Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. C
Limerick Prison
12 January 2023

Aged 23

To the Minister: 18 July 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
AED	Automated External Defibrillator
AGS	An Garda Síochána
CCTV	Closed Circuit Television
CIRM	Critical Incident Review Meeting
CPR	Cardiopulmonary Resuscitation
CSC	Close Supervision Cell
DiC	Death in Custody
EAP	Employee Assistance Programme
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
OSG	Operational Support Group
PHMS	Prisoner Healthcare Management System
PIMS	Prisoner Information Management System
SOC	Special 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 and phone calls.

3.2 This report is structured to detail the events leading up to Mr. C's death in prison on 12 January 2023 and management of the events associated to his death.

4. Administration of Investigation

4.1 On 12 January 2023, the OIP was notified that Mr. C had passed away in Limerick Prison. The investigation team attended the prison on 12 January 2023 and met prison management, who provided an overview of Mr. C's time in prison. Inspectors also met with persons who had contact with Mr. C 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 The OIP made initial contact with Mr. C's NoK, his mother, by letter on 8 February 2023. The investigation team subsequently met with Mr. C's sister, Mr. C's partner and the family solicitor on 21 February 2023.

5.3 The family asked a number of questions, which are outlined in section 13 of this report.

5.4 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. C's family in mind.

5.5 The OIP is grateful to Mr. C's family for their contributions to this investigation. The investigation team has been informed that Mr. C's mother has since passed. The Inspectorate offers its sincere condolences to the family for their loss.

6. Limerick Prison

6.1 Limerick Prison is a closed, medium security prison for men and women. It is the committal prison for men for counties Clare, Limerick and Tipperary and for women for all six Munster counties. At the time of Mr. C's passing, it had an operational capacity of 210 beds for men and 28 for women. On 12 January 2023 there were 232 men and 42 women in custody, representing an overcapacity of 110% and 150% respectively.

6.2 At the time of his passing, Mr. C's death was the first of a prisoner from Limerick Prison in 2023; and the third death in IPS custody at that point in the year.

7. Background

7.1 Mr. C was 23 years old when he was committed to Limerick Prison on 9 January 2023. He had been sentenced to five years imprisonment with the final year suspended by Ennis Circuit Court. With remission, he was due for release on 17 December 2025. His father, Prisoner 1, was co-accused along with two other relatives, all of whom were committed to Limerick Prison.

7.2 On committal, Mr. C initially shared Cell 4 on D2 landing with a relative, Prisoner 2. As a new committal, Mr. C was placed on the standard level of the Incentivised Regime.[1]

7.3 On the morning of 10 January 2023, Officer A accompanied the Governor who met Mr. C as a new committal, which is normal practice in all prisons. There was nothing of concern noted by the Governor and Mr. C was approved to be relocated to C2 landing later that morning, where he could mix with others on that landing.

7.4 Officer A reported that when he went to Mr. C's cell to inform him that he was to be relocated to C2 landing he got "*a strong smell of weed coming from the cell*".

7.5 Mr. C and his cellmate, Prisoner 2 were relocated to the Reception area to be searched. Officer A reported finding a quantity of "*what appeared to be drugs concealed"* in the possession of Mr. C. Officer A reported the contraband find to ACO A and to the Operational Support Group[2] (OSG).

7.6 On suspicion of having contraband concealed on his person, Mr. C was placed in a Close Supervision Cell[3] (CSC), Cell 1 on the D1 landing, at 11:24 on 10 January 2023. Persons accommodated in a CSC are subject to special observation at 15 minute intervals.

7.7 Officers A, B and C conducted a search of Cell 4 on D2 landing and reported finding a cigarette lighter but no contraband.

[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

[2] The Operational Support Group (OSG) was established by the Irish Prison Service in 2008 to support prison Governors in preventing contraband entering prisons.

[3] See paragraph 8.1 of this report.

7.8 On 12 January 2023, Mr. C was found unresponsive in the CSC at 06:15. Efforts to resuscitate him were unsuccessful.

8. Placement in Close Supervision Cell (CSC)

8.1 Mr. C was placed in a Close Supervision Cell (CSC) under Rule 63 of the Prison Rules 2007-2020. 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[4].

