Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. L
Limerick Prison
15 November 2020
Age 32

Submitted to Minister: 8 July 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
CCTV	Closed Circuit Television
CNO	Chief Nurse Officer
CPR	Cardiopulmonary resuscitation
CSC	Close Supervision Cell
CTR	Compassionate Temporary Release
DiC	Death in Custody
IPS	Irish Prison Service
ISM	Integrated Sentence Management
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
PHMS	Prisoner Healthcare Management System
PO	Prison Officer
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 for 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. L's death in prison on 15 November 2020 and management of the events associated to his death.

4. Administration of Investigation

4.1 The OIP was notified of Mr. L's death on 15 November 2020 by the Governor of Limerick Prison. The investigation team attended the prison and met with senior management who provided an overview of Mr. L's time in custody. The investigation team also met with prisoners who had contact with Mr. L during his 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 deceased's family is a very important aspect of the Inspectorate of Prisons' role when investigating a death in custody.

5.2 An in-person meeting with Mr. L's NoK, his father, was delayed due to COVID-19 restrictions in place at the time. However, the role of the OIP was explained to the NoK over the phone. An in-person meeting took place on 23 August 2021. The investigation team was informed that Mr. L was a boxing enthusiast in his early teens and had taken part in several amateur competitions. The team was also informed that Mr. L had a recent history of illicit drug use.

5.3 On 21 May 2021, the OIP received a letter from a solicitor, acting on behalf of Mr. L's father, raising concerns. These and other concerns raised by the family are outlined in section 7.

5.4 Mr. L's father informed the investigation team that he spoke to his son on 10 November 2020 while he was on Compassionate Temporary Release (CTR). Mr. L told his father that he was being put under pressure to bring drugs back into prison and that he had concerns about returning to prison following his period of CTR. Mr. L's father stated that he advised his son to have no involvement with drugs. Mr. L is said to have responded that he was determined to turn his life around.

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

5.6 The OIP is grateful to Mr. L's family for their contributions to this investigation and we offer our sincere condolences for their loss.

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 Clare, Limerick and Tipperary and for females from all six Munster counties. At the time of Mr L's passing, Limerick Prison had an operational capacity of 210 beds for men and the male prison was operating at 98% capacity.

6.2 Mr. L was the second death of a prisoner in the custody of Limerick Prison in 2020, and the twelfth death in IPS custody that year.

7. Family Concerns and Questions

7.1 The family considered that some men were being pressurised to breach bail or TR conditions and to secrete contraband in order to convey drugs into the prison. They requested that the OIP highlight the dangers associated with the secretion of contraband.

Mr. L's father informed the investigation team that, following the death of his son, he had been told that Mr. L had been in possession of drugs when he returned to prison. His father asked the following questions:

1. Did Limerick Prison management have any suspicion that Mr. L had drugs concealed when he returned to prison?

   OIP Response: Prison personnel suspected that Mr. L may have had drugs concealed but he denied this to both operational and healthcare staff. See sections 11 and 12 of this report.

2. Why does the IPS not have a body scanner to detect drugs?

   OIP Response: The IPS is currently carrying out research on the use of a body imaging device for the purpose of detecting concealed contraband.

3. We want to know the sequence of events leading to [Mr. L's] passing.

   OIP Response: This report provides the sequence of events.

4. When there is a suspicion that a prisoner may have drugs concealed on their person why are they not removed to hospital as a precaution?

   OIP Response: Mr. L was reviewed daily by healthcare personnel and his temperature was checked. The clinical records examined suggest that his vital signs were normal. Mr. L continuously denied to staff that he had drugs concealed. Nevertheless, the Inspectorate has made a number of recommendations in this report, including that all decisions regarding the supervision and care of a prisoner suspected of concealing drugs internally should be the responsibility of health care professionals and include a recorded risk assessment.

5. Why was Mr. L and others who are involved in drugs not given more support while in prison custody?

OIP Response: Mr. L on 11 May 2020 requested to be "*put back*" on the addiction counselling waiting list. When the Prison Addiction Counsellor A called to see Mr. L on 21 May 2020 he declined to engage. A further entry on the clinical record dated 23 July 2020 related to a discussion between Nurse A and Addiction Counsellor A which recorded that Mr. L "*had declined on numerous occasions*" to engage with the addiction service.

