Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. O
Cloverhill Prison
10 August 2022
Age 52

Submitted to Minister: 8 July 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
AGS	An Garda Síochána
CCTV	Closed Circuit Television
CHDC	Cloverhill District Court
CIRM	Critical Incident Review Meeting
CNO	Chief Nurse Officer
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
CPT	European Committee for the Prevention of Torture
CSC	Close Supervision Cell
DFB	Dublin Fire Brigade
DiC	Death in Custody
GP	General Medical Practitioner
GSOC	Garda Síochána Ombudsman Commission
IPS	Irish Prison Service
LUCAS	Lund University Cardiopulmonary Assist System
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System
PICLS	Prison In-reach and Court Liaison Service
PIMS	Prisoner Information Management System
PSEC	Prison Escort Corps
SOC	Safety Observation Cell

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.

3.2 This report is structured paying particular focus to the care that was afforded to Mr. O during his time in prison.

4. Administration of Investigation

4.1 On 10 August 2022, the OIP was notified that Mr. O had passed away in Cloverhill Prison. The investigation team attended Cloverhill prison on 11 August 2022 and met prison management who provided an overview of Mr. O's time in prison.

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 family of the deceased is a very important aspect of the Inspector of Prisons' role when investigating a death in custody.

5.2 The investigation team was informed that prison management had been advised that Mr. O had been living in Spain. The investigation team was also informed that Mr. O had travelled to Ireland in July 2022 to visit a friend, but due to his erratic behaviour his friend asked him to leave their home. While at Dublin Airport on 4 August 2022, Mr. O was arrested by An Garda Síochána (AGS) due to his behaviour and for refusing to comply with the direction of AGS.

5.3 The investigation team communicated with Mr. O's NoK, who resides in Germany. The NoK did not raise concerns. The OIP received medical consent to access Mr. O's clinical records.

5.4 Although this report is for the Minister for Justice, Home Affairs and Migration, it may inform several interested parties. It is written primarily with Mr. O's NoK in mind.

6. Cloverhill Prison

6.1 Cloverhill Prison is a closed, medium security prison for men, which primarily caters for remand prisoners committed from the Leinster area. At the time of Mr. O's passing Cloverhill Prison had an occupational capacity of 433 with 464 in custody. It was at 108 % capacity.

6.2 Mr. O was the second death of a prisoner from Cloverhill Prison in 2022; and the fifteenth death in IPS custody that year.

7. Background

7.1 Mr. O was a 52 year-old remand prisoner when committed to Cloverhill Prison on 4 August 2022.

7.2 Mr. O had been charged with a public order incident at Dublin Airport, and had been granted a nil cash bond when he appeared before the Court. In order for Mr. O to avail of bail he would have been required to sign a bail bond confirming that he would not commit any offence and be of good behaviour following release. The investigation team were informed by Governor A that he considered that Mr. O was not in a fit state of mind to take up his bail bond.

7.3 Mr. O had no personal belongings on his arrival at Cloverhill Prison. No belongings had been handed over by AGS to the prison escort staff following the court hearing. Mr. O's committal warrant had a signed, handwritten, note on the front of the document. The signature is difficult to decipher but it would appear to be that of the Court Clerk based on the evidence available. The handwritten note states "*needs immediate medical attention as directed by Judge …".*

7.4 Mr. O had a further court appearance on 8 August 2022, at which he was remanded back to the custody of Cloverhill Prison on bail of €50, with a further court appearance scheduled for 15 August 2022.

7.5 It was reported by prison staff that Mr. O's behaviour on committal was erratic and he was accommodated in Close Supervision Cell[1] (CSC) 2 on the D2 landing. Mr. O was medically assessed by the prison healthcare staff and the Prison In-reach and Court Liaison Service (PICLS) team while in the CSC. The objective of the PICLS team is to improve the identification of people suffering mental health issues when they are remanded to prison. The team aims to assist patients, the criminal justice system, and local psychiatric services by ensuring a rapid response and systematically identifying prisoners with a primary diagnosis of psychotic illness.

