Oifig An Chigire Príosún
Office of the Inspector of Prisons

Death in Custody Investigation Report

Mr. L
Midlands Prison
17 July 2023
Aged 26

Submitted to Minister: 8 July 2025

CONTENTS

GLOSSARY

ACO	Assistant Chief Officer
CCTV	Closed Circuit Television
CIRM	Critical Incident Review Meeting
CNO	Chief Nurse Officer
CO	Chief Officer
CPR	Cardiopulmonary Resuscitation
DiC	Death in Custody
IAN	Immediate Action Notification
IPS	Irish Prison Service
LED	Light Emitting Diode
LUCAS Machine	Lund University Cardiopulmonary Assist System
NO	Nurse Officer
NoK	Next of Kin
OIP	Office of the Inspector of Prisons
SADA	Self-Harm Assessment and Data Analysis
SOP	Standard Operating Procedure
WTO	Work and Training Officer

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. L's death in the Midlands Regional Hospital, Portlaoise on 17 July 2023 and the management of the events associated with his death.

4. Administration of Investigation

4.1 On 17 July 2023, the OIP was notified that Mr. L had passed away in the Midlands Regional Hospital, Portlaoise. Mr. L had been found unresponsive in his cell in the Midlands Prison on 17 July 2023 and transferred to hospital. The investigation team attended the prison on 18 July 2023.

4.2 Senior prison management provided the OIP with all relevant information in accordance with the standardised checklist of information required.

4.3 The cause of death is a matter for the Coroner.

5. Family Liaison

5.1 Liaison with the deceased's family is a very important aspect of the Inspectorate of Prisons' role when investigating a death in custody.

5.2 The investigation team communicated with Mr. L's mother (NoK), by letter, on 16 August 2023 and with his sister, via telephone call, on 25 August 2023 and 29 August 2023.

5.3 The NoK did not take up the opportunity to meet the investigation team and did not provide consent to access Mr. L's medical records. IPS policy, in accordance with current legal advice, precludes the release of medical information without the consent of the NoK. The Inspectorate anticipates that this shortcoming will be addressed in the forthcoming Inspection of Places of Detention Bill. The absence of Mr. L's medical records limits the scope of the OIP investigation into the level of care he received during his time in custody.

5.4 Although this report is for the Minister for Justice, Home Affairs and Migration it may also inform several interested parties.

5.5 The OIP offers our sincere condolences to Mr. L's NoK for their loss.

6. Midlands Prison

6.1 Midlands Prison is a closed, medium security prison for adult males. It is the committal prison for Counties Carlow, Kildare, Kilkenny, Laois, Meath, Monaghan, Offaly, Westmeath, Wexford and Wicklow. It has an operational capacity of 875. IPS statistics for 17 July 2023 show that it was over capacity, with 939 prisoners accommodated on that date. This represents 107% of the bed capacity.

6.2 Mr. L was the fifth death of a prisoner from the Midlands Prison in 2023 and the twelfth death in IPS custody that year.

7. Family Concerns

7.1 Although Mr. L's NoK did not take up the opportunity to meet with the OIP, during a telephone conversation with the investigation team, his sister stated that it was her belief Mr. L would not have intentionally self-harmed.

7.2 Mr. L's sister recalled speaking with her late brother, via a telephone call, on the day of his passing and did not have any cause for concern regarding his well-being, expressing her disbelief at what was to follow after their conversation.

7.3 Mr. L's mother conveyed, through her solicitor, that she was anxious to establish the full circumstances surrounding her son's death. As the requisite consent was not received from the NoK, the investigation team could not review the healthcare offered or provided to Mr. L during his time in prison custody.

8. Background

8.1 Mr. L was 26 years of age when he was found unresponsive in the Midlands Prison and subsequently passed away at the Midlands Regional Hospital, Portlaoise.

8.2 Mr. L was already serving a prison sentence when his most recent conviction on 16 May 2023 imposed a further period of detention. Cumulatively, Mr. L's sentences totaled four years, nine months, four weeks and one day with a remission date of 2 August 2025. He was on the standard level of privileges[1].

8.3 Mr. L was accommodated in cell 14 on the A2 landing. He was transferred to this cell on 15 July 2023 and shared it with Prisoner 1, having been moved from cell 18 on the A2 landing where he had been accommodated since 25 April 2023 and which he had shared with Prisoner 2, Prisoner 3 and Prisoner 4.

[1]The Irish Prison Service has an incentivised regimes policy that outlines three levels of privilege – basic, standard and enhanced, the level assigned to each prisoner is dependent on level of engagement with services and quality of behaviour.

