Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. E
Limerick Prison
8 February 2022
Aged 46

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
CNO	Chief Nurse Officer
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
CSC	Close Supervision Cell
IPS	Irish Prison Service
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
OSG	Operational Support Group
PHMS	Prison Healthcare Management System
PIMS	Prisoner Information Management System

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. E's death in prison on 8 February 2022 and management of the events associated to his death.

4. Administration of Investigation

4.1 On 8 February 2022, the OIP was notified that Mr. E had passed away in Limerick Prison. The investigation team attended the prison on the same day and met prison management who provided an overview of Mr. E's time in custody.

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 met with Mr. E's NoK, his mother, and his two sisters on 27 April 2022.

5.3 The family informed the investigation team that Mr. E had made a telephone call to his brother, at 18:00 on 7 February 2022, the evening before he passed away. Mr. E's brother recalled that Mr. E "*seemed to be all right*" during their conversation.

5.4 The family stated that they received a phone call at 08:00 on 8 February 2022 from Chaplain B to inform them of Mr. E's passing. Later that day, at 15:00, the same Chaplain attended the NoK's home.

5.5 Mr. E's mother and sisters raised a number of questions which are outlined in Section 7.

5.6 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. E's NoK in mind.

5.7 The OIP is grateful to Mr. E's mother and family for their contributions to this investigation.

6. Limerick Prison

6.1 Limerick Prison is a closed, medium security prison for adults. 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. E's passing, it had an operational capacity of 210 beds for men. On 8 February 2022, the prison accommodated 199 men and was operating at a capacity of 95%.

6.2 Mr. E was the first death of a prisoner from Limerick Prison in 2022; and the fifth death in IPS custody at that point in the year.

7. Family Concerns

7.1 This section contains the questions raised by Mr. E's NoK and the OIP's responses. A comprehensive account of the timeline and circumstances associated with Mr. E's passing is set out in the main body of this report and should be read together with the answers provided within this section.

7.2 What was the time between the last check on [Mr. E] and when he was found? What time was he found?

OIP Response: The CCTV footage of the prison landing confirmed that Mr. E's cell was checked by an Officer at 22:55:24 on 7 February 2022. Approximately one hour later, at 23.56:23, Mr. E was found unresponsive during another routine cell check conducted by the IPS.

7.3 Was Mr. E showing any signs that he may feel suicidal?

OIP Response: The OIP conducted a thorough investigation into the circumstances leading up to when Mr. E passed and there was no evidence to indicate that he was planning to harm himself.

7.4 Did something happen before [Mr. E] died?

OIP Response: This report provides details on the circumstances surrounding the passing of Mr. E. (See Section 10).

7.5 Why was [Mr. E] in isolation and was isolation the right place for him?

OIP Response: Mr E was placed in isolation as he was symptomatic for COVID-19 (this is covered in Section 10). In accordance with public health advice in place at that time, the Irish Prison Service had procedures in place to endeavour to prevent the spread of COVID-19 within the prison. The Irish Prion Service introduced an algorithm "*IPS Risk Assessment for People Presenting to and in Prisons - Clinical Criteria for Prisoner(s) to be Tested*" which outlined the criteria to be followed during COVID-19. Where a prisoner identified with COVID symptoms they were immediately placed in isolation and testing was arranged by the healthcare team who reviewed and took a swab sample from the isolated person on a daily basis.

7.6 Why didn't someone from the prison call to the house in person to tell the family of [Mr E's] passing rather than making at phone call at 08:00?

OIP Response: At approximately 07:25, on 8 February 2022, Assistant Governor A contacted Chaplain A and requested that arrangements be made to notify Mr. E's NoK of the tragic events. On his arrival to work, Chaplain B was notified by Chaplain A that Mr. E had passed away. Chaplain B immediately telephoned the NoK and later travelled almost 100km to meet the family in person at their home. The actions taken by the team in Limerick Prison, to notify Mr. E's Nok, followed official procedure as affirmed in the IPS protocol '*Chaplaincy and Next of Kin Notification*'. The protocol states that "*…. the chaplain will endeavour to make contact with the family by telephone.* "

8. Background

8.1 On 16 January 2022, Mr. E appeared before Clonmel District Court and was placed on remand in Limerick Prison. Two days later, on 18 January 2022, Mr. E again appeared before Clonmel District Court, via video link, and was again remanded into custody with a further Court appearance scheduled for 15 February 2022.

8.2 A Bail application was heard by video link on 27 January 2022 and Mr. E was granted bail, on his own bond of €500, with a lodgement of €300, but he did not take up bail.

8.3 On 3 February 2022, Mr. E was placed in precautionary isolation due to presenting with COVID-19 symptoms. Although his cell-mate did not present with any symptoms, due to living in close quarters with Mr. E, he too was placed in precautionary isolation.