7.6 Mr. O was scheduled to be released from Cloverhill Prison under the Mental Health Act 2001 to St. Vincent's Hospital Psychiatric Unit on 11 August 2022. However, Mr. O was discovered unresponsive in his cell on 10 August 2022.

[1] Designated special cell to keep prisoners who are considered a danger to others in the prison or whom prison staff consider are disruptive and need to be separated from other prisoners to maintain a safe and secure environment.

7.7 The Garda Síochána Ombudsman Commission (GSOC) conducted an investigation into Mr. O's engagement with and time spent in the custody of AGS.

8. Committal and Healthcare Review

8.1 Upon committal, nursing staff described Mr. O as unwilling to engage and expressed a belief, based on his behaviour, that there was the potential for Mr. O to act aggressively towards staff. The investigation team was informed that Mr. O was placed in a CSC on the D2 landing for "*operational reasons*". According to Governor A, the decision to accommodate Mr. O on the D2 landing was due to his behaviour on committal and to facilitate a review by the PICLS team.

8.2 Mr. O was issued with refractory clothing[2]. Prison Rule 64(8) provides the authority for a prison Governor to require removal of a prisoner's ordinary clothing if a prisoner is placed in a Special Observation Cell (SOC) where the Governor considers that items of the prisoner's clothing may be used by the prisoner to harm himself. There is no evidence that Mr. O was in a SOC. Mr. O was subject to fifteen minute special observation checks in a CSC but there is no specific provision in the Prison Rules covering the placement of a prisoner in refractory clothing in a CSC.

8.3 Mr. O was recorded as being in quarantine under Rule 103[3] of the Irish Prison Rules 2007-2020. Rule 103 was the Prison Rule under which prisoners were placed in quarantine during the COVID-19 pandemic as an infection control measure.

8.4 The investigation team examined documentation including excerpts from the Prisoner Information Management System (PIMS), which detailed that Mr. O was the subject of a P19 disciplinary report upon committal for allegedly disruptive behaviour. The reporting officer was Assistant Chief Officer (ACO) A. Mr. O's behaviour was described as *"bizarre and erratic"* and it was recorded that he had refused to comply with the search procedure on committal. The P19 hearing was conducted on 6 August 2022 by Chief Officer A who concluded that the P19 allegation was not to be upheld as Mr. O was "*very unwell and under the care of the PICLS team*".

8.5 Nurse A recorded on the Prison Information Management System (PHMS) that they were "*unable to complete committal interview as patient is very agitated. Pacing and chanting and shouting in unknown language. Refusing to answer questions, refusing to make eye contact. Very uncooperative. Moved to D2 pending review on regular checks."* It was further recorded that during a review close to midnight, Mr. O was standing on his bed in a state of undress and shouting at the floor and refused to respond to questions asked by the nurse.

8.6 Psychiatric Nurse A recorded on the PHMS system that Mr. O's solicitor, (Solicitor A) phoned Cloverhill Prison on 5 August 2022 and requested an urgent psychiatric review for Mr. O.

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2 Refractory clothing: This is a single piece garment made of material that is resistant to damage such as ripping.

3 Where a prison doctor believes there is a serious risk to the health of a prisoner and makes a recommendation in writing on medical grounds in relation to that prisoner to the Governor, the Governor shall, subject to paragraph (2), implement the recommendation as soon as may be thereafter. (2) Subject to any direction of the Director General under paragraph (4), the Governor may, for the purpose of maintaining good order and safe and secure custody or on other reasonable grounds, decide not to implement a recommendation under this Rule (other than a recommendation that a prisoner, who is suffering from, or suspected of suffering from, a contagious or infectious disease or condition that threatens the health or well-being of others, be segregated in order to prevent the spread of the disease or condition) after - (a) discussing the matter with the prison doctor, and (b) taking account of the likely impact of not implementing the recommendation on the prisoner.