8.2 Chief A reported that Mr. C was placed in the CSC as he was found with prohibited articles on his person and it was suspected that "*he still more prohibitive* [sic] *articles secreted on his person*". The CCTV footage showed Mr. C enter this cell at 11:24 on 10 January 2023. Mr. C was issued with refractory clothing[5]. 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[6] (SOC) where the Governor considers that items of the prisoner's clothing may be used by the prisoner to harm himself. There is no specific provision in the Prison Rules covering the placement of a prisoner in refractory clothing in a CSC.

8.3 Mr. C was subject to 15 minute checks in the CSC. The Special Observation Log contains a preprinted 24 hour list of times – at 15 minute intervals - from 08:00 on one day to 07:45 the following day i.e. 8.00am, 8.15am, 8.30am, 8.45am and so on to 7.45am the following morning. These are the times when an officer is expected to check the person on special observation and the check is recorded by way of ticking a box and initialing the entry confirming that the check was conducted, indicating if the person was "Asleep, Awake, Agitated or Passive'. There is no flexibility to allow the officer enter the actual time they conducted the check, if it was less than or greater than a 15 minute interval.

8.4 In respect of Mr. C, each 15 minute time interval was ticked, recording that the checks were conducted at the specified time.

However, the CCTV footage showed that some checks had been conducted at intervals that far exceeded a 15 minute interval. For example:

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[4] Prison Rule 2007-2020. Rule 63(1) provides that "*A prisoner may, either at his or her own request or when the Governor considers it necessary, in so far as is practicable and subject to the maintenance of good order and safe and secure custody, be kept separate from other prisoners who are reasonably likely to cause significant harm to him or her".*

[5] Refractory clothing is anti-ligature clothing

[6] SOC cells are used for prisoners who require frequent observation for medical reasons or because they are a danger to themselves or others. A prisoner placed in a SOC by the Governor must be examined by the prison doctor as soon as practicable after he has been accommodated in the SOC. He would also be subject to 15 minute checks by operational staff and frequent observation by nursing staff and at least daily and as frequently as the doctor believes it necessary - Rule 64 of the Prison Rules 2007 – 2020.

1. 10 January – check at 12:31:26. - next check 28 minutes later.
2. 10 January - check at 18:29:28 - next check 23 minutes later.
3. 10 January - check at 20:41:27 - next check 22 minutes later.
4. 10 January - check at 21:21:03.- next check 27 minutes later.
5. 10 January - check at 21:48:29 - next check one hour and 10 minutes later.
6. 10 January - check at 22:58:37 - next check 27 minutes later.
7. 11 January – check at 03:46:33 - next check 27 minutes later.
8. 11 January – check at 05:50:00 - next check 27 minutes later.

Some other checks took place at less than 15 minute intervals. For example:

- 10 January – check at 13:54:26 – next check 6 minutes later, followed by another check four minutes later.
- 10 January – check at 15:21:49 – next check 7 minutes later.
- 10 January – between 18:15:17 and 19:00, 6 checks were conducted
- 11 January – check at 06:23:48 – next check 7 minutes later
- 11 January – check at 07:50:13 – next check 8 minutes later
- 11 January – check at 17:01:20 – next check 8 minutes later
- 11 January – check at 22:23:17 – next check 9 minutes later
- 12 January – check at 01:46:15 – next check 10 minutes later
- 12 January 2023 – check at 03:05:53 – next check 10 minutes later

8.5 Mr. C was found unresponsive at 06:15, but the special observation log recorded, with ticks and initials, that checks had been carried out at 06:30 and 06:45 on 12 January 2023. Mr. C was recorded as asleep at those times. These entries were patently false, and had been scribbled over by pen.

9. Disciplinary Report

9.1 On 10 January 2023, Officer A placed Mr. C on a P19[7] Disciplinary Report. Under the heading "*Misconduct Summary*", Officer A recorded the alleged breach of discipline as "*possession of drugs*" and the time of the alleged incident as 10:45 on 10 January 2023.

9.2 In submitting the P19 Disciplinary report to the Governor, Officer A reported that "*on the above date and above time I smelled what I believe to be weed coming from the cell of the above named prisoner."* Officer A reported that Mr. C and his cell mate were relocated to Reception where Mr. C was searched and "*two packages concealed in the prisoners …"* were found. Officer A reported that Officer D, Officer E and Officer F were also present at the time of the search.