9. Events of 17 July 2023

9.1 At approximately 12:00 (midday), Mr. L collected his lunch from the servery located on the prison landing before he returned to his cell at 12:02. His cellmate, Prisoner 1, reported to the investigation team that, following dinner, they remained in their cell playing Xbox. He described Mr. L as being in "*great form*". Officer A completed cell checks at 12:25 and 12:54. He reported that all was well with both prisoners at the time of these checks.

9.2 Officer B reported that he had a brief conversation with Mr. L at approximately 14.10, when the cells were unlocked to facilitate recreation time. Officer B said that Mr. L chose to stay in his cell in order to make a telephone call and there was nothing during their interaction that gave him cause for concern. Prisoner 1 confirmed that Mr. L did not wish to accompany him to the gym as he wanted to make a telephone call to his brother. Prisoner 1 did not consider this to be unusual.

9.3 At approximately 15:30, Officer B reported that he began unlocking cell doors to allow prisoners, returning from the gym, to access their cells. When he arrived near cell 14, at approximately 15:36, he noticed the cell call light flashing. He stated that he lifted the hatch over the viewing panel on the door of cell 14 but his view was obstructed. Officer B immediately unlocked the cell door, noting some resistance, which transpired to be a mattress propped against it. Upon entering the cell, Officer B discovered Mr. L suspended by a ligature formed from a flag and items of clothing tied to the bunkbed.

9.4 Officer B stated that he ran towards the Class Office and used his Tetra radio[2] to call a 'Code Red'[3] and also shouted for a Hoffman knife[4] to be brought to cell 14. Officer C and Work and Training Officer (WTO) A both responded and immediately ran to Mr. L's cell. WTO A stated that he headed back to the Class Office to locate the Hoffman knife where Officer D was in the process of retrieving it, but he was delayed as he struggled to unlock the safety box where it was secured.

9.5 By the time WTO A and Officer D returned to cell 14 with the Hoffman knife, they noted that Officer B and Officer C had Mr. L in their arms and were placing him on the cell floor. Officer C stated that when he entered Mr. L's cell he *"ripped"* the ligature from where it was tied to the bed as he was unsuccessful in his attempt to remove it from Mr. L's neck. Officer B recalled that he subsequently used the Hoffman knife to remove the ligature from around Mr. L's neck.

9.6 Assistant Chief Officer (ACO) A reported that when he arrived at cell 14, he found Mr. L on the floor and with the assistance of Chief Officer (CO) A they placed Mr. L in the recovery position, removed material from his neck, and checked for a pulse and did not find one. This was corroborated by CO A and Officer E's statements.

9.7 Prison nursing staff and two doctors (who were already on site) responded immediately to the 'Code Red'. This is confirmed by the CCTV footage, which evidences that they arrived at cell 14 at 15:38. One of those doctors, Doctor A, observed that when she arrived they found Mr. L lying on his side and facing the wall. Doctor A's assessment, once Mr. L was turned over onto his back, was that Mr. L was "*gone*" noting that his face was "*swollen and blue*". Despite this

[2] A Tetra Radio is carried by prison officers and is used to securely broadcast messages to other members of staff within the prison estate.
[3] 'Code Red' is an emergency that requires a rapid response/assistance
[4] A Hoffman Knife is a safety knife used to free someone from a ligature.

assessment, the prison medical staff continued to attempt to resuscitate Mr. L until ambulance personnel took over Mr. L's care. CCTV confirms that the ambulance paramedics arrived at cell 14 at 15:54.

9.8 At approximately 15:55, Mr. L was moved from his cell and placed on the A2 landing and a Lund University Cardiopulmonary Assist System (LUCAS[5] machine) was applied to provide chest compressions. The OIP was informed that Mr. L was moved to the landing because the cell was too restrictive to apply the LUCAS machine. At 15:59, Fire Brigade staff attended along with an Advanced Paramedic. Chaplain A administered last rites to Mr. L.

9.9 Mr. L was in the process of being moved from the prison landing to an ambulance, by a stretcher, when there was an electrical fault with the landing elevator. A national incident report form documented that at 16:24 an electrical switch tripped causing the elevator, which was carrying Mr. L and the paramedics, to stall, trapping the occupants inside. The delay is reported as lasting for approximately five minutes. Officer F escorted Mr. L to hospital and she stated that they left the Midlands Prison at 16.35. Officer F's account confirms that Mr. L received treatment upon his arrival at the Midlands Regional Hospital, Portlaoise, however he was pronounced dead a short time later at 16.48.

10. CCTV Footage of 17 July 2023

10.1 The investigation team reviewed CCTV footage of Mr. L and the response to his medical emergency on 17 July 2023. The footage reviewed supported the timeline of events provided by both staff and prisoners.