8.4 Two negative COVID-19 swab test results were returned in respect of Mr. E but he was required to remain in isolation as he continued to present with 'flu like' symptoms. His cell mate Prisoner 1 who was also in isolation with Mr. E, was allowed to return to the general prison population on 5 February 2022, leaving Mr. E alone in the cell.

8.5 As mentioned previously in Section 5, Mr. E made a phone call, at 18:48 on 7 February 2022, and spoke with his brother for six minutes. During the conversation, Mr. E mentioned that he was still in a cell on his own, he was feeling weak, and had a sore throat and a headache. Mr. E also shared with his brother that he had no cigarettes and that he was feeling bored.

8.6 At the time of his passing, Mr. E was the sole occupant of a double cell, cell 10 on the C3 Landing. He was 46 years of age.

9. Events of 7 and 8 February 2022

9.1 On 7 February 2022, Officer A interacted with Mr. E during the course of the day, including at breakfast, dinner and before lockup reporting that on all occasions Mr. E, "*seemed to be in good spirits*". Nurse A confirmed that she interacted with Mr. E on 7 February 2022 during a COVID-19 review and found "*nothing remarkable apart from him feeling 'unwell' in relation to COVID symptoms*". Class Officer A reported that in his dealings with Mr. E on 7 February 2022 "*he seemed fine… and I had no cause for concern.*"

9.2 On the evening of 7 February 2022, Mr. E activated his cell call bell at 20:09. Nurse B stated that she arrived at the cell at 20:51 accompanied by Officer B and Officer C. The cell call record confirmed that the cell call was reset at 20:20:35 and Nurse B and the two officers were observed on CCTV footage attending Mr. E's cell at 20:21:07, thus earlier than Nurse B believed. Mr. E requested paracetamol for a "*self-reported headache"* and it was provided to him. Nurse B records evidence that Mr. E, "*was pleasant in manner to all staff present, no signs of distress noted or voiced*". Officer B and Officer C shared the same view, both confirming that there was nothing unusual about Mr. E's presentation or behavior at that time.

9.3 Officer B, who was the Night Guard, checked Mr. E's cell at 20:58:14, 21:52:21, and 22:55:21, with nothing of concern observed.

9.4 At 23:56:36 on 7 February 2022, during a routine cell check, Officer B lifted the flap over the viewing panel on Mr. E's cell door and used his torch to look into the cell. Officer B reported that when he looked into Mr. E's cell, he observed Mr. E with a ligature around his neck and he was hanging from the top bunkbed. Officer B stated that he called a "*code red*"[1] over his radio at "approximately *12am"*. CCTV footage confirms that Officer B used his radio to request assistance, within seconds of discovering Mr. E.

9.5 Officer C was the first to respond to the 'code red' alert and CCTV footage confirmed that he arrived at Mr. E's cell at 23:57:12. He looked into Mr. E's cell and then ran down the landing. Officer C confirmed that he departed almost immediately after arriving at Mr. E's cell in order to retrieve the Hoffman knife[2] to cut the ligature. CCTV footage confirmed that he returned shortly afterward, at 23:58:10, with an item in his hand. A number of officers were witnessed on CCTV at that time, 23:58:10, on the landing where Mr. E's cell was located.

9.6 Assistant Chief Officer (ACO) A unlocked Mr. E's cell at 23:58:20. At approximately 23:58, CCTV footage evidences that Nurse B ran down the landing with a red medical emergency bag in her possession, which she confirmed was a resus bag[3]. Nurse B stated that when she arrived on the landing she was informed how Mr. E had been found and she advised staff to contact emergency services. Officer D stated that she called 999 and requested an ambulance.

9.7 At 23:58:23, Nurse B entered Mr. E's cell along with ACO A and Officer B. Nurse B recorded that Officer E, Officer C and Officer F were also present. ACO A reported that he was assisted by Officer C, Officer E and Officer F in removing the ligature, made from a t-shirt, from Mr. E's neck and placing him on the cell floor.

[1] A 'code red' alerts others to an emergency situation that requires immediate assistance.
[2] A Hoffman Knife is a safety knife designed for cutting ligatures. In a prison it is kept in the Class Office which is at the end of each landing.
[3] A resus bag, also referred to as a resuscitation bag or a resuscitation kit, is equipment used to assist in the resuscitation of a patient.