8.7 Also on 5 August 2022, Psychiatric Nurse A recorded that he and Psychiatrist A had reviewed Mr. O. Mr. O refused to provide any medical history and would not provide consent to access his previous medical history. Mr. O's behaviour was described as unpredictable and highly agitated, due to this the medical interview was discontinued. It was recorded on the PHMS that it was likely Mr. O had relapsed into a manic psychotic illness. Psychiatric Nurse A recommended that Mr. O remain on the D2 landing for further review and he was prescribed Olanzapine (20mg). The medication was not administered as Mr. O declined it.

8.8 On 8 August 2022, at 11:22, Psychiatric Nurse A noted a conversation they had with Garda A from Dublin Airport Garda Station who was present when Mr. O was arrested at Dublin Airport on 4 August 2022. Garda A provided Psychiatric Nurse A with some details in relation to the circumstances surrounding the arrest of Mr. O, advising that he [Mr. O] had been refused boarding. Mr. O left the airport but he returned to the Garda station at Dublin Airport where he remained for two hours, refusing to leave. Mr. O was observed talking to the wall for prolonged periods. Garda A stated that Mr. O became agitated and resisted when an attempt was made to remove him from the station and he was arrested. Garda A confirmed that there "*would be no objections in the event bail to hospital was recommended for [Mr. O]*".

8.9 On 8 August 2022, Psychiatrist B recorded on the PHMS at 13:46 that a call had been received from Garda B[4] advising that the Judge "*would be striking out charges against [Mr. O] if treatment could be arranged given his current mental state*."

8.10 Also on 8 August 2022, Psychiatrist C recorded on the PHMS at 17:06 that contact had been made with both the Clinical Director and Consultant Psychiatrist at St. Vincent's Hospital Fairview regarding the possible admission of Mr. O. It was confirmed by the Consultant Psychiatrist that Mr. O would be accepted for treatment in the event of being released from prison custody.

8.11 Later on 8 August 2022, Solicitor A informed Psychiatrist C that Mr. O had been remanded back to the custody of Cloverhill Prison with bail of €50 and his next court appearance was scheduled for 15 August 2022. Psychiatrist C recorded on the PHMS that the solicitor also stated that she would "*attempt to have his matters re-entered prior to the date at CHDC [Cloverhill District Court] in an effort to have his charges struck out.*"

8.12 The investigation team met with Doctor A and separately with Psychiatrist A on 22 August 2022 regarding Mr. O's committal and medical reviews on 4 and 5 August 2022. Doctor A described Mr. O presenting as psychotic. Doctor A advised the investigation team that a friend of Mr. O's had informed Solicitor A that Mr. O had a history of mental health illness. It was reported that Mr. O had previously spent time in a psychiatric hospital outside of the jurisdiction and it was believed he had not taken his prescribed medication for the previous ten months. Psychiatrist A reported that Mr. O would not engage with healthcare staff and that Mr. O presented as agitated, animated and experiencing a psychotic episode. Mr. O refused to provide a urine sample or take any medication. It was reported that Mr. O repeatedly shouted, "*my family is in Jesus, give me my shoes my family lead me to hell."*

8.13 Psychiatrist A informed the investigation team that accessing treatment in a community based psychiatric facility is extremely challenging. Psychiatrist A referenced 'A Vision for Change[5]', a

[4] Garda B arrested Mr. O at Dublin Airport
[5] HSE (2006) A Vision for Change: Report of the Expert Group on Mental Health Policy

2006 policy document, which outlined an approach towards the provision of mental health services for prisoners in Ireland. Psychiatrist A pointed out that, seventeen years later, mentally ill persons in prison custody still cannot easily gain access to psychiatric community-based facilities, this lack of access results in prisoner-patients not receiving the mental health treatment they require. This is consistent with the Inspectorate's findings during its recent thematic evaluation of the provision of psychiatric care in the Irish prison system.[6]