8. Background

8.1 On 19 February 2020, Mr. L was committed on remand to Limerick Prison and placed in cell 2 on D2 Division. Mr. L was 32 years old when he died in Limerick Prison on 15 November 2020.

8.2 On 15 October 2020, Mr. L was sentenced to two years and six months with 12 months suspended. Mr L's release date with remission would have been 3 April 2021.

8.3 Mr. L's infant son passed away while he was in custody. Mr. L was granted CTR from 9 November 2020 to 11 November 2020 to allow him attend the funeral.

8.4 Mr. L returned to Limerick Prison on the afternoon of 11 November 2020 as per a condition of his CTR (further details in section 9) and was accommodated in cell 1 on D2 Division. This cell was furnished and equipped as a Safety Observation Cell (SOC) (see further, section 10 of this report).[1]

8.5 The cause of his death is a matter for the Coroner.

9. Compassionate Temporary Release

9.1 On 8 November 2020, a prison chaplain informed Mr. L of the death of his infant son.

9.2 On 9 November 2020, the prison received a letter from Mr. L's solicitor requesting that Mr. L be approved for CTR. Governor A submitted an application to Operations Directorate, IPS HQ, recommending that Mr. L be approved CTR. Official A at IPS HQ approved CTR with effect from 9 November 2020. Mr. L was required to comply with the following conditions while on CTR:

- *Be of Good Behaviour*
- *Do not convey messages in/out of Prison*
- *Keep the Peace*
- *Shall be of sober habits*
- *Shall not enter a pub, club or other licensed premises or off-license premises*
- *Shall reside at the home of his father*
- *Agree not to change address without another CTR form*

[1] A SOC is used to accommodate prisoners who need additional observation due to safety or medical reasons. Placement in a SOC should be accompanied by 15-minute checks by prison officers and every hour by a member of the healthcare staff. A CSC is used to accommodate prisoners who are vulnerable or are disruptive and need to be separated from other prisoners to maintain a safe and secure environment.

- *Must return to Limerick Prison by 16:00 on Wednesday 11 November 2020*

9.3 Mr. L's CTR commenced at 15:29 on 9 November 2020. The investigation team was informed by the family that Mr. L did not stay with his father while on CTR but remained at his partner's home where his son was being waked.

10. Return to Prison on 11 November 2020

10.1 Officer A reported that Mr. L returned to Limerick Prison at 16:30 on 11 November 2020. Mr. L was placed in isolation in cell 2 on D1 Division "*on suspicion of having contraband concealed on his person".* As already mentioned, this cell is furnished and equipped as a Safety Observation Cell (SOC). According to Officer A, Mr. L went to sleep almost immediately. Officer A stated that he entered the cell of Mr. L on two occasions to check on him. During the first check, Mr. L informed Officer A that he had not slept in four days due to the death of his baby. Later Officer A accompanied by Nurse B checked on Mr. L and reported that his speech was "*slurred and* [he] *appeared to be under the influence of something*".

10.2 ACO A reported that Mr. L was placed in a "*special observation cell"*. Chief Officer A reported that Mr. L was placed in *"a SOC"* on D1 following his return from CTR as it was "*standard practice and acts as a deterrent*" to those who avail of temporary release "*from being put under pressure to bring in contraband.*"

10.3 However, the Prisoner Healthcare Management System (PHMS) recorded that Mr. L was accommodated in a *"CSC"* (Close Supervision Cell). The lawful basis for the placement of a person in a SOC differs from that for placement in a CSC.

10.4 SOCs are certified under Rule 18 of the Prison Rules 2007-2020 and should only to be used when a prisoner poses an immediate threat of serious harm to self and/or others. A prisoner's time in a SOC should be subject to health care supervision.

10.5 A CSC may only be used when alternative and less restrictive methods of control are considered by the Governor as inadequate and used for the shortest period possible and in circumstances which include the:

(i) Protection of the prisoner or others,
(ii) Preservation of good order and /or
(iii) Reasons of security and safety.

10.6 Rule 63 of the Irish Prison Rules 2007-2020 requires the prison doctor to examine a person placed in a SOC as soon as practicable after s/he has been accommodated in the cell. The Rule states that the person placed in a SOC shall not remain there for more than 24 hours "*but the Governor may, having consulted the prison doctor and considered all other matters, if exceptional circumstances exist that would warrant the extension of the period, direct that the period be extended for not more than four further periods none of which shall exceed 24 hours*". When a person is placed in a SOC, "*the Governor may require a prisoner's clothing, including underwear, to be removed ….. where he or she considers that items or parts of the prisoner's clothing may be used by the prisoner to harm himself* …."