9.8 Nurse B recorded that her initial assessment of Mr. E was that he was unresponsive to verbal and physical stimuli, there was no pulse present, no rise or fall noted to his chest, his pupils were fixed and dilated, cyanosis[4] was evident to his lips and skin, pooling of the skin noted to his legs and ankles and, whilst he was warm to touch around his chest area, his peripheries were cold to touch. Nurse B attached AED[5] pads to Mr. E and commenced Cardiopulmonary Resuscitations (CPR). Nurse B stated that she continued to give CPR to Mr. E in cycles and rotations, but she noted that there was "*no shockable rhythm detected*"[6]. Nurse B recorded in the Prison Healthcare Management System (PHMS) that ACO A and Officer F also assisted in CPR rotations where there was "*no shockable rhythm detected*". Officer C witnessed the attempts to revive Mr. E, stating that several attempts were made by the nurse and other officers but each attempt was unsuccessful.

9.9 Nurse B documented that the ambulance and paramedics arrived on the scene at 00:15. CCTV footage confirms that the first two paramedics arrived at Mr. E's cell at 00:15:46 followed by another team of two paramedics at 00:16. Nurse B's records state that the paramedics assessed Mr. E and determined that there were no signs of life. The paramedics pronounced Mr. E's death at 00:18. All four paramedics were observed, on CCTV footage, exiting Mr. E's cell at 00:23:53.

9.10 Officer D rang An Garda Síochána (AGS) at 00:33 on the instruction of ACO A. Garda A and Garda B entered Mr. E's cell at 02:05 accompanied by ACO A and Officer B who identified Mr. E's body to AGS. Funeral Directors entered Mr. E's cell at 02:25 and Mr. E's remains were removed to University Hospital Limerick shortly thereafter.

9.11 Assistant Governor A reported contacting Chaplain A at approximately 07:25 to inform her of the passing of Mr. E. Chaplain B was notified of the passing of Mr. E, by Chaplain A, when he arrived to work. Chaplain B contacted the NoK by telephone at 08:43. Chaplain B visited the family in their home at approximately 15:00 on 8 February 2022.

10. Medical Care

10.1 On 16 January 2022, Nurse C conducted a committal interview with Mr. E and recorded on the PHMS that Mr. E advised that he was receiving drug treatment in the community by way of a methadone prescription. It was also recorded that Mr. E disclosed that he had *"abused benzos*[7]**"**. Mr. E displayed no signs or symptoms of COVID-19 on committal.

10.2 During the committal interview, Nurse C recorded that she enquired about Mr. E's emotional well-being. Nurse C noted that Mr. E stated that he had no thoughts of suicide, he had not engaged in any deliberate self-harm and felt that life was worth living.

[4] Cyanosis is a blue or purplish discolouration, associated with a lack of oxygen.
[5] AED stands for an Automated External Defibrillator which is a portable device used to treat a person whose heart has stopped working. The pads are placed on the patient to allow an electrical shock to be delivered to their heart when it is not beating effectively.
[6] 'No shockable rhythm detected' refers to when the AED machine determines that delivering a shock would not be effective based on the current presentation of the heart.
[7] 'Benzos' is the colloquial name for a class of depressant drugs called Benzodiazepines.

10.3 On 17 January 2022, at 08:20, Nurse D recorded that Doctor A visited Mr. E whilst he was in a Close Supervision Cell[8] (CSC). The record, from the visit, stated that Mr E was *"lucid and coherent and nil complaints verbalised"*. The IPS Cell Occupancy report recorded Mr. E as an occupant of cell 12 on the D2 landing, which is not a CSC. The investigation team sought clarification from Limerick Prison management regarding the entry and were informed that Doctor A had erroneously recorded Mr. E as being in a CSC and he had never been accommodated in such a cell during his time in custody.

10.4 Also, on 17 January 2022, Nurse E confirmed that Mr. E had been prescribed 70mls of methadone daily, through his local pharmacy, in the community. On that same day, 17 January 2022, Nurse D, in the company of Nurse F, dispensed methadone, as prescribed, to Mr. E, which ensured that his drug treatment continued whilst he was in the care of the prison.

10.5 As was the case with any new committal in January 2022, Mr. E was closely monitored by prison medical staff for COVID-19, following his arrival at Limerick prison. Nurse D and Nurse C recorded on the PHMS that Mr. E had nil COVID-19 related issues and presented as asymptomatic on the 18, 19 and 20 January 2022. On 21 January 2022, Nurse D examined Mr. E and took a COVID-19 swab test. Nurse D noted that Mr. E was *"asymptomatic, no red flags"*. On 23 January 2022, Nurse D recorded that the COVID-19 virus was not detected in the swab taken from Mr. E.

10.6 Mr. E was placed on precautionary isolation on 3 February 2022 recording "*a sore throat, headaches, an upset stomach cannot rule out COVID"* and had to remain in his cell. As mentioned previously in paragraph 8.4, Prisoner 1, Mr. E's cell-mate was not presenting with any illness, but due to being in close proximity to Mr. E, he too was placed in precautionary isolation and remained in the cell with Mr. E.