9.3 The Daily Contraband Findings Report, forwarded on 10 January 2023 by OSG Officer A to Limerick Prison Management described the contraband found as "*7 grams of cannabis resin & 3 Tablets"*. OSG Governor A confirmed to the investigation team that An Garda Síochána (AGS) had taken possession of the contraband, but the IPS was not informed by AGS if the drugs were analysed or their classification.

[7] The P19 system refers to the disciplinary system in place under the Prison Act 2007. A breach of prison discipline generates a P19 report. If a prisoner is found guilty of a breach of prison discipline, Governors may impose sanctions, such as a loss of privileges, including phone calls.

9.4 On 11 January 2023, Assistant Governor A conducted the disciplinary hearing in the presence of Chief Officer B. At the hearing, Mr. C admitted that the prohibited articles found on his person the previous day were for his own use and he denied having more contraband. Assistant Governor A suspected that Mr. C was concealing more contraband and told him (Mr. C) that he would be remaining in the CSC for a further 24 hour period. The CCTV footage confirmed that Assistant Governor A entered the CSC at 09:53 accompanied by Chief Officer B.

9.5 On 12 January 2023, Assistant Governor A informed the investigation team that Mr. C had a history of "*bringing stuff in*" to the prison. He confirmed that no contraband had been found in the search of the cell which Mr. C occupied prior to being removed to Reception. Assistant Governor A stated that he had no concerns for Mr. C's wellbeing when he engaged with him during the disciplinary hearing, as Mr. C "*presented perfectly*", and that Mr. C had also been reviewed by the doctor.

10. Events of 11 and 12 January 2023

10.1 On 11 January 2023, the Night Guard, Officer G was observed on CCTV footage lifting the viewing flap of Mr. C's cell door at 19:39:37, using the in-cell wall light switch to turn on the light and briefly looking into Mr. C's cell before moving away from the cell door.

10.2 At 19:39:46, Officer G lifted the viewing flap on the cell door and activated the light. Officer G was observed on CCTV footage kicking the bottom of the cell door. At 19:40:22, Officer G departed from the cell door but returned six minutes later at 19:46:21. Officer G conducted another cell check using a torch to view the interior of the cell, before moving away.

10.3 At 19:46:45, Officer G returned to the cell door and again kicked the bottom of the cell door while looking through the viewing panel, leaving the cell door at 19:47:14 and returning to conduct the next check at 19:58:44.

10.4 Mr. C is recorded in the special observation log as being awake during all the checks conducted between 19:00 and 20:00 on 11 January 2023 and asleep from 20:15 to the time he was found unresponsive.

10.5 Officer G reported that, at 06:15 on 12 January 2023, while conducting a cell check, she observed Mr. C lying in bed and she "*wasn't happy*" with how he looked and contacted ACO B, who was in charge of the prison on the night. ACO B who was in charge of the prison held the master key.[8] He stated that, on arrival at Mr. C's cell, he and Officer G entered it and, on finding Mr. C unresponsive, he contacted Nurse A over the Tetra Radio system,[9] requesting his attendance. This tallied with Nurse A's recollection of events. ACO B and Officer G both reported commencing CPR[10] while they waited for the nurse to arrive. ACO B also reported that he contacted the staff in the Control Room, directing them to telephone for an ambulance.

10.6 Nurse A stated that, on arrival to the cell at approximately 06:24, they found that Mr. C was *"not breathing and had no pulse"*. The Automated External Defibrillator (AED) was applied and Nurse

[8] All cells are double locked at night. The second lock is with the master key which is held by the officer in charge. A cell can only be opened at night with the master key.

[9] Tetra radio is the official secure radio communications network used by staff within the Irish Prison Service.

[10] Cardiopulmonary resuscitation (CPR) is an emergency treatment that is provided when someone's breathing or heartbeat has stopped. For example, when someone has a heart attack or nearly drowns. CPR can help save a life.

