towards Mr. T's cell as he wanted to speak to Mr. T and the other occupants. Prisoner 3 stated *"Mr. T's body locked, I thought it was a fit",* and further reported that Prisoner 2 was *"trying to reassure Mr. T".* Prisoner 3 stated that as an officer responded he walked down the landing and spoke to another prisoner. He was then sent to the yard for approximately one hour. He reported returning to his cell at 11:45 and was informed by an officer that Mr. T had passed away.

12.6 Prisoner 3 stated that officers accused Mr. T and other prisoners of taking illicit drugs which officers stated had led to Mr. T's passing. The prisoners denied that they took drugs and Prisoner 3 informed the investigation team that Mr. T had not taken drugs recently. Prisoner 2 was very upset and unhappy with the way he and Prisoner 1 were treated following the passing of Mr. T. He reported that he believed that officers had shown "*no regard for what had happened*" and believed that prison management lacked empathy towards prisoners who had known Mr. T a long time, advising the investigation team that they were not provided with additional access to psychology or chaplaincy services to speak about the loss of Mr. T.

12.7 Prisoner 3 stated that Prisoner 2 was transferred immediately after this incident to Wheatfield Prison in Dublin although he had no relatives or connections in Dublin. When the OIP Inspectors attended Limerick Prison on 28 December 2022, Prisoner 2 had already been transferred from Limerick to Wheatfield Prison. It was recorded that Prisoner 2 was transferred for "*operational reasons*".

12.8 On 20 June 2023, Prisoner 2 met with the investigation team and stated that he was a lifelong friend of Mr. T. Prisoner 2 stated he had spent time on the A, C and D Wings with Mr. T. Prisoner 2 stated that Mr. T was *"complaining about pains in his head … hands and down through his body…. This was nearly every day. He would keep his cell in darkness and avoid going out in summertime. That's why he would always be in his cell. He used to complain to medics about these pains, complaining to the doctor. He would get pain killers and be put back to the cell, just standard pain killers. They (pain killers) didn't help him. He was back and forward to the Doctor…. He couldn't sleep….Medics would go to his cell, take blood pressure and listen to his heart and tell him he was ok".* Prisoner 2 stated that Mr. T, *"asked to go to hospital loads of times but they wouldn't bring him….I could see he was in distress. This went on for seven or eight months. He complained and was put to the chokie[16]."* On checking the cell movement history record the investigation team noted that Mr. T was moved to D1 landing cell 2 for one night on 4/5 October 2022; according to the records this was on the direction of the Chief Officer – section 10.10 also refers,

12.9 On 25 December 2022, Prisoner 2 stated that he was on the opposite side of the cell dressing to go to the yard when he heard Prisoner 1 call to Mr. T asking him if he was okay. Prisoner 2 stated, *"I grabbed Mr. T under the armpits from the front. Mr. T was seized up. I put him on his side on the ground."* Prisoner 2 stated that he checked Mr. T's airway before commencing CPR attempts.

12.10 Prisoner 2 stated that the officer almost immediately arrived to the cell and called for medical assistance. Prisoner 2 reported that he had first response medical training and started CPR.

12.11 Prisoner 2 informed the investigation team that they were removed from the landing, put out in the yard and, about 30 minutes later, he was told that Mr. T had passed away. Prisoner 2 was highly critical of how he was treated in the aftermath of Mr. T's passing by officers and senior management. He stated that he received no access to psychology or chaplaincy, he was placed in a single person cell on the D2 Landing with Prisoner 1 and provided with two mattresses and one quilt, but no sheets or towels. Prisoner 2 stated that when officers opened the cell door they "*kicked their dinner at them*". The following day they requested cutlery, bed clothing and towels. Prisoner 2 reported that, on 27 December 2022, a nurse checked on them and refused to leave the cell until officers provided bed clothing and towels. The nursing staff did not respond to the investigation team enquiries regarding this matter.

12.12 On 28 December 2022, Prisoner 2 stated that he was unlocked and informed that he was being transferred to Wheatfield Prison. He remained in Wheatfield for three months before returning to Limerick Prison on 26 March 2023. Prisoner 2 informed the investigation team that he had to ask for a counsellor in Wheatfield Prison. The records evidenced that Prisoner 2 had attended an appointment with the Psychology Service on 3 February 2023. Prisoner 2 claimed he only had two video calls while in Wheatfield Prison. Prisoner 2 was of the view that the only reason he was transferred back to Limerick Prison was because his wife passed away. Prisoner 2 stated that he was provided with immediate access to psychology in Wheatfield Prison following the death of his wife. Prisoner 2 stated that when he met the psychologist he also discussed the

[16] "Chokie" is a colloquial term used by prisoners to refer to a Close Supervision or Special Observation Cell.

impact Mr. T's death had on him. Prisoner 2 stated that the psychologist showed compassion towards him and he believed they assisted in securing his return to Limerick Prison.

