Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. D

Castlerea Prison

26 January 2023

Age 25

Submitted to Minister: 8 July 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AGS	An Garda Síochána
CCTV	Closed Circuit Television
CIRM	Critical Incident Review Meeting
CNO	Chief Nurse Officer
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
DiC	Death in Custody
IPS	Irish Prison Service
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System
SOP	Standard Operating Procedure

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, Home Affairs and Migration 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, Home Affairs and Migration 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 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 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 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. D's death on 26 January 2023 and management of the events associated with his death.

4. Administration of the Investigation

4.1 On 26 January 2023, the OIP was notified by Governor A by telephone that Mr. D had passed away in Castlerea Prison. The investigation team attended the prison the next day and met with prison management. The IPS subsequently provided written documentation in accordance with the agreed checklist of information that is to be made available for OIP investigations.

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 Inspectorate of Prisons' role when investigating a death in custody.

5.2 The investigation team met with Mr. D's mother (NoK), sister, an aunt and uncle on 30 November 2023. The family raised a number of concerns, which are outlined in **section 7**.

5.3 Although this report is for the Minister for Justice, Home Affairs and Migration it may also inform several other interested parties. It is written primarily with Mr. D's family in mind.

5.4 The OIP is grateful to Mr. D's family for their contributions to this investigation. We offer them our sincere condolences on their loss.

6. Castlerea Prison

6.1 Castlerea Prison is a closed, medium security prison for adult males. It is the committal prison for remand and sentenced prisoners in Connacht and also takes committals from Counties Cavan, Donegal and Longford. It has a capacity of 340 and at the time of Mr. D's passing was over capacity with 342.

6.2 Mr. D's was the first death of a prisoner from Castlerea Prison in 2023 and the fourth death in IPS custody that year.

7. Family Concerns

7.1 When the investigation team met with Mr. D's family, they stated that they were very unhappy with several aspects of his passing. These concerns are outlined below. The family expressed hope that the OIP investigation would find answers which they had been unable to obtain themselves.

7.2 The family concerns were:

1. The family stated that Mr. D had been attacked in the community a few days prior to his committal to Castlerea. He suffered a head injury which was inflicted with a hatchet. The family wanted to know if that injury was assessed and whether he had a scan while in the care of Castlerea Prison. They were concerned that he may have died from an undiagnosed or untreated head injury.

   OIP Response: This injury was sustained while he lived in the community and was initially treated, including the insertion of staples, at a community Accident & Emergency Department. There is no evidence that a scan was conducted at that stage or that a scan was required after Mr. D was committed to custody. IPS medical records indicate this injury was properly managed while he was in custody.

2. Mr. D's mother complained that she did not get to view or identify her son before his wake.

   OIP Response: When a person is pronounced deceased in prison custody, An Garda Síochána (AGS) is notified and takes charge of the person's remains until the post-mortem is completed. The OIP currently has no remit over AGS but it is the Inspectorate's experience that normally a member of AGS would contact the family to explain why a post-mortem was necessary and when they can view the remains.

3. The family considered it inappropriate that a Prison Officer (whose name they could not remember) rang to tell them that no foul play was suspected and Mr. D's toxicology result was clear. The family also stated that a Garda informed them the IPS would not be in a position to state this.

OIP Response: The investigation team spoke to the Governor who contacted the family to inform them of Mr. D's passing. Whilst the Governor could not recall what was specifically stated he is adamant that he would not have passed on any information that would have indicated how the event occurred, particularly as he would not have known at the time. The Governor also stated he would not have used terminology such as "*no foul play suspected*".

4. The family stated a member of AGS told them during a phone call that there was a lengthy delay in unlocking Mr D's cell when he was found unresponsive. They found this news distressing.

OIP Response: The CCTV footage does not substantiate this concern. The evidence from Mr. D's cellmate also confirms a prompt response by IPS Officers.

5. Mr. D's mother was particularly upset by events at her son's graveside after the funeral mass. She stated that, at the graveside, a representative from Castlerea Prison (she did not know their name but thought it was a Governor grade) handed her a bag containing Mr. D's belongings. In addition to finding the timing and circumstances inappropriate, she said that, if she had received the property earlier, she would have used some items during the Offertory Procession at her son's funeral mass. She was never asked to sign for these belongings. Her distress was compounded by discovering that several of the items did not belong to her son.