A reported that the AED advised "*no shockable rhythm*[11]" A "no shock" message from the AED may indicate that there is a pulse present, a pulse has been regained or the person is pulseless, but is not in a shockable rhythm. Nurse A took charge of CPR and was assisted in rotation by ACO B, Officer B, Officer H, Officer I and Officer J.

10.7 Nurse A recorded the arrival of the ambulance crew at approximately 06:45. An advanced paramedic and three other paramedics took over the care of Mr. C. Nurse A stated that CPR continued until 07:05, at which time the attending paramedics decided to cease CPR. This was corroborated by Chief Officer A. Nurse B recorded in the Prisoner Healthcare Management System (PHMS) that Mr. C was, "*Examined by* [Dr. A] *this a.m. at 0810 hrs in CSC on D1 and pronounced dead*".

10.8 At 07:40, members of An Garda Síochána (AGS) attended the prison and were escorted to Mr. C's cell by ACO B.

10.9 Assistant Governor A requested the local community Priest A to contact Mr. C's NoK, his Mother as the prison chaplain was not available. Priest A contacted Limerick Prison at 09:35 to confirm he had met with Mr. C's mother. At approximately 08:15, Assistant Governor A accompanied by Chief Officer A informed Mr. C's father Prisoner 1, who was in the custody of Limerick Prison, of his son's passing.

10.10 The investigation team was provided with the cell call record for the D1 CSC cell from 09:00 on 10 January 2023 to 23:59 on 12 January 2023, while Mr. C was in the cell. No cell call activations were recorded during that period.

10.11 Prisoner 3 was accommodated on D1 landing at the time of the incident. Prisoner 3 stated that on the night of 11 January 2023, Mr. C "*was screaming to himself, I think he thought he was talking to someone. I heard the officers checking him. That's all I heard".* Other prisoners on the landing had nothing to report.

10.12 The Chaplain supported Mr. C's father following the death of his son and other relatives who were in custody at the time. The chaplain arranged for the funeral mass to be streamed on the internet and Mr. C's father, two other relatives and a friend attended the streaming of the funeral.

11. Medical Care

11.1 A nursing committal interview was conducted by Nurse A on 9 January 2023 and no medical concerns were recorded.

11.2 On 9 January 2023, Nurse C documented on the PHMS that Mr. C did not have any Covid-19 symptoms, his antigen test was negative and a Covid booster was requested on his behalf.

11.3 On 10 January 2023, Nurse C recorded two further entries on the PHMS. The first entry referred to Mr. C's placement in a CSC "*placed in CSC ?? contraband"*. The second entry noted that Mr. C was *"seen in cell, appears alert and orientated, states he had "a bit of hash" denies any other drugs/contraband, nil slurring of speech, appears well".*

[11] An AED (automated external defibrillator) will advise no shockable rhythm when a normal sinus rhythm is present or there is pulseless electrical activity.

11.4 On 11 January 2023, Mr. C attended a committal interview with Doctor A. Doctor A recorded on the PHMS that Mr. C was "*seen in D1 with suspicion of contraband, denies same, offered help by referring to A&E but declined same*".

12. Critical Incident Review Meeting

12.1 On 16 January 2023, a Critical Incident Review Meeting[12] was chaired by Assistant Governor A. In attendance were Chief A, Nurse D, Nurse E, Chaplain A and Prison Clerical Officer A as minute taker.

12.2 Assistant Governor A informed those present that they were awaiting the results of the post mortem and that he had requested Chief Officer A to investigate the incident.

12.3 Assistant Governor A stated that a preliminary review of CCTV showed nothing "*untoward*".

12.4 Nurse D and Nurse E reported that the response from Healthcare team to Mr. C's medical emergency was rapid and comprehensive.

12.5 It was recorded that, due to the Chaplain being unavailable on 12 January 2023, the Prison requested the services of a community based priest, Priest A, to make contact with the NoK. Assistant Governor A requested the Chaplain to contact Mr. C's mother and to speak with his father who was in their custody.

12.6 Three recommendations were recorded at the conclusion of the critical incident review meeting, these were:

1. Assistant Governor A would request Psychology to make contact with Mr. C's relative, Prisoner 1 in the coming days.

2. To continue to offer all staff involved peer support and EAP (Employee Assistance Programme) through CISM[13] protocols.