9. Events of 9 and 10 August 2022

9.1 On 9 August 2022, Nurse B recorded on the PHMS that officers had raised concerns that Mr. O was not eating or drinking. Mr. O was provided with additional cartons of milk and was monitored throughout the day by officers and nursing staff. Nurse B recorded on the PHMS at 19:42 that Mr. O was assessed from his cell door, was lying on his bed and would not engage in conversation. Nurse B also documented that the night nurse, Nurse A, was informed that Mr. O was not eating or drinking and that he had been encouraged to do so. Mr. O was placed on the GP list for review the following morning, 10 August 2022.

9.2 Nurse A recorded that she conducted overnight cell checks on Mr. O at 20:00, 22:00, 00:00, 02:00 and 04:00. It was noted that Mr. O appeared to be sleeping in his bed during all of these checks. At the 06:00 check, it was recorded that Mr. O was sitting on the in-cell toilet. Nurse A recorded that Mr. O failed to respond when asked questions through the cell door.

9.3 Officer A was Night Guard on the D2 landing. Due to a medical emergency at approximately 06:20, involving a fellow staff member, Officer A left the D2 landing to accompany their colleague to the prison surgery and awaited the arrival of a Dublin Fire Brigade (DFB) ambulance. ACO A redeployed Officer B to replace Officer A on the D2 landing.

9.4 On taking up duty on the D2 landing, Officer B completed the first cell check at 06:30. At 06:45, Officer B reported checking on Mr. O who was observed sitting on the in-cell toilet.

9.5 Officer B conducted his next check of Mr. O's cell at approximately 06:55 and again observed Mr. O sitting on the in-cell toilet. Officer B reported that Mr. O appeared to have not moved since his previous check. Officer B said that he had kicked the cell door in a hope of getting a reaction from Mr. O but did not receive a response. Officer B immediately alerted ACO A using his radio.

9.6 ACO A arrived at approximately 07:00 and unlocked Mr. O's cell door. ACO A described Mr. O as being unresponsive. ACO A called for medical assistance (a code red[7]) over the radio. An ambulance which responded to the earlier medical emergency of a staff member had just departed the prison and returned. Officer C, who was on duty at the Main Gate, accompanied the ambulance paramedics to the D2 landing. Mr. O was removed from the toilet and placed on the cell floor.

9.7 Nurse A responded to the code red call for immediate medical assistance. Nurse A arrived at approximately 07:02 at Mr. O's cell carrying the red emergency medical bag and Automated External Defibrillator (AED) machine. Nurse A reported finding Mr. O unresponsive and, on their

[6] Available at this link: https://www.oip.ie/wp-content/uploads/2024/02/OIP-Thematic-Inspection-Report-on-Provision-of-Psychiatric-Care-in-Prisons_Feb-2024-Publish.pdf See also section 12 of this report.

[7] Request for an immediate medical response

initial review of Mr. O, could not detect a pulse. There was no evidence that Mr. O was breathing.

9.8 Nurse A attached the AED to Mr. O which provided the audio message of 'no shock advised'. This can mean one of three things: the person has a pulse, regained a pulse, or is pulseless but is not in a "*shockable*" rhythm. Nurse A reported commencing CPR[8] assisted by ACO A which continued until paramedics from the ambulance service arrived at approximately 07:07. Paramedics then took charge and continued resuscitation efforts on Mr. O.

9.9 DFB Ambulance paramedics continued CPR until approximately 07:12 at which time an advanced paramedic took over and continued resuscitation attempts until approximately 07:22, when the decision was made by the advanced paramedic to cease efforts of resuscitation as Mr. O had passed.