The investigation team examined the prison records and there was no evidence that:

- healthcare personnel were consulted in relation to the placement of Mr. L in a SOC;
- the Governor sought the Director General's approval to extend Mr. L's time in the SOC;
- or that the Director General authorised the extension of time in the SOC.

10.7 Records received by the investigation team confirmed that Mr. L was wearing refractory clothing (a tear-proof poncho style garment).

10.8 Copies of the journal relating to Mr. L's time in cell 2 on D1 confirmed that he was checked by prison staff every 15 minutes. The extracts provided to the investigation team were from a "*Special Supervision Book*" which recorded that Mr. L had been placed on a restricted regime on "*suspicion of contraband*" but it does not specify that he had been placed in this SOC cell under Rule 18 of the Prison Rules.

10.9 The IPS developed algorithms in response to the Covid-19 pandemic having regard to the public health advice in place at the time. The algorithm in place in November 2020 required committals to be isolated "*in a designated isolation cell*" under Rule 103 of the Prison Rules. The Covid-19 infection control measures as determined by the IPS under Rule 103 included:

> a) Quarantine of all new prisoners (testing of all new committals to the prisons was in place, which allowed for prisoners to exit quarantine and enter the general population "*if asymptomatic (after 6 swab only)"*) and
>
> b) Isolation of a suspected case or a prisoner with symptoms to prevent the risk of transmission of infection.

10.10 In Limerick Prison, all committals were initially accommodated on D1 Division where daily COVID-19 checks were conducted in accordance with the algorithm in place at the time.

10.11 To sum up, it appears to the Inspectorate that Mr. L was placed on the D1 Division in furtherance of the applicable IPS policy on quarantine of new committals. However, his placement in SOC cell 2 on that landing appears to have been made on suspicion that he might have been concealing contraband, but without applying the formal safeguards that should accompany a healthcare placement in a Safety Observation Cell.

10.12 The investigation team also received a record of telephone calls made by Mr. L to his family and his partner up to 9 November 2020. No calls were made by Mr. L following his return to prison from his period of CTR and there was no evidence that Mr. L had access to a telephone following his return from CTR.

11. Engagement with Healthcare

11.1 On 8 November 2020 at 16:11, Nurse B recorded on the PHMS that they had been asked by an ACO to review Mr. L as he had just been informed of the death of his child. Nurse B recorded that Mr. L was "*understandably upset*" but presented as "*rational during the review*". Mr. L was placed on the list to see the prison doctor the following day and was reviewed again by the night Nurse C.

11.2 On 11 November 2020 at 18:52, Nurse B recorded that the surgery had not been informed by operational staff that Mr. L had returned from CTR. Nurse B stated that they only became aware

of Mr. L's return to prison when they visited D1 landing in the course of their duties. Nurse B recorded that Mr. L had been placed in a CSC "*due to the possibility of concealing drugs*". Mr. L denied concealing drugs and refused to provide a urine sample to the nurse. Nurse B noted on the PHMS that Mr. L was "*advised of the risk of concealing drugs.*" Officer A, who accompanied Nurse B entering Mr. L's cell reported that Mr. L's "*speech was slurred and appeared to be under the influence of something*". Nurse D attended Mr. L's cell on commencement of night duty on 11 November 2020 and documented that Mr. L did not want to hold a conversation.

11.3 Prior to Nurse D going off duty on 12 November 2020, she noted on the PHMS at 07:04 that Mr. L was asleep when checked. The Prison Officer had informed Nurse D that Mr. L was awake during the night and told them that he was "*hoping to be allowed back to own cell on compassionate grounds".* At 11:37, Chief Nurse Officer A screened Mr. L for Covid-19, recording a normal temperature and noted that he was "*very anxious to return to landing*". Officer A corroborated this account, reporting that Mr. L was extremely anxious as to when he could return to the landing. Nurse B reviewed Mr. L in the early afternoon of 12 November 2020. Mr. L refused to provide a urine sample and again denied he had concealed drugs. During night rounds Nurse D checked on Mr. L, who was found to be awake, but did not engage in conversation.