3. *"Telephony enabled radio for Medic 1 to allow direct contact with Ambulance Dispatch".*

[12] Staff meeting held following the death of a prisoner.
[13] Critical Incident Stress Management – a mental health support system.

13. Family Questions

13.1 This section contains questions raised by Mr. C's family.

1. If the prison staff knew [Mr. C] had drugs in him, why wasn't he taken to the hospital to be x-rayed?

   OIP response: Doctor A reviewed Mr. C on 11 January 2023 as a new committal and during their engagement Mr. C denied concealing contraband. Doctor A offered to refer Mr. C to hospital but he declined (paragraph 11.4 refers)

2. What drugs was [Mr. C] found in possession with?

   OIP response: A white substance and tablets were found in the possession of Mr. C (see para 9.3).

3. How many times was [Mr. C] checked and were his 15 minute checks conducted?

   OIP response: This is addressed at paragraph 8.4 of this report.

4. How many times did [Mr. C] activate the cell call and was there anyone there to respond when he did?

   OIP Response: There were no cell call activations (paragraph 10.10 refers)

5. Did the Prison Doctor go to see [Mr. C] at any stage?

   OIP response: Doctor A reviewed [Mr. C] on 11 January 2023. See section 11 of this report.

6. Why didn't anyone from the prison come to see the family?

   OIP response: It is common practice for the chaplains, on behalf of the Governor, to contact the family of a person who dies in custody. When Mr. C passed, the Prison chaplain was unavailable and prison management asked the local Priest to call to the family home on their behalf.

7. Why was [Mr. C] in the padded cell from Monday to Thursday?

   OIP response: This is addressed at paragraph 7.6 and section 8 of this report.

8. Why was [Mr. C's] father not told that Mr. C had died?

   OIP response: Assistant Governor A told the investigation team that he and Chief A had informed Mr. C's father of his son's passing at 08:15 on 12 January 2023 (this is addressed in paragraph 10.9 of this report).

9. What time was [Mr. C] discovered unresponsive?

   OIP response: Mr. C was found unresponsive at 06:15 on 12 January 2023 (para 10.5 refers),

10. What time was the ambulance called?

    OIP response: Chief A reported that an ambulance was called at 06:20 (para 10.5 refers). Four paramedics were viewed on the CCTV footage entering the cell at 06:45.

14. Recommendations

14.1 The OIP makes the following eight recommendations:

1. 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[14]. This recommendation was also made in the OIP's report on the death in custody of Mr. I 2020 and partly accepted by the IPS.

2. 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 is brought to an end immediately. 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.

3. 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. Kicking the bottom of a cell door is not a reliable method to verify signs of life. This recommendation was also made in the OIP's report on the death in custody of Mr. I 2020 and accepted by the IPS.

4. 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[15]. This

[14] 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

[15] 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.

recommendation was made in OIP's report on the death in custody of Mr. I 2020 and accepted by the IPS.

5. From a preventive standpoint, it is crucially important that prison management and healthcare staff have rapid access to reliable information about the composition of any drugs found in a prison. Samples of drugs found in prisons should be swiftly analysed and the results communicated to prison management and healthcare staff in a timely manner. If the analysis is conducted by, or on behalf of, An Garda Síochána, clear channels of communication should be put in place to ensure that the results are quickly made known to prison management and healthcare staff.

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.[16] This recommendation was also made in the OIP's report on the death in custody of Mr. I 2020 and accepted by the IPS. The IPS advised that they had established a sub-group to examine remote monitoring of vital signs technology. The group has met with European colleagues and further discussions are planned.

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 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[17]. This recommendation was also made in the OIP's report on the death in custody of Mr. I 2020 and accepted by the IPS.

8. The Irish Prison Service should ensure that staff understand the importance of accurate records and the consequences of creating an inaccurate record/report of their duty. Regular audits should be carried out by line management to ensure compliance. Similar recommendations have been made in the past in OIP's reports on the deaths in custody of Messrs A 2012, H 2014, I 2018 and G 2021.

   As regards, more specifically, the recording of special observations of prisoners, the Inspectorate recommends that the relevant record books be amended to require prison officers to record the actual time at which they carry out each such observation.

[16] 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.

[17] 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.

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.