9.10 Doctor A pronounced Mr. O's death at 09:45.

10. CCTV Footage/CSC Journal

10.1 The investigation team reviewed CCTV footage of Mr. O's committal to Cloverhill Prison. Mr. O was conveyed from Court to Cloverhill Prison in a Prison Escort Corps (PSEC) Van arriving at the prison at 19:50 on 4 August 2022. A number of prisoners exited the vehicle, Mr. O was last to step out of the van at 20:03. Nurse A was present.

10.2 An ACO can be seen reading a document to Mr. O before he entered the Prison Reception area. He was then patted down and handcuffs were removed. Reception staff described Mr. O as speaking continuously. The investigation team observed Mr. O's lips continuously moving and his movement appeared lethargic as he was guided and placed in a holding cell in the Reception area at 20:04 where he remained until 22:50.

10.3 Mr. O walked slowly and swayed slightly when he was being transferred from the holding cell to the CSC. Nurse A walked behind Mr. O as officers appeared to be encouraging him to walk, one officer was guiding Mr. O with an open hand on the small of his back as they slowly moved. Mr. O was off camera while in the search area - according to staff reports he did not comply with their instructions and would not permit officers to search him resulting in a P19 disciplinary report referred to in paragraph 8.4. Mr. O then continued through Reception escorted to the D2 landing. At 22:54, Mr. O was placed in CSC 2. Mr. O was provided with refractory clothing. Mr. O's personal clothing was placed on the landing floor outside the cell. When the cell door was locked an officer departed and returned with a bag and placed Mr. O's clothing in the bag which was hung from the railing outside the cell door.

10.4 The investigation team reviewed footage of the D2 landing from 9 August 2022 overnight into 10 August 2022. The accounts of staff set out in section 9 of this report are corroborated by the CCTV footage.

[8] Cardiopulmonary resuscitation

10.5 The investigation team reviewed the CSC Journal. A CSC Journal is the document in which staff are required to record all interactions with the occupant of a CSC including, anyone who enters the cell, time of entry and leaving, out-of-cell time, a record of each cell check conducted, and document anything of concern. There is also a requirement on supervisory staff to check and sign journal entries.

10.6 As stated in paragraph 8.2, Mr. O was subject to special observations while in the CSC requiring staff to check on him every fifteen minutes. The CSC journal has a pre-printed grid divided into fifteen-minute time intervals. When an officer completes a check they record this in the CSC journal by ticking a box opposite the relevant time the check was conducted. As outlined in section 9, Mr. O was discovered unresponsive at 06:50. The CSC journal recorded three checks conducted at 07:00, 07:15 and 07:30 which was after Mr. O was found unresponsive. These three entries were initialed to confirm the checks were completed. The investigation team noted that an (unsuccessful) effort had been made to erase the three entries. This would clearly suggest that CSC entries were being pre-filled by staff, entirely negating the value of this recording safeguard. See also, in this regard, the comments and recommendations in section 12 of this report.

11. Critical Incident Review Meeting

11.1 On 10 August 2022, a critical incident review meeting[10] (CIRM) was held Governor B. In attendance were Chief B, CNO A and Chaplain A.

11.2 An overview of Mr. O's time in custody and the timeline of events were recorded in the minutes of the meeting. It was noted that on committal, Mr. O was agitated and would not engage with staff or provide information.

11.3 It was also noted that Mr. O's NoK resided outside of the State. Chaplain A stated that he had contacted the NoK and informed them of the passing of Mr. O over the telephone and that Mr. O's NoK provided some background information relating to Mr. O's family.

11.4 It was recorded that, on 8 August 2022, Mr. O would not engage with the nurses and would not provide a blood sample. CNO A reported that a further attempt to take a blood sample was planned for 9 August 2022.

11.5 One recommendation was made at the CIRM:

- That consideration should be given to procuring an Automatic Chest Compression Machine (LUCAS)[11].

11.6 At the time of writing this report, the investigation team was informed that Cloverhill Prison had not secured a LUCAS machine.

[10] Staff meeting held following the death of a prisoner. The purpose of the meeting is to review the circumstances and activities surrounding an incident, identify learnings, commend good practice and recommend changes, if required, to prevent a similar occurrence.