10.2 Officer B reported that, when he attended Mr. L's cell on 17 July 2023, he noticed the cell light flashing. CCTV footage confirmed that the cell call light, located at Mr. L's cell door, became illuminated at approximately 14.58 on 17 July 2023. Initially the light flashed but 10 seconds later it changed to a solid red colour. At 15:03, the light began flashing again and remained that way until 15.36 when Officer B attended the cell, some 38 minutes after it was first activated.

11. Cell Call Activation

11.1 A cell call point is located in every cell in the Midlands Prison. When the cell call button is pressed, it connects to the landing reset unit and illuminates the landing cell indicator light, both located outside the cell. Pressing the cell call button also sends an activation notification to the Class Office, via an alarm and a LED[6] display. To cancel the activation, the corridor reset unit needs to be pressed at the cell. When a cell call notification is accepted by the Class Office but not attended to (the reset unit has not been pressed) within a pre-set time period, the notification should return as a priority call and registered within the prison Control Room.

11.2 As previously detailed in section 10.2, Officer B attended cell 14, some 38 minutes after the cell call button was first activated. Due to the time that elapsed between the cell call button's activation to when it was answered, OIP inspectors reviewed the Cell Call System on 18 July

[5] A Lund University Cardiopulmonary Assist System (LUCAS) provides mechanical chest compressions to patients.
[6] Light Emitting Diode

2023. This included testing the cell call function on three different cells as well as accessing the relevant manuals and communicating with the Governor of Works regarding the system.

11.3 During testing of the Cell Call System, the investigation team noted that the volume of the notification in the Class Office was low. Any additional sound in or around the Class Office, at the time of a cell call notification, had the potential to distract from an incoming notification. The investigation team determined that the volume of the notification in the Class Office had been preset and could not be adjusted either within the Class Office or by an Officer on duty.

11.4 The test indicated that once a cell call notification was accepted within the Class Office, the light changed from a flashing light to a solid red, despite the cell not being attended. When the light began flashing again (approximately five minutes later), due to the cell reset button located at the cell door not being pressed, there was no audio sound notification in the Class Office to notify that the call was now a priority as it had yet to be answered. Based on the test, it would appear that Mr. L's cell call button had been activated, then accepted in the Class Office but not attended to for more than half an hour until Officer B began unlocking cells.

11.5 Officer B was asked about the cell call activation relating to cell 14 on 17 July 2023. He stated that he was not aware that the cell call button had been activated as he was performing his other duties, which included involvement with the movement of prisoners. Officer B stated that the Control Room did not notify him that the cell call button had been activated and that he would never intentionally ignore an alarm.

11.6 The investigation team conducted a further visit to the Midlands Prison on 17 August 2023 and found that the Cell Call System had been changed. The initial audio notification in the Class Office was louder and when a cell call was accepted but not attended to, a further audio notification was heard in the Class Office and the only way this was silenced was by using the cell reset button located at the cell door.

11.7 The investigation team also attended the Control Room in the Midlands' Prison on 17 August 2023 to examine the registration of priority calls. A test, conducted on a cell on Mr. L's landing, recorded that the cell call notification was registered and then accepted by the Class Office. As part of the test, the call was ignored. Five minutes later, an Alarm Priority Call notification appeared on a screen in the Control Room but then disappeared approximately ten seconds later without triggering any further activation or notification.

11.8 Two members of IPS staff were located within the Control Room on the day of the test. They confirmed that they had not received any instruction to respond to the Cell Call system notifications, priority or otherwise. They confirmed there was no Standard Operating Procedure (SOP) for the Cell Call System at that time.

11.9 A SOP from the Midlands Prison entitled 'Cell Call System' became effective on 11 September 2023. The same SOP has since been revised and the latest version became effective on 22 January 2024. Within the latest SOP, it clearly states, *"The Officer in the Control Room must radio call the Officer of the relevant landing to inform them that there is an outstanding priority call"*. In addition, the investigation team has also had sight of a Chief's Order[7], issued by the Midlands Prison, dated 24 July 2024, which provides a list of compliance checks to be undertaken by the Assistant Chief Officers and submitted to the Chief Officers on a weekly basis,

[7] A written Order (instruction) put in place by a Chief Officer working in the Midlands Prison

in relation to the cell call system. The Order clearly states that Chief Officers must submit a weekly report on the compliance checks at the management meetings every week.