11.4 On 13 November 2020 at 09:24, Doctor 1 recorded on the PHMS that they had reviewed Mr. L and recorded that he looked "*unsteady and drowsy*". CNO A also reviewed Mr. L on the morning of 13 November 2020, recording on the PHMS at 10:11 that she found him to be alert and orientated, noting that Mr. L had requested to return to A Division. Mr. L had a urine sample ready for collection, when tested it yielded negative results for substances screened. CNO A recorded that there was still "*concern that he may have concealed substances*" but he continued to deny concealing contraband. Doctor 1 asked the CNO to arrange for a supervised urine sample to be obtained from Mr. L.

11.5 Mr. L provided a supervised urine sample at approximately 12:00 on 13 November 2020 to Nurse C. Nurse C reported that Mr. L was "*alert and coherent while conversing although appeared drowsy."* At 14:38, Nurse C recorded that Mr. L's day two Covid-19 temperature was within the normal range and also noted that Mr. L denied having Covid-19 symptoms. Mr. L again asked the nurse if he could return to the landing. The nurse noted on PHMS that Mr. L's urine sample indicated it was "*positive for benzo's [benzodiazepines] & cocaine".*

11.6 At 18:30, Nurse C reviewed Mr. L. officers informed Nurse C that Mr. L had been sleeping throughout the day. Mr. L again provided a supervised urine sample and admitted to taking tablets on return to Limerick Prison. Mr. L stated that he took a *"line of cocaine*" while on CTR "*but denied concealing contraband on the person".*

11.7 On 14 November 2020, Nurse E conducted a day three COVID-19 check on Mr. L. Nurse E recorded that there were "*no red flags*" and that Mr. L was *"lucid, orientated and eating/drinking well*". Doctor A attended Mr. L's cell and recorded testing him for Covid 19. Nurse B attended in the company of Dr. A and recorded that Mr. L declined medical review but again requested to return to the landing. Nurse B recorded that that Mr. L was *"requesting to leave CSC in the morning"* and *"advised he will have to be cleared by IPS staff"*. This suggests that Nurse B was under the impression that Mr. L was being held in isolation for security reasons (in a CSC) rather than because of medical need (in a SOC).

11.8 In its report on its 2019 periodic visit to Ireland, the Council of Europe's European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) noted that:

"The CPT's delegation again found that there was a lot of confusion among prison staff and management about the specific purpose of a CSC and of a SOC. Consequently, it appeared that a CSC and a SOC were at times used interchangeably."[2]

The Committee expressed the view that:

"the most effective approach would be to do away with the differentiation between a CSC and a SOC and instead focus on the reasons for the placement of a prisoner in one of these cells. […] If a CSC and a SOC were considered as inter-changeable, this would allow for the policies governing the use of these cells to focus on the reasons for the placement. That is, if a prisoner is placed in one of these cells as a security measure, it is for the Governor and senior prison officers to manage the placement; whereas, if the placement is as a medical measure, it is for the health care staff to manage the placement. A single policy regulating the use of these cells (CSC and SOC) would be more effective and efficient."[3]

The Inspectorate understands that similar concerns were expressed by the CPT following its most recent periodic visit to Ireland, from 21 to 31 May 2024.

12. Events of 13 to 15 November 2020

12.1 Officer B was on duty on D1 on 13 November 2020 and reported that on occasions Mr. L seemed "*unsure of location and incoherent*" and he slept a lot of the day. Officer B stated that Mr. L *"seemed quite normal"* and was "*seen by the doctor and medics throughout his tour of duty*" on 14 November 2020.

12.2 On 14 November 2020, Assistant Governor A asked Mr. L if he had possession of any drugs. Mr. L denied having possession of drugs. This exchange between Assistant Governor and Mr. L was confirmed by Chief Officer A and Officer A. Later that evening, when Officer C unlocked Mr. L to allow him to clean his cell, Officer A described Mr. L as disorientated and incoherent.

12.3 Officer D master locked the cells for the night at 19:03. The first check on Mr. L's cell following the lock back for the night was conducted by Officer E at 19:40. A further twelve checks were conducted up until 22:50.