OIP Response: The OIP was informed by the Governor that the handover of property was prearranged between the Governor and Mr. D's sister. The Governor stated that the arrangement made was that Mr. D's personal property would be returned to the family on the date of the funeral, outside the cemetery. The OIP was advised that the property was handed to the partner of Mr. D's sister. The Governor also advised that all the items in the cell that were in Mr. D's possession, together with property in his reception locker were returned to the family. The Governor pointed out that very often a prisoner who is being released donates some clothing or other items to another inmate and this may explain why the family did not recognise some items of property returned.

6. The family were annoyed to learn, after his death, that they had never been told that Mr. D had been resuscitated on a previous occasion (3 November 2019) when he had been found in an unresponsive state in Castlerea Prison.

OIP Response: It would not be normal practice to notify a family of an incident if a person responded to treatment and there was no immediate danger to their life. As per the Prisoner Healthcare Management System (PHMS) records, Mr. D was successfully resuscitated, refused to attend hospital and

was closely monitored following the incident. As Mr. D was over 18 years of age and had regular contact with his family it would have been a matter for Mr. D to decide if he wished to inform his family of the event in question.

8. Mr. D's Background

8.1 Mr. D was 25 years old when he died in Castlerea Prison on 26 January 2023. He had been there for three months, having been committed on 29 October 2022. He was serving a 15-month sentence and was due for release with remission on 5 October 2023.

8.2 He was accommodated in a two-person cell – No. 7 on B2 landing. He occupied the bottom bunk. This landing was designated for prisoners who were vulnerable. Mr. D was placed there at his own request because he felt under threat from some other prisoners due to drug debts and community feuding. He had three identified enemies from whom he was required to be kept apart in Castlerea Prison. He shared Cell 7 with a friend, Prisoner 1, from his home area; and both were employed as landing cleaners.

8.3 Mr. D was well known at Castlerea Prison as he had been in their custody on five occasions since 2017. He had last been released on 16 March 2022. His offending history was varied and included drugs offences (both possession and supply) which is relevant for the current investigation. Medical records showed he was a regular substance user who had received in-patient treatment during 2015 and 2019. His medical history also included self-harm attempts.

8.4 At the time of his death, he was on three prescribed medications: Lyrica, an analgesic used to treat nerve pain (in Mr. D's case for pain arising from a road traffic accident two years earlier); Zispin Soltab, an antidepressant; and Duac, an acne preparation.

8.5 Mr. D had a release date to look forward to. He had a supportive external social network with twelve approved visitors, of whom several came to see him regularly and provided sufficient money for him to spend in the prison tuck shop. While he engaged in limited written correspondence (two incoming letters and one outgoing letter, all personal), Mr. D had regular phone contact with his family and friends.

8.6 At the time of his death, Mr. D was on the Standard level of the Incentivised Regime.[1] He had been reduced to basic level on 7 December 2022 for breach of the prison rules, being in possession of contraband. The penalty was 10 days loss of phone calls and 10 days loss of tuck shop privileges.

[1] The Incentivised Regimes Programme provides for a differentiation of privileges between prisoners according to their level of engagement with services and behaviour. The objective is to provide tangible incentives to prisoners to participate in structured activities and to reinforce good behaviour, leading to a safer and more secure environment. There are three levels of regime – basic, standard and enhanced, with different privileges associated with each regime level.

9. Events of 25-26 January 2023

9.1 Evidence obtained from CCTV footage of the landing outside Mr. D's cell is outlined in **section 11**.

9.2 On the afternoon of 25 January 2023, Mr. D had a visit with his partner and their child. The investigation team reviewed the CCTV footage of the visit. It showed that Mr. D entered the visiting area at 14:28 and left at 15:14. During that time their baby was passed between the couple and Mr. D is seen embracing his partner.

9.3 The IPS Operational Support Group also reviewed the CCTV footage and concluded that "*Given the position of this camera, it is difficult to see if any contraband is passed*." The prison officers who supervised the visiting area, Officer A and Officer B, in their respective reports stated that they did not notice anything untoward during that visit.

9.4 Prison officers who supervised Mr. D at the visiting area or on the landing noticed nothing of concern. Mr. D received prescription medication as normal at 19:00 and the administering nurse officer (NO) A stated Mr. D "*presented to the cell door for meds at 7pm, alert and orientated*." While three other prisoners on B2 landing were on Special Observations, Mr. D was not deemed to require such attention.