12. Critical Incident Review Meeting

12.1 On 18 July 2023, a Critical Incident Review Meeting[8] was chaired by Prison Governor A. In attendance were Assistant Governor A, Chief Officer A, Chaplain B, Doctor A, Chief Nursing Officer (CNO) A, Nurse A, Nurse B, Doctor B, Staff Support Officer A, WTO A and Prison Clerical Officer A.

12.2 Doctor B reported that Mr. L was referred to a Psychology Service "18-24 year old Building Identity Initiative" on committal. During his first session, on 14 April 2022, he disclosed he had experienced suicidal thoughts when committed but said that he did not have any thoughts of suicide or self-harm at the time of the appointment. He attended two appointments and was offered a further three appointments but declined to attend. It was relayed to the meeting that Mr. L had reportedly informed the Class Officer, when he declined the final psychology appointment, that he did not want to engage with the Psychology Service in the prison. Mr. L was discharged by the Psychology Service on 9 June 2022.

12.3 The meeting heard from CNO A that, when Mr. L was previously in Mountjoy Prison (when this occurred was not specified) he presented with two lacerations to his neck which he claimed were associated with substance use and not an attempt at self-harm.

12.4 CNO A reported that prior to his death, Mr. L was considered generally well and that the prison healthcare team was not aware that he had recent intentions to self-harm. Staff were unaware of any changes in Mr. L's behaviour and mood. However, during resuscitation attempts on 17 July 2023, healthcare staff noted that Mr. L had an injury to his arm but it had not been reported to them as a self-harm incident.

12.5 The meeting made three recommendations:

1. Create a prisoner information campaign to provide prisoners with advice on what to do if they have concerns relating to another prisoner's well-being.

2. Develop a SOP on safely removing a person from a cell with limited space when other prisoners may be unlocked in the area. The issue was to be raised with the National Suicide and Self Harm Prevention Steering Group.

3. Determine clear communication guidelines between Operational and Healthcare staff during emergency situations and to discuss this with the National Suicide and Self Harm Prevention Steering Group.

12.6 The investigation team has since followed up with senior management Governor A at the Midlands Prison regarding the recommendations made at the CIRM.

12.7 In respect of the first recommendation, it was confirmed that a leaflet regarding suicide and self-harm, developed between the Midlands Psychology and Healthcare teams and IPS Operations, based on information provided by the Health Service Executive, was distributed to all cells in the prison. In addition, it was confirmed that a document entitled, *'Emotional regulation and Self-*

[8] Staff meeting held following the death of a prisoner.

Harm', produced by the Red Cross, was also disseminated to prisoners. A copy of the information, shared with prisoners, was provided to the investigation team.

12.8 In response to the second recommendation, Governor A advised that the IPS has procured a number of LUCAS chest compression devices. In respect of creating the space required to operate the LUCAS devices, the investigation team was informed that this will be included in the training delivered to staff by the Healthcare team. It would appear that an SOP, as recommended at the CIRM meeting, has yet to be developed.

12.9 The third recommendation has yet to be actioned as, according to senior management at the Midlands Prison the National Suicide and Self Harm Prevention Steering Group is currently suspended whilst under review by the Director of Care and Rehabilitation of the IPS. Governor A shared that the plan, in the Midlands Prison, is to run tactical decision exercises around the dynamic management of emergency situations for both operational and healthcare staff.

13. Accounts of Prisoners on A2 Landing

13.1 Mr. L's cellmate, Prisoner 1, described his relationship with Mr. L as "*very close*", noting that Mr. L was "*always in good spirits*". However, he had noticed a change in Mr. L's mood following an alleged incident of self-harm, where he cut his arm, which occurred two weeks prior to his death. Prisoner 1 said that he believed that Mr. L was struggling with the upcoming anniversary of the death of his father coupled with the news that his mother had recently taken ill.

13.2 Prisoner 1 stated that Mr. L had asked Officer B if he could see a psychiatrist/psychologist but that this support never transpired. Officer B denied this request had ever been made to him, but did report that Mr. L had disclosed scratching his arm off a metal screw, approximately ten days prior to his death. Officer B stated that he had brought Mr. L to see Nurse C who wiped the graze with an antiseptic wipe and Mr. L did not share anything of concern nor did he ask for assistance.

13.3 Mr. L's cell mate, Prisoner 1 alleged that Mr. L had recently informed Officer G that he was suicidal and did not feel himself. He also later detailed another interaction, which he said had taken place on 14 July 2023, when Mr. L had asked Officer H if he could go to the "*pad"*[9] as he was feeling suicidal but that this request had apparently been denied. Prisoner 1 alleged witnessing this conversation as it occurred in his cell with Officer H. He reported that Mr. L had secured a flag around his neck during this interaction. Officer H provided a statement in which he denied that he had any such interaction with Mr. L and said that he was not aware of any incident where Mr. L had threatened or attempted to self-harm.