12.4 The investigation team reviewed CCTV footage from 00:14 to 02:56 on 15 November 2020, during which time a total of 12 checks were conducted by officers. Regular 15 minute checks continued from 02:56 to 04:16 in line with IPS policy in place at the time. Officer F checked Mr. L at 02:15 and 02:30 on 15 November 2020 and reported seeing nothing to cause him concern. Officer G conducted cell checks on D1 landing at 03:15, 03:30 and 03:45 and reported that Mr.

[2] CPT/Inf (2020) 37, paragraph 60.
[3] CPT/Inf (2020) 37, paragraph 61.

L "*appeared to be sleeping in a semi-upright positon"* during these checks. At 03:58 and 04:16 on 15 November 2020 Officer E reported observing Mr. L sleeping in a semi upright position in his bed.

13. Discovery on 15 November 2020

13.1 At 04:25 on 15 November 2020, Officer E informed ACO B that Mr. L looked unwell. According to Officer E, Mr. L had been in a semi upright position in his bed since he took up duty at 19:15 on 14 November 2020 but on his 04:24 check Mr. L "*appeared to be slightly slumped to one side."* ACO B reported trying to rouse Mr. L by knocking on the cell door and calling his name but no response was forthcoming. ACO B went to the main gate to obtain the master keys to unlock the cell.

13.2 Officer H reported entering the cell with ACO B and Officer E and stated that Mr. L "*was seated semi-upright with his head leaned to one side and some liquid coming from his mouth, he was unresponsive when we tried to wake him*". Mr. L was removed from the bed and placed in the recovery position on the floor. The ACO directed Officer E to contact Nurse B. Officer I who was in charge of the Control Room rang for an ambulance.

13.3 Nurse B reported receiving an emergency a call at 04:30 requesting that she attend the D1 landing. Nurse B collected the emergency bag from the prison surgery and proceeded to the landing. On arrival, Nurse B assessed Mr. L and reported finding "*no sign of life, no pulse indicated, no response to light*". Nurse B commenced cardiopulmonary resuscitation (CPR) assisted by Officers E and H.

13.4 PHMS notes detailed that an Automatic External Defibrillator (AED) was placed on Mr. L throughout CPR attempts. On all occasions it displayed *"no shock advised message*". A "no shock message" can mean one of three things: the person does have a pulse, the person has regained a pulse, or the person is pulseless but is not in a "*shockable*" rhythm.

13.5 CPR continued until the National Ambulance Service paramedics arrived at 05:00 and took over from Nurse B. All treatment ceased at 05:18 and the cell was locked. Chaplain A and Chaplain B prayed for Mr. L at the cell door. Members of An Garda Síochána arrived at 07:25. The Doctor pronounced Mr. L's time of death at 08:25.

14. Critical Incident Review Meeting

14.1 A critical incident review meeting[4] took place on 18 November 2020. In attendance were Governor A, Chief Officer B, Chief Officer A and CNO A. The note of the meeting recorded that Mr. L was accommodated in a SOC and subject to 15 minute monitoring following his return from CTR on 11 November 2020.

14.2 Governor A reported that he had received an update that the early indication was that Mr. L did in fact have drugs concealed on his person.

[4] A staff meeting held following the death of a prisoner.

14.3 The CNO stated that Mr. L repeatedly denied he had drugs in his possession. Governor A told the meeting that Mr. L had slept all night until he was found in an unnatural position, at which point staff raised the alarm.

14.4 The CNO informed the meeting that CPR commenced at 04:30 on 15 November 2020 and an AED was attached to Mr. L but no shockable rhythm was found.

14.5 Governor A reported that arrangements were made for Mr. L's father to collect his son's personal belongings. Chief Officer C and Chaplain B to meet him on arrival.

14.6 There were no recommendations recorded.

15. Engagement with Limerick Prison Personnel

15.1 The investigation team met with senior management in Limerick Prison on 10 and 11 March 2022.

15.2 Prison management advised the investigation team that they were concerned that Mr. L may have concealed contraband internally on his return to prison. The investigation team was informed that persons returning from temporary release and new committals suspected of concealing contraband are routinely placed in either a CSC or SOC, depending on cell availability. However, there was no written procedure to support this practice.

15.3 Concerns were expressed to the investigation team by both healthcare personnel and prison management that there appeared to be an increase in the number of persons entering prison with contraband concealed internally.