13. Family Questions and Answers

13.1 **The family stated that the Chaplain initially told them that Mr. T had taken a heroin overdose but rang back later to tell them that the information conveyed during the initial phone call was incorrect and apologised for the error. Why were we informed that the cause of death was a heroin overdose?**

The Chaplain informed the investigation team that when contact was made with the family to inform them of the sad news they asked if Mr. T had taken drugs. The Chaplain stated that the family were informed that nobody knew what had caused Mr. T's death but they were informed that Mr. T was on the landing before he became ill and drugs could have been a factor but the precise cause of his passing was not known. The Chaplain stated that they also informed the family that the post mortem, when completed, would determine if drugs were a factor in his death.

13.2 **Was there a doctor on call? If not, why not?**

The Prison Doctor was not in Limerick Prison on the morning of 25 December 2022 as it was not a rostered work day. Nursing staff were on duty and immediately responded to the call for medical assistance and arrangements were made promptly for the transfer of Mr. T to hospital by ambulance.

13.3 **Why was there a delay in contacting the family?**

The investigation team were informed by Limerick prison management that the delay in notifying the family was due to "operational reasons". The Governor stated that, when Mr. T collapsed, the nursing staff with the support of operational staff concentrated on attempting to keep Mr. T alive, while other staff members called for the emergency services, requested IPS HQ approval for a hospital temporary release order and made the necessary arrangements for ambulance personnel to get to the cell as quickly as possible. It was Christmas morning at 11:25 when Mr. T was removed from his cell and it was hoped that on arrival at the hospital the prognosis would be positive. Sadly, escort staff rang at 12:30 to report that Mr. T had passed. The arrangements were immediately made with the chaplain to inform the NoK.

13.4 **Mr. T had been saying he was unwell for a long time, why was he not sent to the hospital?**

The decision as to whether or not a prisoner is referred to hospital is a matter for the medical team. Mr. T had regular engagement with both the doctor and nurses, the details of which are outlined in section 10 of this report. According to Prisoner 2, Mr. T had requested to be sent to hospital on multiple occasions. However, the investigation team found no evidence in the medical records that such requests had been made, nor that they were considered or acted upon.

13.5 **How did the media get information about Mr. T's brother who had been involved in an accident? Was it from the IPS or Gardaí?**

The investigation team found no evidence in the documentation reviewed to suggest that IPS staff engaged with the media in relation to Mr. T's brother. The OIP currently has no remit over An Garda Síochána.

13.6 **Why did the Governor not contact the family?**

It is common practice within the IPS for the chaplain to contact a bereaved family on behalf of the Governor. The investigation team was informed that the Chaplain was the nominated liaison on behalf of the Governor. Nonetheless, the OIP considers that it is good practice for the Governor to contact the NoK directly when a person dies in a prison for which they have responsibility.

13.7 **Why did it take the paramedics 30 minutes to get to the prison and how was Mr. T removed from the prison?**

The ambulance was requested at 10:35 and ambulance personnel were in the cell at 10:51. Mr. T was removed from the cell on a stretcher at 11:25 and conveyed to hospital by ambulance.

13.8 **Why is there not a defibrillator in the prison?**

There is an Automatic External Defibrillator (AED) in Limerick Prison and it was used in the resuscitation attempts.

14. Recommendations

14. The Office of the Inspector of Prisons has made four recommendations:

1. It is recommended that an additional question be included in the doctors and nurses committal interview process to enquire from a new committal if there is a history of any serious illness in their family such as aneurysm, cancer or other serious health conditions. This information would be beneficial in making clinical decisions.

2. When a prisoner is conveyed to hospital in a seriously ill condition the next-of-kin should be informed without delay thereby complying with section 2.3 of the Irish Prison Service Protocol *'Chaplaincy and Next of Kin Notification'* which requires that the family (next of kin) be contacted as quickly as possible in the case of grave illness.

3. Governors should, as a matter of good practice and courtesy, attempt to make direct contact with the NoK when a person dies in a prison for which they have responsibility. When a family is collecting personal belongings at a prison, they should always be met by a member of the prison's management team.

4. When a death in prison custody occurs, prisoners who share a cell with the deceased should receive immediate (emergency) psychological support as soon as practicable.

15. Support Organisations

15.1 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.