9.5 Mr. D and his cellmate, Prisoner 1 were locked back for the night around 19:00. The CCTV footage for B2 landing indicates that checks were conducted every hour on the hour throughout the night.

9.6 Prisoner 1 reported making a phone call to his brother from the in-cell phone at around 22:00 and his brother "*could hear [Mr. D] snoring*." Prisoner 1 went to bed after the phone call and woke up around 04:00 "*to have a cigarette."* Prisoner 1 called Mr. D but there was no response so he called him again and there was still no response. Prisoner 1 recalled turning on the light and touching [Mr. D] whom he reported was "*stone cold.*" Prisoner 1 stated that he then *"banged the door with a brush"* and reported that "*the officers came running*" and *"the response was quick"*. Prisoner 1 also stated that he tried CPR on Mr. D "*but he was long gone at that stage*".

9.7 The records showed there was an in cell call activation (defined as when the cell button is pressed in the cell) at 18:43 on 25 January 2023. "*Priority calls*" were registered at 18:46; 18:49 and 18:52, with the bell being reset at 18:54 by an officer who checked the cell. Priority calls are automatically repeated after 180 seconds and transfer from the Class Office on the landing to the Control Room, if there is no response to the initial call during that time. There were "*Guard Tours*" (defined as an officer patrolling the landing at regular intervals who pressed a button located outside the cell of Mr. D, to register their patrol) this button was pressed at 21:58; 22:58; 00:01; 01:00; 02:00; 03:01 and 04:01. The CCTV footage viewed confirmed the attendance of an officer outside Mr. D's cell at the aforementioned times. These "*Guard Tours*" were conducted in accordance with the IPS policy in place at the time.

9.8 The cell call was activated by Prisoner 1 at 04:30 and this call became a priority activation at 04:33. Officer C can be seen on CCTV footage responding to this call activation at 04:36:36. Officer C cancelled the activation by pressing the button outside the cell, he lifted the viewing panel on the door, looked inside the cell and immediately raised his radio to his face as he walked away from the cell. Officer C reported hearing "*a call from a cell on B2 at 4.30 am. Upon*

investigating prisoner JS informed me that his cell mate [Mr. D] was unresponsive. I called nurse officer B *and ACO* A *to the cell.*"

9.9 ACO A, Officer C and NO B entered Cell 7 at 04:41. NO B recorded on the PHMS that upon entering the cell Mr. D was lying in a supine position, "*no breathing, no pulse, eyes widely dilated, very cold to the touch with evident blood pooling No resuscitation attempted*".

9.10 An ambulance was called, and arrived at 05:10. IPS records indicated that the paramedics concurred with NO B's conclusion that Mr. D had been dead for some time and therefore no resuscitation attempts were made.

9.11 Prisoner 1 was relocated to another cell and senior IPS staff (attached to Castlerea Prison and Headquarters) were notified of the passing of Mr. D.

9.12 Governor A arrived on the scene at 06:10 and took command. He made several attempts to phone Mr. D's mother (his NoK) between 06:00-07:00 but these were unsuccessful. He managed to contact Mr. D's partner at 07:10 and notified her of Mr. D's passing. The partner informed Mr. D's mother, who shortly afterwards phoned the prison and spoke with Governor A.

9.13 AGS were notified of the passing of Mr. D. The first Gardaí arrived at the prison at 05:49 and Garda Scenes of Crime investigators arrived later.

9.14 Some aspects of IPS recording require improvement. For example, Governor A and ACO A's records describe "*approximate*" times for all events, whereas others are more precise. Several staff statements are neither dated, nor signed. In one instance, Prison Officer D provided his report in unclear terms and in the conditional tense, stating "*To the best of my recollection… I would have… Mr. D would have…*" Some statements give no indication that the officers were involved in a death in custody; they merely refer to *"...assisting with an incident.*" The OIP has made recommendations in the past and spoken to IPS Headquarters regarding the quality of reports and need for staff to appreciate the importance of accurate record-keeping.

9.15 Prompt attempts were made to obtain a doctor to certify Mr. D's death. This was done by Doctor A when he arrived at the prison at 09:20.