15.4 More generally, this case highlights the difficulties experienced by the IPS in effectively monitoring people living in prisons who may have been internally secreting drugs. Visual observation by prison staff from outside cells is not always sufficient to detect a risk to life. The following recommendations emphasise the vital role that should be played by health care staff in such monitoring, including at night. Consideration should also be given to the potential of remote monitoring of vital signs technology to assist them in that task.

16. Recommendations

16.1 The OIP has made seven recommendations:

1. In cases where it is suspected that a prisoner may be concealing drugs internally (for example, if they continue to display signs of intoxication but no drugs have been found during a thorough cell search), health care professionals should take the lead in decision making regarding the supervision and care of that person. All such decisions should include a recorded risk assessment. A similar recommendation was made in the Inspectorate's report on the death in custody of Mr. I 2020 and accepted by the IPS.

2. If it is deemed necessary to isolate a person from the general prison population, because of a suspicion that that they have internally concealed drugs or other items of contraband, they should be subject to health care, not security observation – including at night – irrespective of whether they are held in a Special Observation Cell (SOC), Close Supervision Cell (CSC) or separation cell. In this regard, the Inspectorate endorses the view of the Council of Europe's European Committee for the Prevention of Torture (CPT) that the most effective approach would be to do away with the current differentiation between a CSC and a SOC and instead focus on the reasons for the placement of a prisoner in one of these cells[5]. This recommendation was made in the Mr. I 2020 report and was partly accepted by the IPS.

3. There is no systematic justification or rationale for the routine placement of prisoners in refractory clothing, irrespective of whether they are accommodated in a SOC or a CSC cell. Such a measure could only be justified if a prisoner placed in a SOC is considered to be at risk of suicide, and it should not applied if a prisoner is placed in a CSC for security reasons. The Inspectorate recommends that this practice be brought to an immediate end. This Inspectorate recommendation is fully consistent with the views of the Council of Europe's European Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT) on this subject.

4. In order to enhance the effectiveness of the healthcare monitoring of such persons, the Inspectorate recommends that the IPS explore the potential of employing remote monitoring of vital signs technology in prisons in Ireland. This recommendation was made in the Mr. I 2020 report and was accepted by the IPS.

5. The Irish Prison Service should introduce a healthcare focused policy to respond to the threats and safety risks posed by the internal concealment of drugs and other items of contraband. This policy should clarify the roles and responsibilities of management, prison officers, and healthcare staff. This new policy should provide for a central role for healthcare professionals in decision making regarding the supervision and care of a person where there is a suspicion of internal concealment of drugs and other items of contraband. All such decisions should include a recorded risk assessment[6]. This recommendation was made in the Mr. I 2020 report and was accepted by the IPS.

6. The Irish Prison Service should intensify its efforts to physically prevent contraband from entering prisons and to detect its presence once on the premises, including through technological means[7]. This recommendation was made in the Mr. I 2020 report and was accepted by the IPS.

7. The Irish Prison Service should engage with other relevant stakeholders to develop a multi-agency strategy to counter contraband entering a prison. This strategy should examine the use

[5] See document CPT/Inf (2020) 37, at paragraph 61 - https://www.coe.int/en/web/cpt/-/council-of-europe-anti-torture-committee-publishes-7th-periodic-visit-report-on-ireland

[6] It should be noted that this recommendation has already been accepted by the Irish Prison Service in response to the recommendation made by the Inspectorate in its report on the death in custody of Mr C 2021. Consequently, the Inspectorate requests that the Irish Prison Service provide an update on the implementation in practice of this recommendation in its Action Plan in response to this report.

[7] [7] It should be noted that this recommendation has already been accepted by the Irish Prison Service in response to the recommendation made by the Inspectorate in its reports on the deaths in custody of Mr C 2021 and Mr E 2021. Consequently, the Inspectorate requests that the Irish Prison Service provide an update on the implementation in practice of this recommendation in its Action Plan in response to this report.

of technology, architectural disruptions, as well as how to prevent exploitation and coercion being used as a means to traffic drugs and other contraband into a prison[8]. This recommendation was also made in the Mr. I 2020 report and was accepted by the IPS.

17. Support Organisations

17.1 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

[8] It should be noted that this recommendation has already been accepted by the Irish Prison Service in response to the recommendation made by the Inspectorate in its reports on the deaths in custody of Mr C 2021 and Mr E 2021. Consequently, the Inspectorate requests that the Irish Prison Service provide an update on the implementation in practice of this recommendation in its Action Plan in response to this report.