13.4 Prisoner 5 stated he had heard Mr. L telling Officer G just over a week prior to his death, that he needed "*the pad*" as his head was "*not too good*" and that he was going to "*kill himself*". Prisoner 5 alleged that Mr. L was told by Officer G to go back to his cell, in a dismissive, uncaring manner. Officer G denied ever speaking with Mr. L in an aggressive or uncaring manner and stated that he did not have any immediate concerns about Mr. L based on their interactions.

[9] The 'Pad' is a slang word which refers to a safety observation cell which is where prisoners who need frequent observation for medical reasons or due to self-harm concerns.

13.5 The investigation team heard accounts from Prisoner 6 and Prisoner 7 which also alleged that Mr. L had shared with prison staff that he was going to harm himself. Prisoner 7 stated that he and a few other prisoners had informed an unnamed officer that Mr. L was *"looking for the pad"* but said that they too had been dismissed.

13.6 Following the death of Mr. L, a letter was received by the OIP in July 2023 from a group of prisoners who claimed to know Mr. L, expressing their concern at the way he had been treated prior to his death. The letter included 50 signatures. The letter described the sadness felt about the loss of Mr. L and the authors' belief that there had been signs that Mr. L required additional support, which had been missed or ignored by prison staff. Another letter received by the OIP in January 2024, signed by over 50 prisoners, attempted to place blame for failing to prevent Mr. L's death on a named Prison Officer, Officer G.

13.7 The investigation team spoke with and obtained statements from prison staff that were in direct contradiction to the accounts of prisoners. All staff who provided statements reported that, from their point of view, there had been no indication that Mr. L's well-being was of concern. Officers claimed that if they had concerns they would have taken appropriate action to provide Mr. L with the correct support.

14. IPS Policy on Suicide Prevention

14.1 The investigation team reviewed the IPS Suicide and Self-harm Protocol (Version 4), dated 30 December 2022. The protocol specifically states that it applies to all staff working clinically within the IPS Psychology Service. In addition, the 2020 – 2021 Report, Self-harm in Irish Prisons, fourth report from the Self-Harm Assessment and Data Analysis (SADA) project, report was consulted. The investigation team is also aware of the SOPs in existence, regarding the use of Safety Observation Cells and medical special observation, which also address self-harm and suicide prevention. The IPS has confirmed that it does not have a specific service-wide Suicide Prevention Policy.

14.2 The IPS does have a National Suicide and Harm Prevention Steering Group. The IPS Acting Clinical Lead confirmed that the steering group is a central forum for stakeholders across the prison estate to consider the current risk concerns regarding prisoners, including the effectiveness of preventative supports. As already mentioned, this group is suspended at present but the investigation team has been informed by the IPS Acting Clinical Lead that it is intended that it will be reinstated. He also advised that other groups, aimed at preventing suicide among prisoners, are also operating within the prison estate, and include the IPS Healthcare and Psychology teams, In-reach Psychiatry via the National Forensic Mental Health Service Hospital, the Red Cross and the Samaritans.

15. Recommendations

15.1 The Office of the Inspector of Prisons makes the following five recommendations:

1. The Chief Inspector of Prisons has previously raised an Immediate Action Notification (IAN) regarding the cell call system in Cork Prison and identified the significant risks associated when a cell call notification is not responded to in a timely manner. This has also been specifically highlighted in the report on the death in custody of Mr. G 2021. The OIP reiterates that it is a core duty of Prison Officers to respond swiftly to cell call notifications. It recommends that the IPS draw up a national Standard Operating Procedure regarding cell call notifications, including a national standard in relation to cell call response times. The IPS should also devise a system for monitoring compliance and regular testing of all associated equipment across the entire prison estate.

2. It is recommended that the IPS develop and implement a national service-wide Suicide Prevention Policy and Strategy.

3. As recommended at the CIRM, a SOP on safely removing incapacitated persons from cells with limited space should be developed.

4. It is recommended that Prison Officers be reminded of their obligation under Prison Rule 87(1)(b) which requires them to examine equipment in their area of responsibility and report any defects which could compromise good order, safe or secure custody or health and safety. This regular check should include verifying that the Hoffman knife safety box is accessible. A similar recommendation was made by the Inspectorate and accepted by the IPS in the death in custody report in relation to the death of Mr. G 2021.

5. It is recommended that an inventory should be compiled by prison staff of any item(s) taken into the possession of An Garda Síochána. This formed part of a recommendation in the report on the death in custody of Mr. C 2022, which has been accepted by the IPS.

16. Support Organisations

16.1 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.