9.16 Chaplain A arrived on the landing at 09:30.

9.17 Mr. D's body was removed from the cell by undertakers at 11:10 and taken to Galway for post-mortem examination. The cell was sealed pending completion of the AGS investigation and B2 landing was locked down. A written record was commenced by Officer E of everyone who had entered the cell following the passing of Mr. D.

9.18 A cell search was conducted by Garda A and three IPS staff; ACO B, Officer F and Officer G. They found "*10 blue marked/C and 1 white pill*." Garda A bagged and took possession of the pills at 12:15. It remains unclear whether or not prison management has been made aware by AGS of the results of any analysis of these pills.

9.19 As soon as Mr. D's post-mortem examination was completed, on the afternoon of 26 January 2023, AGS released the cell back to the IPS, having determined there were "*No suspicious circumstances*." Another search by the IPS subsequently detected a rolled-up piece of burnt foil.

9.20 The investigation team interviewed Mr. D's cellmate, Prisoner 1. He stated that around 19:15 on 25 January 2023, they both smoked *"strong heroin"* (he thought it was mixed with Fentanyl) and took *"fake Valium tablets"* in their cell. Prisoner 1 said Mr. D fell asleep around 21:45 and he himself went to sleep soon afterwards. When he woke to roll a cigarette at 04:00, he tried to rouse Mr. D but was unable to do so and summoned assistance immediately. He said "*The Officer came running. The Officer was there in no time. The response was quick. I tried CPR [*cardio pulmonary resuscitation*]…. but he was long gone at that stage.*"

9.21 Prisoner 1 also said that he and Mr. D would often have taken tablets together in prison but he had never seen him react negatively. He considered that Mr. D had a high tolerance for drugs. Although Mr. D was "*very stoned*" after smoking the heroin and consuming the tablets, Prisoner 1 was not concerned for him.

9.22 Subsequent IPS phone monitoring included Mr. D's final call to his partner. The records indicate that they both "…*appear to discuss something illicit but unclear if it is about contraband.*" IPS analysis of Prisoner 1's phone calls revealed that he rang Mr. D's mother after the death and said they had both *"taken Lyrica this morning*."[2]

9.23 The investigation team and IPS also interviewed two other prisoners on B2 landing, Prisoner 2 and Prisoner 3. Apart from one of them confirming that he knew Mr. D had obtained drugs and saying he heard shouting during the night, neither was able to shed any significant light on the events of 25-26 January 2023.

9.24 The IPS 'Injury Incidents' form classified Mr. D's death as "*Unintentional Self-Injurious behavior*."

10. Medical Care

10.1 Mr. D was seen regularly by medical staff during his time in Castlerea Prison. The PHMS records showed that a head injury was noted on his committal interview and Mr. D did not express undue concern about it. Mr. D was seen shortly afterwards for a Covid-19 quarantine screening; and his medications were confirmed by his community pharmacy on 1 November 2022 which were: Ventolin Inhaler, Mirtazapine and Lyrica. The medical records confirm that Mr. D was prescribed Lyrica and Mirtazapine on 1 November 2022, this prescription was renewed monthly and he was on these medications at the time of his passing.

10.2 On 2 November 2022 Doctor B saw Mr. D and he recorded that: "*Has staples in scalp x few days – struck with hatchet – attended A&E….. Mood fair until Lyrica S/E's and detox mentioned. Threatened to cut himself if meds stopped. Advised re addictive potential of meds… Plan – Will D/W GP*[3]*.*"

10.3 On 3 November 2022, NO C saw Mr. D and noted "*Tried contacting Galway hospital re discharge summary/when staples should be removed. No answer. Wound inspected today. Looks to be healing OK. Small amount of exudate noted but appears to be from a scab lifting slightly. C/O slight pain. Pain relief given*."

[2] Lyrica is a brand name of Pregabalin, an anticonvulsant, analgesic and anxiolytic amino acid medication.
[3] Will discuss with General Practitioner (GP)

10.4 On 7 November 2022, eight staples were removed from Mr. D's scalp by NO C. She noted "*Wound looks to be healed. Small amount of dried blood noted. No dressing required. Advised to be careful when washing hair.*"

10.5 An IPS PHMS note entered by NO D showed that Mr. D had been resuscitated in his cell at Castlerea on 3 November 2019 while serving a previous sentence. On that occasion, he had been found unresponsive at 23:30. He responded quickly to CPR and emergency medication to counteract the effect of opiates, and he elected not to go to hospital. After spending the remainder of the night under medical observation, he was returned to the general population the next day. He told a doctor that he had taken the drug "*Spice"* for recreational purposes, rather than self-harm. Medical follow-up was thorough and staff advised him about the risks of using illicit substances, including the possibility of fatal consequences. They also offered referral to addiction services but Mr. D declined the offer.