[11] A Lund University Cardiopulmonary Assist System (LUCAS) provides mechanical chest compressions to patients.

12. Recommendations

12.1 In the Inspectorate's February 2024 Thematic Inspection Report: An Evaluation of the Provision of Psychiatric Care in the Irish Prison System, the OIP concluded that the legitimate treatment needs of mentally ill prisoners are not currently being met, and their safety and dignity are not being respected. It remains unacceptable that prisoner-patients such as Mr. O, suspected of minor offences, and suffering from a mental health disorder, cannot more rapidly access in-patient psychiatric treatment in local civil psychiatric hospitals. In this case, due to the commendable efforts of Mr. O's legal representative, the PICLS team, the staff of the D2 landing and the prison's health care team, Mr. O's mental health care needs had been clearly identified, and the Court had agreed to his transfer to a local civil psychiatric hospital. Nonetheless, Mr. O died in prison before his legitimate mental health treatment needs could be met. This only serves to underscore the urgent need to forge new system wide clinical care pathways, including rapid transfer to local civil psychiatric hospitals, for prisoner-patients such as Mr. O.

The Inspectorate has made five recommendations:

1. The Inspectorate reiterates the recommendation in its thematic report that urgent consideration be given to the systemic changes that are required to facilitate the swift transfer of persons suspected or convicted or minor offences, who have mental disorders, to local psychiatric hospitals. As this is likely to require the development and opening of appropriately secure, intensive care facilities/designated beds in civil psychiatric hospitals, this calls for a multi-agency approach.

2. It is imperative that the falsification of records is treated with the utmost seriousness. IPS management and oversight bodies should be in a position to rely on the veracity of official records. This is not the first occasion on which the Inspectorate has raised serious concerns regarding the standard of record keeping in prisons and highlighted the seriousness of prison staff falsifying official records. To ensure the integrity of the system, the Inspectorate recommends that IPS management take immediate and comprehensive steps to ensure accurate records are maintained. Similar recommendations have been made in the Inspectorate's reports on the deaths in custody of Mr. H 2014 and Mr. D 2019.

3. There is no systematic justification or rationale for the routine placement in refractory clothing of prisoners accommodated in a CSC cell. The Inspectorate recommends that this practice be brought to an immediate end. This Inspectorate recommendation is fully consistent with the views of the European Committee for the Prevention of Torture (CPT) on this subject.

4. In order to enhance the effectiveness of health care monitoring, the Inspectorate recommends that the IPS explore the potential of employing remote monitoring of vital signs technology in prisons in Ireland. This recommendation was previously made and accepted in the report of Mr. K 2024, published in July 2024. The Director General committed to the establishment of a sub-group to examine this technology. The OIP is looking forward to receiving the findings of the sub-group.

5. Mr. O was not permitted to board a flight at Dublin Airport and was subsequently arrested at the airport by the Gardaí. This would suggest that he may have arrived at the airport with a valid form of identification. However, when committed to Cloverhill Prison Mr. O had no identification or personal belongings. The only identification on committal was a name on the warrant. The

Inspectorate recommends that a Person Escort Record should be introduced and completed for every movement of a prisoner into or out of a prison whether by IPS staff or Gardaí. This should include details of risks of self-harm and vulnerability in addition to security considerations and include any comments or threats made by a detained person. A similar recommendation was made in Ms. X 2019, published in November 2022. The Director General stated that "*an information sharing group was established to look at information sharing between various Justice Bodies, they have begun the process of looking at the sharing of risk relevant information…*". The IPS provided a quarter two 2024 update that "*The Irish Prison Service has been engaging with An Garda Síochána with regard to the exchange of information …* ". It is very disappointing that two years following a commitment by the IPS that an agreement in relation to the sharing of information, which can be critical to the preservation of life, has yet to be reached.

13. Support Organisations

13.1 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.