10.7 On the morning of 4 February 2022, Nurse C recorded a negative COVID-19 test result in respect of Mr. E. It was also recorded that he was to remain in isolation until he was symptom free for 48 hours. This was in line with the algorithm, which was operating at the time, entitled "*IPS Risk Assessment for People Presenting to and in Prisons - Clinical Criteria for Prisoner(s) to be Tested*" which outlined the criteria to be followed in certain circumstances during COVID-19[9].

10.8 At 12:22 on 4 February 2022, Nurse G recorded that Mr. E was "*complaining of a sore throat and feeling tired*" but did not have a fever. She recalled that he was *"in quiet form*". At 14:45, on the same day, Nurse F recorded that she liaised with the IPS Infection Control Team. The advice received was that Mr. E should be tested again for COVID-19 the following morning (5 February 2022) and if the result was negative, then Mr. E's cell-mate could return to the general prison population. Nurse G reported that while administering Mr. E's medication on the 4 February 2022, he did *"not indicate any suicidal thoughts or display any concerns"*.

10.9 On 5 February 2022, Mr. E continued to report feeling unwell to Nurse A, presenting with possible COVID-19 symptoms, and was again tested. On 6 February 2022 a negative COVID-

[8] Close Supervision Cells (CSCs) accommodate prisoners considered to be a danger to others in the prison or who are disruptive and, in the opinion of prison management, need to be separated from the general prisoner population in order to maintain a safe and secure environment.

[9] Where a prisoner identified with Covid symptoms they were immediately placed in isolation and testing was arranged by the healthcare team. If a prisoner received a negative result from the swab test, isolation was stopped once a prisoner had been asymptomatic for 48 hours.

19 result was recorded on Mr. E's PHMS record, however, he remained in isolation in accordance with the IPS Algorithm.

10.10 On 6 February 2022, day four of Mr. E being in isolation, Nurse G stated that she screened Mr. E for COVID-19 and administered his medication. Nurse G recalled that Mr. E reported that his throat was improving but he still felt weak. Nurse G stated that there was no sign that Mr. E was in distress. Later that day, at 19:50, Nurse D, in the presence of Officer H, provided Mr. E with two paracetamol for a headache. Nurse D reported that there was nothing unusual about Mr E's presentation and Officer H supported this assessment, noting that Mr. E was "*his usual courteous self*".

10.11 Information relating to the remaining healthcare records is contained in Section 9 of this report as they form part of the timeline of events leading up to when Mr. E passed away.

11. Critical Incident Review Meeting

11.1 A critical incident review meeting[10] (CIRM) was chaired by Assistant Governor A on 8 February 2022. In attendance were Chief Officer A, Chaplain A, Chief Nurse Officer (CNO) A, Officer G, and a minute taker, Prison Clerical Officer (PCO) A.

11.2 Assistant Governor A went through a timeline of the events which occurred before, during and after Mr. E was found unresponsive. He informed those present that Mr. E appeared to be sleeping when he was observed by the Night Guard at approximately 23:00 on 7 February 2024. Assistant Governor A thanked the medical and operational staff for, "*their duty and care surrounding the very sad loss of [Mr. E]".*

11.3 Chaplain A informed those in attendance that Mr. E was very content when she last spoke with him.

11.4 PO G, OSG, reported that the cell had been searched and there was nothing found.

11.5 No recommendations were recorded at the conclusion of the critical incident review meeting.

12. Recommendations

12.1 Mr. E passed away during a period of time which was heavily influenced by public health measures due to the presence of COVID-19. The OIP conducted a COVID-19 thematic inspection of Limerick Prison in April 2021. The Inspectorate made a number of recommendations regarding the welfare of prisoners in isolation, including the following:

Measures must be taken to mitigate the detrimental effects of isolation or quarantine, including psychological support during and after quarantine/isolation in order to assist prisoners in coping with the impact of COVID-19 and subsequently imposed restrictive measures.

This recommendation was accepted by the IPS. The OIP was informed by the IPS that a COVID-19 outbreak-specific mental health protocol had been developed by the IPS Psychology Service.

[10] Staff meeting held following a serious incident such as a death. 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.

12.2 The IPS Psychology Service confirmed to the investigation team that a protocol was introduced in March 2021 in relation to the management of mental health in prisons for people in isolation. Information on the protocol and the avenues of referral was relayed to prisoners through the prison TV channel. Referral could be made by operational and/or healthcare staff and/or chaplains.

12.3 Local management confirmed that the information regarding mental health wellbeing, while in isolation, was conveyed through the prison TV channel. As outlined in this report neither the operational or healthcare staff had any concern for the wellbeing of Mr. E, consequently no referral was made to the psychology service.

12.4 The Inspectorate has made no recommendations in this report.

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.