10.6 At committal in November 2022, Mr. D stated he had not taken any drugs since being an in-patient at a rehabilitation facility in May 2022. The notes indicate his mood was normal and he did not mention having any thoughts of deliberate self-harm.

11. CCTV Footage

11.1 As part of this investigation, the inspection team conducted a detailed analysis of CCTV footage of B2 landing on the night of 25-26 January 2023. Footage of the response to Mr. D corroborated the accounts of prison personnel.

11.2 At 04:36:36 an officer lifted the cell door flap and looked into Mr. D's cell before briefly departing. At 04:41:06 the officer returned accompanied by two other officers before unlocking and entering the cell. At 04:41:21 a nurse carrying a medical red bag arrived and entered the cell. Prisoner 1 was relocated to another cell on the same landing. At 05:10:03 members of the ambulance service arrived and entered Mr. D's cell.

11.3 At 05:49:42 members of AGS arrived on the landing and entered the cell. Ambulance staff were still at the cell area. They were standing outside the cell door for most of the time and it is evident resuscitation efforts had ceased. At 06:25:58 ambulance staff departed the landing before the cell was physically secured.

12. Critical Incident Review Meeting

12.1 A Critical Incident Review Meeting (CIRM) was held at 11:00 on 26 January 2023. It was attended by: Governor A, Assistant Governor A, Acting Chief Officer A, CNO A, Chaplain B, PEO A, Psychologist A and a minute taker. However not all IPS personnel who were on B2 landing and/or entered Mr. D's cell were in attendance. That is understandable in light of staff shift patterns, though every effort should be made to ensure those with first-hand experience always attend the CIRM. At the very least, the record should show that such efforts were made, reasons for non-attendance and any contributions that were made by non-attendees.

12.2 A detailed timeline of events was recorded. The meeting noted the possible impact upon Mr. D's cellmate and that he had been placed on Special Observations. It commended the fact that everyone within the IPS and external agencies responded very quickly and that vulnerable prisoners were looked after.

12.3 Within 72 hours, support was to be offered to the staff involved and a "*cell drop*" implemented to offer support from the Samaritans to all prisoners on the landing.

12.4 No recommendations were recorded at the conclusion of the CIRM, but there were a number of actions.

12.5 The purpose of the CIRM is to establish the facts, to provide an opportunity to share views on how the situation was managed and identify any additional supports or learning. It is good practice that a "Hot Debrief" was undertaken, and that appropriate priority was given to safeguarding the health and welfare of Mr. D's cellmate.

12.6 However, there is no evidence that a "Cold Debrief" was held after Mr. D died. The purpose of a "Cold Debrief" is quite different - it is intended to provide an opportunity for post-crisis reflection within two weeks of the incident, as well as confirmation that any recommendations or actions were actually implemented. Since no "Cold Debrief" was conducted, there is no record of whether or not the actions agreed at the "Hot Debrief" were achieved. Furthermore, convening a "Cold Debrief" is a requirement of the IPS SOP entitled *'Critical Incident Reporting and Debriefing Procedures'* which came into effect on 1 July 2020.

13. Recommendations

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

1. All IPS records involving deaths in custody should be dated and signed. All timings of significant matters such as cell entries and arrival of emergency services should provide exact times **section 9.15**.

2. It is crucially important that any contraband seized in the immediate aftermath of a death in prison custody should be swiftly analysed and the results of that analysis made available in a timely fashion to the management and the health care team in the prison concerned. This information can greatly assist in reducing the risk of future deaths. The Inspectorate invites the IPS to review its existing procedures in this area.

3. The record of "Hot" and "Cold" CIRM should show who was invited to attend; reasons for non- attendance; and anything significant that non-attendees contributed to the proceedings e.g. in writing or by phone, **section 12.1**.

4. A "Cold" CIRM should be conducted within 14 days of the incident to provide further opportunity for everyone involved, including prisoners where relevant. The purpose should be to identify learning, support everyone involved and assess progress in relation to actions that were identified at the "Hot Debrief", **section 12.5.**

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.